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Women's health

Strange medicine

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IT IS a bizarre time for women's health. In March Arkansas passed a law banning abortions after 12 weeks of pregnancy. Then North Dakota went even further, signing a law to ban all abortions after six weeks—six!—the most severe restriction in America. These measures flout legal precedent. Or as Arkansas's Democratic governor put it (the legislature overrode his veto), his state's ban is "blatantly unconstitutional". Even stranger than the current fight over abortion, however, is the current fight over contraception.

Today is the last day for public comment on the contraceptive coverage mandate—Obamacare's requirement that insurers cover contraception without making patients pay an additional fee. It has been the subject of fierce debate for nearly two years. Despite the Obama administration's attempts at compromise, the fight shows no sign of abating. That is too bad.

One would think that both sides of the abortion debate could rally behind contraception. Young, unmarried women have particularly high rates of unintended pregnancy. In 2008 more than half of these unintended pregnancies ended in abortion. Reduce the rate of unintended pregnancies, reduce the rate of abortion. Expanding access to contraception would seem a reasonable way to advance this goal. But no one can agree on how to do so.

In 2011 the Obama administration proposed that insurers cover contraception for women without a co-pay. The National Academy of Sciences had recommended as much:

Under the health department's first proposal, insurance plans sponsored by some religious employers would be exempt from the requirement. This did nothing to assuage the United States Conference of Catholic Bishops or other conservative groups. So the health department adjusted the proposal in February 2012, then again in February 2013. Under the most recent version, non-profit religious organisations would not have to cover contraception. Female employees would be able to get free contraception through a separate plan, with insurers footing the bill. Those insurers would then pay lower fees on state health-insurance exchanges.

This did not placate the bishops. Thirteen state attorneys general have sent a letter to the health department voicing their own objections. Lawsuits over the mandate continue (Stuart Taylor provides a good overview). The question now is whether the Obama administration will keep trying to find a compromise.

The administration might do well to learn from another recent experiment. In 2011 Kathleen Sebelius, the health secretary, took the extraordinary step of rebuffing her own colleague, Margaret Hamburg of the Food and Drug Administration (FDA). Dr Hamburg had recommended that emergency contraception be made available to women of all ages without a prescription, as medical societies had urged for years. Mrs Sebelius, mindful of the imminent presidential election, rejected the idea. On April 5th a federal judge scolded her, calling the restriction on emergency contraception "politically motivated, scientifically unjustified, and contrary to agency precedent." The judge ordered that emergency contraception be made available over the counter within 30 days.

So, what's the lesson? There is a limit to how much one should try to please those opposed to contraception. Mrs Sebelius is right to try to accommodate the concerns of religious employers. But at this point, she has to move forward.