Presentation for FI Women's Seminar

July 2015

I want to begin by raising some of the facts in relation to women's employment in the ILO report and then I will address the situation in Britain with respect to austerity and its impact on women and then I will talk for a bit about the situation in the US on healthcare and reproductive rights and relate that back to women's economic situation in the US as they are linked and we can never separate reproductive rights from the impact of race and class (this is the case in the US, but it holds elsewhere).

I. ILO Report on Trends in women's work

What can we learn about women's participation in the workplace? According to the ILO, women face serious obstacles getting access to decent well-paying work. Looking at the gender gap in work participation, defined as the difference between women's and men's labour force participation rates. Between 1995 and 2015, the global female labour force participation rate decreased from 52.4 to 49.6 per cent. The corresponding figures for men are 79.9 and 76.1 per cent, respectively. Worldwide, the chances for women to participate in the labour market remain almost 27 percentage points lower than those for men. Even when women are able to enter the labour market, they face low skilled, low quality and low paying jobs; in Europe and North America, women's labour force participation rates have increased but this arisen as men's jobs were initially hard hit by the economic crisis especially in Finance and construction.

Women are more likely to be unemployed than men, with global unemployment rates of 5.5 per cent for men and 6.2 per cent for women. The gap in unemployment has fallen in advanced capitalist countries where women entered the workforce to help with family incomes following not only the crisis (which the ILO points out) but also because of long-term stagnation in wages since the introduction of neoliberalism in the advanced capitalist world.

Globally, youth unemployment remains an issue of concern. Unemployment is affecting young women more than young men in almost all regions of the world. In Northern Africa and the Arab States, the female youth unemployment rate is almost double that of young men, reaching as high as 44.3 and 44.1 per cent, respectively. In contrast, youth unemployment is higher for young men than for young women in Northern America, Eastern Asia and Northern, Southern and Western Europe.

In 2015, a total of 586 million women were own-account or contributing family workers. Women remain overrepresented as contributing family workers. Some progress has been made, however, in closing the gender gap in this regard. Globally, the share of contributing family workers has decreased significantly among women (by 17.0 percentage points over the last 20 years) and to a lesser extent among men (by 8.1 percentage points over the same period), resulting in a decrease in the gender gap from 19.5 percentage points in 1995 to 10.6 percentage points in 2015. This trend is part of an economic restructuring shift away from agricultural work in developing capitalist economies, which largely consisted of subsistence and small-scale activities and where agribusiness has shifted agricultural production away from subsistence farming leading agricultural peasants becoming agricultural workers. That said, however, many working women remain in employment

statuses and in occupations that are more likely to consist of informal work arrangements. In sub-Saharan Africa and in Southern Asia, a high proportion of women work as contributing family workers (34.9 per cent and 31.8 per cent, respectively) or as own-account workers (42.5 per cent and 47.7 per cent, respectively (p. xii-xiii).

Moreover, 52.1 per cent of women and 51.2 per cent of men in the labour market are wage and salaried workers. This in itself constitutes no guarantee of higher job quality. In fact, globally, nearly 40 per cent of women in wage employment do not contribute to social protection. Those proportions reach 63.2 per cent in sub-Saharan Africa and 74.2 per cent in Southern Asia, where informal employment is the dominant form of employment. In Southern Asia, for instance, informal employment represents over 80 per cent of non-agricultural employment. In three out of six regions, informal employment is a greater source of nonagricultural employment for women than for men (sub-Saharan Africa, Latin America and the Caribbean and Southern Asia).

Globally, the services sector has overtaken agriculture as the sector that employs the highest number of women and men. By 2015, slightly more than half of the global working population was working in services (50.1 per cent). While 42.6 per cent of all men work in services, substantially more than half of the world's women are employed in that sector: since 1995, women's employment in services has increased from 41.1 per cent to 61.5 per cent.

Sectoral and occupational segregation contributes significantly to gender gaps both in terms of the number and the quality of jobs. Women in employment are overrepresented in a narrow range of sectors and occupations. In upper-middle-income countries, more than one third of women are employed in wholesale and retail trade services (33.9 per cent) and in the manufacturing sector (12.4 per cent). In high-income countries, the major source of employment for women is the health and education sector, which employs almost one third of all women in the labour market (30.6 per cent). Agriculture remains the most important source of employment for women in low-income and lower-middle-income countries. In Southern Asia and sub-Saharan Africa, over 60 per cent of all working women remain in agriculture, often concentrated in time and labour-intensive activities, which are unpaid or poorly remunerated.

Occupational segregation has increased further over the last two decades with skill-biased technological change, notably in developed and emerging countries. Between 1995 and 2015, employment increased fastest in emerging economies. The absolute change in employment levels was twice as high for men as for women (382 million for men and 191 million for women), regardless of the level of skills required.

