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Danielle Marie Pullan

The Gap Between Abortion Policy and Abortion Access in Europe

A Mixed-Methods Comparative Study

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Abstract

This dissertation evaluates the space between policy and implementation, where politics, social values, and economic concerns all affect abortion access. In Europe, abortion laws are broadly similar on paper, but abortion is not equally easy to access. The dissertation develops a framework for evaluating the institutional influences on abortion policies, dives into one case of implementation in depth, maps one component of abortion access across several countries, and tests several potential explanatory variables for differences in levels of access.

Chapter 2 explores the competing policy influences of European norms and the Catholic Church as a political institution, arguing that Italy is more European than Catholic in its approach to abortion policy. Chapter 3 analyzes interviews with healthcare personnel and administrators in southern Italy. These street-level bureaucrats implement abortion policy, operating within a system that does not have enough abortion providers. I find that in many cases, doctors are not morally opposed to abortion but make the choice not to provide it for reasons related to their quality of life and prospects of career advancement. Chapter 4 introduces a new dataset of abortion provider locations in ten European countries and explores the possible social, political, and economic explanations for the unevenness of this distribution.

These chapters address the overarching research question of why is there a gap between abortion access de facto and what abortion policies say de jure. I argue that it is because of the state's implementation choices of its *de jure* policy. The choices of the state and its agents are political, and they reflect individuals' religious, political, and financial values.

About the author

Danielle Marie Pullan was a doctoral researcher at the IMPRS-SPCE from 2020 to 2024. She completed the program in conjunction with her PhD studies at the University of Cologne, Faculty of Management, Economics and Social Sciences

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Presented by

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Born in
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Contributors and Publication Status

The paper presented in Chapter 2, "Between the Church and the State," is coauthored with Payton Gannon. Both authors contributed equally to the concepts, literature review, and writing of the paper. Ms. Gannon consents to the use of the paper in this dissertation. Several colleagues offered comments that improved this paper for which we are grateful: Letizia Mencarini, André Kaiser, Ceren Çevik, Jennifer Newman, Chanley Small, Elifcan Çelebi, Naomi Mezey, Marco Panessa, and two anonymous reviewers. This paper was not presented at any conferences or workshops. This paper was accepted for publication in the Journal of Religion in Europe in February 2024 and is in the final stages of the publication process, but it does not yet appear online at the time of this submission. The text included in this dissertation is the accepted version of the manuscript.

The paper presented in Chapter 3, "Doctors' Rights vs. Patients' Rights," has no coauthors. Lucia Sollecito provided (paid) live interpreting services during interviews. I am grateful for comments on this paper from Payton Gannon, Giulia Mariani, Frédéric Strack, Silvia De Zordo, André Kaiser, Moritz Raykowski, Marco Panessa, Vanessa Endrejat, Keonhi Son, Ceren Çevik, Letizia Mencarini, and the CCCP Women & Nonbinary Researchers Working Group. This paper was presented at the European Conference on Politics and Gender (July 2022, Ljubljana, Slovenia), the European Consortium for Political Research General Conference (August 2022, Innsbruck, Austria), and the Cologne Political Science Workshop (September 2022, Cologne, DE). This paper is not yet published but it was under review at the time of submission and has since received a decision of "revise and resubmit."

The paper presented in Chapter 4, "What Attracts Abortion Providers?", has no coauthors. Thanks go to Chitralekha Basu, André Kaiser, Payton Gannon, Leonce Röth, Lea Kaftan, Patrick Heller, Jeren, Rona Torenz, and Marco Panessa for comments and discussions that improved this paper. It was presented at the ECPR Joint Sessions of Workshops (April 2023, Toulouse, France), the 29th International Conference of Europeanists (June 2023, Reykjavik, Iceland), the Economy & Society Summer Conference (July 2023, Evanston, IL, USA), and the American Political Science Association Annual Meeting and Exhibition (August/September 2023, Los Angeles, CA, USA). This paper is not yet published, but it is part of a special issue proposal currently under consideration.

All three papers were presented in an overview of this dissertation for the IMPRS Doctoral Colloquium at the MPIfG in June 2023.

Figures and Tables

Chapter 1: Introduction

This dissertation evaluates the space between policy and implementation, where politics, social values, and economic concerns all affect abortion access. Specifically, its focus is in Europe, a region where abortion laws are broadly similar on paper, but anecdotally, abortion is not equally easy to access across all European countries. At the outset of this dissertation, I sought a way to quantify abortion access, and I have partially addressed this academic goal, but I understand now that to do so adequately will be the subject of several more papers in the next phase of my career. What I have done, however, is provide an initial framework for evaluating the influences on abortion policies, dived into one case of implementation in-depth, mapped one component of abortion access across several countries, and tested several potential explanatory variables for differences in levels of access.

The three papers in this dissertation are presented as a portfolio of my skills as a researcher. Chapter 2 is a conceptual and theory-building paper. Chapter 3 is my first qualitative field study, presenting findings from interviews and diving deep into one region in the south of Italy. In Chapter 4, I demonstrate skills with quantitative data: building my own dataset, harmonizing it with other data, generating compelling visuals, and interpreting regression results. Treating my PhD as a portfolio has allowed me to develop at least a passing familiarity with a variety of approaches and set me up well for a career in academia.

In this introduction, I will only briefly summarize my key findings from each of the following chapters. Its primary purpose is to draw the thread through these three different studies and show how they all contribute to answering the same overarching research question: why is there a gap between abortion access *de facto* and what abortion policies say *de jure*? I will first review the theoretical framework of reproductive justice, the empirical literature on abortion, and the relevant studies on religion and politics. I will then summarize and contextualize my empirical chapters in

these literatures. In presenting the three articles together as one dissertation, I will also reflect upon what questions remain unanswered, hopefully to be addressed in my future research.

At a high level, my explanation of why there is a gap between *de jure* and *de facto* abortion policy is about the state's implementation of its *de jure* policy. This is a potential weakness in any policy: if it is written well but applied inconsistently, or if it is applied as written but the law does not provide enough specificity to ensure equal access to the right to abortion, this right is not secure. Ross & Solinger (2017, 185), reproductive justice scholars, summarize Articles 16 and 25 of the Universal Declaration of Human Rights: "no right can achieve the status of a human right if it doesn't apply to all people – along with its corollary that no right is secure if it is not secure for everybody."[1] The choice of the state and its agents in how to implement abortion policies comes down to questions of religion, politics, and money, and this is the red thread that I will pull through this introductory chapter, first by exploring three relevant fields of literature, and then as I summarize the following chapters.

1.1 Reproductive Justice

Abortion policy sits at the intersection of several fields of study. I came to the topic from an academic background in political science and public administration, but heavily supplemented by an informal education in feminist and reproductive health groups of which I was a member when I lived in Washington, DC. To understand how abortion is regulated, it is not enough to understand the basics of political calculations or policy processes. Like other comparative politics scholars, I have developed a passing familiarity with the political systems of many countries and their approaches to abortion regulation. But my research is also informed by reading legal opinions and legal briefs from multiple countries and supranational organizations (Ziegler 2023). I have had to learn the biomedical differences between a procedural abortion, a medication abortion, emergency contraception, and normal contraception in order to fully engage in the conversation about how these medications and

[1] See also Luna (2009) for an expansion of this argument

procedures can be regulated (Lean et al. 1976; Safe abortion: Technical and policy guidance for health systems 2012; Upadhyay, Coplon, and Atrio 2023; Wingo, Ralph, and Kaller, Shelly, Biggs, M. Antonia 2021). Researching abortion requires engagement with philosophy, particularly bioethics and feminist theory, that add depth to the normative arguments activists make for and against abortion (Jecker, Jonsen, and Pearlman 2007, pt. III, Section 1; Scully, Baldwin-Ragaven, and Fitzpatrick 2010; hooks 2000a). I've dabbled in the history of social movements and feminist discourses in order to understand how we reached current policy positions (Ferree 2021; Korolczuk 2021; Caruso 2024; Krook and Mackay 2011). Public opinion and political attitudes on abortion are another key component to evaluating a policy, and this is complemented by the morality policy literature, where we come to understand that policies that draw upon our first principles motivate people to make decisions and form their attitudes differently than they do for more redistributive policies. I've read critical race theory (Bell Jr 1995; Cook 1995; Crenshaw 1995), as race and other intersecting identities are key factors in understanding patterns of access to many social services, including healthcare (Briggs 2017; hooks 2000b; Suarez-Balcazar et al. 2024). Intersectionally marginalized people face a multiplicity of barriers to changing their economic class (Crenshaw 1995; Arruzza, Bhattacharya, and Fraser 2019; McReynolds-Pérez et al. 2023; Folbre 2021). Wealthy, highly-mobile people around the world have a disproportionately easy time accessing many services, including abortion care. The literature from feminist political economy helps us understand how to study an issue that is in some ways treated as a matter of public concern yet in other ways treated as a private elective choice that society bears no burden to pay for (Dwarswaard, Hilhorst, and Trappenburg 2011; Flink-Bochacki et al. 2024; Folbre 2010, chap. 10).

All of these many divergent strands of scholarship come together in the theoretical framework of reproductive justice. This framework was created by Black[2] feminists in the United States in

[2] According to the AP Style Guide, it is proper to capitalize Black, Indigenous, or the name of other marginalized ethnic groups, but not white, because capitalizing "white" is a strategy employed by white supremacists. For more, see (Associated Press 2020)

response to the mainstream women's movement largely attending to the needs of white, wealthy women at the expense of people of color. Where white feminists pushed for "reproductive rights" with a heavy emphasis on abortion and contraception, Black feminists knew firsthand that their communities had different needs. Therefore, they described reproductive justice (hereafter "RJ") as containing both positive and negative rights: the right *to have* a child is just as important as the right *not to have* a child (Ross and Solinger 2017). The reproductive justice movement additionally advocates for a right to parent children in safe environments, taking a more holistic view towards family building and the social and economic conditions that enable one to make reproductive choices that are truly free from coercion.

This strand of theory developed in the United States, and the country's history is integral to understanding RJ. This by no means suggests that RJ is not applicable outside of the US, and I will later return to this point, but we must begin with some historical context. Why do we need this sojourn through US American racial politics in the 19 and 20th centuries to understand a dissertation about abortion access in Europe in the 21st? Because the Reproductive Justice framework is a fundamental motivator of this line of research. The idea that the black-letter text of the law will necessarily match conditions on the ground for abortion seekers is an inherently privileged perspective that will, at best, generally be true only for the dominant group in a given society. In the US, this manifests along race and class lines (which are so often aligned, due to this very history), but in other geographies, it will manifest along whatever social divisions are most salient to the distribution of power and rights in that society.

During the era of chattel slavery in the US, reproductive control was a fundamental element of how enslavers grew their wealth and expanded their power (Roberts 1997, chap. 1). Children born to enslaved Black women were considered property of the enslaver, which meant that enslavers wanted these women to bear as many children as possible (Cooper Davis 1998; Koppelman 2010).

This naturally led to horrific cases of sexual abuse against Black women by their white enslavers (Posey 2023; The Life of Sally Hemings n.d.). With the end of the Civil War, race relations changed (in ways that are far too complex to adequately explain here) and it was no longer profitable for white capitalists if Black women bore many children. Forced to acknowledge (some) human rights of Black people, the white men in power sought other avenues to consolidate their own power and retain a superior social position above formerly enslaved Black people.

The 20th century saw advances in science and medicine that supported the rise of the eugenics movement around the world (Roberts 1997, chap. 2). Societies became captivated with the idea of improving the human race by encouraging only the "best" genetic specimens to reproduce (Herzog 2018). These ideas of deservingness were, of course, informed by the existing racist power structures. Black communities suffered from a lack of services of many types, including healthcare, and a general disadvantage to whites who had been accumulating generational wealth literally built on the backs of formerly enslaved people (Goodwin 2022; Posey 2023). Those doctors who did serve Black communities often brought their biased ideas into the exam room, judging that Black women ought not to procreate and frequently abusing the power they held by virtue of both social status and access to information. Black and Indigenous women were sterilized against their will at alarming rates, sometimes explicitly due to their race, but other times due to the application of other social labels that were code for subprime genetic stock such as "feeble-mindedness" and "sexual impropriety" (Roberts 1997, chap. 2; Akbari 2021).

As white women gained increasing social, economic, and bodily freedom throughout the 20th century, the gulf between the predominantly white women's movements and Black women grew (Luna 2017). The US Supreme Court recognized a right to contraception for unmarried women in *Eisenstadt v. Baird* (1972) and famously recognized a national right to abortion in *Roe v. Wade* (1973), addressing two of the primary concerns of newly-liberated white women who prioritized

their careers and strived to “have it all.” Meanwhile Fannie Lou Hamer, activist and leader of the Mississippi Freedom Democratic Party, enlightened national audiences to the concept of the “Mississippi appendectomy” – when a Black woman has a medically unnecessary and usually nonconsensual hysterectomy – a phenomenon that Hamer herself suffered in 1961. According to her report, more than 60% of the Black women from her home county had been sterilized without their consent at the same hospital (Paul 1968).

The advocacy of Black women like Hamer extended beyond reproductive justice for Black women into a wide variety of other social and civil rights issues – she got her start in politics due to local voter suppression efforts. Yet she was not welcomed with open arms by white feminists. In some ways, she is the perfect example of the intersectional discrimination people of multiple marginalized identities face (Kendall 2020): as a Black person, she was expected to work to advance the general position of the Black community, which was widely understood to be about voting rights and equal access to societal institutions. But as a woman, she was expected to support the mainstream women’s movement and its emphasis on negative reproductive rights. As a Black woman, both of these were issues she cared about, but she additionally had concerns that specifically affected the community of Black women. Intersectionality meant that the totality of issues she faced was greater than the sum of the parts of her identity.

The theoretical concepts of intersectionality and reproductive justice developed throughout the 1990s into the 2000s. Legal scholar Kimberlé Crenshaw first coined the term “intersectionality” in her (1989) article about the inadequacy of antidiscrimination laws that only ever addressed gender and race as separate aspects, without considering the increased impact on people whose gender and race were both marginalized. The Women of Color-led reproductive advocacy organization SisterSong (Luna 2016) was co-founded and led for a time by scholar and activist Loretta Ross, who went on to write key texts about RJ (Ross 2017). The intellectual discourse has continued to develop

into a robust literature that explores many different facets of reproduction in ways that are socially just. Reproductive justice fundamentally argues that the framing of "choice" around issues like abortion is inadequate, because many people are unable to make an uncoerced choice due to their race, class, economic position, religion, disability, and other identities. The framework of reproductive justice has been taken up by scholars in related disciplines (Morison 2021; Onwuachi-Saunders, Dang, and Murray 2019; Poehling et al. 2023) to address topics ranging far beyond only contraception and abortion to include rights in childbirth (Ross and Solinger 2017, chap. 4), access to pregnancy care and assisted reproductive technologies (Roberts 1997, chap. 2; Vertommen 2017), disability and autonomy (Jarman 2015; Powell 2022), how to best support parents through social policy (Folbre 2010), and the effects that social problems like climate change (O'Donnell Heffington 2023, chap. 4) and police violence (Kendall 2020) have on fertility intentions.

The words "race" and "racism" elicit very different reactions in Europe, even among the most progressive and worldly of individuals, than they do in the United States. It is taboo to discuss race, even in an academic context, and more often euphemisms like "person with a migration background" are used, or the phenomenon is seen through the lens of xenophobia alone. Several European countries do not gather data on race, seeing it as a phenomenon that does not apply to their society (Oltermann and Henley 2020). Race is a socially-constructed concept, and therefore it means something different in different societies, but variations of racism and colorism exist around the world (Kendi 2019, chap. 9). The key learnings from the RJ literature for non-US American contexts, however, are about the more general role of identity politics, particularly intersectional identities. It is normatively important to explicitly note which groups are excluded from aspects of our societies.

While the Reproductive Justice framework was founded by Black American women, its theoretical umbrella includes many marginalized people (García Coll, Surrey, and Weingarten 1998; Killian

2023). At every stage of US American history, exploitation of Black people based on their race was inextricably tied to capitalism and to power (Kendi 2016; Hoffer 2010). Even countries that never engaged in mass-scale chattel slavery still have social class systems that value some identities more than others, designating "insiders" and "outsiders" to the socially dominant group.[3] Just as in the US case, membership in the dominant group is often policed by policing motherhood and ensuring that the "right" people reproduce. Ultimately, Reproductive Justice is a way to examine social inequality broadly, because the right and ability to control one's own family size is a question of identity and marginalization in general (Onwuachi-Saunders, Dang, and Murray 2019).

In Europe, the salient dimension for social organizing has long been economic class rather than other social identities. Reproductive Justice as a framework teaches us that rights that are only available to the rich are not really rights (Ross and Solinger 2017, chap. 4). Access to healthcare and family support systems is absolutely relevant in any society with economic inequality (Fledderjohann, Patterson, and Owino 2023). Though they are not the focus of my dissertation specifically, RJ would also emphasize the need to understand migrants' experiences with reproductive care in Europe, along with people who are not Christian (Grotti et al. 2018). To date, there is insufficient scholarship that translates the lessons of reproductive justice outside of the US American context and applies them to the very real and important inequalities that also exist in other global societies, and I aim to contribute to this gap in the literature.

1.2 Abortion-specific Literature

As described above, abortion studies incorporate information from so many disciplines that they almost become a discipline of their own. This dissertation contributes to the empirical studies of abortion policy and abortion access through the incorporation of new cases and new data. Some

[3] See the book edited by Lie & Lykke (2017) for chapters that highlight examples from diverse geographies, or Herzog (2018) for a specifically European discussion

might consider this a subset of the RJ literature, but I separate this discussion here to emphasize the theoretical nature of RJ and the empirical nature of the studies discussed here.

One empirical division in studies on abortion is the focus on patients versus on doctors and systems. Studies focused on patients' experiences and patients' motivations tend to be more anthropological or from the public health field and less political in nature, and thus are not where I make my primary contribution. These studies are essential, however, to understanding the entire picture of abortion access. Some studies focus on patients' perceptions of the abortion procedure and their own medical and support needs (Baron, Cameron, and Johnstone 2015; Cartwright, Bell, and Upadhyay 2023; Grimes et al. 2022; Harrison et al. 2024; Hukku et al. 2022; O'Shaughnessy 2024; E. Pleasants et al. 2024; Purcell et al. 2014).

The Turnaway Study was an extremely influential study of patients' experiences in the US that leveraged a natural experiment: one group of patients requested an abortion just before the legal time limit, and another requested the abortion just after the limit and were thus denied their request. This study, summarized in Diana Greene Foster's (2020) book, is reflected in many journal publications as well. Together, they tell the story of what happens when pregnant people decide that they need an abortion but then they are denied that abortion because of a policy: generally worse outcomes for education, career, family, and other markers of adult success in a capitalist world. This has also expanded outside the US case into similar studies conducted in Nepal (Puri et al. 2015, 2023; Gautam et al. 2023).

Another group of patient-focused publications looks specifically at those abortion seekers who travel, often across borders, to receive care. Most of these patients travel because they could not access care at home, either in an absolute sense because they were not eligible for an abortion due to gestational age limits or broader bans (De Zordo et al. 2021, 2023; Garnsey et al. 2021; Mishtal et

al. 2023; Zanini et al. 2021; L. Brown 2019; Lennerhed 2019), or in a relative sense because they could not get the care they needed in their home region (Autorino, Mattioli, and Mencarini 2020; Baird 2019; H. Brown 2019; Makleff et al. 2023; Rahm et al. 2023; Sethna and Doull 2013; McKenna and Leslie 2018).

Bridging the gap from patient-focused studies to studies on systems of care provision and the medical profession, some studies examine the spatial distribution of services and how easy or difficult it is for people to reach places where care is offered. There are some nonacademic resources that prove useful in this area: these are mainly websites aimed at prospective patients sharing information about where care is available or, crucially, where care is *not* available (Interactive Map: US Abortion Policies and Access After Roe 2022; Clinic Browser 2020; Directorio de clínicas asociadas en ACAI 2023; Doctors and clinics 2022; Global Map of Norms regarding Conscientious Objection n.d.; Mapa global de normas sobre objeción de conciencia 2022; Mappa degli Ospedali Italiani che offrono il servizio di interruzione di gravidanza 2021; Lalli and Montegiove 2021; Swartzendruber and Lambert 2020). This sort of data is then analyzed by academics employing geospatial techniques to estimate how much time the typical abortion seeker spends traveling, and ultimately what that costs them (B. P. Brown et al. 2020; Cartwright et al. 2018; Krems et al. 2024; E. A. Pleasants, Cartwright, and Upadhyay 2022; Sato et al. 2021; Thompson et al. 2021; Torenz et al. 2023).

Calkin (2019) refers to this literature as the "political geography of abortion." With the exception of the Torenz and Sato studies, this political geography work is focused in the United States. Coming from the perspective of comparative politics, this single hegemonic country focus is to the detriment of the scientific community's understanding of the topic more broadly and is likely largely specific to the political, economic, and social context of the United States (Gannon and Pullan 2023).

A smaller but growing segment of the abortion literature focuses on the perspectives of medical professionals. Some political scientists along with scholars of organizational behavior and sociology of professions explore what it meant for abortion to become "medicalized," e.g. to be regulated by the state and/or professional organizations of physicians instead of left in the private sphere where it was managed by midwives and traditional remedies (Amery 2014; Pullan 2020). These studies seek to understand how doctors think about abortion and understand their role in the broader system of reproductive healthcare (Beynon-Jones 2013; De Zordo 2018; Dempsey, Connolly, and Higgins 2023; Duffy et al. 2018; Fink et al. 2016; Gannon 2023; Hartwig et al. 2023; MacNamara et al. 2024; Mills and Watermeyer 2023; Puri et al. 2018; Reeves et al. 2023; Vázquez et al. 2023; Veldhuis, Sánchez-Ramírez, and Darney 2024), which is related to the discussion on whether healthcare professionals ought to be allowed to conscientiously object to abortion (De Zordo 2017; Ennis et al. 2021; Fiala and Arthur 2014, 2017; Harries et al. 2014; Küng et al. 2021). A few (US American) abortion providers have shared their own perspectives at length in their memoirs (Parker 2017; Wicklund and Kesselheim 2009; Taylor 2023).

Progressing along the continuum from most micro-focused to more macro-focused work, we encounter a group of studies that have a greater emphasis on healthcare regulatory institutions and power structures, examining the structures in which medical professionals operate, both legally and professionally (Krajewska 2021, 2022; Stifani, Vilar, and Vicente 2018; Stifani et al. 2022; McLeod, Pivarnik, and Flink-Bochacki 2021; Medoff 2012; Mercier, Buchbinder, and Bryant 2016; Mishtal et al. 2022; Rosen and Ramirez 2022). Some studies specifically focus on the role of religious health systems and hospitals (Freedman 2023; Freedman, Landy, and Steinauer 2008; Hebner et al. 2023; Wascher et al. 2018). These studies still rarely make the jump to a political science, public administration, or political economy perspective.

Most political scholarship on abortion remains within the realm of parliamentary behavior and discourse analysis (Baumann, Debus, and Müller 2015; Oh, Elayan, and Sykora 2023; Strange 2022; Cahn 2023; Hunt 2021; Hunt and Friesen 2021; Hunt and Gruszczynski 2019; R. B. Siegel 2008; D. P. Siegel 2024). This is still important work to do, but it fails to connect social movements, professional societies, and individual experiences with the political institutions that set the playing field for those experiences (Oberman 2018). It also fails to connect with the public administration literature on bureaucrats and the potentially political nature of seemingly technocratic and "neutral" policy implementation decisions (Guaschino 2022; S. Thomson 2024; Krook and Mackay 2011; Raffler 2022; J. Thomson 2019).

A notable subset of the abortion literature with which I only engage in a limited way in this dissertation is the literature on medication abortion.[4] Much of this literature is clinical in nature, confirming the safety of self-administering an abortion with medications at home (Aiken, Lohr, et al. 2021; Aiken, Starling, et al. 2021; Johnson et al. 2022). The aspects of this strand of the literature that are most relevant to this dissertation are those that discuss the social implications of medication abortion. Many scholars have commented on the potential for inverting the power relations in abortion care as more and more people rely on abortion pills that they can order directly to their home instead of deferring to the authority of doctors and clinics (Calkin 2023; Jelinska and Yanow 2018; Koenig et al. 2023; Mark, Foster, and Perritt 2021; Nandagiri and Berro Pizzarossa 2023). Future studies on the political geography of abortion in the vein of Chapter 4 of this dissertation will need to reckon with the ways that some abortions will, in all likelihood, become more accessible as more people use medication for their abortion, but also come hand-in-hand with legal risks in countries where medication abortion is restricted. Additionally, the most medically risky

[4] Per the Society of Family Planning (Upadhyay, Coplon, and Atrio 2023), this is the appropriate nomenclature for an abortion that is done primarily with medications. Abortions done primarily with instruments, which have been known variously as uterine aspiration, dilation and curettage, dilation and evacuation, or more colloquially, surgical abortion, should be referred to as "procedural abortion."

cases, pregnancies that are further along in gestation or encounter complications, will still require physical support nearby, so medication abortion is not a panacea.

1.3 Religion and Politics

Religion and politics is a fundamental literature for all three papers in this dissertation. Because of the cases I study, the primary religion of interest has been Catholicism, though Chapter 4 also considers the role of Protestantism among the population. This focuses the literature to a manageable subset to summarize in this introduction. I also do not endeavor to summarize here the entire breadth of all scholarship on religion's place in social and political systems, but specifically concentrate on the scholarship about morality, sexuality, and family-building.

Two of Anna Maria Grzymała-Busse's books were key sources of inspiration for this dissertation. In *Nations Under God: How Churches Use Moral Authority to Influence Policy* (2015), Grzymała-Busse takes us on a tour through several different country cases and the role different religious institutions have played in shaping policies, concluding that a linkage between national identity and religious identity is the key to religious influence on policy by contrasting cases where this happens with other cases where the national identity is more secular.

