Dobbs v. Jackson Women's Health: Undermining Public Health, Facilitating Reproductive Coercion

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Abstract: *Dobbs v. Jackson Women's Health* continues a trajectory of U.S. Supreme Court jurisprudence that undermines the normative foundation of public health — the idea that the state is obligated to provide a robust set of supports for healthcare services and the underlying social determinants of health. *Dobbs* furthers a longstanding ideology of individual responsibility in public health, neglecting collective responsibility for better health outcomes. Such an ideology on individual responsibility not only enables a shrinking of public health infrastructure for reproductive health, it facilitates the rise of reproductive coercion and a criminal legal response to pregnancy and abortion. This commentary situates *Dobbs* in the context of a long historical shift in public health that increasingly places burdens on individuals for their own reproductive health care, moving away from the possibility of a robust state public health infrastructure.

Dobbs v. Jackson Women's Health Organization continues a trajectory of U.S. Supreme Court jurisprudence that undermines the normative foundation of public health — the idea that the state is obligated to provide a robust set of supports for healthcare services and the underlying social determinants of health. *Dobbs* furthers a longstanding ideology of individual responsibility in public health, neglecting collective responsibility for better health outcomes.[1] This shift not only enables a shrinking of public health infrastructure for reproductive health, it facilitates the rise of reproductive coercion and a criminal legal response to pregnancy and abortion. This commentary situates *Dobbs* in the long historical shift in public health which increasingly places burdens on individuals for their own reproductive health

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care, moving away from the possibility of a robust state public health infrastructure. In Part I, we trace these ideological shifts, beginning in the 1980s and leading into the 2022 *Dobbs* decision. Part II considers the importance of this shift for abortion services, which dually undermines a robust public health infrastructure for reproductive health care and facilitates reproductive coercion. The paper concludes by turning to the evolving critique of a politics of abandonment and coercion waged by reproductive justice and human rights advocates, who reframe the question of abortion care as one that requires state support for public health. In Part III, the paper revisits core critiques of reproductive justice advocates, who have long reframed the question of abortion care as one that demands a robust public health infrastructure.

This shift from public health provision to individual criminal prosecution has direct effects on access to abortion care today. The rhetoric of individual responsibility is used in a similar manner, once again leading to inequitable health outcomes among the same historically oppressed populations while also enabling the prosecution of pregnant people, providers and others.

I. The Rise of Individual Responsibility in Public Health — from HIV/AIDS to COVID-19

Despite the wealth of research on social determinants of health, public health policy has increasingly taken an approach that emphasizes individual responsibility.[2] This ideology of personal responsibility shifts the onus for mitigation of risk away from social determinants of health and onto the individual, constituting a significant shift in public health governance.[3] The COVID-19 pandemic unambiguously exposed the public health threat this shift posed as the U.S. health policy response focused on individual responsibility.

This shift toward individual responsibility for health has profoundly shaped government responses to a range of public health challenges and crises, most recently the COVID-19 pandemic.[4] The abiding COVID-19 response from the U.S. government, across Republican and Democratic Administrations, has largely abandoned a robust population-based public health approach — from the failure to ensure access to personal protective equipment (PPE), mask guidance, or workplace safety regulations — epitomized by the CDC Director's misguided advice that "your health is in your hands."[5]

This transformation was enabled by law. During the pandemic, the U.S. Supreme Court, followed by lower courts, played a central role in limiting the ability of the federal government to adequately respond to COVID-19. Several attempts to better address the pandemic — from the eviction moratorium and OSHA vaccination requirements to the federal mask mandate — were struck down when challenged by conservative groups.[6] Each of these decisions has contributed to dismantling state capacity to build a robust public health infrastructure that would allow for slowing the spread of COVID-19 and addressing other public health threats.[7]

This individualization of public health responses is not new to the COVID-19 pandemic. The ideology of personal responsibility has been used as a trope to delegitimize the role of the state in social services provision since at least the 1980s, though it has much deeper historical roots. In the last few decades, the idea of personal responsibility has undermined state support for public health and welfare. Political leaders often caricatured people receiving public support as "welfare queens" or deployed narratives of an "undeserving poor."[8]

These tropes created a political environment ripe for dismantling public health services, systems, and infrastructure through reduced public sector funding coupled with an increasing reliance on privatized health insurance. Over the course of the 1980s, the Reagan Administration steadily cut the budget of the Department of Health and Human Services and began to restrict eligibility for disability coverage. The Reagan Administration's push for deregulation of healthcare and limits on welfare provision left people on their own, abandoning the state's role in ensuring the public's health.