Unpaid household and care work in both high and lower income countries, women continue to work fewer hours in paid employment, while performing the vast majority of unpaid household and care work. On average, women carry out at least two and a half times more unpaid household and care work than men in countries where the relevant data are available. Although this gender gap remains substantive, it has decreased over time, mostly because of some reduction in the time spent by women on housework, while there have been no significant reductions in the time that they spend on childcare. **Women, however, continue to work longer hours per day than men when both paid work and unpaid work are taken into consideration. In particular, employed women (either in self-employment or wage and salaried employment), have longer working days on average than employed men, with a gender gap of 73 and 33 minutes per day in developing and**

developed countries, respectively. Even when women are employed, they still carry out the larger share of unpaid household and care work, which limits their capacity to increase their hours in paid, formal and wage and salaried work. (p. xv)

As a consequence, women are more likely than men to work short hours, whether voluntarily or against their choice (thus finding themselves in "time-related underemployment"). Across the world, women represent less than 40 per cent of total employment, but make up 57 per cent of those working on a part-time basis. Estimates based on 100 countries show that more than one third of employed women (34.2 per cent) work less than 35 hours per week, compared with 23.4 per cent of employed men.

The gender gap in employment and job quality means that women have limited access to employment-related social protection, where such schemes even exist.

a) Lower rates of formal wage and salaried employment, together with fewer hours and fewer years in insured employment for women, have adverse consequences for seniority premiums in pay and for coverage by employment-related contributory schemes. In particular, maternity cash benefits and health care are essential if women's specific needs during their active years are to be met, as are adequate pension levels for women in old age.
b) As a consequence of gender gaps at work, coverage (both legal and effective) by contributory compulsory social protection schemes is lower for women than for men, leaving an overall gender social protection coverage gap. Globally, the proportion of women above retirement age receiving a pension is on average 10.6 percentage points lower than that of men. Nearly 65 per cent of people above retirement age without any regular pension are women. This means that 200 million women in old age live without any regular income from social protection (old age or survivors pension), compared to 115 million men. Low female labour participation rates, together with the limited development of non-contributory pensions, weigh significantly on women's effective pension coverage in Northern Africa, the Arab States and Southern Asia, where the proportions of older women in receipt of a pension are inferior to 10 per cent.
c) Globally, the gender wage gap is estimated to be 23 per cent; in other words, women earn 77 per cent of what men earn. Even when considering hourly wage rates (given the fact that women are working shorter hours than men), women continue to face a persistent gender wage gap, amounting to 10 per cent or more in countries for which data are available. These gaps cannot be explained solely by differences in education or age, but are also linked to the undervaluation of the work that women undertake and of the skills required in female-dominated sectors or occupations, the practice of discrimination, and the need for women to take career breaks to attend to additional care responsibilities, for instance after the birth of a child.
d) While virtually all countries provide some forms of maternity protection for employed women, close to 60 per cent of women workers worldwide (nearly 750 million women) do not benefit from a statutory right to maternity leave.
e) Problems with implementation, awareness of rights, insufficient contributory capacity, discriminatory practices, informality and social exclusion mean that, across the world – only an estimated 330 million women workers (28.2 per cent) would receive either contributory or non-contributory cash benefits in the event of childbirth.

II. **In Britain**

The last time I spoke about women and austerity at an FI women's seminar, the statistics were that women were bearing the 73% of the brunt of austerity. A report recently commissioned by the House of Commons library determined that the latest figure is that 86% of austerity since 2010 is being borne by women (https://www.theguardian.com/world/2017/mar/09/women-bearing-86-of-austerity-burden-labour-research-reveals).

"In total, the analysis estimates that the cuts will have cost women a total of £79bn since 2010, against £13bn for men.

It shows that, by 2020, men will have borne just 14% of the total burden of welfare cuts, compared with 86% for women (https://www.theguardian.com/world/2017/mar/09/women-bearing-86-of-austerity-burden-labour-research-reveals)."

What is happening is that some of the worse cuts of austerity are now coming into force in 2017. The impact of austerity and why it hits women so hard relates to several things that we addressed generally above, specifically the predominance of women working in the public sector (with a high percentage of women of colour employed in the public sector), the overrepresentation of women in part-time work due to family and caring responsibilities, women working in traditional women's work which is undervalued in terms of both skill used and wages received (this is not just the wage gap, but also relates to a question of comparative worth for traditional women's labour).

In Britain, we have seen not only wages, but also incomes decreasing for women. This is due to the nature of austerity. Austerity in Britain has several components which impact upon women far more strongly:

1) **Wage freezes** (or wage increases being capped) in the public sector: 1% public sector worker pay freezes impact women more than men as 65% of those working in the public sector are women.

- According to the *Report on Wage Growth* undertaken by Alex Bryson (UCL) and John Forth (NIESR) there has been a 3% drop in median hourly earnings between 2005-2015 for workers in 32 public sector occupations whose salaries are set by the government on the advice of independent pay review bodies. It found median hourly pay fell by an even greater amount – 6% – during that period for workers across the board, as the recession of 2008 hit wages hardest in the private sector.