In her newer book *Sacred Foundations: the Religious and Medieval roots of the European State* (2023), Grzymała-Busse narrows her focus to Europe, describing the coevolution of the Catholic Church and European state structures, and the way that at a certain point in time (which varied by country), the state generally co-opted structures that been built by the Church for administration. Churches had a physical presence in most communities, and clergy played the role of arbiter and judge in the absence of a secular bureaucracy for administering justice. This meant that state and Church functions were for some time entangled, and the state and Church were often vying for power and control, as seen in, for example, the exchange of power between "divinely-ordained" kings that submitted to the Church's authority, where other monarchs sought to drive the Church and its influence out of their lands to consolidate power. These texts are discussed at length in our

analysis of what makes a country a "Catholic country" and the ways the Church has applied its influence in various contexts in Chapter 2. We also engage with other scholars working on the politics of the Catholic church (Agnew 2010; Antosik-Parsons 2024; Borowik and Grygiel 2023; Da Costa 2018; Fahey 1998; Inglis 1998, 2007; Kowalewski 1993; Thornton 2003; Troy 2008).

There is an entire subset to this discourse, however, on the interconnection between religion (particularly the Catholic Church) and morality policies like abortion, euthanasia, marriage equality, prostitution, divorce, etc. (Budde et al. 2018; Calkin and Kaminska 2020; Knill 2013; Knill and Preidel 2015; Knill, Preidel, and Nebel 2014; Schmitt, Euchner, and Preidel 2013). Still other scholars discuss these topics in relation to the Catholic Church, but without explicitly framing them in the morality policy discourse (Blofield 2006, 2008; Dillon 1996; Dobbelaere 2017; Hofman 1986; Holman, Podrazik, and Silber Mohamed 2020; Jelen, O'Donnell, and Wilcox 1993; Jelen and Wilcox 2005; Vaggione 2017; Zwerling et al. 2024). There are few scholars who examine the relationship between non-Christian religions and abortion attitudes and policies (Sommer and Forman-Rabinovici 2019; Whittaker 2002), but given the cases examined in this dissertation, Christianity and particularly the institution of the Catholic Church are the most relevant religious actors.

Religion also obviously plays a role in the literature on conscientious objection described above. Conscientious objection as a principle is rooted in the notion of religious freedom and that the individual ought not be compelled to act against their own convictions. This discourse quickly veers into the legal sphere, as each country's law differs in its precise wording and emphasis, which has led to a myriad of court cases where doctors' rights to practice their religion as individuals is set against the rights of patients or the obligations of their profession, a reference I invoke in the title of Chapter 3. Practitioners as well as social scientists continue to debate the ethics and practicalities of conscientious objection (Heino et al. 2013; Davis and Davidson 2006; Fleming et al. 2018; Fiala and Arthur 2017), and the issue is likely to become even more salient to the general public as the US

Supreme Court weighs in in summer 2024 (Texas v. Becerra 2024). There is a need for more scholarship that balances both sides of this debate and proposes pragmatic and functional solutions for how to balance religious conscience claims against others' human rights (Zampas and Andión-Ibañez 2012).

1.4 My contributions

Having outlined the literature strands to which I plan to contribute, I will now summarize the following chapters, highlighting the ways in which my work complements the existing scholarship.

As suggested by the title of this dissertation, all three of these papers tackle the question of why abortion access *de facto* does not match the theoretical level of abortion access described *de jure* in the policy realm. Their common answer: because of choices made by the state institutions and the bureaucrats who work for them. These chapters also seek to describe and explain why access varies within one country or region that is otherwise similar. One major contribution of this dissertation is in methodological rigor: I approach this question from three different perspectives: first a conceptual and theory-building paper, then a qualitative in-depth case study, and then I look for a wider understanding in a comparative, quantitative design.

In Chapter 2, we look at Catholic countries and European countries as two groups of cases that we would expect to be similar to one another. The overlap of countries that are both Catholic and European are the most interesting to us, and we seek to explain whether they belong more to one group than the other, and if so, why. Even within the realm of countries where the majority religion is Catholicism, the state has a history with the Church as an institutional political player, and the descriptive attributes of their abortion policy are similar to other Catholic countries' abortion policies, there is variation. The Catholic Church opposes liberal policies on sexual and morality topics in general, including divorce, contraception, and abortion. Despite lobbying around the world for similar policy positions in country cases with many shared attributes, we see variation in the levels of

abortion access from consistently conservative Poland to recently-liberalized Ireland and ambiguously "decriminalized" Mexico. We pose Europe as a contrary political influence on some of these countries, concluding that Italy in particular was drawn to the European model of abortion policy rather than the Catholic one.

Chapter 2's variation of the overarching research question of this dissertation is: Why is abortion access different across Catholic countries despite similar influences? The answer: because some Catholic countries had another institutional influence that was stronger than the Catholic one – Europe. We reach this conclusion after comparing short case vignettes of European and Catholic countries, and then we detail the theory in a longer form analysis of influences in the Italian case. This chapter focuses on the *de jure* side of the titular gap, examining which institutions have been successful at influencing policy in a variety of cases. This chapter showcases my engagement with the literature in religion and politics, nation-building, and the interaction between a State and a Nation (in the sense of Anderson's (2016) theory) in developing a communal standard of morality and morality policy, adding to the literature described above on how morality policies are built and modified over time.

Transitioning from Chapter 2 to Chapter 3, I make my contribution to the literature that engages with the role of religion in public administration and in healthcare systems, summarized above. Chapter 3 is a case study on the implementation of abortion policy in Puglia, a region in Southern Italy. My case selection in this chapter is again driven by observable inequality in abortion care provision. Autorino, Mattioli, & Mencarini (2020) observed patterns of conscientious objection, abortion provision, and inter-regional travel for abortion within Italy. All of Italy is governed by one abortion law, Law 194 of 1978, but since 1999, healthcare administration has been delegated to each region (Cicchetti and Gasbarrini 2016). I chose Puglia for my field research because it combines

a high abortion rate with a high rate of doctors who object to abortion, suggesting that a few doctors perform quite a lot of abortions.

When abortion care is not available close to home, economic inequality leads to stratified reproductive outcomes (Colen 1995; Agigian 2019). All residents of Italy are legally entitled to the same standard of care, but regionalization introduces multiple barriers to an equal implementation of the service: individual administrators have the power to stand in the way of both funding and management choices that would facilitate abortion access if they personally are opposed to it, and differing levels of wealth across regions would almost certainly mean that different levels of service are funded. This geographic and cultural disparity in access is a problem for advocates of reproductive justice.

Chapter 3 is based on interviews conducted with medical professionals, administrators, and activists working on this topic, and one of its contributions is the introduction of this interview data. The rich, micro-scale data illuminates the experiences of not only abortion providers, but also conscientious objectors to abortion, building upon the literature that centers medical personnel's experiences to understand abortion policy and engaging with the literature on the ethics of conscientious objection. I find that one reason conscientious objection in Italy is particularly problematic is because of the public nature of its health system: when almost all abortions are performed in public hospitals, that means that the doctors who are opting out of abortion service through conscientious objection are in a sense street-level bureaucrats (Knill and Tosun 2012) declining to implement the abortion law. Patients do not have an alternative way to access the service when these gatekeepers deny them, and the law does not make clear whose rights are more important: the patient's right to care, or the doctor's right to conscience. The system continues to function as well as it does because of consciously committed (Dickens 2008) doctors' goodwill.

I strive for this research to be useful and interesting to readers outside of the academy in addition to its scientific contributions. Therefore, I conclude Chapter 3 with policy recommendations for how the system could be more effectively overseen and administered without fundamentally changing the abortion law in Italy, given widespread opposition to reopening debate on the law.

While the three papers comprising this dissertation all contribute to our understanding of how implementation choices explain the gap between abortion laws and abortion access, Chapter 3 dives deepest into the mechanisms at play here. By the nature of this qualitative single-case study design, it is well-suited to explaining exactly how a mechanism works, while the other chapters take a more macro perspective. By prying open the black box of how street-level bureaucrats choose to interpret Law 194 and especially how they choose to be a conscientious objector or not, I contribute to the more general policy studies and public administrative literature. I understand these individuals to sit at the intersection of private beliefs but also political power, and thus their choices that are grounded in personal convictions have political implications that are relevant to the discipline more broadly.

In sum, Chapter 3 addresses why abortion access differs regionally within Italy, finding that it is because of the policy choice to regionalize the national law, and because of the way regional administrators are trusted to implement this law without any designated watchdog to ensure compliance. This chapter also explores how abortion remains relatively accessible in a region that structurally would be expected to have a low level of access. The answer to this latter question rests in the tireless commitment of the abortion providers of Puglia, some of whom have been working with little to no help from colleagues in their hospital for years. These providers work to improve reproductive justice in their region by employing conscientious commitment, but they worry what will happen in these communities when they retire or if the few colleagues who support their work burn out and register as conscientious objectors.

The phenomenon of geographically uneven distribution of abortion services is presented on a larger scale in Chapter 4. In this Chapter, I introduce data from 10 European countries on where abortion providers are located, and by normalizing this raw count to the population of different regions and generating a map, it is visually apparent that abortion care is not equally accessible across these countries. The ten countries included are all located in Western Europe and all have rather similar abortion policies *de jure*, but they employ different strategies to manage their healthcare resources. The paper then goes on to explore independent variables from politics, economics, and social and moral values that might be related to this distribution through multilevel and linear fixed effects regression models. I find statistically significant relationships between the abortion provider density and regions that are more Protestant (but in the opposite way I would have expected: there are *fewer* providers in Protestant places), and support for LGBTQ+ equality (this time as expected, *more* providers when there is more support for LGBTQ+ equality). I also find a noteworthy null result: there is no statistically significant relationship between regional politics and abortion provider density. This is surprising and bears further investigation in future research, as the literature from the US case would lead me to expect a relationship between regional political attitudes and abortion access (Kim et al. 2023; Medoff 2012; Medoff and Dennis 2011; Roth and Lee 2023).

Chapter 4 is the most explicitly connected to this dissertation's overarching questions about why there is a gap between *de jure* abortion policies and *de facto* abortion laws. The exploratory design with five hypotheses and a wide variety of independent variables and control variables is well suited to addressing this fundamental question. By zooming out to this multi-country comparative quantitative approach, the theory of reproductive justice becomes easier to see again. Residents of all ten of these countries have a legal right to access abortion services for roughly the same length of time (about 12 weeks without regard to the abortion seeker's reason and permissible exceptions for

medical reasons beyond this time period up to about 22 weeks of gestation), yet they have different experiences exercising those rights.

Reproductive justice scholars taught us of the importance of looking to social and historical context to explain why different social groups have differing experiences exerting their reproductive autonomy. Throughout history and across different societies, states have taken an interest in controlling reproduction, and scholars have postulated many explanations for this behavior. Most of them boil down to the idea that certain groups are more desirable to reproduce than others, though which groups are the "in-group" obviously differs with each context. Chapter 4 begins a line of inquiry that can be profitably expanded upon in future research, exploring potential causes of this inequality.

In Chapter 4, I make two further empirical contributions to the study of abortion access by gathering and mapping the data on where abortion providers are located across 10 countries, and by testing possible explanations for this distribution. Here, I build on the geospatial analyses of abortion care that are primarily conducted in the US. I also complement the patient-centric studies in Europe that study how much time and money is involved in traveling to access abortion care. Chapter 4 is the first paper of which I am aware that addresses similar questions of spatial distribution and its determinants in the European comparative setting.

Altogether, this dissertation reaches cohesive conclusions: there are indisputably gaps between what is written in abortion laws and what actually happens in abortion care provision that result in patients who "should" be allowed to have an abortion under the law struggling to access that care in reality. The data in Chapter 4 demonstrates that 17% of women of reproductive age in these countries live in a region with literally zero abortion providers, and a further 8% live in regions with effectively zero abortion providers; a total of 25% of women in Western Europe. This gap can at least

partially be explained by choices made by the public administration sector, bureaucrats who are nominally judged to be apolitical, but whose (arguably strategic) inaction (McGoey 2012a, 2012b) results in few medical professionals being willing to provide care where the care is needed. To some degree, these systems are influenced by religion and specifically the Catholic Church, but this influence is less than one might think. This is demonstrated in the examples of the predominantly European abortion policy in stereotypically Catholic Italy (Chapter 2), the overuse of conscientious objection by doctors who do not morally object to abortion but cannot bear the unpleasant working conditions (Chapter 3), and the surprising findings in the comparative model showing that there are actually fewer abortion providers per capita in Protestant regions than in Catholic ones (Chapter 4).

1.5 Future Research

The work done in this dissertation has already inspired me to begin additional research projects, in addition to ideas I have for future projects. Firstly, in addition to collaborating on Chapter 2 with Payton Gannon, we have begun a fruitful cooperation on other research about abortion access in Italy and comparative cases, one paper of which is already published (Pullan and Gannon 2024) and another of which is under review (Gannon and Pullan 2023). We plan to write together about regional differences in abortion policy implementation within Italy among other topics. It would also be interesting to compare the perspectives of patients and doctors to develop an even more thorough understanding of one system's abortion policy implementation.

A second strand of further research that I have planned involves the dataset introduced in Chapter 4 of this dissertation. I would like to test for relationships between abortion provider density and more variables, such as the share of hospitals with a religious affiliation, the region's female labor market participation, various indices of gender equality and other gender-related policies. I remain curious about why there is no demonstrable link between regional parliaments and regional abortion provider density, so perhaps more qualitative investigation would yield further information on this topic. I would also like to dig into the results of Table 4.1 qualitatively to explore why capital cities,

arguably most similar cases, would have such different abortion provision levels. I would also like to pursue additional geospatial analyses with this dataset to estimate travel times and costs for patients to reach clinics in these regions. In particular, this data could be paired with population data on migration, nationality, or (in the unlikely event it is available) race to understand whether similar correlations between race and economic class like in the US exist in the European context. It would also be fruitful to consider the data at even more local geographical units to understand more specific neighborhood wealth differentials, though this would probably require focusing in on a smaller area rather than the full set of ten countries.

The framework we develop in Chapter 2 will also lend itself to future research. Scholars could specifically analyze other countries that are both Catholic and European, or they could focus on the Catholic non-European countries and posit alternative influences for these countries that might explain variation among them. France would be a particularly interesting case to consider, especially given the salience of its recent constitutional reform enshrining the right to abortion; we excluded it from Chapter 2 in part due to lack of expertise, as most of the literature relevant for this analysis is only published in the French language, but I would love to see a French-speaker apply this theory in the French case.

Moving away from the specific data and case expertise I have developed in this dissertation, I would like to pursue further projects that explore reproductive justice in the European context. Additional data would be required to evaluate whether people of color, immigrants, poor people, disabled people, and other marginalized groups experience particular barriers to abortion care and other reproductive care in Europe. In this vein, I am also interested in projects that will link abortion with other reproductive and family-building policies, and I have already begun a collaboration with Matthew Trail to evaluate the intersection of attitudes on abortion and foster care among US American evangelicals.

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Chapter 2: Between the Church and the State: Catholic and European Influences on Abortion Governance in Italy and Beyond

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Abstract

Supranational cultural institutions and communities play an interesting role in the development of abortion policy both historically and today. In this paper, we consider two such institutions: the Catholic Church and the European community. The Church is famously anti-abortion, and we describe the ways in which the Catholic position manifests itself in different countries. Conversely, almost all European countries have liberal laws that allow abortion on demand for 12 weeks of pregnancy. Italy sits at the intersection of European and Catholic identities. Italy adopted European-style liberal abortion laws early, but Italians continue to identify with the Church in surveys, which is one of the causes of high levels of conscientious objection by medical professionals. Italy's abortion policy pleases neither Catholics nor secularists. We explain this by understanding Italy's abortion law as liberal *de jure*, but its culture is still heavily influenced by Catholicism, resulting in limited abortion access *de facto*.

Keywords: abortion governance, Catholicism, European Union, Italy, Latin America, religion in politics

2.1 Introduction

How do societies decide to regulate moral questions in an era of increasing globalization, pluralism, and religious difference? We review abortion policy development as influenced by two major institutions: the Catholic Church and the European community. These two pillars of Western society have grown and developed together, influencing each other and each influencing various nations in Europe and their former colonies. In this examination, we disentangle one from the other by looking at the countries that sit at the intersection of Catholic and European identity, particularly Italy.

To those unfamiliar with Italy, it may seem like an unconventional place to study abortion. One might wonder whether, due to its geographic and historical proximity to the Church, abortion is even legal in Italy. On the contrary, however, Italy adopted a liberal abortion law earlier than almost any other Catholic country, and it has furthermore been very committed to maintaining this policy despite attempts at reform. Inspired by this tension in the Italian case, we thus ask ourselves: how does the Catholic Church seek to influence abortion policies, and why is it more successful in some countries than in others? What role, if any, does Europe, understood broadly as inclusive of the EU institutions as well as specific other European countries, play in influencing abortion policy in countries that are both Catholic and European?

In this paper, we make both theoretical and case-specific arguments. First, we develop a theory about the ways that Catholicism and Europeanism influence abortion policies by exploring several shadow cases. This theoretical contribution could profitably be applied to understand the determinants of other European and/or Catholic countries' morality policies. We then apply this theory to the Italian case, where we argue, perhaps surprisingly, that Italian abortion policy is much less Catholic than a layperson might assume, in large part due to the historical antagonism between the Church and the Italian state. Catholicism plays a role in the implementation of Italian abortion governance, but not the letter of the law. Despite having a secular State that wrote secular laws, the

Italian Nation (Anderson 2016) remains committed to some Catholic values that undercut the effectiveness of this law.

2.2 Existing Literature

Our arguments grow out of the robust literature on religion and politics, as well as general policy literature. We begin from a historical institutionalist approach in our analysis of the relationship between the Church and individual states, as well as the relationships between states (Grzymała-Busse 2015; 2023). We understand the Church as an institution to wield soft power (Nye 2005) in the realm of statecraft, sometimes engaging in slightly harder ways in countries that were amenable to the Church taking over some state functions (Kissane 2003). We consider each state's history with the Church in addition to its modern-day religiosity following path dependency theory (Mahoney & Schensul 2006): historical efforts by the Church to influence policy still have lasting effects today, because the country has continued down that path for many years, even if it does not have a close relationship with the Church today.

Building on the morality policy literature, we understand abortion policy to be worthy of separate study because we would not expect it to develop and be influenced in the same ways as redistributive policies or along the lines of class conflicts (Kreitzer et al. 2019). Abortion policies are more similar to policies on LGBTQ+ rights (Knill & Preidel 2015), euthanasia (Burlone & Richmond 2018), and drug use (Euchner et al. 2013) in terms of what motivates policymakers (Kreitzer et al. 2019) and how people develop their attitudes on these topics (Kurzer 2001). The Catholic Church has historically involved itself in morality policy debates, and other scholars have considered why the Church was more successful in some arenas than others (discussed in Section 6.3).

Demographer Gianpiero Dalla Zuanna summarizes the challenge of evaluating the impacts of the Catholic Church's involvement in such policies: "An understanding of how and to what extent religion influences marital and reproductive behavior in a particular geographical context during a specific time period thus requires historical reconstruction. In addition to analyzing Church principles and values, one must also examine the behavior of the individuals involved: theologians, the Church

hierarchy, parish priests, and the parishioners themselves" (Dalla Zuanna 2011, 1). As political scientists of the historical institutionalism school, we would argue that in addition to these micro and mezzo level actors, national and supranational institutions and actors must also be considered. Thus we turn to the development of the modern European state and the international European community, evaluating how these various institutions influence one another as well as interacting with the Church as another political player.

For the secular components of our analysis, we turn to more traditional political science theories for how policies develop. Policy diffusion theory (Shipan & Volden 2012) suggests that states that are geographically proximate or culturally or legally intertwined in some other way will influence each other. As the peoples of Europe coalesced into modern states, some of them were influenced heavily by the Church, as well as by each other (Grzymała-Busse 2023). Some scholars have already explored the similarities among European nations – and particularly European Catholic nations'– stances on abortion, though with an emphasis on individual attitudes rather than institutional influences (Jelen et al. 1993). At the same time, the right for each state to determine its own abortion policies is an explicit principle of European treaties, and there is some cross-national variation in both abortion policies (Center for Reproductive Rights 2023) and abortion access (Pullan 2023). While European values like free movement may draw states closer together, it can also emphasize their differences, such as when abortion patients travel from one country to another in search of care that is denied by one state but available in another (Garnsey et al. 2021).

Nation theory can also provide guidance in evaluating communities. Anderson (2016, p.6) famously defined nations as "imagined political communities" where nations are "imagined" as "both inherently limited and sovereign." In this theory, Nations are distinct from States and governments; one State often contains many Nations. Nations are bound by a shared mythology and history, but not necessarily formal institutions. Anderson explains how nationalism as a concept rose contemporaneously with the decline in influence of traditional cultural and religious institutions. Nations are thus shaped by religion, but also sometimes defined in opposition to religious

institutions. This paper will use nation theory to shed light on the difference between the Nation of Italy, referring to the people and their cultures and values, and the State of Italy, the constellation of formal institutions that build policies and regulate domestic and international behavior, as well as how the nation and the state interact.

This paper also contributes to a growing literature on abortion access in Europe and especially in Italy, where conscientious objection is a defining feature of its policy, as we will discuss below. Other scholars have sought to explain why Italy has such a high rate of conscientious objection (Gannon 2023; Pullan 2022a; Minerva 2015), analyze the effects this law has on patients (Gerdts et al. 2016; Guzzetti et al. 2021; Zanini et al. 2021) and doctors (De Zordo 2018), how the Italian law came to be from a legal perspective (Caruso 2020), and how the law's implementation affects demographic trends such as abortion rates and patient characteristics (Autorino et al. 2020; Aiken et al. 2021; Fiala et al. 2022).

2.3 Case Selection and Method

To explore the competing influences of both Catholicism and Europeanism on abortion policy, we qualitatively explore a variety of country cases. In the following sections, we delve into what makes a country Catholic or European and, consequently, what an archetypical Catholic or European abortion policy looks like. We develop these pictures by exploring representative cases that fall into three groups: Catholic and European, Catholic but not European, and European but not Catholic. This allows us to identify patterns among the Catholic and European countries that can be used to untangle which elements are most related to which influences. In these cases, we consider components of the policy itself (e.g. the circumstances under which abortion is permitted, requirements for access such as waiting periods or counseling, and conscientious objection) as well as attributes of the policy development process, such as the historical timing, political process, and the historical development of Church-state relations.

We evaluate how important both abortion as a policy area and the Catholic religion were to the state's priorities, as well as the religiosity of the people living in that state, understanding that

these may not be congruent. The State may have a more or less contentious relationship with the Church as a political actor for a wide variety of historical reasons, and the people may be more or less committed to their religious and cultural association with the Church. Taken together, these evaluations describe the relationship between the Church and the State and allow us to position the abortion policy as closer to one or the other of these institutions.

Anderson's nation theory can also clarify this proposition: a State or government may be secular, even if at least one of the Nations living in that State ties religion deeply to its existence (Anderson 2016, ch. 2). This is certainly true for Italy: Catholicism is a cultural value held by many Italians, but as we will explore in further detail below, the State apparatus developed a strong opposition to Catholic institutions. Our case selection is partially based on which countries have distinctive Nations and States, to shed a light on the influences of the people and their culture of the nation versus the influences of the formal State institutions.

Thus, we develop our understanding of Catholic abortion policy and European abortion policy through the exploration of ten shadow cases. For the intersection of Catholic and European, we take Ireland, Portugal, and Poland. We argue that these three represent the spectrum of Catholic-European abortion policies and policy development trajectories and that while there are other countries that might be considered both Catholic and European, they are generally similar to one of these three (e.g. Spain to Portugal, Malta to Poland). For Catholic countries outside of Europe, we include Uruguay, Mexico, and Argentina, again with an aim towards a representative image of countries that fit this profile. These three countries reflect different levels of religiosity among the people as well as differing histories of legalization of abortion. We notably excluded countries where abortion is completely illegal, as this is more of an anti-abortion policy. For our final set of non-Catholic European countries, we include countries with more religious pluralism like the UK and Germany, as well as less religious countries like the Netherlands and Sweden.

We then apply this understanding of Catholic versus European influences on abortion policy to the Italian case. We select Italy not only out of personal interest, but because it is often

stereotyped as the heart of Catholicism. It is true that in many ways, Catholicism and Italian identity are inextricably tied, but we argue that this connection is cultural and tied to the Nation, not legal, and that in fact the Italian State apparatus is quite secular. Our theory explains why a country with such seemingly strong ties to the Catholic Church has an abortion policy that is actually quite liberal on paper: secular European influences and the history of antagonism by the Church as a political actor drove Italy to adopt a European-style policy, where other countries that had closer state relationships to the Church adopted policies that more closely followed the Church's ideological teachings.

2.4 Catholic Abortion Policy

2.4.1 The Church's Stance and Role in Policymaking

Though there is no mention of abortion in the Bible, the Catholic Church today is vocally and consistently anti-abortion. The Church lobbies for policies preventing or limiting abortion all over the world. The Church's influence is less prominent in recent decades as more and more younger people live together before marriage, engage in premarital sex, and use contraceptives, all of which are forbidden by the Church (Caltabiano & Dalla Zuanna 2021).

2.4.2 Catholic Countries

What makes a country a "Catholic country"? Historically, countries often had an official state religion, but this is less and less common in the West (Pew Research Center 2017b). What can be clearly measured is the religious denomination of a country's citizens, as well as how often those people attend religious services and how important they evaluate religion to be in their lives and their cultures (Pew Research Center 2017a; Pew Research Center 2018). Particularly in Europe, many states co-developed with the Church and/or adopted the Church's administrative structures as templates for their new state structures (Grzymała-Busse 2023).