In the early 1980s, cutbacks to social welfare and public health spending coincided with the onset of the HIV/AIDS epidemic, limiting the capacity of the state to adequately respond to people's needs during that emerging public health crisis. The fact that the HIV/AIDS epidemic had disproportionate effects on

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people of color, sexual and gender minority groups, and the poor was framed by conservatives as the result of risky (and often immoral) individual sexual choices. This approach further served to politicize the epidemic response and frame it in the emerging neoliberal context of personal responsibility.[9] The personal responsibility narrative also helped pave the way for the rise of the carceral state, which expanded in the 1980s as welfare programs were scaled back. In this moment, not only did the criminal legal system grow, many social services were absorbed into or regulated by the carceral state.[10]

This shift from public health provision to individual criminal prosecution has direct effects on access to abortion care today. The rhetoric of individual responsibility is used in a similar manner, once again leading to inequitable health outcomes among the same historically oppressed populations while also enabling the prosecution of pregnant people, providers, and others.[11]

II. Dobbs: Undermining Reproductive Health Care and Facilitating Reproductive Coercion

With *Dobbs*, the Court has ensured that states can abdicate responsibility for reproductive health services. The history of abortion jurisprudence is aligned with the broader historical trend to scale back public health infrastructure. Almost as soon as *Roe v. Wade* was decided, the Supreme Court's 1977 decision in *Maher v. Roe* deployed a personal responsibilty argument, placing the burdens of reproductive health care on the woman seeking an abortion.[12] The Plaintiff in the case challenged a Connecticut law that banned the use of Medicaid funds for non-medically necessary abortions. The Court held that a state is not obligated to pay for non-medically necessary abortions simply because it paid for pregnancy-related services. Thus, the Court reasoned that Connecticut was under no obligation to pay for the abortions of poor women because the ban was rationally related to the "strong and legitimate interest in encouraging normal childbirth."

This refusal to acknowledge state responsibility for ensuring access to abortion services, as a full set of options for reproductive health care, was reinforced in the 1980 case *Harris v. McRae*.[13] In this instance, the Plaintiffs challenged the Hyde Amendment — the ban on federal funds to reimburse the cost of abortions under Medicaid. The Court held that the Hyde Amendment served a rational governmental purpose and that states participating in the Medicaid program are not obligated to fund medically-necessary abortions where federal monies are not permitted for reimbursement. In doing so, the court explained that, as first articulated in *Maher:*

> Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigency.[14]

The court's position is clear: because the government does not cause poverty, it is not obliged to pay for the care of a poor woman. Even while the Supreme Court ostensibly acknowledged a right to privacy, it repeatedly allowed states to block state funding for abortion, shifting responsibility towards individuals for accessing necessary health care and, where women could not afford access to abortion, denying choice and thus coercing pregnancy. This finding ignores the role of the state in supporting systems of oppression that perpetuate poverty and oppression among historically marginalized groups.

Following from this shift in the role of the state in public health, *Planned Parenthood v. Casey*, a landmark decision upholding the constitutionality of several provisions of the Pennsylvania Abortion Act, established the undue burden standard — that a state regulation is unconstitutional only if it has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion before viability. This decision enabled lower courts to find many state level abortion regulations — designed to prevent access but written under the guise of protecting women's health — constitutional, further limiting the right to abortion.[15] *Casey* helped undermine abortion access even as it reinforced the idea that women have a right to liberty and bodily autonomy.

The *Dobbs* holding does not feign concern over healthcare access. By making abortion a political decision, as opposed to a medical decision, this U.S. Supreme Court holding enables the end of abortion access altogether. The health and human rights impact of this decision has already played out in states with severely restrictive abortion bans, the cruelty of which is on full display: some do not contain exceptions for rape or incest. Even people who are privileged enough to have the resources to travel out of state may not be safe; efforts to limit travel for abortion care are next on the anti-abortion legislative agenda. Not only have these laws undermined the health care infrastructure

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necessary for a robust public health response to pregnancy, but they also enable the regulation of pregnancy through harsh criminal law.

This approach to abortion — which refuses to see any role for the state in ensuring access to a full spectrum of reproductive health care — is consistent with the ideological shift that has defined the response to public health crises in our contemporary moment, shifting responsibility away from the state and onto the individual.