- School teachers saw a drop in median real earnings from £25 an hour in 2005 to £22 an hour in 2015.
- Police officers saw a median real earnings fall from £20 an hour to £18 an hour over the same period.
- Doctors experienced a drop from £38 an hour to £30 in median real earnings.
- Prison officers saw median real earnings fall from £16 an hour to £15 an hour.
- Nurses reported median real earnings of £16 an hour in 2005, rising to £17 an hour in 2010, before dropping back to just over £16 in 2015, showing a slight rise of 1.4% over the decade.
- The hourly median wage figures were adjusted for inflation, based on 2015 prices and rounded to the nearest pound

(https://www.theguardian.com/society/2017/jul/03/damning-government-report-shows-scale-of-public-sector-pay-cuts)."

2) **Cuts to the public sector.** Interestingly, while more men lost their jobs as compared to women following the public sector cuts, men have been able to find full time work while women that lost their jobs have been far less successful in finding full time work. An important point that needs to be mentioned is that women working in the public sector at all levels have higher wages than those working in the private sector. Given occupational segregation, loss of a public sector job and going to work in the private sector will mean a pay cut. This is still the case even with the public sector pay freeze which lowered public sector wages. Lack of unionisation and hence collective bargaining clearly impacts upon wages in the private sector.

3) **Privatisation** of the profitable parts of the public sector and outsourcing of part of the public sector to private market providers where the public sector no longer covers the employment of all workers and workers' contracts are done by private market providers; this has been the case with caring sector and service provision to the NHS which is dominated by women. It has documented that social care for the elderly is not fit for use and former public sector workers are not even covered by the 1% wage cap and have to fight for that money.

4) **Cuts to the welfare state** which women are far more dependent on than men: employment support allowance, sickness benefits, this has impacted on child benefit, housing benefit, widow's benefits, disability benefits, and benefits for carers. There are additional issues relating to the cuts to housing benefit where the amount of benefit overall that can be received has been decreased (and the amount available to cover housing will not cover it in many places within London for example; 5 bedroom homes are no longer available. Added to this is a new rule making 18 year old ineligible to receive housing benefits unless they are in work or studying (others will of course be stuck living at home with parents and siblings where there is far less money to spare as benefits have been reduced).

5) **Changes to child-tax credits** which impact upon working women that pay taxes: "Cuts in Child Tax Credit (CTC) and the equivalent element of Universal Credit, announced in 2015, have started to come into effect. Families where the oldest child was born after April 2017 will no longer get the family element of CTC, worth £545 a year. The child element of CTC, worth £2,780 a year, will not be payable for children born after April 2017 who have at least two siblings. As a result of these changes, a couple with two children can meet only 59% of a minimum budget, down from 61% a year ago. For a lone parent with a newly-born child, the proportion has fallen more dramatically from 56% to 50% of MIS in a single year. […] This means such a family has only half what they need today compared to nearly two thirds in 2010. For a single person out of work, the 'safety net' is now providing barely a third of income needs. On the other hand, for pensioners, benefit levels have kept pace with inflation and remain at a level approximately sufficient to cover minimum income requirements (https://www.jrf.org.uk/report/minimum-income-standard-uk-2017)." There is nothing else to call this than Malthusian and punitive. To add insult to injury, if you want

to know how low the Tories have sunk, we can talk about the "rape clause" which allows a child born of rape (if it is the 3rd child) to get the child tax credits, of course, if the mother reports the rape.

6) Part of the attack on **accessing benefits** relates to conditionality attached to receipt of job seekers allowance which requires proof of job searches and if you are unsuccessful may require mandatory work (often as a requirement to receive benefits, you are forced to work (workfare) at a far lower level of income as you only the amount of benefits as opposed to a full wage rate. In fact, part of the increase in "employment" related to those that were in training or mandatory work assignments where income was paid by the government and not the employers.

7) **For disabled people**, there is the work capability assessment where your accessing the higher level of benefit depends upon the decisions of private companies determining whether you are disabled enough to receive that benefit. This is important, as if you have a family carer, carer's benefit is tied to whether you score high enough on a scale which is linked more to physical impairment, not mental health issues. If you do not fit well enough into the scales established by the state, you can be forced onto the lower job seekers allowance rather than the higher level of employment support allowance; a group called work related activities group which was between these two levels has now been abolished.

8) This is combined with the **destruction of work conditions** in the private sector, leading to increasing precarious employment characterised by zero hours contracts (where the worker does not have continual work and is brought into work when there is need for workers) and the fact that part-time work is predominately done by women. In fact, the greatest increase in employment during the period of the Con-Dems and Tories has been in self-employment; even here, women are doing it part-time compared to men doing it full-time. This is due in most part to their responsibility for caring (children, sick, disabled and elderly members of the family). Women work predominately in part-time work due to family and caring responsibilities, they are also concentrated in traditional women's employment which is often rated as unskilled work.