In countries with a substantial Catholic presence, the Church can have a significant influence on both policy choice and social attitudes towards certain behaviors (Fahey 1998, Troy 2008,

Kowaleski 1993). The Catholic Church affects policy by taking public positions and lobbying, and it also has a substantial influence over a populous' attitudes about aborion, gay marriage, sex, and other social issues rooted in clergymembers' position at the pulpit (Grzymala-Busse 2015, Jelen, O'Donnel & Wilcox 1993, Thorton 2003, Dobbelarere & Perez-Agote 2015). This is not to suggest that Catholic countries always act in lock-step with the wants or values of the church, but that the opinion of the Church holds sway over people's beliefs and policies generally (Grzymala-Busse 2015, Thorton 2003, Holman et al 2020). Borowik & Grygiel (2023) test this in Poland, finding that the Church is only able to influence citizens' attitudes to a limited degree on so-called biopolitical topics like abortion, in vitro fertilization, and homosexuality. Additionally, Agnew (2010) explores the geopolitical strategy employed by the Catholic Church as compared to other religious denominations as a matter of the Church's survival in a modern context, including a shift from the traditional centers of Catholicism in Europe to former colonized States in the wake of cultural change in Europe. Catholic-affiliated social movements (Vaggione 2017) and economic and political power structures (Blofield 2006) also play a role in shaping a country's cultural values to be aligned with their religious beliefs. We therefore consider a combination of variables including the religiosity of the population, power of the Church politically and socially, and history and development of the Church in each State (Anderson 2016, Grzymala-Busse 2015) when we describe a country as "Catholic."

In this section, we review the history of the state, its policies on abortion, and how this intersected with the state's relationship with the Catholic Church. This list is not exhaustive but is meant to highlight the key variations in Catholic countries' abortion governance. Because we will contrast Catholic influence with European influences below, we must consider Catholic countries that are not European, to observe how Catholicism influences abortion policy separately from the influence of Europe; this is why we include several Latin American examples that similarly have a history with the Church and/or a sizable Catholic population.

There is much valuable scholarship about the role of the Catholic Church in the development of the modern secular state, particularly in Europe. The Church's infrastructure and hierarchy have

existed longer than European States. As borders shifted, kingdoms and empires rose and fell, and modern forms of government began to develop, throughout it all, the Church had a presence in each community (Grzymała-Busse 2023). Bishops served as regional administrators, and there was ongoing conflict between the pope and various kings over who should be entitled to appoint bishops and other clergy members. The position of the Church in a given territory often largely depended on the personal relationships between royals and clergy, and particularly how successfully the Church was able to maintain control of its historical institutions (Grzymała-Busse 2023, p.43).

2.4.3 Catholic European Countries

2.4.3.1 Republic of Ireland

For many years, the Republic of Ireland (hereafter Ireland) was seen as the quintessential Catholic country when it came to moral issues like abortion, divorce, and marriage equality. Throughout the 1980s-2000s, repeated attempts to liberalize in these areas were rejected. The tide turned, however, in 2018 when the Irish people voted to repeal the previous restrictions and allow abortion to be regulated by the parliament, thereby legalizing abortion. This passed by an overwhelming majority, but after a very heated campaign, which has been studied by many scholars of social discourse (Brown & Calkin 2020; Ralph 2020).

Ireland's Catholic identity is fundamental to its national identity (Calkin & Kaminska 2020; Kozlowska et al. 2016), supporting Irish independence from Britain by differentiating the two peoples (Grzymała-Busse 2015). More than many states, Ireland deeply integrated the Catholic Church into its State functions, particularly those related to children and mothers (Kissane 2003). Thus the State had a structural interest in appeasing the Church, as the removal of Church support would leave the state with significant gaps in welfare provision. While their geographical neighbors were liberalizing abortion laws, the Irish State remained against abortion, adopting the Eighth Amendment to the Irish constitution in 1983 (Field 2018). This amendment declared the life of a pregnant person and the life of a fetus to be of equal weight, which meant that abortion was only

permitted if the pregnant person's life was in danger. Irish voters reaffirmed over and over again their commitment to not legalizing abortion.

So what changed to cause such a stark reversal in 2018? As demonstrated by parallel liberalizations on marriage equality and divorce, the influence of the Church over both State institutions and the Nation's hearts and minds had waned. Scandals in the Church, combined with an already decreasing identification with religion and increased support for religious pluralism, led the Irish public to vote in favor of regulating abortion by a dramatic margin (Calkin & Kaminska 2020; Inglis 2007). Today, abortion in Ireland is legal in the first 12 weeks of pregnancy on request. Services are provided at hospitals throughout the country thanks to a robust peer-to-peer support network of doctors willing to perform abortions (Stifani et al. 2022).

2.4.3.2 Portugal

Portugal, like Ireland, resisted abortion liberalization, not allowing voluntary abortions until 2007 (Feio 2021). Portugal today has a conscientious objection provision, and 80% of doctors are conscientious objectors as of 2013 (most recent data available)(Feio 2021). This has led to reports of struggles to access abortion (Feio 2021).

Portugal has been deeply Catholic since its founding (Vilaça & Oliveira 2015), but in 1911 was proclaimed a secular republic (Vilaça & Oliveira 2015). Between 1911 and 1974, Portugal experienced radical political change, with the Catholic Church being reinstated as the state religion and then removed in favor of a secular government again (Vilaça & Oliveira 2015). There are serious National anti-clerical leanings because of the role of the clergy during Portugal's period of military dictatorship (Vilaça & Oliveira 2015).

Portugal's moves towards liberalization occurred following highly public abortion court cases (Stifani et al. 2018). As a result, the law was reformed to allow abortion in cases of fetal abnormality, rape, and threats to the life and health (including mental health) of the pregnant person, but abortions in Portugal remained rare (Vilar 2002). In the 1990s, an attempted referendum failed to liberalize the law (Stifani et al. 2018). Finally, in 2007, the Portuguese won the right to voluntary

abortions. There is limited research on abortion in Portugal, and we recommend it as well as an interesting case for future research.

2.4.3.3 Poland

The Polish history of abortion governance is complex and different from that of most other countries considered in this paper, primarily because Poland first adopted a very liberal abortion law and later a very conservative one under different regimes (Krajewska 2021; Mishtal 2017). Today Poland allows abortion only in cases of rape or the life of the pregnant person. Poland draws media attention as the second-most conservative abortion law in the EU (following Malta's complete ban), and as one of the few countries in the world that is actively limiting abortion access rather than expanding it.

To summarize, the Polish nation has been dominated by various foreign rulers throughout its history, with only short periods of independence until the formation of the Third Polish Republic in 1989. Poles have long been Catholic, and the Church served as a constant throughout eras of significant change in the ruling State, making Catholicism extremely important to the Polish Nation (Grzymała-Busse 2015, ch. 4). The Church has consistently had access to state actors that allowed them to influence policy (Grzymała-Busse 2015, ch. 4). Religiosity and church attendance in Poland are the highest in Europe (Halman et al. 2022).

Like many communist countries, in 1956 Poland adopted a very liberal abortion policy. In this era, abortion became the primary method of family planning (Calkin & Kaminska 2020). In the late 1980s, a rapid decline in the official abortion rate began, and in 1993 a new law was adopted that only allowed abortion to save the pregnant person's life or health, or in cases of fetal abnormalities or rape (Ciaputa 2019). In 2020, the fetal abnormality indication was removed, making the already conservative law even more restrictive (BBC News 2020).

2.4.4 Catholic Countries Outside Europe

2.4.4.1 Uruguay

Uruguay has a strained relationship with the Catholic Church: Catholicism is the largest practiced religion, but the plurality of people in Uruguay do not identify with any religion, making it the least religious country in South America (Soper & Fetzer 2018). Uruguay became the first Latin American country to allow abortion in 2012 (Wood et al. 2016), but it is still technically criminalized with specific exceptions (Berro-Pizzarossa 2023). Both individual doctors and entire facilities can be conscientious objectors (Wood et al. 2016; Berro-Pizzarossa 2023). Nationally, 30% of doctors are objectors, and in some regions it is much higher: 80% according to Wood et al. (2016) or 100% according to Berro-Pizzarossa (2023).

Despite the low level of Catholicism in Uruguay compared to the rest of Latin America, the Catholic Church still exerts its influence through presence in public spaces, though this is resisted by the State (Da Costa 2018). Going back to the colonial era, Uruguayans always fiercely resisted the Spanish colonists' efforts at conversion (Soper & Fetzer 2018). When Uruguay was founded, though the leaders were Catholic, they did not view religious hegemony as fundamental to national identity. Uruguay officially embraced a secular state in 1861, significantly earlier than most of Latin America (Fernandez Anderson 2016). Unlike in the majority of Latin America, Catholicism is not the official religion of Uruguay and religious instruction is banned in public school (Fernandez Anderson 2016), which scholars have described as laïcité (Da Costa 2018).

Against this backdrop, it is fair to question whether Uruguay is actually a Catholic country at all. We include it in this analysis for several reasons: firstly, despite this history, the Catholic Church has substantial soft power (Nye 2005) and affects the Nation. Secondly, it is a common case study in abortion policy literature because of their position as the first in its region to legalize (Berro-Pizzarossa 2023). Thirdly, the Uruguayan journey through laïcité (Da Costa 2018) is similar to Italy's Nation-State dynamics, which we will discuss in more detail below. It is undeniable that Uruguay has a history with Catholicism, even though the Church and the State have developed in separate directions.

2.4.4.2 Argentina

In 2020, the Argentinan parliament legalized abortion up to 14 weeks of pregnancy. The law requires that the procedure be performed at no cost to the patient within ten days (Ruibal 2023), but despite this, abortion access is difficult for many pregnant people because of conscientious objection (Latourrette 2023). This law was particularly significant because the current pope, Francis, is from Argentina and the first Latin American pope, a move interpreted as the Vatican's recognition of the importance of Latin America to the Catholic Church (Donadio 2013).

The Argentinian government first took up the topic of abortion legalization in 2018, but the bill ultimately failed in the Senate. Due to the sustained pressure from activists, in just two years, they were able to return this topic to the legislative agenda in a move that was heralded as the beginning of a "marea verde" or "green wave" across Latin America (Casas 2021). Prior to this law's passage, abortion was available in cases such as a threat to the pregnant person's health, or a pregnancy resulting from rape. Pope Francis and the Catholic Church were seen as a driving force behind the anti-abortion movement, but the pro-abortion activists won this battle (Daby & Moseley 2021).

2.4.4.3 Mexico

In 2021, Mexico also took steps toward abortion legalization. The Supreme Court declared the criminalization of abortion to be unconstitutional, but this was distinct from declaring abortion fully legal and required further action at the state level. In 2023, the Mexican Supreme Court went a step further and overturned all federal penalties relating to abortion (Associated Press 2023). This ruling will require all federal healthcare institutions to provide abortions to those who request them (Associated Press 2023). Some of Mexico's states, however, still criminalize abortion in their state penal codes (Associated Press 2023).

Catholicism was fundamental to the founding of Mexico. A priest is credited with lighting the match of Mexican independence, and initially only Catholics were allowed to be citizens (Agren

2016). The Church and the State would then go through centuries of tension and conflict, with the State trying to control the Church (Agren 2016).

There are also concerns that despite the recent court ruling, cultural opposition to abortion remains strong, and the right for medical personnel to object on conscience grounds has been enshrined in Mexican law since 2018 (Kitroef & Lopez 2021). Prior to the Supreme Court ruling in 2021, abortion was legal in Mexico City and the state of Oaxaca, but conscientious objection impeded access (Küng et al. 2021). These regions experience similar problems to Italy: longer waits for patients seeking abortion and increased stress and work for nonobjecting doctors (Küng et al. 2021).

2.4.5 Summarizing Catholic Abortion Policy

As we come to see, abortion policies differ significantly even among Catholic countries. Both European and Latin American Catholic countries continue to liberalize their abortion law, with some exceptions. Catholicism informs global cultural values in many different ways, and the Church has been more or less involved in the politics of different nations. From the six cases above, we can extract policy elements that are typical of a Catholic abortion policy, summarized in Figure 1 and Table 1.

These policies allow for conscientious objection among care providers or sometimes entire healthcare structures. Counseling and waiting periods for abortion seekers are usually required. There is variation in how Catholic countries handle therapeutic abortions (those deemed medically necessary later in pregnancy due to risks to the pregnant person's health, or when the fetus is incompatible with life), with some allowing it all the way until birth and others placing a limit around the time when the fetus could in principle survive on its own with medical assistance ("viability"). Catholic countries generally legalized abortion relatively recently, with three of the six cases we explore here legalizing in 2018 or later. Each country reviewed here has an individual relationship with the Catholic Church, and we see variation in the level of Catholicism in the population as well as the degree to which the State adopts Catholic priorities.

2.5 European Abortion Policy

In this section, we will explore the national and supranational institutions that evaluate abortion policy, review the key court decisions, and highlight representative examples of country-level abortion governance approaches across Europe.

In policy studies, the phenomenon of policy diffusion describes cases where countries with cultural, social, and geopolitical ties seem to "catch" a policy from a neighbor and adopt it as their own (Shipan & Volden 2012; Berry 1990). Feminist institutionalist scholars (Krook & Mackay 2011) have observed policy diffusion in other gendered policies, such as gender quotas (Krook 2006; Piatti-Crocker 2019) and mainstreaming (True & Mintrom 2001). We extend this line of thinking to abortion policy, arguing that it has diffused throughout Europe, leading to a European cultural consensus of relatively similar positions across the continent.

Abortion laws in Europe fall into a few distinct time periods (Figure 2). First to legalize abortion were communist countries, a phenomenon that is studied by other scholars but is beyond the scope of this paper (Hyne 2015). The first European effort to limit abortion was in Ireland in 1983, as discussed above. This move inserted a prohibition on abortion into the Irish constitution, but abortion had never been legal in Ireland; this strengthened their commitment to prohibiting abortion and made it more difficult for pro-abortion activists to legalize abortion. The only country in Europe to have once legalized abortion and taken significant steps to restrict it is Poland. Notably, these are both countries where Catholicism had a strong influence.

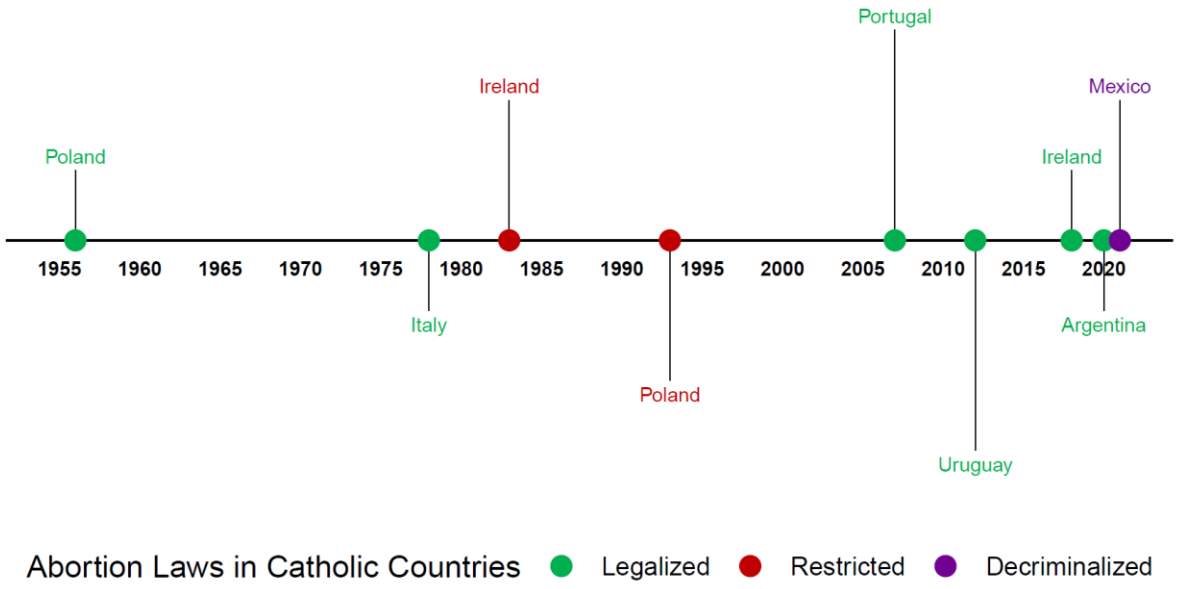
Among secular European countries, abortion became increasingly accepted and was legalized in more and more countries, with former communist countries reaffirming their choice to keep abortion legal in the early 1990s. A handful of countries legalized after the year 2000, but for most, this issue of abortion was settled in the 1970s.

Particularly in the Schengen area where borders are open between European countries, travel for abortion is a well-documented phenomenon (Sethna & Davis 2019; Garnsey et al. 2021).

This is one way in which the European Union's lack of a uniform abortion policy nonetheless has an effect on abortion access.

Religious pluralism and the separation of church and state are explicit values of the European Union (Council of Europe 1950; European Parliamentary Research Service 2022), but most people in Europe still identify as Christian. Most European nations can be clearly categorized as either Catholic or Protestant based on what religion is practiced by their citizens, with the closest balance in Germany (42% Catholic, 28% Protestant) (Pew Research Center 2017a). Only the Netherlands has a plurality of people reporting no religious affiliation.

Figure 2.1: Historical timeline of abortion legalization in Catholic countries



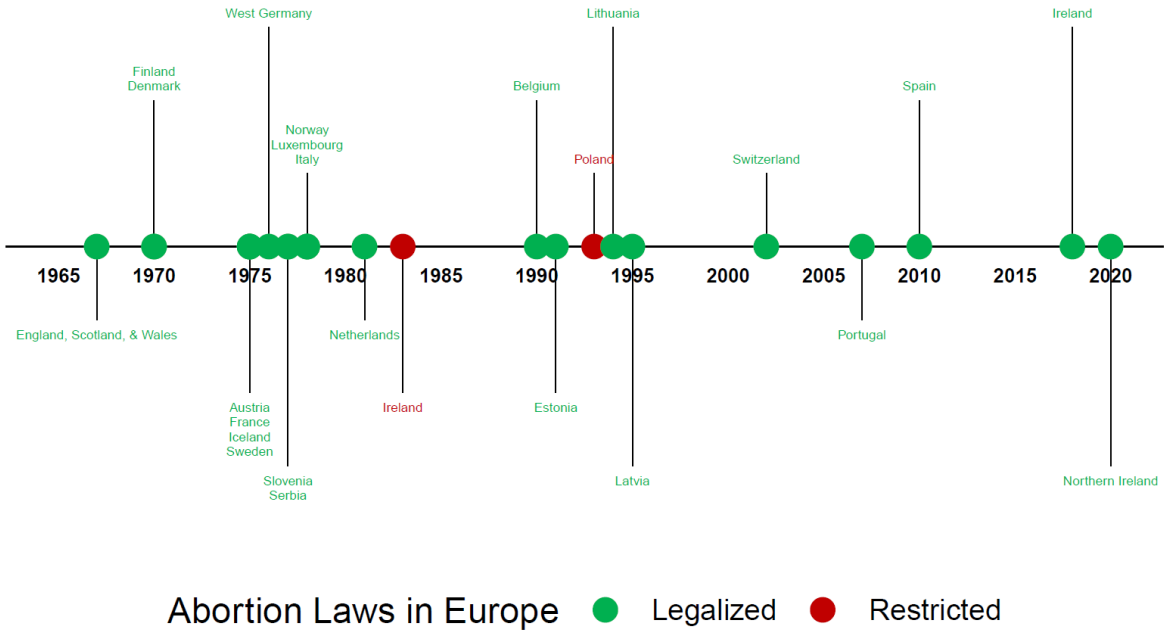
Source: Compiled by authors from the preceding sections

Table 2.1: Provisions of Abortion Regulations in Catholic Countries

Country	Gestational Limit: Elective	Gestational Limit: Therapeutic	Waiting Period	Mandatory Counseling	Cost	Conscientious Objection
Ireland	12 Weeks	None	3 days	Yes	Free	Yes
Portugal	10 Weeks	24 weeks	3 days	Yes	Free	Yes
Poland	Abortion only allowed in rare circumstances					
Uruguay	12 Weeks	None	5 days	Yes	Free	Yes
Argentina	14 Weeks	None	None	None	Free	Yes
Mexico	Legalization and restrictions differ by region					Yes
Italy	12 Weeks	Viability	7 days	Yes	Free	Yes

Source: Compiled by authors from the preceding sections

Figure 2.2: Timeline of National Abortion Laws in Europe



Source: Abort Report 2023

Similarly, abortion governance is not uniform across the European Union or the broader European community (Katsoni 2021; see Table 2). As this diverse community of states has increasingly harmonized their policies across many areas, recognition of a right to abortion is not required for membership (Pullan 2022b). The European Convention on Human Rights includes a right to life, but it does not take a stance on whether this is meant to apply to fetuses or if it privileges the life of the pregnant person (Council of Europe 1950).

Table 2.2: Policies restricting abortion in European Countries

	Austria	Belgium	Croatia	Cyprus	Czech Republic	Denmark	Estonia	France	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Lithuania	Luxembourg	Netherlands	Poland	Portugal	Romania	Slovakia	Slovenia	Spain
Mandatory Waiting Period		x		x					x		x		x	x	x		x	x		x		x		x
Mandatory Counseling		x							x		x	x		x		x		x				x		
Conscientious Objection Allowed	x	x	x		x	x	x	x	x	x	x		x	x	x		x	x	x	x	x	x	x	x

Countries not listed do not employ any of these three abortion restrictions but may employ others.
Sources: Anedda et al. (2018); Hänel (2019)

European treaties spend much text defining and protecting the shared values of human rights across the EU. Conscientious objection is fundamentally rooted in human rights claims: the right for individual doctors to practice their own religion and moral values. The right to bodily autonomy is also rooted in the human rights of abortion seekers. In this way, the European Union and the Vatican are sometimes in tension (Mishtal 2014). We now turn to case studies of national European laws to determine what characterizes a European abortion policy.

2.5.1 Sweden

Sweden has a very liberal abortion policy. As such, Sweden has the highest abortion rate in Europe and one of the highest rates of medication abortion use (RFSU 2020). In 2018, 93% of abortions were medication abortions, and 84% of abortions took place before 9 weeks (RFSU 2020). Sweden also has a nationalized healthcare system; thus, abortion is covered for free like other medical procedures. Sweden is seen to have one of the most progressive abortion policies because it

is widely available, free for patients, and on demand (European Parliamentary Forum for Sexual and Reproductive Rights 2021).

In 1938, Sweden was one of the first countries to legalize abortion in at least some circumstances (RFSU 2020). For the next 40 years, Sweden had many reforms to their abortion law, and in 1975, they legalized abortion on demand in the first 18 weeks of pregnancy (RFSU 2020). Abortion is allowed after 18 weeks with approval from the National Board of Health and Welfare.

Sweden is one of the six EU countries that does not have a conscientious objection provision (Anedda et al. 2018). In 2020, two midwives brought a case against Sweden in the European Court of Human Rights, arguing that they were not hired because they refused to participate in abortion and this violated their religious freedom (RFSU 2020). The Court refused to take up the case, saying that Sweden had the right to enact their own abortion laws (Grimmark v. Sweden 2020). A spokesperson for RFSU, a major Swedish reproductive health nonprofit, summarized the Swedish approach to abortion care: “It is not a human right for nursing staff to refuse to provide care.” (Elks 2020).

2.5.2 United Kingdom

The UK’s abortion policy is managed on multiple levels: in the devolved parliaments of Scotland, Wales, and Northern Ireland, as well as in Westminster. England, Wales, and Scotland have the same abortion laws, but Northern Ireland has its own. Abortion has been legal in England, Wales, and Scotland since 1967 (Office for Health Improvement & Disparities 2022). Abortion is legal on broad social grounds, which is interpreted as on demand before 24 weeks.

The UK has nationalized healthcare, and 99% of the abortions performed every year are free to British residents covered by the National Health Service (NHS) (Office for Health Improvement & Disparities 2022). As one of the earliest countries to legalize abortion, England became a destination for international abortion seekers who could not get an abortion at home, especially abortion seekers from the Republic of Ireland before 2018 (Sethna 2019; Garnsey et al. 2021).

Northern Ireland criminalized all abortions until 2020 (Pierson et al. 2022). It is also noteworthy that the Republic of Ireland’s abortion referendum took place in 2018 and their new law

took effect in 2019, so inevitably, access for residents of Northern Ireland, which has an open border with the Republic of Ireland, became easier. Today, abortion policy in Northern Ireland is similar to the policy for the rest of the UK (Pierson et al. 2022).

The UK is an interesting case to consider for many reasons, including the history of the British Empire and, thus, the greater levels of diversity seen in the UK as compared to other European countries. Despite having its own national church(es), British culture accommodates more religious pluralism (Pew Research Center 2018). There was never a concern about undue influence from the Catholic Church in the UK, as the Anglican Church was founded specifically to avoid papal influence (Milton 2017). Despite having very similar religious tenets to the Catholic Church, the Anglican Church was by definition not a threat to the state, as it is led by the British Monarch. In contrast to other cases we have reviewed here, particularly the Republic of Ireland, the Catholic Church did not have sufficient power or institutional influence in the British case to push its dogma into policy, demonstrating that the mere presence of such beliefs or believers among the population is quite different from the political power associated with the Church as an institution and the pope as an actor. The UK stood out early in the European abortion landscape as a destination for people from many cultures, and its cultural attitudes on abortion also reflect pluralism and individual freedom.

2.5.3 The Netherlands

The Netherlands have a reputation for having a very liberal abortion law due to their late gestational limits: voluntary abortions are permitted up to 22 weeks. Beyond this, abortion is still available in case of threat to the life or health of the pregnant person, including their mental health. There is a waiting period of five days after requesting the abortion, and abortion is performed for free for residents of the Netherlands but at a cost to foreigners (Government of the Netherlands 2022).

