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Reproductive Equity Support: A Cross-National Comparison of Medically Assisted Reproduction and Abortion Policies

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Abstract

This article offers a new way of classifying and measuring state support for reproductive equity across countries, focusing on medically assisted reproduction (MAR) and abortion. Drawing on the notion of stratified reproduction and comparative welfare state research, we propose a two-dimensional framework to capture how policies can shape different sets of inequalities and how access to reproductive care is provided. The two dimensions that compose our framework are "permissiveness," the degree to which government policies enable access to reproductive care by legalizing services, defining who qualifies as a patient, and/or imposing restrictive measures on service delivery, and "generosity," the extent to which government policies subsidize the costs of authorized services for individuals deemed eligible. We applied the permissiveness–generosity framework to quantitative data on MAR and abortion policies from 2020 from the International Reproduction Policy Database across 30 high-income countries. We then investigated the cases of Austria, Germany, and Switzerland, which group together in the overall plotting, more in-depth. The quantitative mapping revealed diverse approaches to reproductive equity, with some countries having both permissive and generous policies, while others focus on one dimension or provide limited support altogether. The case studies show that despite overall trends towards greater reproductive equity in recent decades, state support for individuals' equal access to MAR and abortion remains limited and has taken different pathways in this group of countries. This study contributes to a better understanding of how state policies promote equal access to reproductive care and enable individuals to pursue their desired reproductive pathways, regardless of their characteristics or socioeconomic position.

Keywords
abortion; Austria; Germany; medically assisted reproduction; reproductive equity; stratified reproduction; Switzerland; welfare state

1. Introduction

This article introduces a new way of classifying and measuring institutional contexts for reproduction, focusing on medically assisted reproduction (MAR) and abortion. Reproduction is an important area of state regulation, including contraception, abortion, assisted reproduction, and pregnancy care. States can forbid, hinder, permit, or ensure individuals' access to different reproductive healthcare services. As stratification of reproduction has been well documented in numerous studies, it is crucial to understand the mechanisms through which government policies mitigate or exacerbate inequalities in individuals' access to reproductive care.

Comparative research on reproduction policies has largely focused on a particular aspect in isolation, such as contraception, abortion, or assisted reproduction. However, it is important to investigate reproduction policy as a regulatory domain more broadly. This is not only because regulations of these different subfields often influence each other, for example, by touching on common ethical concerns among the general public (Zagel, 2024), but also because analysing them together allows us to see how government interventions shape processes of reproduction as a whole (Almeling, 2015).

There is a large diversity in how countries facilitate access to MAR and abortion. These two aspects of reproductive care have been subject to exceptionally intense political debate in many countries. When these services are legal, they are provided in a medical setting that is closely attached to general healthcare. However, compared to other less controversial reproductive services such as contraception and pregnancy care, MAR and abortion are more visibly subject to political decisions and policy choices regarding what medical care the state is obliged to provide, to what extent, in what condition, and for whom. Therefore, we take MAR and abortion as important aspects of reproduction that exemplify how states provide support for equity.

This article proceeds as follows. First, drawing on the notion of stratified reproduction and employing insights from comparative welfare state research, we build a two-dimensional framework of permissiveness and generosity to capture the institutional arrangements that shape access to MAR and abortion. We then apply this framework empirically, using data from the International Reproduction Policy Database (IRPD) on MAR and abortion policies across 30 countries. Finally, using this framework on three case studies—Austria, Germany, and Switzerland—we illustrate the divergent pathways taken by these countries in their reproductive equity support in MAR and abortion. We aim to contribute to a deeper understanding of how government policies shape reproductive equity in contemporary society.

2. Background

In this article, we propose a framework to capture multidimensional differences in reproduction policy from the perspective of what we call "reproductive equity support" in the welfare state (Zagel & Tamakoshi, 2025).

In the next section, we discuss the literature on which we build our framework: stratified reproduction and comparative welfare state research.