9) In Britain (and this holds for the US as well), women work predominately in **part-time work** due to family and caring responsibilities, they are also concentrated in traditional women's employment which is often rated as unskilled work and with lower pay and skill ratings.

As I said earlier, women's employment in the public sector is at 65% of public sector workers; women of colour are also highly represented in the public sector. The 1% public sector wage free has not only impacted upon potential earnings, but also on the value of wages in terms of goods that be purchased (that is the real wage is falling). With rising inflation going well above the 1% public sector pay, it means that what tiny nominal wage increase falls below rising prices of an inadequate Consumer Price Index (rather than the Retail Price Index which included housing) means that real wages are falling. Moreover, as part of austerity, increases in benefits were also tied to the consumer price index which does not include housing costs (which are very high in London for example). So with inflation increasing to 2.9%

(https://www.theguardian.com/business/2017/jun/13/uk-inflation-rises-faster-than-expected-four-year-high), benefits received are not keeping touch with increasing costs. Moreover, since inflation has only recently begun to rise, the amount of benefits is only ascertained on a yearly basis and, as such, has not kept pace with inflation.

Let's not forget pensions as these are important. Given that women have had lower wages throughout their working lives, the fact that many have worked in part-time work, their pensions if tied to their income will be lower than those received by men. We live longer with lower pension incomes and hence elderly women will stand a higher chance than men of living in poverty in their later lives.

In terms of the impact upon women of colour the situation, of course, is worse. A key finding of a recent report by Runnymede Trust and the Women's Budget Group, has been that BAME women in all income groups are hit the hardest by the Government's austerity programme. As of the last autumn statement, 86% of Treasury net 'savings' through tax and benefit measures since 2010 had come from women, with BAME women losing the greatest proportion of their individual income. When accumulating losses in benefits, tax credits, and the value of cuts to public services, this Government's direction of travel means that BAME women stand to lose a further 11.5 per cent of their earnings by 2020. Though others will lose out, there seems to be a dearth of meaningful responses to the disproportionate losses incurred by women from Black African and South Asian backgrounds (http://www.huffingtonpost.co.uk/sarah-champion/bame-women-austerity_b_15185604.html). Looking at the issues of race, class and disability and how austerity impacts upon women of colour, we have the following information.

> "By 2020 Asian women in some of the poorest families will be £2,247 worse off. That goes up to £3,996 for black single mothers. White men in some of the richest households, by contrast, are set to lose only £410. Disabled and chronically ill women – many of whom are carers themselves – face huge and continuing cuts to disability support, from fit-for-work tests to the latest changes to personal independence payments (https://www.theguardian.com/commentisfree/2017/mar/16/women-austerity-poor-vulnerable-gender-inequality)."

III. In the US: reproductive rights and health care

In order to understand the level of onslaught against women in the US under the Trump administration and in Congress, you need to know that this is not a new development. This war has been going on for decades. However, there have always been some limits to pushing a misogynist agenda due to either lack of control over both houses of Congress, insufficient control over all members of either political party in Congress (not all Republican members of Congress would support these laws) and the possibility of Presidential vetoes for the most odious legislation.

In many senses the current situation is not different, the attacks on women's rights (reproductive, employment, and healthcare) will continue. So, what is different now is not only the election of Trump and the control over both houses of Congress by the Republicans that has upped the ante. At this point, the vast majority of Republicans are Christian fundamentalists and also believe the usual free market nonsense that is so dear to Republican politicians. While attacks on reproductive rights were predominantly waged at a state level using legislation and plebiscites with the possibility of

provoking Supreme Court decisions (SCOTUS) and the use of pieces of failed legislation in the US Congress, we are seeing an acceleration of these attacks.

The elections of 2016 have heightened the situation whereby misogynists in political power have unleashed an attack where not only reproductive rights are being attacked, but also women's access to health care, employment, income, and potentially housing rights are facing attack.[1] Trump's appointments of fundamentalist Christians to positions of power, such as his Vice-President and as cabinet members, means that the voices of these people are no longer confined to the state and federal legislatures and they will use that power.

Among the first attacks against women in Trump's Executive Orders was the reintroduction of the **Global Gag Rule** where countries receiving foreign aid from the US could not discuss the option of abortion, could not refer people to get one. Moreover, not only has Trump reintroduced it (it was eliminated under Obama; just as it has always been under Democratic Presidents), he has expanded it. So, it is not only international family planning institutes that are covered by the Gag Rule, but all international global health providers that are recipients of US foreign aid.[2] Given that the Helms Amendment (1973) had already prohibited the use of foreign funds for abortion as a form of family planning you may be wondering why The Global Gag rule keep on being reintroduced by Republican Presidents?[3] This is yet another example of how misogynist ideology finds its way into not only foreign policy but also impacts healthcare globally as acceptance of US Foreign Aid constrains health care provision not only for American women but that of countries overseas.