The Supreme Court has not always taken such a harsh view. As recently as 2015, there was hope that the Court might go in a different direction. In prior rulings, including *Whole Women's Health* v. *Hellerstedt* and *June Medical Services v. Russo*, the majority acknowledged that laws limiting access to abortion leave pregnant individuals with few to no supportive services. In reworking the undue burden standard so that courts had to consider the effect of restrictive abortion laws, the Supreme Court acknowledged that this has a disproportionate impact on poor women and people of color, implicitly acknowledging structural barriers to seeking care.[16]

In undermining the ability of people to end their abortions, *Dobbs* also facilitates reproductive coercion by the state. Reproductive coercion — or state control over reproduction to achieve broader objectives of social control — is a long-studied concept in the anthropology of reproduction. Such instances of reproductive coercion through abortion regulations have profoundly negative, and inequitable, implications for perinatal and child health. Abortion bans have not included exceptions for rape or incest or for a fetus with severe fatal anomalies.[17] Even as pregnant people who seek abortion services are being abandoned by the state, the Court implicitly allows for government actions to achieve state ends that include, as the dissent points out, forced childbirth.

States that have imposed abortion restrictions already have worse maternal and infant health outcomes due to multiple factors, including the decision not to expand Medicaid eligibility and the limited number and inequitable distribution of healthcare providers and health services.[18] These inequities will rapidly worsen with abortion restrictions and bans, including the effect of *Dobbs* on miscarriage care and medically-necessary abortions. Such health outcomes will disproportionately impact pregnant people of color due to structural racism and because a greater number of births are among pregnant people of color in states that have imposed these restrictions.[19]

III. The Reproductive Justice Critique: Remembering the Structural Determinants of Health

Reproductive justice offers a different vision. It firmly grounds the entire spectrum of reproduction in the norms and principles of human rights — expanding narratives of (individual) reproductive choice to broader and more inclusive concepts of health justice. In this expansive rights framework, built on decades of work and formalized by Black feminists in the 1990s, birthing people have "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[20] Scholars grounded in this tradition address restrictions to abortion within this broader framework of structural barriers to public health.

Structural barriers shape decisions about sexuality and fertility, access to abortion, birth, and postpartum services. More broadly, structural inequities shape access to basic resources like housing, income, and healthcare that shape the landscape of reproduction. Restrictions on abortion perpetuate a long tradition of racist policies that enable reproductive control of people of color and constitute a broader attack on reproductive health. Legal scholar Dorothy Roberts, for example, has long critiqued the idea of "choice" because of its misleading implication that women truly can do what they want with their bodies. The rhetoric of choice abstracts reproductive decisions from their context and falsely implies personal responsibility and moral blame; "choice" suggests that women and birthing people find themselves in these challenging situations solely because of their individual decisions. Indeed, Black, Indigenous, and other people of color have been subject to reproductive coercion and control by the state since the foundations of the United States — from chattel slavery to forced displacement, child removal, and forced sterilization.[21] These state-based instruments of reproductive control live on in structural racism and are embedded in policies that systematically shape an individual's ability to determine their reproductive futures.

The core tenets of reproductive justice, which highlight structural inequality, challenge notions of individual responsibility and provide understanding of the societal conditions that undermine the ability of people to have positive health outcomes. Drawing on new conceptions of human rights, advocates have argued that sexual and reproductive health and rights, including abortion care, requires more than individual choice and personal responsibility. The right to control one's fertility is a pressing reproductive

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need, with reproductive health encompassing a wide range of health-related human rights — framing the enabling economic, social, and cultural conditions in which choices are made and the infrastructures that allow those choices to come to fruition.[22] These economic and social conditions for abortion care are exercised at the societal level, requiring collective action to ensure access to public health.[23]

Conclusion

The *Dobbs* decision exacerbates an existing crisis in public health that emerged from a long history of executive, legislative, and judicial attacks that undermined the possibility of robust welfare, public health, and social security systems in the United States. Yet glimpses of another way are present in recent cases — if not in the majority, then in the dissents.[24] The justices acknowledge that poverty and a lack of material resources impact an ability of a woman to access abortion. To address the medical, political, and legal abandonment of people who need abortions, there must be a greater policy commitment to a robust public health response that centers questions of economic redistribution and access, and is rooted in the values of reproductive justice and human rights.

Note

The authors have no conflicts to disclose.

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