Dutch abortion policy developed from the bottom up, with individual patients and doctors adopting change before policy actors caught up. By the 1960s, it was widely acknowledged that

illegal abortion was common, and in the liberalizing climate of sexual politics that swept the West, more women seemed emboldened to ask for it (Outshoorn 1986). The Dutch government's initial response was to delegate this issue to the professional associations of doctors, but the doctors could not reach consensus. Meanwhile, the infrastructure to provide abortions grew, to the point where abortion was effectively available on demand, despite the absence of a law officially allowing this. A bill legalizing abortion was finally passed in 1981 and went into effect in 1984 after three more years' delay to work out the details of policy implementation (Outshoorn 1986).

On the timeline of European abortion laws, the Netherlands looks to have legalized after the rest of Western Europe, but in a reversal from what we see in many Catholic nations, abortion access *de facto* actually exceeded abortion access as defined *de jure* in the law. Culturally, the Dutch people experienced the same shift in public morality and perception of abortion as their European peers, but due to the complexities of the Dutch political system and the specific parties and individuals that were in power during this period, formal legal approval was delayed (Outshoorn 1986).

2.5.4 Germany

In Germany, abortion is regulated under the criminal code (Deutsches Strafgesetzbuch (StGB) § 218 und 219). Officially, it is still a crime to have or provide an abortion, but these crimes are not punished if the patient undergoes mandatory counseling and observes a waiting period (StGB § 218 (1) 1-3). Functionally this means that abortion is available on demand (StGB § 218 (1)1). After 12 weeks, abortion is only permitted if the pregnant person's health is in danger (StGB § 218 (2)).

Abortion is a morally complex issue in German culture because of their history. Abortion has long been criminalized to some degree, but penalties were reduced in the Weimar Republic of the early 1900s (Ferree 2002). Then under the Nazi regime, abortion was heavily punished among Aryan women but encouraged for Jews and other groups. After World War II, it remained criminalized in both East and West Germany until the 1970s. East Germany passed what was at the time the most

progressive law in Europe in 1972, allowing abortion on demand until 12 weeks. When East and West Germany reunified in 1990, their laws had to be reconciled. This led to the compromise that remains in place today, where abortion is formally illegal, but permitted under certain conditions (Ferree 2002).

There has been little momentum to change the German abortion law since the early 1990s, with the exception of one provision that regulated the dissemination of information about abortion. Section 219a of the criminal code prohibited doctors from publicly sharing any information about abortion, on the grounds that this was "promoting" or "advertising" abortion services. Dr. Kristina Hänel was famously fined for providing clinical information about the type of abortions performed in her practice on her website. In June 2022, this provision was repealed (Schuetze 2022).

2.5.5 Summarizing European Abortion Policies

European abortion policies look distinctly different from Catholic ones. While most European cases do allow for conscientious objection, there is no consensus on whether waiting periods or counseling should be required. The median date when European countries passed their abortion laws is 1978, representing a wave of policy diffusion among secular and Protestant countries that did not affect the policies in most Catholic countries. Healthcare and ethics experts were key actors in these policymaking processes, introducing a different element to the debate that was largely absent in Catholic countries.

2.6. Application to the Italian Case

Italy's abortion black-letter law looks like that of its European neighbors. It allows on-demand abortion in the first 90 days (Law 194 of 1978, § 4) which is interpreted as 12 weeks (Gannon 2023) of pregnancy and allows therapeutic abortions in cases of fetal abnormality or life of the pregnant person until 21-24 weeks (depending on local definition) (Gannon 2023). Italy's abortion liberalization journey does not follow the pattern of other Catholic states: Law 194 was passed in 1978, despite condemnation by the Church and Church-affiliated civil society organizations

(Mattalucci 2017). Italy also held a referendum in 1981 reaffirming the 1978 abortion law that liberalized access in the country. The vote to reaffirm the abortion law passed by a higher proportion (70%) than the vote to keep divorce legal (60%) that occurred in 1974 (Mori 1984). In the following sections, we argue that Italy's difference from other Catholic countries on these morality issues is in part due to tension between the Catholic Church and the Italian State.

2.6.1 Italy and the Church

When considering Church-State relationships, Italy is in a unique position because of its geographical relationship with the Vatican. When Italy was unified in 1861, it claimed much of the land of the Papal States until only the Vatican remained in the hands of the Pope. From 1870 to 1929, the Pope considered himself a prisoner in the Vatican, and Catholics were forbidden by the Church from participating in Italian politics (Grzymała-Busse 2015, ch. 3; Thornton 2003). Mussolini negotiated the Lateran treaties, which were ratified in 1929, ending the period of antagonism between the Church and the Italian Government and establishing Italy as a Catholic State (Thornton 2003). After World War II, the Church was closely aligned with the Christian Democratic Party, which controlled the government from 1945 to 1981, though there were still tensions between Church and State (Grzymała-Busse 2015, ch. 3). Toward the end of this period, Italy legalized divorce and abortion against the Church's express wishes (Thornton 2003).

In 1984 Italy officially became a secular State, which threatened the authority not just of the Church in local Italian communities, but the pope himself (Grzymała-Busse 2023). In order to protect its own position, the Church had successfully delayed the organization of the Italian State well into the modern era by engaging in their own political machinations. The tension between the Church and the secular State in Italy persists, as modern politicians debate the appropriate role for religion and religious values in policy decisions (Thornton 2003). Culturally, Italians still identify strongly with the Catholic Church and identify Catholicism as an integral part of Italian nationalism (Pew Research Center 2017b), but they also attend church less and less often (Vezzoni & Bilocati-Rinaldi 2015) and increasingly support secular values (Pew Research Center 2018).

2.6.2 Italy and Secular Europe

Italy is influenced by the cultural identity of Europe and is also subject to its supranational bodies, specifically the courts of the Council of Europe and the European Union. Italy was found to be in violation of the European Social Charter twice in recent history. In 2014 in *IPPF v. Italy*, the International Planned Parenthood Federation asserted that Italy risked the health of pregnant people due to high rates of conscientious objection, which caused a lack of access to abortion services despite the procedure being legal in the first 90 days of pregnancy. The case also alleged that Italy discriminated against the medical procedure itself by treating abortion differently than other legal medical procedures. On both issues, the Committee found in favor of IPPF, concluding that Italy violated the European Social Charter by making abortion services too hard to access.

The European Committee of Social Rights had a similar finding in *CGIL v. Italy* (2015). This complaint raised the same questions as the case by IPPF and added issues about the employment of nonobjectors in Italy. CGIL (*Confederazione Generale Italiana del Lavoro*) is the largest union for public service workers in Italy. Most doctors in Italy are employed by the state-run hospitals and are thus members of this union. CGIL alleged that nonobjectors faced longer work hours, heavier workloads, and harassment in the workplace. The Committee reaffirmed that Italy was violating the rights of patients because of the high level of conscientious objection, but also acknowledged the rights of doctors. They also found that the state was not violating nonobjecting doctors' rights in terms of workload and hours, but it was violating their rights by not having any systems to prevent or report harassment. As with many supranational judicial institutions, however, the Committee lacks the power to enforce these suggestions.

Italy has been chastised by European courts, but these court decisions did not ultimately result in much change. Abortion access remains difficult due to the high number of conscientious objectors, and working conditions for nonobjecting doctors remain undesirable (Pullan 2022a; Gannon 2023). While European values and contentious relations with the Church may have led Italy to adopt a secular abortion law earlier than most Catholic countries did, there is little social will to

change the status quo, resulting in a situation that both pro-abortion and anti-abortion advocates find objectionable (Pullan 2022a).

2.6.3 Pulled between the two

Despite this long and fraught history between the Italian government and the Catholic Church, the overwhelming majority of Italians still consider themselves Catholic (78%) and the Church plays an important role in the culture of Italy (Pew Research Center 2017b). It is important to note, however, that actual church attendance rates have been decreasing over time (Vezzoni & Bilocati-Rinaldi 2015). Since the Church lost its chief party ally in Italian politics in the 1990s, its agenda-setting powers have diminished, but it still plays a less direct role by counseling its members on the morality of social issues (Grzymała-Busse 2015).

Morality policy scholars Knill, Preidel, & Nebel (2014) have explored the role of the Catholic Church in policymaking in Europe, theorizing that the combination of how Catholic (measured in share of the population) and how religious (measured in regular church attendance) a country's population is affects the Church's success in influencing policy. With a larger, more religious Catholic population, the Catholic Church has greater power to mobilize its members for political purposes, affecting the speed of adopting reforms (Knill et al. 2014). This hypothesis explains why the two European countries that did not perform same-sex marriages (at the time Knill & Preidel published (2015)) were Italy and Ireland. But despite being more Catholic and more religious (by the aforementioned definitions) than Italy, Ireland adopted a permissive policy on same-sex partnerships in 2010, leaving Italy as the only country in Western Europe that had not, at the time the article was written, adopted any policy (Knill & Preidel 2015). The authors conclude that this is because Italy had institutional opportunity structures that favored the position of the Catholic Church, and Ireland did not.

Schmitt et al. (2013) also observe that Italy stands apart from other Catholic countries, in this case Spain, by failing to adopt any change that either liberalizes or restricts the morality policies of prostitution and same-sex marriage. The authors apply veto player theory (Tsebelis 2002) to

morality policy, concluding that the Catholic Church has built and maintained a coalition that is both larger and more ideologically congruent in the Italian political context than in the Spanish one. This allowed the Church's coalition to block changes proposed by progressive actors and retain the status quo in Italy but not in Spain. Calkin & Kaminska (2020) have similar findings, concluding that the relationship between the Catholic Church and the local political players allows the Church to function as a veto player in Ireland but not in Poland. These studies suggest that the Catholic Church does not influence all countries' policies in the same way or with the same success. With the Church's ability to influence policy highly dependent on the details of a country's political system and party makeup, this suggests that Italian politics explain Italy's outlier position on morality policies: the Italian State defined abortion policy for itself, with minimal concessions to the Church.

Italy's Law 194 proposed what appeared to many to be an eminently reasonable compromise: abortion would be broadly legal, but no individual would be compelled to support this service, nominally based on their freedom of conscience. As we have described above, this combination led to ineffective policy implementation and difficulties accessing abortion *de facto*. By privileging the position of the conscientious objector, Italy effectively undercut its European-style secular policy with a strong tool for the Church to use. Unlike in the other countries we have examined that allow conscientious objection, in Italy the Church has been explicit about its attempts to encourage conscientious objection among gynecologists who are Church members (Caldwell 1986), and has maintained Italy's cultural zeitgeist against personal involvement in abortion through both overt and covert strategies. This is, however, not an inherent component of the law, but rather a facet of implementation and culture.

Italy exists at the intersection of the Catholic and European worlds, and these dual identities pull its abortion policy in opposite directions. Despite liberalizing its abortion law on a similar timeline to other European countries and despite adopting similar legal provisions, Italy struggles to provide abortion access *de facto* because of Italy's Catholic impulses and social values. Other Catholic countries have adopted similar conscientious objection provisions, and they, too, see

cultural resistance (in the Nation, per Anderson 2016) to their relatively liberal abortion laws (made by the State). Thus, evaluating the success of Italy's abortion liberalization depends on what one means by success. On the ground, we see struggles similar to those in Portugal, Uruguay, and Mexico, where stigma, conscientious objection, and Catholic social values in the Nation make access to services difficult, leaving both doctors and patients isolated (Gannon 2023; Pullan 2022). The tension between Catholicism expressed through conscientious objection and the secular principles of healthcare and safety written into the law makes its implementation neither fully Catholic nor fully European.

2.7. Conclusion

We have proposed an approach to disentangle the competing influences of the Catholic Church and secular Europe on abortion policy in Catholic European countries. Our focal case is Italy, where we argue that – perhaps surprisingly to those unfamiliar with Italian history, law, and culture – the formal State institutions and particularly Law 194 which governs abortion are much more influenced by European policy norms than by Catholic ones. We substantiate this argument by exploring cases that are European and Catholic, Catholic but not European, and European but not Catholic. We contextualize this analysis in the religion and comparative politics literature, engaging policy diffusion theory (Shipan & Volden 2012), key works about the influence of the Church on modern European states (Grzymala-Busse 2023; 2015), and nation theory (Anderson 2016). In future research, this methodology could be applied to other country cases not discussed in this paper, such as France, Malta, Spain, etc., and also expanded to include other institutions that might affect abortion governance.

As other Catholic countries both in and out of Europe have begun liberalizing their abortion laws in recent years, some (e.g. Portugal and Uruguay) have adopted similar laws to Italy. However, by trying to accommodate both secular and Catholic preferences in the regulation of abortion, a country ensures that neither camp is satisfied. *De jure* abortion access can be rendered *de facto* impossible due to conscientious objection (Fiala et al. 2017). Catholic teachings about abortion are

fundamentally in tension with secular international norms as supported by the European Union and non-Catholic European countries. The tension is so difficult to navigate that European courts have weighed in on Italy's situation, judging that Italy has failed in its obligation to implement its own democratically-adopted laws. Italy is torn between the secular values of the State, and the deeply rooted Catholic values of the Nation.

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Chapter 3: Doctors' Rights vs. Patients' Rights: analyzing the implementation of Italian abortion policy in Puglia

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Abstract

Abortion has been a complicated moral debate for many societies throughout history. In Italy, the law regulating abortion explicitly weighs the rights of not only patients seeking abortion but also doctors whose medical skills are needed to perform the procedure. The region of Puglia is puzzling because it has a high rate of objection, but also a high rate of abortion. I conducted interviews with medical personnel, healthcare administrators, and civil society actors across Puglia to understand how they are able to continue providing abortion services in spite of this apparent contradiction. I find that many medical personnel register as objectors not because of a genuine moral conviction against abortion, but rather because the working conditions that nonobjectors face and the perception that working in abortion could hinder their careers. I conclude by offering recommendations for how administrators could improve the implementation of this law without fundamentally changing its principles.

Keywords: abortion governance, conscientious objection, health policy administration, Italy, morality policy

3.1 Introduction

Societies have long struggled with how best to balance the moral question of abortion. Laws and court decisions weigh the interests of pregnant people's self-determination and ability or desire to carry a healthy pregnancy to term versus the ethical obligations society has to potential future babies. In western societies where we increasingly rely on professional healthcare providers to manage pregnancy and birth, abortion is a choice that involves not only the pregnant person, but also their doctor.

In Italy, this balance is particularly delicate: patients have a right to abortion care, but doctors also have a right to conscientious objection ("CO"). The state-run healthcare system (*Servizio Sanitario Nazionale,* "SSN") struggles to balance doctors' rights with patients' rights. In this study, I investigate why Italy has such a high rate of CO with an aim to recommend how the public bureaucracy might administer this law in a way that improves outcomes for both doctors and patients. I explore the case of Puglia, a region in the southeast that has a (typical) high CO rate, but also a curiously high abortion rate. Through qualitative interviews with medical doctors, other healthcare workers, and SSN administrators at the local level, I investigate how Puglia continues to provide this abortion care and whether CO is actually causing a problem.

My interviews reveal that many objectors make this choice not because of genuine conscientious convictions, but because of the working conditions that nonobjectors face. Structural organizational choices lead to nonobjectors' working lives getting worse and worse in a vicious cycle. I also find that there are far fewer people actually working in abortion care in Puglia than the number of nonobjectors reported by the Ministry of Health. Thus, I find that CO causes problems for nonobjecting doctors, in addition to patients.

I conclude with recommendations to improve the administration of this law without fundamentally changing it. Genuine moral opposition to abortion definitely also exists, and the law protects these

doctors from having to violate their conscience. The state needs to balance protecting these doctors with protecting their nonobjecting colleagues from burnout, which risks leaving patients without doctors who can care for them.

3.2 Abortion in Italy

Abortion has been legal during the first 90 days of pregnancy since the passage of Law 194 of 1978. Abortions may only be performed by gynecologists. Before the procedure, patients must have their pregnancy certified, which is typically (but not necessarily) done at a *consultorio*, a dedicated family planning clinic that also counsels patients about pregnancy and abortion. Seven days later, the patient may proceed with an abortion. Up until 9 weeks of pregnancy, the abortion may be induced with pills, but abortions later in the pregnancy require a quick procedure where the patient is anesthetized. Not all hospitals offer both methods, and patients report not being able to choose the method they would prefer (LAIGA 194, 2021; Obiezione Respinta). Beyond 90 days, abortions are only performed for "therapeutic" reasons, such as a threat to the pregnant person's life or health, or if the fetus will not survive birth.

Almost all abortions in Italy are done in public hospitals. As Italy has a public healthcare system, this includes most hospitals in the country, though there are some private facilities that complement the public system. There is disagreement about whether Law 194 requires that every hospital with a gynecology department must offer abortion services, but most of my interviewees do believe the law requires this, even those who are opposed to abortion (see section 6 below). Public healthcare provision is organized at the regional level, and each region is broken into more local districts called ASLs (*Aziende Sanitarie Locali)*. The administrators of one ASL district are generally responsible for distributing resources across several hospitals and other structures within their territory (Cicchetti & Gasbarrini 2016).

The most controversial feature of Law 194 is Article 9, which permits any healthcare worker opposed to abortion to register with their employer as a conscientious objector (henceforth "objectors" are anti-abortion, "nonobjectors" are pro-abortion). Specifically, gynecologists, anesthetists, and other healthcare workers in the gynecology department (e.g. nurses) are included in this law. The Ministry of Health is required under the law to report on the levels of conscientious objection each year for these three groups.[5] For procedural abortions, at least one nonobjecting gynecologist, anesthetist, and nurse are required. The absence of sufficient staff from any of these categories results in the service ceasing, either temporarily (e.g. when someone is on vacation) or permanently until new staff are hired.

Conscientious objection is not explicitly defined, but it is understood to refer to one's religious convictions. In historical terms, its inclusion in Law 194 is a concession to the Catholic Church. In the first six months after the law's passage, 72% of gynecologists in Italy registered as objectors in response to Catholic organizing efforts (Caldwell, 1986). This rate has only decreased slightly over time: as of 2021, 63.4% of gynecologists are recorded as objectors (Ministero della Salute, 2023).[6]

Law 194 uses language that is secular, but that clearly privileges the importance of women being mothers: the title, for example, is the "standards for the social protection of maternity and voluntary interruption of pregnancy" ("*Norme per la tutela sociale della maternità e sull' interruzione volontaria della gravidanza")*. The language throughout the law emphasizes how abortion should not be used in lieu of birth control and how abortion seekers should be offered all kinds of assistance if it will convince them not to have an abortion. In practice, the social support available to new parents through state-sponsored institutions is insufficient, leading to private, often religiously-affiliated, centers offering alternative support (Ms. Gallo, Interview 7). Pro-abortion advocates claim that these centers do not live

[5] For a detailed discussion of this report and known problems with the data therein, see Pullan & Gannon (2023)

[6] Please note that reports from the Ministry of Health are consistently published on a two year delay. As in this example, a citation to Ministero della Salute 2023 refers to the data from 2021 which was published in 2023. This is therefore also the most recent data available.

up to their promises and can end up causing more harm (Ms. Greco, Interview 3). In other contexts, the strategy of imbuing laws with moralized language has been demonstrated to have a stigmatizing effect (Kwiatkowska et al 2023). Having established this basis of knowledge on Italy's abortion law, we turn now to existing scholarship about how abortion is regulated both in Italy and elsewhere.

3.3 Abortion governance in the literature

Abortion governance has a robust literature that sits at the intersection of several social sciences. Two major theoretical frameworks that scholars apply to abortion policy are reproductive justice and social reproduction. Reproductive justice (RJ) is a three-pronged framework founded by Black women in the US who found that the reproductive rights movement did not adequately address their needs. RJ advocates support not only a right to not have children (the basis of reproductive rights advocacy), but also the right to have children, and the right to parent those children in a safe environment (Ross & Solinger 2017, Roberts 1997). Social reproduction grows out of studies of capitalism from a Marxist feminist perspective (Haslett & Brenner 1989). It discusses the reliance that capitalist systems have on the unpaid labor that raises children and builds communities (Fraser 2016), as well as the systems that social groups use to maintain their own position (Folbre 2020, p.73). Bryson (2023) brings these two strands together, suggesting that we can both understand biological reproductive labor as labor, and at the same time we can acknowledge the intersectional reality that social reproductive labor has always been different for women of different races and classes, with white women often outsourcing social reproductive labor to women of color.

If we think of abortion as having "supply" (doctors and medical infrastructure) and "demand" (patients and their reasons for seeking abortion), this paper contributes to the supply side of the conversation. More work has been done on demand covering a variety of geographies (Aiken et al., 2020; Foster, 2020; Gerdts et al., 2016). A key aspect of the Italian case is that the Italian SSN employs doctors as civil servants, and in this sense, they become street-level bureaucrats responsible for implementing policy (Knill & Tosun, 2012). This is different than in other countries where healthcare is more privatized and

doctors are essentially seen as business owners who can privately choose whether or not to offer a service.

Among countries with nationalized healthcare, several abortion studies have been done in the UK (Beynon-Jones, 2013; Chavkin et al., 2017; Cochrane & Cameron, 2013; Schulz & Schmitter, 2017), Canada (McKenna & Leslie, 2018; Stettner, 2016), and Italy (Autorino et al., 2020; Bo et al., 2015, 2017; Caruso, 2020a, 2020b; De Zordo, 2017; Gannon, 2023) among others. In the Italian case, the Catholic Church is a major cultural influence, though it was unsuccessful in preventing Italy from legalizing abortion earlier than most other Catholic countries (Pullan & Gannon, Forthcoming). By formally "medicalizing" abortion, most Western countries have endowed medical authorities with some state powers, even in non-nationalized healthcare situations (Amery 2014). Because abortion seekers depend on people with expertise in abortion (who could in principle not be doctors), but the state only authorizes doctors (or even a subset of doctors), these individuals have a monopoly on legal abortion. This weakens the claim that they are private individuals whose conscience rights must be protected.

This public-private division manifests differently in morality policies (Engeli et al., 2012, Knill 2013) including abortion, as compared to other areas of policy studies (Euchner et al. 2013, Euchner & Preidel, 2018). The morality policy literature has paid particular attention to the role of religion (and even more particularly, the Catholic Church as an institution) in policy (Knill & Preidel 2015, Green-Pedersen & Little 2021). Italy sits in an interesting position in this discussion, with some scholars viewing it as a classic "Catholic" country and thus anticipating policy outcomes aligned with Catholic values (Schmitt et al. 2013), while others argue that Italy's abortion governance is actually more similar to European norms than the ideal Catholic position (Pullan & Gannon Forthcoming).

The most apparently Catholic element of Italy's abortion policy is the permittance of conscientious objection. The two aforementioned studies by Bo et al. (2015, 2017) critically evaluate the Ministry of

Health's claims about CO and whether it impacts patients' outcomes and wait times. Autorino et al. (2020) compare where patients reside and where abortions were performed to determine that Italians are traveling between regions, suggesting that access is unevenly distributed. De Zordo (2017)'s work is aptly titled with a quote from her interviews: "Good doctors do not object." She investigates the impacts of objection and reasons behind it with an anthropological lens, establishing that there are "fake objectors" who avoid working in abortion services due to stigma and the heavy workload. I build upon her work by linking it to questions of public policy and administration in order to understand the institutions and structural choices that might be behind this phenomenon, discussed in sections 6 and 7. There is a growing body of literature that takes healthcare professionals' perspectives into account when evaluating health policy (Hartwig et al., 2023; Dempsey et al., 2023; McLeod et al., 2021; Reeves et al., 2023; Rommell et al., 2023; Stifani et al., 2018; Duffy et al., 2018), including their views on conscientious objection (Fink et al., 2016; Küng et al., 2021; Wicclair, 2010; Fiala & Arthur, 2017). This study adds to the discussion by incorporating new data from the Italian case.

While abortion governance may be a special subtype of governance and administration studies, this discussion cannot be divorced from more general scholarship in public policy and administration. Some researchers argue that Italy or Southern Europe in general are simply less organized and less committed to newer academic theories like New Public Management than other western democracies (Cepiku & Meneguzzo, 2011; Dent, 2005; Tomo, 2019), while others challenge this conception (Galanti, 2011). Clientelism in Italy's public sector is well-documented (O'Brien, 2013). What seems to be a consensus is that Italy's public sector employees assert their independence from managers, both elected and appointed, though the system arguably could function more effectively if it were centralized (Di Giulio & Vecchi, 2019; Tomo, 2019) and more thoroughly overseen (Raffler, 2022).

Bureaucratic decisions are rarely neutral; they are in fact inherently political (Guaschino, 2022). Bureaucracy requires technical skills to produce information (Lindberg et al., 2022) and local knowledge

to apply policy on the "street level" (Knill & Tosun, 2012), but the fact that this work is technical does not insulate it from political bias. Guaschino (2022, p. 123) observes that political actors have been known to shift responsibility for an issue to a bureaucratic agency, which allows those actors to claim ignorance of the policy details. But distancing themselves from the technical choices that are made in policy implementation is, of course, a political choice too.

3.4 Case selection & research questions

The questions that motivated this research come primarily from a public administration perspective, but also engage with sociological, anthropological, and morality policy literatures. In essence: why are so many gynecologists registered as objectors? Is that a problem, and if it is, what can be done about it?