Both Trump and the US Congress moved against the ACA (also known as Obamacare). Shortly after being sworn in Trump wrote an Executive Order which allowed the Department of Health and Human Services (controlled by Tim Price) and other executive departments and agencies the discretion to roll back the ACA. Congress also moved to repeal the ACA but rather precipitously, as they did not have a coherent replacement and their constituents protested vigorously. Many Republican members of congress represent low income areas especially in the Southern US and the elimination of the ACA would have significantly impacted their constituents who were furious and this was expressed strongly when congress members came home to speak with their constituents. This frightened enough Members of Congress to draw back until there was a replacement plan.

[1] In Missouri, legislation is going through the State Congress and has the support of the Governor. This legislation will allow landlords and employers to discriminate against women that are using contraceptives or have had an abortion. See: http://www.newsweek.com/womens-rights-birth-control-abortion-missouri-discrimination-628538. If the law passes, it would certainly require physicians to violate the privacy of patients and an injunction would certainly be filed as it is a violation of constitutional rights of privacy for women and would cause medical practitioners to violate confidentiality. What the Missouri state legislators and Governors are probably hoping is that a SCOTUS decision could undermine the right of privacy and that clearly this would have an impact on Roe vs Wade which is based on the right of privacy unfortunately rather than the autonomy of one's own body. If successful, this would open women's private lives for scrutiny and impact upon access to housing and employment.

[2] See Guttmacher Institute on anti-abortion ideology and foreign policy and health care: https://www.guttmacher.org/gpr/2017/06/when-antiabortion-ideology-turns-foreign-policy-how-global-gag-rule-erodes-health-ethics?gclid=CNb87uq63tQCFTEz0wodJrEHPg.

[3] The Helms Amendment (1973) states 'No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions (http://www.genderhealth.org/the_issues/us_foreign_policy/helms/).'

Given the manner of the attack, it became clear that many of the protections for women and those with low incomes that were embodied in the ACA were under serious threat.

Again, the problem is not only Trump, it is the fact that there is a Republican-controlled Congress which is led by those that want to privatise and undermine social security, want to cut funding of Medicare (healthcare for the elderly and disabled) and Medicaid (provides money for healthcare for those on low incomes distributed from the Federal government to the states) and also who want to defund Planned Parenthood (PP), a major provider of women's healthcare as part of Medicaid funding, which will leave large numbers of women without access to routine health care, including contraceptives, routine cancer screening (breast, cervical), STD screening, and prenatal health care), and contraceptive provision.[4]

In the space of a week after the 115th Congress met, the first round of the repeal of the ACA began. While there were attempts by the Democrats to maintain some of the positive provisions (*e.g.* access to affordable contraceptives, pregnancy care, maternity care and neonatal care including breastfeeding coverage, coverage for younger adults under age 26 (6 million people are covered) on their parents' health insurance, coverage for people with pre-existing conditions (pregnancy is considered a pre-existing condition; 52 million people are identified as having pre-existing conditions in the US), coverage for children on Medicaid or Children's Health Insurance Program (CHIP) providing comprehensive healthcare for children (8,397,651 children are covered)[5], maintaining the Medicaid expansion which ensures coverage for the 11 million people with lower incomes, and protecting veterans' health care through the Veterans' Administration. However, they lost the votes on these amendments and as a result, if this access to free contraceptives is not maintained, 55 million women will no longer have access to affordable birth control.[6] Kirsten Gillibrand's amendment attempting to protect the gains for women's healthcare (e.g. access to no-copay contraception on health insurance plans, access to healthcare during and after pregnancy, support for breast feeding) lost on a vote in the Senate of 49:49 with only two Republicans willing to fight for the gains made for women. This first attempt at repeal is instructive as it gave an indication of which portions of the ACA would face elimination. It has recently come to light that Trump is considering allowing all employers to eliminate free access to contraceptives on health insurance packages on the lines of a moral or religious exemption. This use of the conscientious objector clause would not only impact small religious-based organisations, but also universities and large publicly traded companies.[7]

[4] The lie that Planned Parenthood does abortions with federal funding is part of this attack; this is false, money for abortions on Medicaid is done through separate state provision of funds consistent with the requirements of the Hyde Amendment.

[5] The numbers are enrolment numbers as of May 2, 2016, see, http://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] See, http://www.dailydot.com/irl/congress-women-healthcare/?fb=dd

[7] See, https://www.vox.com/policy-and-politics/2017/5/31/15716778/trump-birth-control-regulation.

The defunding of Planned Parenthood is extremely serious and of course will hit women with low income the hardest.[8] Both versions of the ACHA defund Planned Parenthood for one year. The Republican right (and that is most of them these days) has initiated the defunding of PP as part of the repeal of the ACA. In both proposed House and Senate Bills, PP would be defunded for at least one year. Planned Parenthood receives money through Medicaid funding distributed to states. The Planned Parenthood network is one of the primary providers of contraceptive care to women across the country, it provides routine health care such as pregnancy testing, cancer screening (pap smears, breast cancer screening), STD testing and support, for many women who cannot access routine reproductive healthcare.[9]

While the ACA did not meet the requirements for developing a coherent provision of health care (having health insurance does not guarantee access to comprehensive health care unfortunately), there were some provisions that were extremely helpful enabling larger numbers of people to access some form of healthcare in the US.[10]Clearly single payer healthcare in the US would be far preferable, but this was not even on the table when the ACA was developed. Eliminating the ACA without a replacement would prevent access to basic healthcare for large numbers of people.

Round 2 of the repeal of the ACA and the attempt to create a 'Trumpcare' package For an indication of how this bill impacts women, the terms women and mothers only appear in the bill in the context of abortion and in calling for those on Medicaid to start work two months after birth of the child.[11] Since the vast majority of people on Medicaid are in working families (80%) and 59% are actually working in low-paid employment, the proposed demand that you are in work seems simply

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[8] The importance of the role of Planned Parenthood in provision of health care and reproductive care cannot be understated.

> 'Medicaid is the single largest provider of reproductive health services to women of childbearing age. The program accounts for 75 percent of all public funding for family planning services. In 2015, more than 20 percent of all women ages 15 to 44 were enrolled in the Medicaid program.
>
> Many women enrolled in Medicaid rely on specialized family planning clinics like Planned Parenthood for their health care. Six in ten women receiving contraceptive care at a publicly funded family planning clinic consider that provider their usual source of health care, and for four in ten women, the family planning clinic is their only source of care (https://rewire.news/article/2017/01/13/congress-latest-attack-low-income-people/).'

[9]The Planned Parenthood network of clinics has wide reach throughout the country and other smaller clinics cannot replace its services if funding is withdrawn. It is an essential and critical component of family planning on the nationwide level in the US (https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net). Already some states have defunded PP and it is impossible that local centres (https://thinkprogress.org/abortion-providers-trump-presidency-144c37b5094e#.59e8gvdrr) will be able to cover for the loss of funding for PP (http://www.vox.com/identities/2017/1/12/14189500/defund-planned-parenthood-congress-paul-ryan-republicans).

[10] See: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.
[11] See: https://qz.com/1013409/the-senate-health-care-bill-literally-omits-women-and-mothers-except-to-talk-about-abortion-or-work-requirements/

gratuitous. Of those not in work, 35% are disabled or ill, 28% are taking care of home and family, 18% are in school, 8% are looking for work and 8% are retired.[12]

The AHCA has come under heavy criticism for a number of reasons. The creation of high risk pools for those that actually will use their health insurance and state stability funds to reimburse insurance companies to ensure that insurers do not suffer large losses.[13] This brings us to the issue of what defines **necessary and essential healthcare** and leaving it up to the various states to determine. The lack of clarity about what is considered an essential and necessary healthcare benefit in the House and Senate bills is deeply concerning; discussions of prenatal and pregnancy care being not essential because it only impacts women was raised by Republican members of the House.[14]

Additionally, the **Medicaid expansion of the ACA** (which was not adopted by all states, specifically 19 Republican-controlled states did not adopt it) covered healthcare coverage based on household income alone; provided your income is 138% of the Federal poverty level.[15] Both versions of the AHCA eliminate the Medicaid expansion; the Senate version doing so after 2021.[16] Most important, is the change in the nature of Medicaid which is currently based on need and a Federal-State financing partnership and will, if the Senate bill passes, be based on a block grant which does not adapt to need; block grants have been shown historically to decrease access to social services.[17] The

[12] For information of the work requirement to take up Medicaid

[13] See: https://www.washingtonpost.com/graphics/2017/politics/obamacare-senate-bill-compare/?hpid=hp_rhp-top-table-main_graphic%3Ahomepage%2Fstory&tid=a_inl&utm_term=.eaf73a8c3753

[14] See Amy Davidson post in the *New Yorker* (http://www.newyorker.com/magazine/2017/07/03/the-senates-disastrous-health-care-bill).

[15] The Federal poverty levels (FPL) depend on the size of the family and relate to household income. FPL is used to calculate eligibility for Medicaid and CHIP in the context of health insurance in the US:

- $12,060 for individuals
- $16,240 for a family of 2
- $20,420 for a family of 3
- $24,600 for a family of 4
- $28,780 for a family of 5
- $32,960 for a family of 6
- $37,140 for a family of 7
- $41,320 for a family of 8 (https://www.healthcare.gov/glossary/federal-poverty-level-FPL/).

Eligibility depends upon being within 100-400% of FPL and in states with Medicaid expansion you need to be below 138% of FPL. In states that have not passed the Medicaid Expansion, if your income does not fall below 100% of FPL you will not qualify for Medicaid and CHIP.