Because CO was my primary interest, I wanted to study a region with a high CO rate. I was heavily influenced by Autorino et al. (2020)'s analysis of travel patterns between Italian regions, which added nuance to our understanding of CO. Comparing their data with the data published each year by the Ministry of Health (Ministero della Salute, 2021), I chose Puglia, a region in the southeast (the "heel of the boot"). This region has a high CO rate (typical for the south especially), but also a high abortion rate (atypical for the south), as shown in Figure 1. Autorino et al. (2020) could also show that patients from other southern regions were traveling to Puglia. How was Puglia able to perform so many more abortions than their neighbors, who all have similar CO rates?[7]

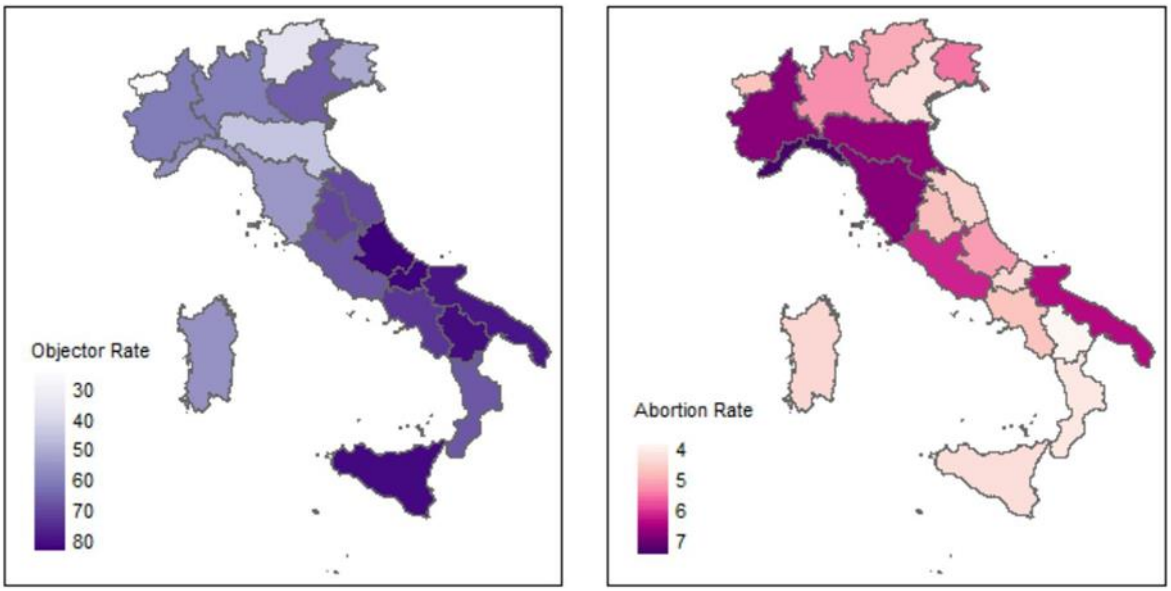
To ask causal questions, I first needed to answer some descriptive ones. What was the current status of abortion provision in the region? To answer this, I spoke with staff in all six health administration

[7] Trends in the abortion rate and conscientious objection rate over time are substantively interesting but beyond the scope of this paper. Generally, abortion rates are declining (Ministero della Salute 2023, Tabella 3.5) and CO rates remain relatively stable. Despite the proliferation of medication abortion (Ministero della Salute 2023, Tabella 25), fewer abortions are performed in Italy's health system today than in previous decades. Law 194 technically does not allow any abortion that is not supervised by a gynecologist (e.g. self-managed abortion), so conscientious objection remains an obstacle.

districts (ASLs) and asked them about their current abortion services. For those hospitals where I could not find an interviewee, I gathered information from other interviewees working nearby.

I also wanted to understand which institution or actor is responsible for implementing and overseeing Law 194, from the perspective of healthcare workers and administrators. I initially hoped that, by asking my earlier interviewees about this, I would be directed to other interviewees who could more directly answer my first questions: why are there so many objectors, is it a problem, and what can be done about it? But anticipating that I might not find a single person or institution who was universally understood to be responsible for this issue, I gathered opinions from all of my interviewees about the implementation of and compliance with Law 194. These evaluations then inform my recommendations for future improvement.

Figure 3.1: Conscientious objection (left) and abortion (right) rates in Italian regions as of 2020



Data Source: Ministero della Salute (2021)

Maps produced by author using R package *tmap* (Tennekes 2018) and shapefiles from GISCO 2023

By assembling a complete picture of CO in Puglia, I hoped to find an answer to how Puglia stands out from its southern neighbors by providing a relatively high rate of abortions in spite of high rates of conscientious objection. Logically, this suggested to me that there must be a small number of individuals performing many abortions without support from their colleagues. This hypothesis is ultimately supported by the findings presented in section 6.

3.5 Methods

Interviews were conducted between December 2021 and May 2022 across all six provinces of Puglia (each province being its own ASL). The recruitment began in late October 2021 and was most active December 2021 through February 2022. The interviews are detailed in the Appendix.[8] It was essential in order to answer my research questions that I find diverse participants in terms of geography, professional position, and also objection status, which I made clear in my interview requests.

Snowballing was by far the most successful technique for recruiting interviewees. The few individuals who responded to my cold-calls were exclusively nonobjectors and primarily located in or near the largest city of Bari. I specifically asked my interviewees to refer me to colleagues who were objectors and colleagues who worked in the more peripheral parts of Puglia. It is therefore important to note that my sample is not representative of all doctors in Puglia:[9] I believe that I spoke with people with the strongest convictions for and against abortion, with few interviewees reflecting a moderate position,

[8] Interview requests were primarily made via email and supplemented by phone calls. The emails included a message in both Italian and English, and interviewees were offered the option to speak either language, with an interpreter present for Italian language interviews to ensure that I understood nuances correctly. I began with a list of all hospitals in Puglia from the website of the regional division of the SSN in Puglia, and I searched online for their contact information. When there was no direct contact for the gynecology department, I contacted the hospital's general administration to request it. I also contacted several different actors at each of Puglia's six ASL districts.

[9] It was not my objective to representatively profile the personal characteristics of which doctors object or do not object (e.g. gender, religion, nationality), though this would make for an interesting future study. There is a gap in the literature concerning the identities of abortion providers that substantively interests many discussants of this work. I spoke with people of different genders who held strong opinions on both sides of the abortion debate. Interviewees were mainly ethnic Italians.

despite most interviewees reporting that most doctors in Puglia actually have rather moderate positions on this issue.

I interviewed 24 subjects in 16 separate sessions. The interviewees are profiled in Table 1, and the details of the sessions are provided in the Appendix. One-on-one interviews were preferred, but on some occasions when I was expecting a single interviewee, they spontaneously invited another person. In other cases, I judged that if I forced the issue of having individual interviews, I would jeopardize being able to interview the subject at all. In retrospect, the two-subject interviews were some of the most interesting ones, as they demonstrated interesting dynamics between objectors and nonobjectors, or between administrators and healthcare workers. I was careful to always solicit both speakers' opinions, and I do not believe that any of my interviewees felt coerced or limited, but it is always possible that some interviewees felt that they could not speak candidly in front of another participant.

Table 3.1: Profile of interviewees

	Nonobjector (Pro-abortion)	Objector (Anti-abortion)	Neutral position
Gynecologists	8	7	
Nurses	1		
Obstetricians	1		
Administrative Staff			4
Activists	2	1	

Thirteen of the sixteen sessions took place face-to-face, with three on Zoom due to either COVID-19 concerns or the interviewee's preference. Of those thirteen, eleven took place in a hospital or ASL office. One interviewee invited me to a private medical office, and another invited me to their home. Twelve of the interviews were conducted in Italian, for which we were joined by a professional interpreter who provided live translation; the other four interviews were conducted in English. There are at least two interviewees from each of Puglia's six ASL districts, which provided the required

geographic diversity. Interviews ranged from 31 to 125 minutes (the shortest and longest both being single-interviewee sessions).

The interviews were semi-structured, guided by the same set of questions but also open to discussing topics of interest to the interviewee. The questionnaire was deliberately open-ended and was iterated throughout the interview process, employing the method of constant comparison from grounded theory (Glaser & Strauss, 1967). Throughout the interview and analysis process, core tenets of grounded theory guided my approach, including purposive sampling until theoretical saturation was reached for objectors/nonobjectors and doctors/administrators, as well as seeking to develop theoretical explanations grounded in the data rather than confirming pre-existing theories from the literature (Bryant, 2017).[10]

3.6 Findings

3.6.1 Passing the buck

Before even conducting interviews, I already had found interesting information that helps answer the question of who is responsible for implementing and overseeing Law 194. In the process of recruiting interviewees, I was broadly shut out of speaking with many institutions. There are 31 public hospitals and six ASL administration districts in Puglia, and I attempted to contact all of them, but most either never responded to repeated attempts or explicitly declined to speak with me. In one revealing case, I was referred in a circle from one person in the hospital to another person in the hospital to the local

[10] All interviewees gave their written informed consent to participate in the research project. The informed consent document and data protection plan were approved by the Ethics Council of REDACTED FOR REVIEW. All interviewees were promised anonymity, with the exception of Dr. Silvana Agatone who regularly speaks publicly on these topics and consented to the use of her name in this paper. Interviewees were not compensated. Audio was recorded of all interviews with the interviewees' consent, and the author personally transcribed the interviews from these recordings. All transcripts use pseudonyms for the interviewees, other actors referenced by name, and the hospital or ASL. Citations to specific interviews in this paper use these same pseudonyms, detailed in the Appendix. Transcripts were processed in the software MaxQDA using a coding scheme that is both based on the interview guide and inductively formed through themes that recurred. All coding was done by the author. Pre-planned interview questions differed slightly based on the professional category (medical or administrative), and among medical personnel, objection status of the interviewee.

ASL office and then back to the first person I had tried to speak with. I interpret this as "passing the buck": each actor determined that it was not their job to speak on behalf of their organization about abortion services. Either there is widespread confusion about who is responsible for overseeing this law, or more likely, nobody is actually responsible for it.

This impression was also confirmed by interviewees, who recounted both hospital administrators and ASL administrators not even knowing how many of their employees were nonobjectors (Dr. Rossi, Interview 1; Dr. Conti, Interview 8). It seems that in each hospital that operates an abortion service, the responsible party for guaranteeing abortion access is the collective of doctors who are willing to provide abortion services. If these doctors do not take it upon themselves to coordinate holiday schedules, or if these doctors leave the employment of the hospital, there is not another figure in administration who will step in to ensure that the service continues. In one unusual case, I spoke with a doctor who themself was an objector and did not personally want to perform abortions, but when they moved into a position of authority, they undertook the effort of organizing an abortion service in their hospital, which previously had not offered abortion care (Dr. Marchesi, Interview 14). On the one hand, this reflects a real commitment to administering the law without regard to the doctor's personal convictions. On the other, it relies on there always being other doctors willing to do the "dirty work" of abortions, without providing any structural incentive for this.

3.6.2 Evaluating abortion access in Puglia

The current state of abortion services in Puglia at the time of research diverged substantially from what is reported by the Ministry of Health (see Table 2). Even though I did not speak with individuals at each hospital, by speaking with at least two people in each ASL district, I was able to ask them about which hospitals in their district do or do not provide abortion services. ASL administrative staff were particularly well-equipped with this information, sometimes even knowing exactly how many doctors worked in each location. The Ministry of Health publishes data on an approximately two-year delay, so

data for the research period of late 2021 and early 2022 is best reflected in the report from Ministero della Salute (2023).

One particularly interesting piece of data that is not captured in the Ministry report is hospitals that do operate an abortion service, but only because they have made special arrangements with people who are not employed in the hospital. I was informed of three such examples in Puglia. These cases took place at hospitals where there were not sufficient staff members to operate an abortion service, but someone in administration of the hospital or the ASL had arranged for another person to come into the

Table 3.2: Comparison of field data findings to Ministry annual report

	My findings	Ministry report
Public hospitals in Puglia with a gynecology department	--	32
Public hospitals operating abortion services	11	21
Private abortion services[11]	3	Not reported
Approximate number of nonobjectors working in all public abortion services in the region (for Ministry: # of nonobjectors)	25	55
Average doctors per public abortion service	2.27	2.62
Abortions services that rely on contract arrangements due to insufficient staff (included in public hospitals number)	3	Not reported
Number of abortions in Puglia in 2021	--	5,152
Average abortions per week per nonobjectors working in abortion services ("Parameter 3" in Ministry Report)[12]	4.68	2.1 (max. 7.1 in or location)
Total number of gynecologists working in Puglia public hospitals	--	283
Rate of conscientious objection among gynecologists	88.3%	80.6%

[11] I include the data that was reported to me about private abortion services by interviewees working in the public sector, but this was not the focus of this study. I did not interview anyone working in a private abortion service.

[12] I follow the same methodology as described on page 65 of the 2023 Ministry report, except using the number of abortion providers I gathered instead of the total number of nonobjectors that they report. The 2023 Ministry report acknowledges the difference between the number of nonobjectors and the number who are actually working in abortion services, but does not report this data and continues to use calculations based on the total number of nonobjectors, despite knowing that these are not equivalent. One interviewee specifically told me that their hospital has one abortion provider and usually has "10-12 women [requesting abortion] per week, 40-50 a month, or 600 in one year," which would suggest the Ministry's maximum reported value of 7.1 is also incorrect.

hospital once or twice a week to perform the service (Ms. Toscana, Interview 16). Sometimes these were doctors employed at a different hospital in the region, suggesting that they are actually responsible for operating two abortion services (unconfirmed but likely double counted in the ministry's reported number of public hospitals operating abortion services, despite both of these services by definition only being operational part-time). In another case, a doctor who did not work in the public healthcare system was contracted to provide abortion services (Dr. Russo, Interview 2). This individual could not be hired full time since court precedent in Puglia prohibits hiring staff based on objection status because this constitutes religious discrimination (*Aborto - Interruzione volontaria della gravidanza -- obiezione di coscienza,* 14.09.2010). Other interviewees confirmed that the Puglia regional healthcare authority does not inquire about objection status until after a job offer has been made (Dr. Conti, Interview 8; Dr. Romano, Interview 5). I also spoke with one and heard stories of additional nonobjectors who would be willing to perform abortions, but are currently not assigned to work in the department that performs abortions (e.g. working as administrators or working in general gynecology instead of the division for family planning) (Dr. Rossi, Interview 1; Dr. Bartholdi, Interview 15). This underscores the importance of distinguishing nonobjectors from abortion providers in the Ministry's reports: when nonobjectors who do not work in abortion are included, all of the statistics about CO and the working conditions of nonobjectors look artificially better than they really are.

It was also emphasized to me throughout the interviews that this data changes frequently (Dr. Rossi, Interview 1; Dr. Ferrari, Interview 2; Ms. Toscana, Interview 16; Ms. Mancini & Ms. Costa, Interview 9). The numbers above represent a snapshot in time. The Ministry collects and reports this data only once a year, and there is no centralized system for reporting or tracking it. I interviewed people who had personally changed their objection status, and I was told stories of many more.[13] As these individuals change their willingness to perform abortions, hospitals understandably gain or lose their ability to staff

[13] I do not disclose which interviewees, in order to protect their anonymity. This includes changes from objecting to not objecting as well as changes from not objecting to objecting.

an abortion service (Dr. Rossi, Interview 1). There is no state-sponsored resource that reports which hospitals actually operate abortion services so that patients can find them, only the aggregate number (Ms. Marino & Ms. Greco, Interview 3; Dr. Bruno, Interview 7).

3.6.3 Why are there so many objectors?

In short: it is difficult and unpleasant to work as a nonobjector, for both personal and professional reasons. I will begin with the structural reasons. Interviewees reported a trend in Puglia towards a hard division between family planning (which is responsible for all voluntary abortions) and "normal" gynecology (Dr. Bianchi, Interview 4; Dr. Bartholdi, Interview 15; Dr. Rossi, Interview 1; Dr. Romano, Interview 5). In the past, most hospitals in this region allowed doctors to work on both sides of this divide, which provided some balance in their days and made sure that abortion was not an overwhelming share of anyone's work. Nobody was able to tell me specifically who had pushed for this division or why, but its prevalence across the region suggests the decision was made at a level above the ASL, such as the region of Puglia or perhaps higher in the Ministry's hierarchy.

With this division, doctors are forced to choose between devoting most of their working hours to abortion and contraception, or having a well-rounded working week that includes working with new mothers and babies, which is broadly considered to be happier work. The problem is therefore twofold: firstly, abortion is seen as the less desirable work, with some interviewees reporting that experience working in abortion doesn't weigh as heavily as other experience for career advancement (Dr. Rossi, Interview 1), and some reporting that it can actively hold back one's career if the department is administered by someone who is very opposed to abortion (Dr. Esposito, Interview 4; Ms. De Luca, Interview 8). Secondly, this "undesirable" work is piled on the plates of the few doctors who declare themselves nonobjectors (Dr. Bianchi, Interview 4; Dr. Romano, Interview 5). While they might be willing to do this work as a part of their job, they do not want to do it all the time. Some described the work as heavy, unhappy, and emotionally draining (Dr. Romano, Interview 5; Dr. Rizzo, Interview 11).

This alone was enough to convince some "moderate" nonobjectors to register as objectors for the sake of having a more pleasant job (Dr. Marchesi, Interview 14; Dr. Giordano, Interview 10). Those who continue to work in abortion report that it is difficult to take time off and that they feel guilty doing so, because they know that there are patients whose abortion care will be delayed as a result (Dr. Esposito, Interview 4; Dr. Bianchi, Interview 4; Dr. Romano, Interview 5; Dr. Caparelli, Interview 16; Dr. Agatone, Interview 12).

One particularly evocative interview took place in a separate building across town from the main hospital structure (Dr. Romano, Interview 5). Dr. Romano described that this division in workplaces aligned with the division between family planning and normal gynecology. Initially, they spent only part of their week in this facility, but over time they had to spend their entire working week there, primarily performing abortions with a small team. This isolation and demanding workload led to strong feelings of burnout. Another interviewee shared their experience of changing to become an objector. At one time, they had led a hospital's abortion service, but when forced to choose a side, they told me that "if it had not been for this situation, I never would have given up being a nonobjector." This interviewee was very cautious in speaking to me and was quite afraid that their admission – that they did not actually morally object to abortion, but had changed their status because of the working arrangement – could result in being forced to join the abortion service if I did not appropriately anonymize them.[14]

3.7 Discussion

The most common refrain I heard in my interviews, regardless of the speaker's professional position or stance on abortion, was that Law 194 "is a good law." There is a strong desire to avoid opening up the debate on abortion in the parliament and society. Their criticisms are rooted in a lack of clarity about

[14] Out of an abundance of caution to prevent harm to this interviewee, I deliberately do not cite this story to a specific interview, so as to ensure their anonymity.

how the law applies in specific situations, as well as a frustration with the policy drift that has occurred thanks to those who use the law in ways it was not originally intended (Hacker, 2005).

Among nonobjectors, administrators (who officially do not declare a pro- or anti- position on abortion), and people who had changed their objection status, it was widely agreed that “fake objection” exists, confirming De Zordo’s (2017) finding. This study’s new contribution is data that allows us to understand why. Several factors emerge to explain why medical personnel would opt to register as an objector even if they do not morally object to abortion:

- Abortion services are organizationally segregated, making the content of the work less fulfilling and the social environment sometimes lonely and sometimes actively hostile
- Medical professionals are paid the same whether or not they object, so there is no financial incentive to undertake the less desirable work
- Administrators do not always know the working conditions in the abortion services they are responsible for, often leaving the task of staffing an abortion service up to the head of gynecology, but then not giving that department head authority over hiring

In some ways, the ASL administrators’ hands are tied. The text of Law 194 and the regional court decision of 2010 set conflicting mandates without proposing alternative solutions for compliance with the law. We should understand that the job of the ASL is not simple, and that in Puglia in particular, it is harder than in other regions to maintain appropriate staffing for abortion services (Dr. Ferrari, Interview 2). Administrators were also the least responsive group to my invitations to interview; some doctors I spoke with even tried to encourage their local administrators to speak with me, but without success.

Many of my interviewees who were based at hospitals distrust and even disdain the ASL administrators. One interviewee described the medical director of their ASL as "a useful idiot" who was appointed to the position because they would do what the regional government wanted and not cause problems (Dr.

Moretti, Interview 13). Other interviewees suspected that the directors of their ASLs did not wish to speak with me because they were ill-informed on the abortion law and their obligations, or simply because they did not want to do more work and were under no legal obligation to consent to an academic interview (Dr. Caparelli, Interview 16; Dr. Esposito, Interview 4; Dr. Bianchi, Interview 4). Some nonobjecting interviewees suggested that ASL directors could be fruitfully targeted by activists wishing to change health policy (including on abortion), but that most Italians do not know who these individuals are or how to contact them (Dr. Conti & Ms. De Luca, Interview 8). In these medical professionals' opinions, the local ASL directors or other senior employees within the ASL would be much more receptive to change than national actors at the Ministry of Health, but most protest on the abortion law (on both sides of the issue) is directed at the national Ministry.

Contrary to some hospital-based interviewees' evaluations, I met some very well-informed and helpful ASL staff. These interviewees knew more about what happens in the hospitals of their district than hospital-based interviewees knew about the administration. One interviewee shared with me the report they compile each year about CO in their district, and it provides much more detail than is available in the official Ministry reports (Ms. Toscana, Interview 16). They described that this data is sent to the Puglia regional healthcare authority, who is responsible for passing it on to the national Ministry. On a very granular level, the bureaucracy has information on where abortion services are functioning, how many nonobjectors work in each hospital, how many of them actually work in the abortion service, and any special contract arrangements required. Some scholars have even been able to access and analyze the information collected by the National Institute of Health (*Istituto Superiore di Sanità)* and statistical institute (*Isituto Nazionale di Statistica,* ISTAT): Autorino et al. (2020)'s work on abortion provision and intra-national travel shows that these agencies do have more data that the Ministry of Health chooses to exclude from their annual report. Some important data is either being lost in the chain of reporting, or it is being deliberately obscured to strategically allow the Ministry to claim ignorance about CO.

In their seminal book, Proctor and Schiebinger (2008) explore the sociology of "strategic ignorance," a concept that translates well to the intersection of elected representation and unelected technocracy. McGoey (2012, p. 569) summarizes the theory well in her work related to the 2008 financial crisis: "It is not that problems were not visible, but that tangible problems were left unarticulated by groups whose social solidarity was dependent on the willingness to ignore information that was not personally or institutionally advantageous to discuss openly. Ignorance is most convincing when it is shared."

The distance between branches of the healthcare bureaucracy even within one small region harms the SSN's ability to effectively implement policy. While the scope of this study was within Puglia, it cannot be divorced from the broader national situation. With such a large gap between the street-level bureaucrats who have the complete data and the political oversight of the Minister, the entire institution benefits from many individual actors' strategic ignorance (McGoey, 2012). I have no evidence of malfeasance and do not wish to accuse anyone of negligence; rather I highlight that the alternative to malfeasance is incompetence.

3.8 Recommendations to improve administration

There is a clear consensus among interviewees that also aligns with public opinion among Italians (L.S., 2019): Law 194 should not be changed, but it should be implemented more effectively. Accepting that the basic principles of *de jure* rights for both patients and doctors written in Law 194 are what Italy wants, I offer the following six recommendations for how this law could be administered in ways that result in better outcomes for not only patients but also medical personnel who both object and do not object to abortion.

1. Implement systems to increase oversight of objection and monitor where abortion services are operational, and make this general information about the state of abortion provision available to the public.

Because doctors can change their objection status frequently, hospitals' ability to staff an abortion service also can change. It is insufficient to report this once per year (Dr. Agatone, Interview 12; Ms. Marino & Ms. Greco, Interview 3). Civil society groups in Italy have been clamoring for an official resource that offers the basic information of where someone can have an abortion – some have even endeavored to produce their own data source, but it quickly goes out of date (LAIGA 194, 2021; Lalli & Montegiove, 2022; Obiezione Respinta). By digitizing this process, the state could use its resources and position of authority to meet this need for patients. Local hospitals and ASLs could update the information in real time, and it could easily automatically feed into calculations and tables like those in the Ministry's annual report. Doctors might rightly be concerned about their privacy, but the system could easily protect individuals' identities by only reporting the number of staff working in abortion care at each hospital, not their names.

2. Consider objection status when assigning doctors to health facilities.

Arguably Law 194 already requires this, but SSN administrators' ability to intentionally manage their staff is undercut by court decisions in some regions (*Aborto - Interruzione volontaria della gravidanza -- obiezione di coscienza,* 14.09.2010). An ideal change here would be a higher court ruling that hospitals may hire nonobjectors specifically because they have hired many objectors and have a need for services that only nonobjectors can perform, as is practiced in the region of Lazio (de Luca, 2017). This is not within the control of the Ministry of Health, however. At a minimum, if the SSN cannot consider objection status in hiring, they must consistently incorporate it when assigning people who are already hired to specific jobs. Interviewees report that this is most frequently monitored at each department of gynecology, but it would be more effective to monitor it at the ASL or regional level. For example, one hospital where I interviewed had, by complete coincidence, about six nonobjecting gynecologists in a small department, more than were necessary, while many other larger hospitals had fewer than this despite greater need.

3. Allow space for partial objection that is less black and white.

The policy of harshly dividing family planning from other gynecology is clearly driving gynecologists who do not morally object to abortion to register as objectors because they object to the working conditions in the family planning department. This division should be removed so that family planning is incorporated with the rest of gynecological care. When doctors are able to rotate in and out of abortion care, more doctors will be willing to share in this work.

4. Improve the flow of information between the *consultori familiari* and hospital gynecology departments.

Arrange for regular shared events and trainings so that staff working in the *consultori* and hospital are familiar with the other team's work. Despite all working in the same health structure and often literally with the same patients, *consultori* and hospital staff repeatedly contradicted one another and mischaracterized each other's responsibilities in my interviews. Both structures play an important role in family planning and abortion care, but they do not have enough information to work in concert.