[16] For an examination of the impact of access to healthcare due to the Medicaid expansion portion of the ACA broken down by race, ethnicity and gender, see Rand Research Paper, 'The Effect of the 2014 Medicaid Expansion on Insurance Coverage for Newly Eligible Childless Adults' by Michael Dworsky, Christine Eibner, 2016 (http://www.rand.org/content/dam/rand/pubs/research_reports/RR1700/RR1736/RAND_RR1736.pdf).

[17] 'Specifically, Medicaid and CHIP enrolment have helped to decrease disparities in health care coverage for children of color over time. In 2008, seven percent of non-Hispanic white children, ten percent of Black children and 19 percent of Hispanic children lacked health insurance coverage. However, by 2015 only four percent of both non-Hispanic white and Black children lacked coverage and eight percent of Hispanic children lacked coverage. Additionally a study of New York's CHIP program that found enrolment in the program not only reduced pre-existing racial and ethnic disparities in access to care, but also, reduced unmet need and

importance of Medicaid and the Medicaid expansion covering children, women and people of colour cannot be understated.[18] In the 19 states where the Medicaid expansion did not occur, a coverage cap affecting 2.6 million people exists, primarily impacting those without children; but even still 25% of those not eligible for Medicaid in those states have children.[19] Women access Medicaid in higher numbers due to our predominance in part-time low paying jobs; while the majority of people accessing Medicaid are white, people of colour and those on low incomes have benefitted significantly from the Medicaid expansion.[20] So, fewer people will be covered and for a smaller amount of coverage to boot. Under the House version of the bill, it is estimated that 14-23 million American will lose access to healthcare; under the Senate version of the bill, 22 million American will lose access. According to House Speaker Paul Ryan, the issue is not that they will be pushed off health insurance, rather that they would choose not to buy it (the absurdity of this position given incomes in the US and inability to save for health insurance coverage is rather impressive).[21]

B. The Attack on Reproductive Rights

Reproductive rights refer to women's decisions if, when, and how many children that they choose to have. As such, it refers to access to contraceptives, abortion and voluntary sterilisation as well as ensuring that women that do want to have children actually can make that decision given the context of societies that are influenced by racism and class discrimination, independent of religious constraints and actually are able to ensure that their children have access to care and support, healthcare, education, housing, food and clothing to sustain them. These are two sides of the same coin and cannot be separated from each other.

Since the **SCOTUS** rulings in Roe vs Wade and Doe vs Bolton (1973), attempts to undermine and limit women's right to abortion have been constant.[22] Roe and Doe legalised abortion and granted women a negative right to have one; it is a negative right as while the procedure is legal and access must be maintained (so that there must be hospitals and medical centres that provide the

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improved continuity of care. Currently, children of color are enrolled in Medicaid and CHIP at higher rates than white children, with roughly one in four white (26 percent) and Asian (25 percent) children covered by one of the two programs compared to over half of Hispanic (52 percent) and black children (54 percent)(https://www.cssp.org/policy/2017/Protecting-Medicaid-Equity.pdf).'

[19]http://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[20] '**Changes to Medicaid under AHCA would disproportionately affect low-income individuals and people of color for whom the program is a central source of coverage.** Medicaid provides coverage to over half (54%) of families with income below poverty and nearly four in ten (38%) of near-poor families, with incomes between 100% and 199% FPL (Figure 5). Moreover, it covers more than one in five nonelderly Hispanic, Black, and AI/AN adults. It plays an even larger role for children of color, covering nearly six in ten Hispanic (56%) and Black (54%) children and nearly half of AI/AN children (47%) (http://www.kff.org/disparities-policy/issue-brief/what-is-at-stake-for-health-and-health-care-disparities-under-aca-repeal/).'

[21]See, http://www.rawstory.com/2017/06/paul-ryan-22-million-americans-wont-be-pushed-off-insurance-they-will-choose-not-to-buy-it/http://www.newyorker.com/news/news-desk/what-the-senate-health-care-bill-means-for-america.

[22] For Roe vs Wade and Doe vs Bolton decisions and later SCOTUS decision on abortion rights, see https://en.wikipedia.org/wiki/Roe_v._Wade.

procedure) the Federal government does not have the obligation to ensure that women can access this right through provision of funds.