5. Increase funding for social services so that people do not choose abortion solely for financial reasons.

Both objectors and nonobjectors emphasized that social services for new parents are inadequate (Dr. Colombo, Interview 6; Ms. Gallo, Interview 7; Dr. Moretti, Interview 13). Article 5 of Law 194 requires the state to help "remove the causes that would lead to termination of the pregnancy," referring to socioeconomic status. Nobody I interviewed was happy with the idea that some people who would otherwise want to have a baby would choose abortion simply because they couldn't afford a child. Objectors in particular framed this as a "lack of balance," expressing that they believe more resources are offered to help someone interrupt their pregnancy than to help that person keep it. Multiple

interviewees told me about their personal experience trying to find resources for their patients, fundraising from colleagues and neighbors and collecting baby clothes (Dr. Colombo, Interview 6; Ms. Gallo, Interview 7; Dr. Rizzo, Interview 11; Dr. Moretti, Interview 13). There are clearly close connections between some strongly religious objectors and religious charities that provide help for new parents (Ms. Gallo, Interview 7). But why is this responsibility left to charities? The state is not adequately funding social work and other social programs and instead relying on donations and expecting doctors and nurses to perform tasks that are well outside their training as medical experts (Ms. Gallo & Dr. Bruno, Interview 7).

6. Increase funding for contraception education and awareness of *consultori* services.

Puglia was actually the first Italian region to trial free contraception for some of its residents, in 2008 (Internazionale, 2020). After a patchwork of regional programs that offered free contraceptives based on various conditions in different regions, in spring 2023 there was an initiative to cover the cost of birth control pills in the SSN (Quotidiano Sanità, 2023), though it remains to be seen if this will be universally adopted (as some regions have a history of rejecting national mandates related to sexual health (Guerra, 2020)) and how effective it will be. In addition to providing contraception, from the perspective of medical providers, the public needs education about what services *consultori* offer and how to access them.

3.9 Conclusion

By interviewing doctors, nurses, obstetricians, healthcare administrators, and knowledgeable civil society advocates on both sides of the abortion issue, I find answers to both why there is such a high rate of conscientious objection and how a region like Puglia is able to provide abortion services in spite of this. The two are quite related: nonobjectors in Puglia are working in rigidly segregated departments where they are responsible for providing abortion care for most of their working hours. This separation from both their colleagues and the professional activities that they find fulfilling in a traditional

gynecology department leaves these medical professionals feeling isolated and burnt out. I spoke with some doctors who had personally made the choice to register as objectors purely because of the working conditions, despite not morally objecting to abortion. Interviewees who were moderate objectors and nonobjectors report that this is the case for most objectors in their departments. There are, of course, objectors with strong faith convictions, but they do not represent the norm.

These actors almost universally express support for maintaining Law 194 in its current form but changing how it is overseen and implemented. In accordance with this, I provide six recommendations in Section 8 that could improve outcomes for objectors, nonobjectors, and patients alike without fundamentally challenging the first principles expressed in Law 194. Increasing the connections both between the national Ministry of Health and local offices as well as between hospitals and *consultori* family planning centers to improve the flow of information underlies all of these recommendations. The current administrative structures do not effectively assign personnel willing to work in abortion care to abortion services. A rigid divide between the abortion service and other gynecology functions serves as a deterrent to nonobjectors.

Law 194 articulates a commitment to both patients' right to care and self-determination and medical personnel's right to exercise their own genuine moral convictions. If the SSN bureaucracy is to faithfully implement the principles in this law, their "technical" and "administrative" policies must be critically examined for political outcomes. In denying knowledge of the situation on the ground through both their annual reports and the unwillingness to participate in this study, the SSN suggests that their ignorance is, in fact, a strategy to avoid responsibility for overseeing a politically and morally complicated law.

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3.11 Appendix: Table of Interviews

Interview #	Date	Interviewee Pseudonym	Professional Role
1	02.12.2021	Dr. Rossi	Nonobjecting doctor
2	15.12.2021	Dr. Ferrari	ASL Staff
		Dr. Russo	Nonobjecting doctor
3	16.12.2021	Ms. Marino	Pro-abortion activist
		Ms. Greco	Pro-abortion activist
4	19.01.2022	Dr. Esposito	Nonobjecting doctor
		Dr. Bianchi	Nonobjecting doctor
5	19.01.2022	Dr. Romano	Nonobjecting doctor
6	21.01.2022	Dr. Colombo	Objecting doctor
7	29.01.2022	Dr. Bruno	Objecting doctor
		Ms. Gallo	Anti-abortion activist
8	16.02.2022	Dr. Conti	Nonobjecting doctor
		Ms. De Luca	Nonobjecting obstetrician
9	17.02.2022	Ms. Mancini	ASL Staff
		Ms. Costa	ASL Staff
10	17.02.2022	Dr. Giordano	Objecting doctor
11	18.02.2022	Dr. Rizzo	Objecting doctor
12	12.03.2022	Dr. Silvana Agatone (not pseudonymized)	Nonobjecting doctor / activist
13	16.03.2022	Dr. Moretti	Objecting doctor
14	22.03.2022	Dr. Marchesi	Objecting doctor
		Ms. Buonocuore	Nonobjecting nurse
15	31.03.2022	Dr. Bartholdi	Objecting doctor
16	16.05.2022	Dr. Caparelli	Nonobjecting doctor
		Ms. Toscana	ASL Staff

Chapter 4: What attracts abortion providers? Political, economic, and social predictors of abortion provider distribution in Europe

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Abstract

With a democratic right to abortion comes the necessity for medical services that can induce an abortion. Yet the distribution of abortion providers across countries with relatively liberal abortion laws differs widely. By introducing a novel dataset of the geographic location of abortion providers in ten Western European countries, I expand our understanding of abortion access in these countries. I seek to understand the gap between policy and its implementation by exploring what variables might differ between these countries where policies are relatively similar. Specifically, I test the relationships between abortion provider distribution and regional political attitudes, religious denomination and religiosity, social values, and wealth. The findings paint a mixed picture of which social, political, and economic values of a society are associated with easier abortion access.

Keywords: abortion access, health policy, religion, regional politics, political economy of abortion

4.1 Introduction

Abortion is a cultural issue that, while divisive in some societies, has been largely accepted as a legal right and human right across Western Europe for the last several decades. Where there is a right to abortion, citizens' ability to exercise that right is a question of democratic significance. A right that exists only on paper but is impossible to use is no right at all. Thus, it is substantively important to be able to measure and evaluate abortion access as a question of political science, political economy, and public administration.

To date, there is not much literature that addresses the gap between *de jure* policies and *de facto* realities of accessing abortion. Projects like the World Abortion Laws Map (2023), the Global Abortion Policies Database (2018), and Abort Report (n.d.) begin this process by centralizing

abortion policy data, and others such as Forman-Rabinovici & Sommer (2018) and Pullan & Gannon (Forthcoming) offer us tools for how to compare these policies to one another.

More study is needed on the implementation of these policies and the political economic reality of how patients actually get an abortion. Some scholars approach this topic from the perspective of patients, documenting the phenomenon of abortion travel and its costs in Europe (De Zordo et al. 2021; Garnsey et al. 2021; Rahm et al. 2023; Reinholz et al. 2018; Wollum et al. 2024) and in the US (Shapiro, Erhardt-Ohren, and Rochat 2020; B. P. Brown et al. 2020; Cartwright et al. 2018; Pleasants, Cartwright, and Upadhyay 2022; Thompson et al. 2021). In this study, I approach the question from the intersection of the state and the market, interrogating the systems that provide and regulate our healthcare and exploring the way that individual patients and doctors are affected by public institutions.

Despite having relatively similar abortion laws, abortion access is anecdotally not equally accessible across European countries. I aim to quantitatively verify and ultimately explain this by presenting a dataset of abortion provider locations in ten Western European countries, normalized into a comparable measure of "patients per provider" based on the population of women of reproductive age living in each statistical and governmental region, similar to the approach of Torenz et al. (2023). I then seek to understand what social, political, and economic variables are correlated with this distribution of abortion providers. By understanding the relationship between the density of abortion providers and regional politics, cultural values, the prevalence and denomination of religion, and local wealth, policy actors may be able to more effectively align their country's abortion law with the *de facto* situation.[15]

[15] This dataset can also be used to investigate many more questions than can adequately be addressed in a single paper.

4.2 Expectations

At the core of this paper are questions about how society, the economy, and politics affect doctors' private choices about where to live and work and what sort of services to offer, and subsequently how those choices affect citizens' ability to access their democratic right to abortion. Medical services, while usually highly regulated and subsidized by the state to some degree, still generally operate on a capitalist market (Obert et al. 2018; Andre and Velasquez 1988).

Abortion provision is commonly regulated more than other comparable healthcare procedures, sometimes in ways that defy medical expertise (The Safety and Quality of Abortion Care in the United States 2018; How to Protect Abortion Clinics 2020). In the US, these are known as Targeted Regulations of Abortion Providers (TRAP laws) (Medoff and Dennis 2011; Mercier, Buchbinder, and Bryant 2016). Though less overtly politicized, similar phenomena occur in Europe, such as requiring special certification of a clinic to provide abortions on top of other gynecological care, or special permission to opt out of abortion care due to "conscientious objection," when objection to other procedures is not permitted (Fiala and Arthur 2014; De abortusbehandeling n.d.; Kassenärtzliche Vereinigung Rheinland-Pfalz 2022; Minerva 2015).

The healthcare professionals who provide abortions sit at the intersection of public and private: they are individuals with well-rounded lives and careers, but they are also indispensable components of the healthcare machine that delivers necessary services to patients. In nationalized healthcare systems, doctors can arguably (Pullan 2022) be thought of as street-level bureaucrats (Knill and Tosun 2012), responsible for implementing the state's policy as public employees. In more privatized systems, doctors are not explicitly charged with upholding a policy, but they have the potential to gatekeep services from patients, as the relationship between patient and doctor has a significant power asymmetry.

In my first hypothesis, I ask whether there is a link between politics and the density of abortion providers. Doctors could reasonably not prefer working in regions (or whole countries) where there are policies that regulate abortion more than other medicine, creating more work for the doctors. Doctors may also presume that the policies in place in a region represent the social views and values of the residents of this place, which I will test further in later hypotheses.

Scholars have demonstrated the connection between political ideology and control of government leading to anti-abortion policies in the US (Medoff 2012; VanSickle-Ward et al. 2023; Fornaro 2023) as well as the way that politics in return influences citizens' abortion attitudes (Holman, Podrazik, and Silber Mohamed 2020; Scoglio and Nayak 2023), but this connection is less clear in Europe. Brysk & Yang (2023) make a strong argument for the association of abortion attitudes and nationalism. Pullan & Gannon (Forthcoming) present data about the relative stability of abortion policies in Europe, especially in countries that they argue are more influenced by European institutions than by Catholic institutions.

In sum, the literature does not lead us to a clear expectation about how political attitudes on abortion will correlate with abortion access in Europe, but rather presents plausible explanations for opposite outcomes. Thus either outcome to the test for Hypothesis 1 will be an interesting contribution to our understanding of this issue.

> **Hypothesis 1 (Regional Politics):** There will be fewer abortion providers in regions that are historically controlled by culturally conservative parties and more in regions that are historically controlled by culturally progressive parties.

Stigma and the social climate of a place is known to affect doctors' choice to provide abortions there. This can be seen most dramatically in US American examples, such as the community where Dr. George Tiller was murdered because of his work (After Tiller 2013), or the memoirs of doctors

who recount stalking, harassment, and other local efforts to drive them out of a community (Parker 2017; Wicklund and Kesselheim 2009). This needs to be tested in the European context.

Research shows us that there are generally links between topics known as "morality policies" (Engeli, Green-Pedersen, and Thorup Larsen 2012; Schmitt, Euchner, and Preidel 2013). Abortion is the classic example of a morality policy topic, but others include LGBTQ+ equality, euthanasia, drug use, and gun control. These policies engage our first principles of right and wrong more than other policies that might be more logistical or emotionally detached (Euchner et al. 2013). This strand of literature intersects with the literature on conscientious objection when it explores the tension between public and private morality (Euchner and Preidel 2018; Fiala and Arthur 2014; Bo, Zotti, and Charrier 2017; O'Shaughnessy 2022). This leads me to my second hypothesis:

> **Hypothesis 2 (Moral Views):** There will be fewer abortion providers in regions where residents hold conservative cultural views on morality topics.

Of course, morality is closely linked with religion, and the morality policy literature also offers guidance on how to understand the intersection of religiosity and religious institutions with the state and public policy (Knill and Preidel 2015; Green-Pedersen and Little 2021; Calkin and Kaminska 2020; Engeli, Green-Pedersen, and Larsen 2013). Grzymała-Busse (2015) explores this phenomenon, investigating the role of the Church in the development of modern politics in several countries, and then tracing the ways that European states in particular developed alongside and in some ways grew out of the structures of the Catholic Church (Grzymała-Busse 2023; Agnew 2010). Gober (1997) also found an association between the rate of Catholicism in the population of a US state and that state's abortion rate. Other religions both have divergent positions on abortion (Sommer and Forman-Rabinovici 2019), but they may lack either the institutional power (Grzymała-Busse 2015) or political will to mobilize about it (Strack 2023). In the cases studied here, Catholicism and Protestantism are the most relevant religions, which leads me to expect:

Hypothesis 3 (Catholic/Protestant): There will be fewer abortion providers in regions that are predominantly Catholic and more in regions that are predominantly Protestant.

Hypothesis 4 (Religiosity): There will be fewer abortion providers in regions that are more religious, regardless of denomination.

Finally, I investigate the relationship between abortion providers and money. Social and medical services are known to be distributed unequally across society, as was particularly evident during the Covid-19 pandemic (Kanter, Segal, and Groeneveld 2020). The state can mediate this effect by covering the cost of care more or less completely, but this is not always desirable for other political reasons.

Studies of individuals who had abortions confirm that costs commonly delayed the procedure, and that costs went beyond the direct medical services to include travel, sometimes a hotel, time off work, childcare, etc. (Greene Foster 2020; Garnsey et al. 2021; Ely et al. 2017; Makleff et al. 2023). This is an area where Europe will likely differ significantly from the US-centric literature, as most abortions in Europe are paid by either the health insurance system or the state (Grossman, Grindlay, and Burns 2016; Lavelanet, Major, Esther, and Govender 2020), while in the US it is often a significant private expense (McCann 2022).

Nevertheless, nonmedical costs of transportation remain for many abortion seekers in Europe, and thus it is an open question: is there a relationship between the location of abortion services and the wealth of that community? On the one hand, wealthy individuals can afford to travel for an abortion (and historically they do) (Lennerhed 2019), so perhaps doctors would strategically offer their services to be accessible to poorer patients who need them and could not afford to travel (either out of a spirit of goodwill or due to state resource management that directed them to offer services where they were needed) (Medoff 2008). On the other hand, doctors are themselves individuals

who are usually rather wealthy, and they may choose to live and thus offer their services in wealthy communities (Dwarswaard, Hilhorst, and Trappenburg 2011; Sandel 2012).

> **Hypothesis 5 (Wealth):** There will be more abortion providers in wealthier regions than in poorer ones.

One assumption that underlies all of these hypotheses is that there is demand for abortion services everywhere, though it is not realistic to assume that this demand is the same. Projects like Women on Web that mail abortion pills to patients around the world, especially under restrictive laws, along with scholarly accounts demonstrate the basic soundness of this assumption (Calkin 2023). There is a robust ongoing discussion in the literature about the role abortion pills play in abortion access. If patients did not have to travel to a clinic, they could be spared expenses and exercise greater autonomy (Jelinska and Yanow 2018).

There is no global comparative dataset or method that I am aware of that allows us to understand how the demand for abortion, whether it is a set of pills or a procedure, varies around the world, and scholars continue to document how abortion rates change over time and what this means for the underlying and fundamentally unmeasurable concept of demand (Aiken et al. 2024; Aiken, Lohr, et al. 2021; Moseson et al. 2022; Aiken, Starling, et al. 2021; R. W. Brown and Jewell 1996; Gohmann and Ohsfeldt 1993). Fertility as a concept is inherently intertwined with abortion access, as unless abortion is perfectly easily accessible to all residents of a place, some pregnancies will likely continue that were not necessarily wanted (González et al. 2021). It is for this reason that I do not hypothesize a role for fertility in this study and judge it inappropriate to include as a control variable as well.

4.3 Data

This article analyzes new data on abortion providers' locations that enables comparative, quantitative study of this topic for the first time among European cases. The basis of the dataset is several publicly available sources that gather lists and locations of abortion providers, primarily for

the benefit of patients seeking a doctor. These lists are affiliated with professional associations representing reproductive healthcare workers. Notably, the unit of observation in these lists is generally a facility, not a person, with the exception of France. Missing from this dataset is information about how many staff work in abortion care at each facility.[16]

The primary dependent variable this produces is what I call PPP, "patients per provider." This number is calculated by grouping the abortion providers into statistical regions defined by the EU "NUTS" taxonomy (Nomenclature of Territorial Units for Statistics). These units are meant to be roughly comparable across countries, though as noted later, there is national variation in, for example, which level a regional parliament is elected at, or which level administers healthcare policy. I divide the population of women aged 15-49 by the number of abortion providers in that region plus 1 (to avoid dividing by zero in regions with no provider) to produce a PPP number for any NUTS region on any level in Austria, Belgium, France, Germany, Ireland, Italy, the Netherlands, Norway,[17] Portugal, and Spain. NUTS regions all nest within one another and are standardized to have three levels below the national level, then a variable number of more local units. This variable is discussed descriptively in the following section.

$$PPP = \frac{Population\ of\ women\ aged\ 15\ to\ 49\ in\ region}{Number\ of\ abortion\ clinics\ in\ region + 1}$$

I test H1 (Regional Politics) with data from two different sources that measure the cultural ideology of parties: the Chapel Hill Expert Survey (CHES) and the Comparative Manifesto Project (CMP). In CHES, experts code each party's GALTAN position on a scale where 0 represents libertarian /

[16] This is discussed further in the section "Limitations and Recommendations for Future Research." For more details about how this dataset was constructed as well as the exact details and calculations in other variables, see Appendix A.

[17] Though NUTS is a standard created by the European Commission, it is also used in several countries that have close relationships to the EU such as Norway, the UK, Switzerland, and countries seeking EU membership.

postmaterialist and 10 represents traditional / authoritarian. In CMP, coders identify the share of sentences in each manifesto that reflect positive or negative views of traditional morality, which I combine into a net traditional morality value. I combine each measure of cultural ideology with election results from the Observatory on Regional Democracy to calculate a seatshare and time weighted average of party ideology since 2000, a similar approach to Garritzmann, Röth, and Kleider (2021, 2167–68). This results in a single value reflecting the regional politics from 2000-2019, which, while a bit overly simple, is appropriate because the independent variable is not available over time.[18] This weighted average is described by the following equation:

$$Regional\ politics\ score = \sum_{i=1}^{n}\sum_{j=1}^{m}\frac{c_{ij}s_{ij}y_j}{t_j}$$

Within the region, there are *n* different parties and *m* different election periods. The variable c represents the cultural ideology score for the party *i* in election period *j*; *s* represents the seats held by that party in that election period; *y* captures the number of years in the period, and *t* reflects the total number of seats in parliament during this period. This results in a value that accounts for how large a share of parliament each party held for how many years, over the full 20 year period.

H2 (Moral Values) tests cultural and social values as measured by the European Social Survey (ESS). Specifically, I take the variables that measure attitudes towards LGBTQ+ individuals living their lives openly and a general belief that people should have equal opportunities. H3 (Catholic / Protestant) and H4 (Religiosity) also draw from the ESS, which includes questions on the respondent's religious

[18] The CHES measure could in principle range from 0-10, with 0 being the most libertarian score and 10 the most traditional. The weighted average since 2000 ranges from 2.96 in Lazio, Italy to 7.07 in Ceuta, Spain. With the CMP measure, a score of 0 would reflect an even number of positive and negative statements about traditional morality, so negative numbers reflect less support for traditional morality and positive numbers mean more support for it. This variable in general skews towards a positive evaluation of traditional morality, with the lowest value of the weighted average since 2000 in Navarra, Spain (-0.67) and the highest in Zeeland, Netherlands (5.27).

denomination for most countries and their self-reported level of religiosity. For these models, I calculate an average value of the responses to each question per region, as the ESS data's observations are reported for individual people.

H5 (Wealth) measures wealth using gross domestic product (GDP) per capita, sourced from Eurostat, the European Commission's statistical body.

Eurostat is also the source of several other variables used as controls in the models: share of the population who has tertiary education, hospital beds per region, total number of doctors of all specialties, the percentage of doctors who are gynecologists, the percentage of a region that is classified as urban, and the population data used to calculate PPP.

I also include two control variables produced by the OECD and European Observatory on Health Systems and Policies, a division of the WHO. These bodies produce a report each year on each country, from which I extracted the information of (1) which NUTS level is responsible for healthcare administration, and (2) how much autonomy that region has. For the latter, a score of 0 means there is little to no role for the region due to either national management or privatization; a score of 1 means the region is administratively responsible but does not have budget authority; and a score of 2 means that the region can decide on how much funding is budgeted for healthcare. Again following Garritzmann, Röth, and Kleider (2021, 2168), this allows me to approximate a Regional Authority Index that is specific to health policy, unlike the original RAI (Hooghe et al. 2016) which evaluates power distribution between levels of government more broadly.

4.4 Discussion

4.4.1 Descriptive Results

The density of abortion providers by region is presented on the following maps. This number is normalized by the population of the region to facilitate comparison. In Figure 1, red regions are

those with the highest ratio of patients to providers, or in other words, the regions where it would be most difficult for a patient to make an appointment due to lack of provider capacity. Green regions are the other end of the scale, where there are the fewest patients per provider and thus appointments are easier to come by. It is to be expected that there are fewer abortion providers in raw numbers in rural areas than in cities, but regardless of where they live and work, I assume that doctors have the capacity to treat the same number of patients per day. If a doctor is responsible for more patients (a higher PPP score), then they will either see each patient for less time, reducing the quality of care, or see fewer patients.

The map on the left (1A) aggregates the data at the NUTS 2 level, and the middle (1B) aggregates it at the NUTS 3 level. Figure 2 then presents the regions where there are zero abortion providers, regardless of the region's population. Before moving into statistical analyses, the descriptive aspects of this data already tell some interesting stories.

Of the 831 NUTS 3 regions included within these ten countries, PPP ranges from 1763 to 198,763 patients per abortion clinic. The median value is 20,645 and mean is 29,812, with significant skew in the top quartile. If we look at the national level, France has the best ratio of patients to abortion clinics at 14,803 (though they are distributed unevenly across the country), and the Netherlands comes in at the bottom of the table with 221,916 patients per clinic (though being a small, dense country, it is possible that these clinics are still accessible and well-enough staffed to meet patients' needs, as discussed further below).

By including several countries in the same analysis, we can observe both differences within one country and differences across countries: for example, Bavaria in Southeastern Germany and much of Austria have a relative paucity of abortion providers compared to other regions of Germany or Austria, but the scale of the problem is much less than most of Spain, which is colored primarily in

reds and oranges instead of light greens. We can also see the former border of the GDR (East Germany), reflecting an intra-national cultural division; abortion was legalized much earlier in East Germany than in West Germany. While Bavaria and Austria have similar levels of abortion access, the border of Austria and Italy shows a stark contrast, where suddenly almost all regions have an abortion provider. This tells us that while similar cultures may exist in neighboring regions across borders, we can also observe strong national policy effects (as discussed more below on Italy).

Ireland as a whole has relatively high PPP scores compared to other countries in this sample, which is not surprising given that abortion was only legalized in Ireland in 2018. There are significant efforts underway to build up a network of trained providers, but this will take time. In fact, it is notable that no regions in Ireland are completely unserved (Figure 2).

Despite its geography, Norway maintains a low PPP throughout its regions, perhaps due to the country's general experience with managing to provide infrastructure / resources in remote regions.

Spain is the country in this dataset that raises the most concern for abortion access. Methodologically, I was actually concerned about having overcounted abortion providers in Spain due to using multiple data sources to compile the list. The Southern part of the country looks particularly different on Figures 1A versus 1B because of additional data that is available from the Ministry of Health at the NUTS 2 but not NUTS 3 level, so in general Figure 1B is more accurate for Spain, though it lacks the geographical specificity of Figure 1A. Unlike other regions that are red or orange across the map, large parts of Spain have very few abortion providers.