Beginning with the Helms Amendment (1973) which prohibited US Foreign Aid funding to be used by family planning clinics internationally to discuss abortion and followed by the Hyde Amendment (1976) where federal funds were prohibited to be used for abortions, women's rights to obtain an abortion have been undermined. The Hyde Amendment is passed on appropriation bills and impacts all federal funding for the purposes of abortion. It affects those on Medicaid (unless states fund that directly), disabled women on Medicare, it impacts those on CHIP (healthcare for children) it impacts on insurance policies for federal workers, for those women serving in the military, it impacts Native American women as their health coverage is provided by the federal government, it impact veterans who get their health care from the Veterans' Administration, it impacts on women in prison and of course, it impacts on women with low incomes that live in Washington DC. Given the Global Gag rule, this ideologically driven policy not only affects American women, but women that live in countries whom are recipients of US Foreign Aid.[23]

According to the Guttmacher Institute:

> 'For Medicaid and CHIP enrollees, this means that access to affordable abortion care is dependent on where they live. Of women aged 15–44 enrolled in Medicaid or CHIP nationwide in 2015, 58% lived in the 35 states and the District of Columbia that do not cover abortion except in limited circumstances. This amounted to roughly 7.5 million women of reproductive age, including 3.5 million living below the federal poverty level.
>
> In states that do not extend coverage beyond the limits of the Hyde Amendment, a woman whose income is at the Medicaid eligibility ceiling would need to pay nearly a third of her entire family income for a month for an abortion at 10 weeks of pregnancy.[3] (An abortion at 10 weeks costs an average of $500, and the average Medicaid ceiling for a family of three for a month in these states is $1,566.).'[24]

The Hyde Amendment primarily impacts women of colour who are more often on Medicaid due to the racism and poverty that people of colour live with, in the US. According to Guttmacher, 'Thirty-one percent of black women aged 15–44 and 27% of Hispanic women of the same age were enrolled in Medicaid in 2015, compared with 15% of white women, just over half of the 7.5 million women of reproductive age with Medicaid coverage in states that do not cover abortion were women of

[23] The Hyde Amendment is a rider upon Federal appropriations bills. Initially, Federal funds could only be used for abortion if the mother's life was endangered. Under the Clinton Administration (1993), this was amended to allow Federal funds for abortion use in the cases of rape and incest. The Hyde Amendment had to be passed each time the federal budget was passed (https://en.wikipedia.org/wiki/Hyde_Amendment). The most recent version (2017) HR7, entitled *No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017* makes these prohibitions permanent, also prohibiting abortion provision in a federal building and by federal employees. Qualified health insurance plans are no longer able to cover abortions as was formerly the case. See: https://www.congress.gov/bill/115th-congress/house-bill/7.

[24] See, https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact.

color.'[25] Disabled women on Medicare cannot get abortion coverage and if they are also poor they are blocked through Medicaid as well.

So while we have become used to attempts in the US Congress to provide civil rights to zygotes, attempts to prevent working class women from accessing reproductive rights, attempts to eliminate funding for Planned Parenthood, attempts to eliminate different medical procedures for abortion, attempts to legislate against late term abortions, attempts to block fair pay for women, attempts to block domestic violence legislation, and blocking abortion coverage on health insurance plans, what is the difference now? At the state level, continual plebiscite campaigns to make abortion illegal in the state, attempts to introduce legislation to force unnecessary requirements on doctors and abortions centres (TRAP laws; overturned by the SCOTUS decision in 2016 on Whole Woman's Health vs Hellerstedt) which required doctors working in abortion centres to have local admitting privileges and that the centres had to have full surgical hospital requirements, parental consent for minors, unnecessary medical procedures, waiting times, gestational limits stopping abortions after a specific time period, state-mandated counselling, false information that abortions cause sterility or increase risk of cancer, state laws prohibiting use of Medicaid money[26]to enable women with low incomes to access abortion rights.[27]

Elected state and federal officials are not the only problem. Pressure from anti-abortion groups continues and both the Catholic Church and some Protestant church sects have waged an attack on women's reproductive rights. Using conscientious objectors laws, they have attacked parts of the ACA requiring birth control coverage in health insurance plans. The actions of religious groups working to undermine women's bodily autonomy have had significant impact upon accessing reproductive rights. Catholic hospitals routinely do not provide proper reproductive health care including emergency contraceptives, preventive contraceptives, will not provide for voluntary sterilisation and will only provide abortions if the mother's life is at stake (sometimes).[28] While there are other options available for this treatment in most places, there are areas in the US where Catholic hospitals are the only available place for treatment. The constant harassment at abortion clinics by faith-based groups, the murders of abortion providers, the attacks on the clinics and patients are long standing problems.

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[25] See, Guttmacher Institute for the impact of federal restrictions on abortion coverage (https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact).

[26]As discussed above, Medicaid is federal money devolved to the states for use for health care and medical procedures for those with low incomes. In the case of abortion, and given the Hyde Amendment, each state has to cover abortions in the case of the life of the mother being endangered, rape and incest. One state only covers it in cases where the mother's life is endangered in violation of the Hyde Amendment. See: https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid

[27] See Guttmacher institute on abortion laws in various states in the US, https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.

[28] See, http://christianhegemony.org/the-impact-of-catholic-hospitals-on-womens-reproductive-rights. Also, see, the ACLU discussion on health care denied routinely in Catholic Hospitals even in the case of the life of the mother, https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.