Figure 4.1:
Women of reproductive age served by one abortion clinic, grouped at different geographical levels

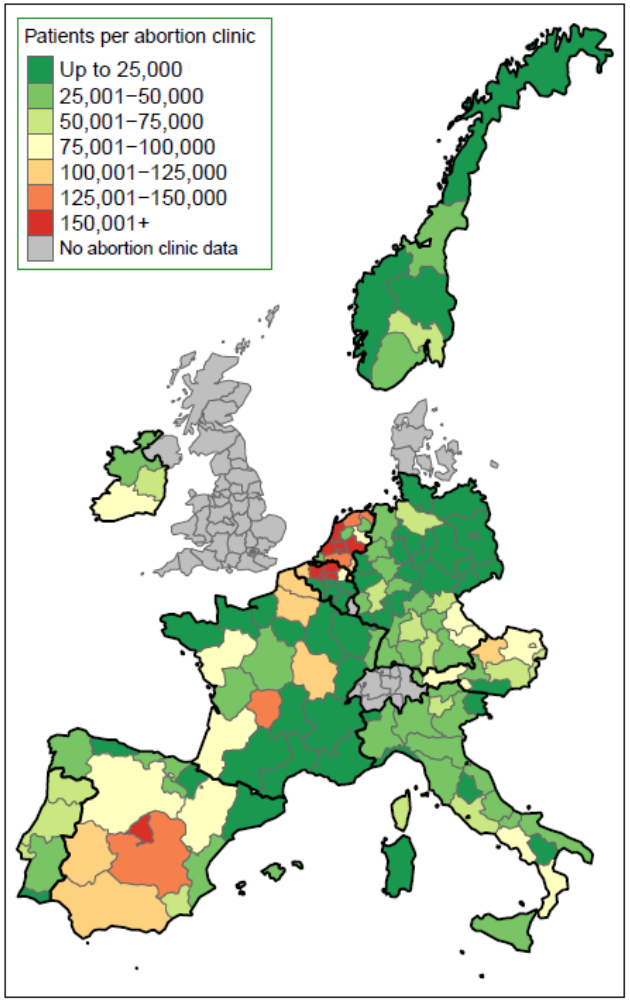


Fig. 4.1A: NUTS 2 level

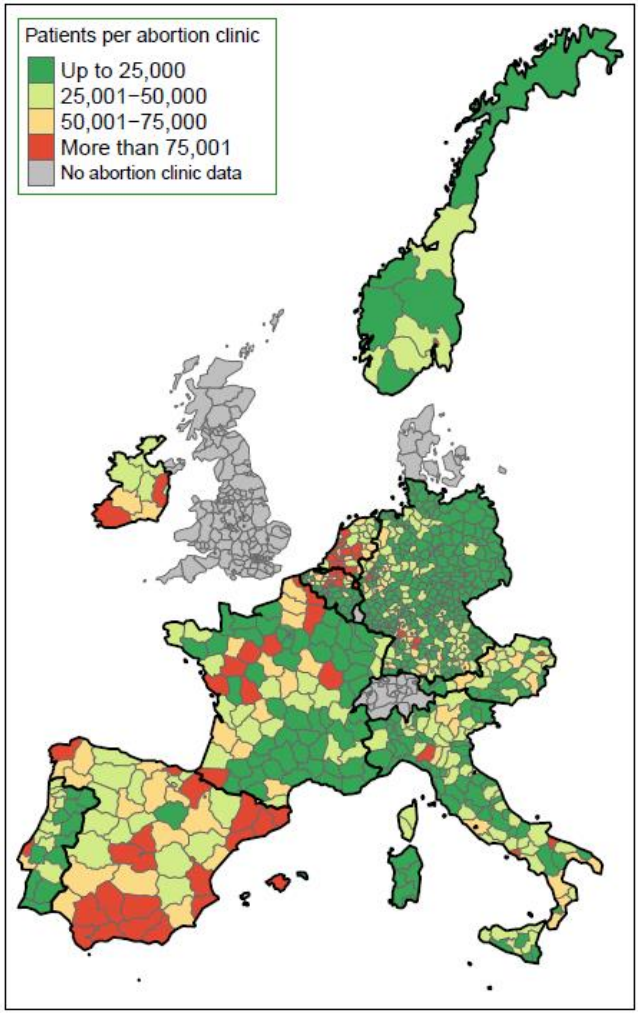
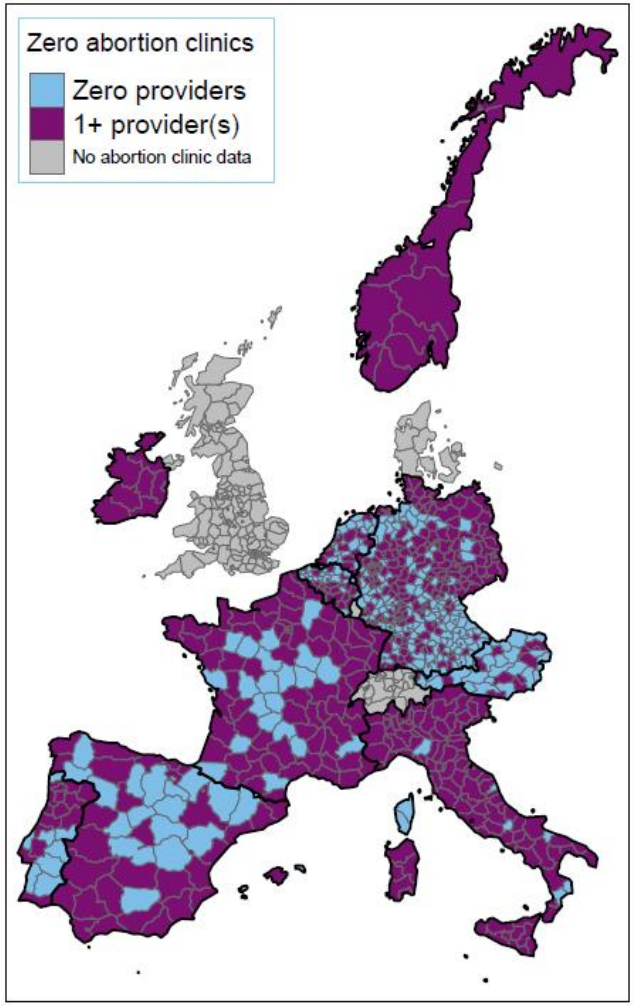


Fig. 4.1B: NUTS 3 level

Figure 4.2:
Regions with zero abortion clinics at NUTS 3 level



Maps created by the author using the *tmap* R Package (Tennekes 2018) and shapefiles from the European Commission (GISCO 2023).

Italy looks quite different in the NUTS 2 and NUTS 3 maps, which reflects its particular healthcare system and policy. NUTS 2 regions in Italy are the governmental regions at which healthcare is managed (*regioni)*, and each region has a high degree of autonomy to administer its own affairs (Cicchetti and Gasbarrini 2016). There is some legal ambiguity about what regions are required to do as far as providing abortion care (Caruso 2020; Minerva 2015), but evidence from one region suggests that healthcare administrators aim to staff one functional abortion service per NUTS 3 region (Pullan 2022). Thus, Italy has almost no NUTS 3 regions with zero abortion providers, but many with only one or a small number of providers that is not necessarily in proportion to the population of the region.

Having one doctor in a highly populated region is hardly better than having zero. The data underlying Figure 2 demonstrates that in total, 17.0% of women of reproductive age in these ten countries live in a NUTS 3 region with zero abortion providers. But if we consider regions with the top 10% of high patient to provider ratios, where abortion is also quite difficult to access, this number jumps to 25.2% of women of reproductive age.[19] It is alarming that in ten countries where abortion is legal in most circumstances, fully one quarter of women who might need an abortion live in a region where this service is not available.

The patch of red in the Netherlands and Flemish Belgium may surprise readers, as the Netherlands in particular has a reputation for having good abortion access. This is a product of how the variable of PPP is calculated. By counting clinics that provide abortions rather than people (which is unfortunately not available), we naively assume that all clinics have the same capacity to treat patients, which is of course not true. It is possible that the few abortion clinics in this region employ

[19] I calculate this by subsetting the data to those with either zero abortion providers or a PPP score that is in the top 10% of all PPP scores and then summing the total population of these regions as a percentage of the population of the entire dataset. The cutoff point for the top 10% of PPP scores is one provider per 63,406 women of reproductive age. Four of the ten capital cities included in Table 1 fall in this group.

a large staff of doctors to meet the region's needs. It is also possible that public transportation and other infrastructure of the region makes it easy for patients to travel to a doctor that is slightly further away (given that NUTS regions are necessarily small in a geographically small country like the Netherlands).

Table 4.1: Patients per abortion clinic in capital cities		
City	**PPP**	**Women 15-49**
Paris	5,077	573,661
Berlin	8,958	842,020
Brussels	14,233	313,122
Dublin	41,694	375,245
Lisbon	52,669	632,027
Rome	62,683	877,557
Vienna	78,546	471,278
Oslo	95,373	190,746
Amsterdam	118,906	356,719
Madrid[20]	198,763	1,590,102

This phenomenon extends to other metropolitan areas across Europe as well, as demonstrated in Table 4.1. Prior expectations would lead us to believe that capital cities are generally wealthy, well-infrastructured, centers of commerce, and generally places where one can access a wide variety of products and services, including abortion care. In this sense, the capital cities could be thought of as most similar cases in a research design, yet their levels of abortion access are quite different by this measure. This suggests that urbanity alone is not sufficient to explain the distribution of abortion providers, and thus we must explore other potential determinants of this distribution.

[20] There are some irregularities with the Spanish data described further in the Appendix, but these do not affect the region of Madrid: my dataset includes seven clinics in Madrid, and this matches the number of facilities the Ministry of Health reports having performed abortions in Madrid.

4.4.2 Regression Models

I run a series of multilevel regression models to test these different hypotheses. All of these models take PPP as the dependent variable and explore its relationship with the various social, political, and economic factors detailed in the five hypotheses. While the data underpinning these models is insufficient to make causal claims, a coefficient with statistical significance would give us confidence that there is actually a linear relationship between the density of abortion providers as measured by PPP and these other variables. For readability, I break these models into several different tables, but for each hypothesis, I present one column with the direct relationship between PPP and the relevant independent variable with no controls, and then a second column with the control variables added.

Because of the structure of the data in nested geographical units, each model uses a statistical technique that acknowledges this grouping at the country level, as well as including the same list of control variables. Like with any model, multilevel models come with pros and cons: on the one hand, the NUTS taxonomy into which my data is organized is a prototypical case of nested data that violates the assumption of OLS regressions having independent observations. It would be wrong not to acknowledge that, despite having different numbers for my dependent variable of PPP, neighboring regions have many national and/or regional attributes in common that cannot be completely measured. The right way to do this, however, is a matter of methodological debate that largely comes down to differences between academic disciplines: economists are skeptical of multilevel models, and psychologists are skeptical of fixed effects models (McNeish and Kelley 2019). As a mixed-methods political scientist, I have no horse in this race, and I thus endeavor to take the best from both approaches.

A multilevel model accounts for the known interconnectedness between my variables at not only the country level, but also the larger NUTS regions in the nested taxonomy. On the other hand, classical statistical wisdom dictated that a multilevel model ought to contain a minimum of 30

clusters (Kreft and Yoon 1994). Because so many social science datasets ultimately cluster into fewer than 30 level 2 groupings, scholars across disciplines have innovated on the statistics that underpin multilevel models (McNeish and Stapleton 2016), and others have just come to accept that multilevel models come with more pros than cons. More recent studies show that, while there are some reasons to be concerned when there are too few clusters, this is not as large a problem as originally expected, and there are mathematical techniques that can improve the accuracy of these models (Bell et al. 2014). The best solution, however, would be to have more data, which is unfortunately not possible within the scope of this paper.

In the body of the text here, I present a primary multilevel model, and in Appendix B I present alternative specifications but with more clusters, as well as a linear model with country fixed effects, that uphold broadly the same findings. Bryan and Jenkins (2016) caution against using fixed effects with exactly the sort of analysis I'm doing, specifically referencing the European Social Survey and similar data in their introduction. Their argument is based on the same foundational critique of Kreft and Yoon (1994), and they observe how the power for statistical power is limited when data is known to have few Level 2 clusters. Another key drawback to the use of country fixed effects is that I cannot meaningfully include any variables that I only have available on the country level, as they will definitionally be colinear. In my models, this includes the share of all doctors who are gynecologists, the level at which healthcare is regulated in each country, and how much autonomy healthcare-regulating regions have.

Thus my conclusion is to present both multilevel models and country fixed effects models. Neither is a perfect fit for my data, but when the different models align, we can have greater confidence in their results. These alternative models are detailed in Appendix B.

The data used for these models is harmonized from a variety of sources, which are described in detail in Appendix A. The NUTS framework for organizing geographical data is crucial to this harmonization, and its use is widespread enough that all of the data could be attributed to a NUTS region, though some data points were available at different levels of the nested hierarchy. For any regression model, it will be more accurate the more observations are included, which would recommend using the lowest level on which the data is available. I have done this for most models, with the exception of those that test H1 (Regional Politics), because in these cases the level of interest is the level at which regional government operates. Relatedly, these models exclude Ireland, Portugal, and Norway due to the way these countries' governments are structured.[21] The regression results are presented in the following tables.

Table 2 presents models with two alternative ways of testing Hypothesis 1 (Regional Politics), where we expected that regions that were historically controlled by culturally conservative parties would have fewer abortion providers. Models 1 and 2 use the GALTAN measure from the Chapel Hill Expert Survey, and Models 3 and 4 use the Traditional Morality measure from the Comparative Manifesto Project. Neither shows any significance. These results are supported by the linear models of the same variables in Appendix B4, which are also insignificant. The observations in these models are the regions at the level of government, so the NUTS level varies by country, which is why they are excluded from the other Appendices.

The literature was mixed for H1 (Regional Politics), suggesting that regional politics would more likely be associated with abortion access in the US, but without the same clear expectation in Europe. This means that a null finding for this hypothesis is still nevertheless interesting: abortion

[21] In Ireland and Portugal, there is not a level of elected government between the national and the local (Schakel 2021). In Norway, there is, but they changed the boundaries of these regions in 2016, which made aggregation of the political data over the period since 2000 impractical.

providers in these ten European countries are not responding to regional morality politics in a consistent way, contradicting Medoff and Dennis' (2011) findings in the US American case. A plausible explanation for this finding is that abortion is generally viewed as a private matter in European politics rather than one for public debate, and abortion laws in most European countries have been settled and out of the political discourse for decades (Pullan and Gannon Forthcoming), unlike in the United States where it remains an ongoing debate and central platform issue for political parties.

Hypothesis 2 (Moral Values) is tested in Models 5-8 in Table 2. Only the variable for measure of LGBTQ+ acceptance is significant, when theoretically we would have expected the equal opportunity variable and LGBTQ+ acceptance variable to confirm the same attitudes, so this finding is perhaps limited in scope. But with a significant negative relationship to PPP, we see that as there are more patients per provider, there is reduced support for LGBTQ+ acceptance, confirming expectations from the literature that attitudes on abortion and LGBTQ+ issues tend to align (Green-Pedersen and Little 2021; Engeli, Green-Pedersen, and Thorup Larsen 2012). These models are particularly sensitive to changing the specifications in the Appendices – Model 8's significant results are usually still significant, but not in Appendix B2 where I run a multilevel model with clustering at the NUTS 2 level. The equal opportunity models remain insignificant across models with controls included.

Hypotheses 3 and 4 about religious denomination and religiosity are reported in Table 3. Models 9 and 10 show that the share of Catholics in the population is only significant when we do not control for other factors. Models 11 and 12, however, find a significant relationship for the share of Protestants in the population, but contrary to what was expected in the Hypothesis. As there are more patients per provider, there are *more* Protestants in the population, not fewer, suggesting that abortion access is relatively more difficult in Protestant areas than non-Protestant ones. This finding is puzzling and merits further investigation. A possible explanation that is not accounted for in this

study is an increased use of contraception in Protestant communities that reduces the need for abortions, which may also be entangled with measurement questions about the fertility rate and how this is endogenous with abortion rates. It does not appear that the mere presence of Protestant beliefs in a community is particularly attractive to abortion providers, nor is the presence of Catholic beliefs repulsive to them. Considering the alternative model specifications, the Protestant model loses its significance when the multilevel model is clustered on NUTS 1 or NUTS 2 (Appendix B1 & B2), but retains it in models that cluster at the level of health administration (B3) and the linear model (B4). The Catholic models are never significant with controls. There are likely further unmeasured differences between Catholic and Protestant regions that merit investigation and clarification in future research.

H4 (Religiosity) expected that regardless of denomination, increased levels of religiosity would correlate with a decrease in abortion providers, but there is no statistically significant relationship between these variables in Models 13 and 14. This variable gains significance in Appendices B1 and B3, which suggests that its importance in the model is more of a statistical artifact than something substantively meaningful.

Finally, the test of Hypothesis 5 can be found in Models 15 and 16 in Table 5. Without controls, there is a small positive coefficient, suggesting that there are more abortion providers in poorer communities (as patients per provider increases, GDP also increases), but the statistical significance disappears when controls are added to the model. This is consistent across all of the Appendix B models as well, so we can be confident that there is not a consistent relationship between abortion providers' locations and the wealth of a community. This would support the alternative explanation that perhaps European state management of healthcare resources distributes healthcare providers in a way that is not correlated with the community's wealth (either positively or negatively), though this would require further research to confirm. While there is not evidence for significant variation

between regions, when we evaluate H5 with a linear model with country fixed effects in Appendix B4.2, we do see statistical significance for the effect of some countries (Germany and Spain, both with a positive coefficient) but not all, suggesting greater variation between states rather than between regions within the same state. Future research could profitably analyze this relationship on an even more granular level.

In sum, these models show that there are fewer abortion providers where there is a greater share of Protestants in the population and where fewer people believe in LGBTQ+ equality. There is no evidence for the effect of regional politics (measured two different ways), the share of Catholics in the population, the level of religiosity in the population, belief in equality of opportunity, or GDP per capita on the independent variable for abortion providers (PPP). Hypotheses 2 and 3 (Moral Values and Catholic/Protestant) can each be partially confirmed, but the other hypotheses have null results. The null result for H1 (Regional Politics) is of substantive interest, as it runs contrary to findings from the US American case.

Table 4.2: Regional politics regressions in multilevel model, clustered by country

	Dependent variable:PPP			
	M1	M2	M3	M4
Regional politics GALTAN (CHES)	1.885	2.613		
	(6.668)	(6.829)		
Regional politics traditional morality (CMP)			-0.757	-0.888
			(6.175)	(7.301)
Autonomy of regional health administration		-11.457		-13.304
		(16.383)		(18.120)
Percent of region that is urban		-20.144		-19.281
		(26.379)		(24.928)
Hospital beds per region		0.00004		0.00004
		(0.0001)		(0.0001)
Percent of all doctors who are gynecologists		-1,976.033*		-2,119.428*
		(1,177.170)		(1,145.027)
Share of population with tertiary education		1.288		0.931
		(0.994)		(0.968)
Constant	53.656	102.075	63.508***	135.073*
	(36.782)	(81.696)	(16.421)	(72.826)
Observations	89	89	93	93
Log Likelihood	-467.879	-456.846	-488.504	-477.693
Akaike Inf. Crit.	943.758	931.691	985.008	973.386
Bayesian Inf. Crit.	953.712	954.089	995.138	996.180

*Note: *p<0.1; >**p<0.05; >***p<0.01*

Countries included: AT, BE, DE, ES, FR, IT, NL
Countries excluded: IE, NO, PT

All regression tables generated with *stargazer* R package (Hlavac 2018)

Table 4.3: Moral Values Regressions in multilevel model, clustered by country

	Dependent variable:			
	M5	M6	M7	M8
Equality of opportunity is important	2.232	10.736		
	(7.625)	(7.692)		
Gay people should live freely			-23.658***	-28.474***
			(6.942)	(7.183)
Autonomy of regional health administration		4.307		6.487
		(8.384)		(9.609)
Percent of region that is urban		0.208		-0.192
		(5.454)		(5.409)
Hospital beds per region		0.0001***		0.0002***
		(0.00003)		(0.00003)
Percent of all doctors who are gynecologists		-752.199		-515.051
		(524.294)		(599.133)
Share of population with tertiary education		0.494***		0.368**
		(0.185)		(0.185)
Constant	31.057*	16.904	76.672***	82.121***
	(17.101)	(28.520)	(13.691)	(28.418)
Observations	849	831	849	831
Log Likelihood	-3,912.159	-3,816.508	-3,906.528	-3,809.940
Akaike Inf. Crit.	7,832.317	7,651.017	7,821.057	7,637.879
Bayesian Inf. Crit.	7,851.293	7,693.521	7,840.033	7,680.383

*Note: *p<0.1; >**p<0.05; >***p<0.01*

Table 4.4: Religious regressions in multilevel model, clustered by country

	Dependent variable: PPP					
	M9	M10	M11	M12	M13	M14
Percent of Catholics in pop.	17.315***	-6.084				
	(4.552)	(6.560)				
Percent of Protestants in pop.			1.089	14.833**		
			(7.379)	(7.301)		
Self-reported religiosity					2.025	-1.136
					(1.258)	(1.466)
		(13.272)		(13.890)		(8.243)
Percent of region that is urban		-5.148		-3.309		-0.436
		(5.765)		(5.196)		(5.476)
Hospital beds per region		0.0002***		0.0001***		0.0001***
		(0.00004)		(0.00002)		(0.00003)
Percent of all doctors who are gynecologists		-298.303		-292.101		-710.426
		(764.608)		(801.787)		(514.829)
Share of population with tertiary education		1.128***		1.153***		0.466**
		(0.198)		(0.193)		(0.184)
Constant	27.050***	1.843	32.895***	-3.919	26.435***	43.992*
	(9.123)	(31.111)	(9.385)	(32.584)	(8.599)	(23.944)
Observations	558	540	558	540	849	831
Log Likelihood	-2,468.402	-2,366.111	-2,475.060	-2,364.397	-3,912.708	-3,818.833
Akaike Inf. Crit.	4,944.803	4,750.223	4,958.121	4,746.793	7,833.416	7,655.666
Bayesian Inf. Crit.	4,962.101	4,788.847	4,975.418	4,785.418	7,852.392	7,698.169

*Note: *p<0.1; >**p<0.05; >***p<0.01*

Table 4.5: GDP Regression in multilevel model, clustered by country

	Dependent variable: PPP	
	M15	M16
GDP per capita	0.0001**	0.0001
	(0.0001)	(0.0001)
Autonomy of regional health administration		4.198
		(5.552)
Percent of region that is urban		2.224
		(5.460)
Hospital beds per region		0.0001***
		(0.00003)
Percent of all doctors who are gynecologists		-953.954***
		(352.026)
Share of population with tertiary education		0.249
		(0.184)
Constant	33.858***	55.893***
	(5.734)	(17.373)
Observations	831	824
Log Likelihood	-3,842.009	-3,795.161
Akaike Inf. Crit.	7,692.019	7,608.321
Bayesian Inf. Crit.	7,710.909	7,650.749

*Note: *p<0.1; >**p<0.05; >***p<0.01*

4.5 Limitations & Recommendations for Future Research

The most significant limitation of this study is the imprecision in how many abortion providers work for a single clinic in the PPP value. This will require further research. It is not practical to verify the staffing levels of all 1700+ abortion providing locations in this study, but a case study focused on specific cities or perhaps one entire country will be a crucial next step for developing this research agenda on abortion access in Europe. On the other hand, expanding the number of countries included in this dataset for further comparative politics studies would also be valuable, particularly filling in the gaps in Western Europe and moving eastward.

It is also possible that different trends would be revealed if the abortion provider data were available as a time series. This would allow greater precision in all of the regressions that have time series data, including the ESS data and the parliamentary composition data. By having more datapoints in a time series, it would also be statistically possible to subset the dataset without reducing the total *n* of the regression to a number too small to be believable, which might reveal country-specific trends.

There are of course more variables that may be related to the distribution of abortion providers than could be addressed in a single paper. Possibilities for future inquiry include measures of women's economic empowerment such as labor market participation, data about the usage levels and cost of contraception, and representation of women and women's interests in parliaments, among others.

How to best account for fertility and the demand for abortion remain open questions. This paper could be improved with the incorporation of a datapoint that could measure how many abortions did not occur due to inaccessibility but would have happened if the patient had been able to have an abortion, or in other words, "abortion intentions" as contrasted with fertility intentions. I am not aware of any such data that could account for this hypothetical scenario, but welcome feedback

particularly from demographers who may have suggestions for how to incorporate this in a way that is not endogenous with abortion access.

4.6 Conclusion

By introducing a new dataset of abortion providers' locations and creating the patients per provider variable, this paper allows inter-regional and international comparison of ten European countries' abortion access. These countries all have relatively similar abortion policies, and now not only anecdotes but also data supports the finding that it is not equally easy to access abortion across these places. Descriptively, I find that 25% of women of reproductive age living in these countries live in a region with either zero abortion providers or the top 10% worst patient to provider ratios. Large swaths of some countries and isolated pockets in others have no abortion access for significant distances, forcing residents to travel either within their country or to another country for care, even though that care is perfectly legal in their hometown.

Statistically, I explore what other political, social, and economic variables are correlated with abortion provider distribution, finding that there are more abortion providers in places where LGBTQ+ people are accepted in society, and surprisingly finding that there are fewer abortion providers in Protestant areas. The lack of relationship between abortion providers and regional political attitudes is substantively interesting because it contradicts established knowledge based on the US American case. Abortion has remained a politically salient issue in the US, but much less so in Europe, and correspondingly, the party that has controlled a region in the last 20 years does not have any significant relationship with the distribution of abortion providers. I also find an absence of a relationship between abortion providers and GDP per capita, belief in equality of opportunity, and self-reported religiosity (separate from denomination).

There is much more work that could be done to measure abortion access in more precise ways and to understand what explains variation in abortion access. This dataset makes a creditable

contribution to this broader scientific project, bringing spatial analysis of abortion access that is heavily studied in the US to Europe. Further work to disentangle abortion provider distribution and fertility rates will be key to advancing our understanding of this topic, and additional case studies that improve the precision of the data will also improve the state of the art.

Questions about abortion access boil down to questions about democracy and women's political participation. What does it mean when a country's laws do not align with the reality experienced by citizens? How can one have a right to do something without the ability to exercise that right? What is the appropriate role for doctors, sitting at the intersection of public services and private decisions: gatekeepers or enablers? To begin answering these high-level questions, we must first arm ourselves with data about the current situation. We now know that abortion access, as measured by the distribution of abortion providers geographically, differs across ten European countries with similar abortion policies. We have some insights into what explains this variation, as well as some interesting null findings for what does not explain it. Improving our measurement and expanding the scope of the data will be necessary to further develop our understanding of the gap between abortion policy and abortion access in Europe and beyond.

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4.8 Appendix A: Detailed Data Description and Citation

4.8.1 Abortion Providers & PPP

Abortion provider locations were drawn from a variety of sources. Abortion-Clinics.eu (2023) is the most internationally comprehensive source, though its owners did not respond to requests for more information, so it could not be verified how frequently this is updated. Thus, when there was a more specific national-based source to use instead, I prioritized a more local and more regularly updated source. I did not use data for a country when it appeared to be geographically inconsistent or incomplete, which led to the exclusion of France, Italy, Switzerland, and the UK. In the end, the Belgian, German, Norwegian, and Portuguese data come entirely from Abortion-Clinics.eu.

Austria and the Netherlands both have national networks of abortion providers: *Österreichische Gesellschaft für Familienplanung* and *Nederlands Genootschap van Abortusartsen*, respectively. I take their lists of abortion providers from their websites: (Adressen van Abortusklinieken in Nederland n.d.; Schwangerschaftsabbruch: Durchführung von Schwangerschaftsabbrüchen: Adressen Kliniken und Ärzt*innen n.d.).

In France, the *Réseau Entre la Ville et l'Hôpital pour l'Orthogénie* maintains the website ivglesaddresses.org (2023), which is aimed at abortion seekers in France. During the data collection process, this was updated multiple times, so confidence in its accuracy as of the time of collection is high. It should be noted that this data would skew towards overestimating the number of providers, because it includes individual clinicians' names, not only facilities, though whenever possible duplicate names at the same address were consolidated. France also allows midwives to perform abortions, which increases the number of providers on this list.

In Germany, the ELSA Studie collected very similar data to what is presented in this paper, in addition to other much more detailed data about abortion care and facilities. Their analysis is mostly

published in non-peer-reviewed reports because the project was funded by the German Ministry of Health, with the exception of Torenz et al. (2023). Their raw data is unfortunately not available outside the project, so I use Abortion-Clinics.eu data instead. In comparing the two, it appears that the ELSA Studie identified about 10% more facilities than are reported on Abortion-Clinics.eu.

For Ireland, I use a list published by the Health Service Executive (2022), which lists hospitals that provide abortion services. Abortion is also available from clinics and some general practitioners, which are not included in this list. Mishtal et al. (2022) name some of these clinics, which I added to the list manually.

In Italy, abortion provision changes frequently because doctors regularly change their status as conscientious objectors (Gannon 2023; Pullan 2022). The Ministry of Health publishes an annual report with numbers of abortion services and nonobjecting doctors per region, but has declined to publish which specific locations offer abortion services (Pullan and Gannon Forthcoming; Lalli and Montegiove 2021). The most reliable source, therefore, is a map produced by *LAIGA 194*, the "Free Association of Italian Gynecologists for the Application of Law 194." This data is notably correct only for the point in time when it was collected, but it is a fair estimate for the order of magnitude and general geographic distribution of services. Its validity is supported by Pullan (2022).

No single organization has an authoritative list of abortion clinics in Spain. In comparing several sources, I cannot determine that one is more complete or more current than the others, so I built a composite list from four sources (Clínicas de aborto en España para abortar de forma segura n.d.; Directorio de clínicas asociadas en ACAI 2023; Spain clinics and associations n.d.; Abortion Clinics in Europe: Clinic Browser 2023). Similarly to Italy, the Spanish Ministry of Health reports on the number of centers that perform abortions each year, but does not specify the names or exact locations of those centers. These are gathered at the NUTS 2 level, so I add these numbers to the count of

abortion providers used to calculate PPP in Spain. This explains the apparent discrepancy between the NUTS 2 and NUTS 3 maps of Spain. There is a noteworthy concentration of abortion providers in the region of Cataluña that goes beyond the scope of this paper but merits further investigation. Nominally, abortion is available in public health facilities in Spain, but 85% of abortions are performed in private clinics (Borraz 2021), which are the facilities included in my list. It is likely that the remaining 15% of abortions are distributed across facilities that perform very few abortions each year, similar to Torenz et al.'s (2023) findings in Germany.

The population data used in the calculation of PPP is from Eurostat (2021), dataset edat-lfse-04.

Abortion provider locations are linked to NUTS statistical regions using postcode data (TERCET NUTS-postal codes matching tables 2020).

4.8.2 Independent Variables & Controls

H1 (Regional Politics) has been tested with two different data sources that function similarly: first, the Chapel Hill Expert Survey (Bakker et al. 2015; Jolly et al. 2022; Polk et al. 2017) and then the Comparative Manifesto Project (Lehmann et al. 2023). Both take Röth & Kaiser's (2019) finding that national party positions can be used when studying regional politics. For CHES, experts directly code the GALTAN position of each party in the dataset. For CMP, I follow Röth's (2017) strategy for selecting indicators to measure parties' positions from their manifestos, though he measured economic positions and I seek to measure a different dimension. I chose variables 603 and 604 from the CMP dataset which reflect the percentage of quasi-sentences in the manifesto that were pro- or contra-traditional morality according to their coders, and combine this into a single number for each party. The CMP dataset includes better coverage of the parties in my study, especially regional parties.

From here, both the CHES and CMP variables are subjected to the same process. I use election data from the Observatory on Regional Democracy (Schakel 2021). Ireland and Portugal are excluded at this stage because they do not hold regional parliamentary elections. Norway is also excluded because they changed their administrative borders during this time period, so I drop elections before 2000 and begin the data with the first election thereafter. I match the CHES/CMP data to the party seatshare from Schakel, and then I calculate a weighted average of party positions by both seats and years that the parliament was in power (years between elections), resulting in one value per region. This number represents the average climate of progressiveness over the last 20 years, as measured by GALTAN in CHES or "traditional morality" statements in CMP.

The next several variables come from the European Social Survey Round 9 from 2018, because this was the most recent wave to include the relevant variables for my hypotheses (European Social Survey European Research Infrastructure 2021). I use two variables to measure cultural progressiveness among the population: ipeqopt and freehms, for which I calculate an average for each NUTS region.

Religious denomination is stored in different variables for each country and was not asked in all countries: Spain, France, Italy, and Portugal are missing this data. I calculate the percentage of Catholics and percentage of Protestants out of all respondents for all regions that have the data. For religiosity, I use the variable rlgdgr, which asks "How religious are you" on a scale from 0 being not at all religious to 10 being very religious.

The final independent variable is GDP per capita, which is sourced from Eurostat, dataset nama-10r-3dgp (2023).

The other Eurostat variables used as controls in the models are:

Share of population with tertiary education	edat-lfse-04 (2021)
Hospital beds per region	hlth-rs-bdsrg (2022)
Total number of doctors	hlth-rs-physreg (2023)
Percentage of doctors who are gynecologists	hlth-rs-spec (2022)
Percentage of a region classified as urban	lfst-r-lfsd2hh (2023)

I constructed the variables for which NUTS level regulates healthcare and how much autonomy that region has from a series of OECD country-specific reports (OECD 2023a, 2023b, 2023c, 2023d, 2023e, 2023f, 2023g, 2023h, 2023i, 2023j).

4.9 Appendix B: Robustness and Model Specifications

As discussed in the body of the paper, there are pros and cons to different types of models, and there are also limitations to the data available for analysis in this paper. My data is known to be clustered and correlated in several ways: NUTS 3 regions nest into NUTS 2 regions, which nest into NUTS 1 regions, which nest into countries. It thus was inappropriate to assume that the datapoints were "independent observations" in the sense that a traditional linear regression model requires.

The primary model in the paper is a multilevel regression model with clustering done at the country level. Multilevel models are in some ways ideal for accommodating clustered data, but they come with limitations. By clustering the data, the ultimate regression is basically run on one datapoint per cluster: in my case, that means ten datapoints, which is insufficient for a robust regression. If I had data for many more countries, this model would have fewer drawbacks, but the data is not available.

To address this deficiency in the fit between my data and a multilevel model, I present here several alternatively specified models. In Appendix B1, I cluster the multilevel model at the NUTS 1 level (*n*=58). Appendix B2 clusters at NUTS 2 (*n*=158). Appendix B3 clusters at the level at which healthcare is administered, which is a mix of NUTS levels for the different countries (*n*=93). For all countries but one, the level of healthcare administration is the same as the level at which they hold regional elections (the Netherlands administers healthcare nationally but has NUTS 2 elections).

The final appendix is B4, which is a traditional linear regression model. While country fixed effects are included, this is still not an ideal solution, because we know the datapoints are related in these multi-layered nested ways. I include it nevertheless as a robustness check.

The comparisons between these models are discussed in the body of the paper, but they broadly speaking say the same thing. This increases our confidence in the main multilevel model. Regional politics only makes sense in Appendix B4, but all other models appear in all variations.

4.9.1 Appendix B1: Multilevel, clustered at NUTS 1

B1.1 Moral Values

	Dependent variable: PPP			
	B1.5	B1.6	B1.7	B1.8
Equality of opportunity is important	0.647	7.522		
	(8.316)	(8.331)		
Gay people should live freely			-25.157***	-13.299
			(8.055)	(8.578)
Autonomy of regional health administration		14.908**		17.070***
		(5.882)		(6.137)
Percent of region that is urban		2.050		1.653
		(6.271)		(6.256)
Hospital beds per region		0.0005***		0.0005***
		(0.0001)		(0.0001)
Percent of all doctors who are gynecologists		-1,057.107***		-901.847***
		(338.995)		(349.786)
Share of population with tertiary education		0.556**		0.446**
		(0.216)		(0.226)
Constant	33.614*	20.339	77.742***	53.528**
	(17.414)	(25.278)	(14.280)	(24.253)
Observations	849	831	849	831
Log Likelihood	-3,839.715	-3,736.719	-3,834.907	-3,735.901
Akaike Inf. Crit.	7,687.429	7,491.437	7,677.815	7,489.803
Bayesian Inf. Crit.	7,706.406	7,533.941	7,696.791	7,532.306

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B1.2 Religion

	Dependent variable: PPP					
	B1.9	B1.10	B1.11	B1.12	B1.13	B1.14
Percent of Catholics in pop.	-3.951	2.638				
	(7.903)	(8.278)				
Percent of Protestants in pop.			-10.260	-1.936		
			(9.903)	(9.921)		
Self-reported religiosity					-6.543**	-5.984**
					(2.662)	(2.577)
Autonomy of regional health administration		0.845		1.310		17.447***
		(5.130)		(4.819)		(6.028)
Percent of region that is urban		0.363		-0.217		2.439
		(6.764)		(6.460)		(6.252)
Hospital beds per region		0.0003***		0.0003***		0.0005***
		(0.0001)		(0.0001)		(0.0001)
Percent of all doctors who are gynecologists		-911.043***		-907.493***		-1,018.087***
		(231.309)		(232.156)		(338.543)
Share of population with tertiary education		0.826***		0.819***		0.443**
		(0.226)		(0.231)		(0.220)
Constant	26.726***	30.075*	27.813***	31.020*	63.656***	61.268***
	(4.712)	(16.028)	(4.528)	(16.281)	(12.402)	(23.529)
Observations	558	540	558	540	849	831
Log Likelihood	-2,435.870	-2,341.313	-2,435.245	-2,341.164	-3,837.881	-3,735.607
Akaike Inf. Crit.	4,879.740	4,700.626	4,878.490	4,700.327	7,683.761	7,489.214
Bayesian Inf. Crit.	4,897.037	4,739.250	4,895.787	4,738.951	7,702.737	7,531.718

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B1.3 GDP

	Dependent variable: PPP	
	(1)	(2)
GDP per capita	0.0001	0.00003
	(0.0001)	(0.0001)
Autonomy of regional health administration		13.628**
		(5.469)
Percent of region that is urban		2.436
		(6.286)
Hospital beds per region		0.0004***
		(0.0001)
Percent of all doctors who are gynecologists		-1,075.383***
		(309.128)
Share of population with tertiary education		0.465**
		(0.216)
Constant	33.907***	41.334**
	(4.181)	(18.648)
Observations	831	824
Log Likelihood	-3,783.180	-3,723.566
Akaike Inf. Crit.	7,574.360	7,465.131
Bayesian Inf. Crit.	7,593.251	7,507.559

*Note: *p<0.1; >**p<0.05; >***p<0.01*

4.9.2 Appendix B2: Multilevel, clustered at NUTS 2

B2.1 Moral Values

	Dependent variable: PPP			
	B2.5	B2.6	B2.7	B2.8
Equality of opportunity is important	-38.935***	11.343		
	(10.775)	(11.761)		
Gay people should live freely			-17.201**	5.068
			(8.696)	(10.249)
Autonomy of regional health administration		9.866**		8.355**
		(3.977)		(3.981)
Percent of region that is urban		18.303*		17.392*
		(9.770)		(9.778)
Hospital beds per region		0.0002**		0.0002**
		(0.0001)		(0.0001)
Percent of all doctors who are gynecologists		-991.935***		-978.182***
		(242.377)		(245.383)
Share of population with tertiary education		0.447		0.432
		(0.300)		(0.328)
Constant	114.447***	19.185	64.676***	35.417
	(22.179)	(32.975)	(15.294)	(27.599)
Observations	849	831	849	831
Log Likelihood	-3,825.218	-3,723.367	-3,829.827	-3,723.849
Akaike Inf. Crit.	7,658.436	7,464.734	7,667.653	7,465.697
Bayesian Inf. Crit.	7,677.413	7,507.237	7,686.629	7,508.201

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B2.2 Religion

	Dependent variable: PPP					
	B2.9	B2.10	B2.11	B2.12	B2.13	B2.14
Percent of Catholics in pop.	6.948	7.972				
	(12.406)	(13.424)				
Percent of Protestants in pop.			-56.647***	-20.521		
			(17.198)	(18.784)		
Self-reported religiosity					-2.244	-0.961
					(2.756)	(2.638)
Autonomy of regional health administration		1.142		0.825		9.140**
		(5.231)		(4.711)		(3.928)
Percent of region that is urban		11.607		9.449		17.530*
		(11.525)		(10.808)		(9.778)
Hospital beds per region		0.0002**		0.0002***		0.0002**
		(0.0001)		(0.0001)		(0.0001)
Percent of all doctors who are gynecologists		-815.739***		-762.619***		-956.091***
		(250.958)		(243.915)		(240.187)
Share of population with tertiary education		1.061**		0.984**		0.309
		(0.435)		(0.439)		(0.306)
Constant	26.561***	15.011	40.751***	22.003	44.949***	51.252**
	(4.853)	(24.182)	(4.613)	(25.228)	(12.667)	(24.039)
Observations	558	540	558	540	849	831
Log Likelihood	-2,420.233	-2,323.230	-2,414.933	-2,322.472	-3,832.585	-3,725.262
Akaike Inf. Crit.	4,848.466	4,664.459	4,837.866	4,662.944	7,673.170	7,468.524
Bayesian Inf. Crit.	4,865.763	4,703.083	4,855.163	4,701.568	7,692.147	7,511.028

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B2.3 GDP

	Dependent variable: PPP	
	B2.15	B2.16
GDP per capita	0.00000	0.00001
	(0.0001)	(0.0001)
Autonomy of regional health administration		8.626**
		(3.681)
Percent of region that is urban		16.195*
		(9.164)
Hospital beds per region		0.0002**
		(0.0001)
Percent of all doctors who are gynecologists		-967.011***
		(223.687)
Share of population with tertiary education		0.327
		(0.261)
Constant	36.263***	48.056***
	(2.885)	(16.618)
Observations	831	824
Log Likelihood	-3,770.989	-3,709.479
Akaike Inf. Crit.	7,549.978	7,436.957
Bayesian Inf. Crit.	7,568.869	7,479.385

*Note: *p<0.1; >**p<0.05; >***p<0.01*

4.9.3 Appendix B3: Multilevel, clustered at level of healthcare administration

B3.1 Moral Values

	Dependent variable: PPP			
	B3.5	B3.6	B3.7	B3.8
Equality of opportunity is important	-41.716***	-8.928		
	(4.999)	(6.523)		
Gay people should live freely			-44.012***	-31.387***
			(4.814)	(6.233)
Autonomy of regional health administration		4.029		4.371
		(3.995)		(4.023)
Percent of region that is urban		7.520		7.894
		(5.211)		(5.111)
Hospital beds per region		0.0001***		0.0002***
		(0.00003)		(0.00003)
Percent of all doctors who are gynecologists		-461.075**		-266.968
		(187.683)		(191.090)
Share of population with tertiary education		0.469***		0.327*
		(0.171)		(0.171)
Constant	127.410***	51.273***	117.057***	83.718***
	(15.537)	(19.329)	(14.149)	(18.105)
Observations	849	831	849	831
Log Likelihood	-3,935.284	-3,827.294	-3,928.918	-3,815.910
Akaike Inf. Crit.	7,878.568	7,672.588	7,865.835	7,649.821
Bayesian Inf. Crit.	7,897.545	7,715.092	7,884.812	7,692.325

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B3.2 Religion

	Dependent variable: PPP					
	B3.9	B3.10	B3.11	B3.12	B3.13	B3.14
Percent of Catholics in pop.	18.117***	2.638				
	(4.217)	(8.278)				
Percent of Protestants in pop.			-11.382*	15.626**		
			(6.079)	(7.205)		
Self-reported religiosity					-1.497	-2.436**
					(1.150)	(1.149)
Autonomy of regional health administration		0.845		34.298***		5.476
		(5.130)		(9.023)		(3.899)
Percent of region that is urban		0.363		-2.617		7.606
		(6.764)		(5.138)		(5.183)
Hospital beds per region		0.0003***		0.0001***		0.0002***
		(0.0001)		(0.00002)		(0.00003)
Percent of all doctors who are gynecologists		-911.043***		1,590.201***		-536.670***
		(231.309)		(417.941)		(182.996)
Share of population with tertiary education		0.826***		1.122***		0.445***
		(0.226)		(0.188)		(0.171)
Constant	30.831**	30.075*	39.581***	-98.836**	47.505***	45.679***
	(14.436)	(16.028)	(12.718)	(42.822)	(12.921)	(14.730)
Observations	558	540	558	540	849	831
Log Likelihood	-2,471.508	-2,341.313	-2,478.463	-2,363.418	-3,969.403	-3,827.717
Akaike Inf. Crit.	4,951.015	4,700.626	4,964.926	4,744.837	7,946.806	7,673.433
Bayesian Inf. Crit.	4,968.313	4,739.250	4,982.224	4,783.461	7,965.782	7,715.937

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B3.3 GDP

	Dependent variable: PPP	
	B3.15	B3.16
GDP per capita	0.00004	0.00001
	(0.0001)	(0.0001)
Autonomy of regional health administration		4.925
		(3.712)
Percent of region that is urban		7.561
		(5.162)
Hospital beds per region		0.0001***
		(0.00003)
Percent of all doctors who are gynecologists		-662.463***
		(177.459)
Share of population with tertiary education		0.361**
		(0.170)
Constant	40.426***	44.288***
	(11.644)	(12.442)
Observations	831	824
Log Likelihood	-3,895.797	-3,802.101
Akaike Inf. Crit.	7,799.595	7,622.203
Bayesian Inf. Crit.	7,818.485	7,664.630

*Note: *p<0.1; >**p<0.05; >***p<0.01*

4.9.4 Appendix B4: Linear, with country fixed effects

B4.1 Regional Politics

	Dependent variable: PPP			
	B4.1	B4.2	B4.3	B4.4
Regional politics GALTAN (CHES)	7.891	1.764		
	(7.019)	(7.041)		
Regional politics traditional morality (CMP)			-1.980	-1.190
			(4.544)	(7.386)
Country fixed effects: Belgium		28.351		32.420
		(34.068)		(33.871)
Country fixed effects: Germany		-43.367*		-43.726
		(23.600)		(28.824)
Country fixed effects: Spain		0.292		-2.873
		(20.553)		(20.348)
Country fixed effects: France		-29.784		-26.116
		(23.216)		(21.512)
Country fixed effects: Italy		-2.941		-11.199
		(26.713)		(25.195)
Country fixed effects: Netherlands		59.113***		63.292**
		(22.348)		(28.788)
Percent of region that is urban		-18.650		-16.169
		(27.050)		(25.424)
Hospital beds per region		0.00005		0.0001
		(0.0001)		(0.0001)
Share of population with tertiary education		1.305		0.830
		(1.112)		(1.055)
Constant	17.185	73.238	58.430***	102.825**
	(35.997)	(59.827)	(8.211)	(46.870)
Observations	89	89	93	93
R^2	0.014	0.387	0.002	0.373
Adjusted R^2	0.003	0.309	-0.009	0.296
Residual Std. Error	56.166 (df = 87)	46.773 (df = 78)	55.791 (df = 91)	46.589 (df = 82)
F Statistic	1.264 (df = 1; 87)	4.928*** (df = 10; 78)	0.190 (df = 1; 91)	4.877*** (df = 10; 82)

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B4.2 Moral Values

	Dependent variable: PPP			
	B4.5	B4.6	B4.7	B4.8
Equality of opportunity is important	-28.733***	12.304		
	(5.293)	(7.806)		
Gay people should live freely			-11.144***	-30.887***
			(4.006)	(7.330)
Country fixed effects: Belgium		-8.799		-17.721***
		(5.461)		(5.748)
Country fixed effects: Germany		-19.719***		-28.223***
		(4.651)		(5.036)
Country fixed effects: Spain		35.219***		26.039***
		(5.664)		(5.500)
Country fixed effects: France		-1.767		-16.672***
		(5.181)		(5.644)
Country fixed effects: Ireland		13.072		9.976
		(9.937)		(9.877)
Country fixed effects: Italy		-1.330		9.091
		(5.649)		(5.563)
Country fixed effects: Netherlands		23.476***		8.642
		(5.932)		(6.740)
Country fixed effects: Norway		-31.699***		-43.308***
		(8.805)		(9.217)
Country fixed effects: Portugal		1.786		2.754
		(6.465)		(6.400)
Percent of region that is urban		-1.051		-1.233
		(5.489)		(5.436)
Hospital beds per region		0.0001***		0.0002***
		(0.00003)		(0.00003)
Share of population with tertiary education		0.527***		0.395**
		(0.188)		(0.187)
Constant	88.187***	-11.862	47.975***	77.565***
	(11.041)	(18.335)	(7.078)	(16.425)
Observations	849	831	849	831
R^2	0.034	0.309	0.009	0.321
Adjusted R^2	0.032	0.298	0.008	0.311
Residual Std. Error	27.809 (df = 847)	23.749 (df = 817)	28.160 (df = 847)	23.531 (df = 817)
F Statistic	29.474*** (df = 1; 847)	28.076*** (df = 13; 817)	7.738*** (df = 1; 847)	29.770*** (df = 13; 817)

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B4.3 Religion

	Dependent variable: PPP					
	B4.9	B4.10	B4.11	B4.12	B4.12	B4.13
Percent of Catholics in pop.	10.448**	-7.157				
	(4.512)	(6.643)				
Percent of Protestants in pop.			-32.452***	15.871**		
			(6.362)	(7.337)		
Self-reported religiosity					1.580	-1.423
					(1.117)	(1.495)
Country fixed effects: Belgium		-17.091***		-14.891***		-9.771*
		(5.103)		(4.556)		(5.467)
Country fixed effects: Germany		-22.153***		-22.504***		-21.757**
		(5.132)		(4.246)		(5.149)
Country fixed effects: Spain						31.283***
						(5.452)
Country fixed effects: France						-4.939
						(4.919)
Country fixed effects: Ireland		1.503		1.020		13.761
		(8.447)		(8.398)		(9.946)
Country fixed effects: Italy						2.640
						(5.431)
Country fixed effects: Netherlands		12.915*		15.235***		20.722***
		(6.705)		(5.124)		(6.269)
Country fixed effects: Norway		-40.888***		-42.339***		-32.386***
		(8.692)		(7.823)		(9.120)
Country fixed effects: Portugal						3.075
						(6.521)
Percent of region that is urban		-5.877		-3.655		-1.864
		(5.782)		(5.202)		(5.517)
Hospital beds per region		0.0002***		0.0001***		0.0001***
		(0.00004)		(0.00002)		(0.00004)
Share of population with tertiary education		1.143***		1.164***		0.500***
		(0.199)		(0.193)		(0.187)
Constant	20.386***	-0.429	31.655***	-91.513***	21.354***	28.085*
	(1.780)	(7.352)	(1.836)	(17.721)	(5.126)	(14.683)
Observations	558	540	558	540	849	831
R^2	0.010	0.365	0.045	0.369	0.002	0.307
Adjusted R^2	0.008	0.354	0.043	0.358	0.001	0.296
Residual Std. Error	23.896 (df = 556)	19.371 (df = 530)	23.468 (df = 556)	19.307 (df = 530)	28.255 (df = 847)	23.772 (df = 817)
F Statistic	5.362** (df = 1; 556)	33.792*** (df = 9; 530)	26.017*** (df = 1; 556)	34.406*** (df = 9; 530)	1.999 (df = 1; 847)	27.901*** (df = 13; 817)

*Note: *p<0.1; >**p<0.05; >***p<0.01*

B4.4 GDP

	Dependent variable: PPP	
	B4.15	B4.16
GDP per capita	-0.0001	0.0001
	(0.0001)	(0.0001)
Country fixed effects: Belgium		-2.852
		(5.744)
Country fixed effects: Germany		-19.811***
		(4.672)
Country fixed effects: Spain		34.343***
		(5.538)
Country fixed effects: France		-2.229
		(4.897)
Country fixed effects: Ireland		15.773
		(9.948)
Country fixed effects: Italy		1.824
		(5.382)
Country fixed effects: Netherlands		24.328***
		(5.943)
Country fixed effects: Norway		-7.298
		(8.604)
Country fixed effects: Portugal		2.888
		(6.443)
Percent of region that is urban		0.027
		(5.563)
Hospital beds per region		0.0001***
		(0.00003)
Share of population with tertiary education		0.302
		(0.191)
Constant	31.539***	18.491***
	(2.355)	(7.019)
Observations	831	824
R^2	0.001	0.300
Adjusted R^2	-0.0004	0.289
Residual Std. Error	28.191 (df = 829)	23.806 (df = 810)
F Statistic	0.649 (df = 1; 829)	26.731*** (df = 13; 810)

*Note: *p<0.1; >**p<0.05; >***p<0.01*

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