2.1. Stratified Reproduction

Extensive social sciences research has shown that reproduction is differentially experienced across different axes of inequalities. Many scholars investigating inequalities in reproduction use the concept of "stratified reproduction," coined by Colen (1986, 1995) and expanded by Ginsburg and Rapp (1995). The concept refers to "the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered" (Ginsburg & Rapp, 1995, p. 3). It has been extensively used to describe and analyze the hierarchical organization of reproductive experiences among different social groups (Greil et al., 2011; Ikemoto, 2015; Lee, 2019).

Studies that build on the notion of stratified reproduction are often conducted on a single-case basis and mostly focus on inequalities observable at the meso- and micro-levels, such as hospital organizations and clinical encounters (e.g., Becker, 2022; Davis, 2019). While these studies acknowledge the impact of government policies on inequalities in the reproductive realm, institutional settings are predominantly seen as contextual factors, and are rarely the focal point of analysis. We still lack a framework for a systematic comparison across a large number of cases regarding policies that exacerbate, maintain, or mitigate the stratification of reproduction.

2.2. Welfare States

Meanwhile, comparative welfare state research has extensively examined the nexus between (state) institutions and inequalities. One of the primary objectives of these studies is to identify which policy strategies are optimal in eliminating inequality and poverty within society (e.g., universal benefits versus means-testing). However, although comparative welfare state studies have examined institutional arrangements across different policy fields, reproduction has been overlooked. Reproduction has also been omitted by large parts of feminist welfare state scholarship, which has mostly focused on policies' impact on gender inequality in paid and unpaid labor (e.g., Lewis, 1992; Sainsbury, 1997).

The study by O'Connor et al. (1999) is exceptional in this regard; it includes a chapter on reproductive rights, particularly abortion policy, with respect to systematic differences in welfare states' interventions. Comparing four liberal welfare states (Australia, Great Britain, Canada, and the United States), the authors contrast two conceptions of rights in relation to welfare states. One is the recognition of the right to abortion as a medical entitlement, the other is the right to abortion as a "body right." In the medical entitlement model, the right to abortion is conceived as part of the general right to healthcare, the needs for which are certified by a medical authority. This conception is adopted in many countries (including Australia and the UK) that have held abortion on the criminal code except for specific cases and conditions. In the medical entitlement model, welfare states support access to legal abortion as a form of medical care. It does not presume the woman's individual right to abortion and instead requires a mediation by a medical authority. Historically, this model tends to be more stable than the other model. The liberalization of abortion in countries treating abortion as a medical entitlement has usually taken place through the expansion of the specific conditions that exempt criminality.

The other type of state regulation identified by O'Connor et al. (1999) is to capture the right to abortion as a body right. In this model, access to abortion is an issue of the legal personhood of the woman, i.e., civil rights to self-determination, without a requirement of proof of a medical need. The conception of abortion rights as a body right legitimizes the service (abortion) as a commodity in a market trade. In relation to welfare states, the body right model carries a certain intricacy (O'Connor et al., 1999). On one hand, the body right claim may lead to social rights being extended to abortion, mandating the state to supplement the market and secure a minimum standard of access. On the other hand, the individualist notion of abortion rights may be pitted against the social rights of welfare state constituents in general. Furthermore, although the right to abortion as a body right aligns more with radical feminist demands, it is historically more vulnerable to anti-abortion movements that mobilize the same individualist term and claim for the rights of competing subjects, including the fetus. The study classifies the United States and Canada as cases that employed the body right frame in the period under study. In these countries, abortion became liberalized through decriminalization, instead of by broadening the definition of medically approved exceptions.

Due to their focus on abortion regulations, the relations between welfare states and reproduction suggested by O'Connor et al. (1999) may be to some extent particular to abortion. However, they are still insightful for a general analysis of reproduction policy in welfare states. Reproductive care services may be conceived of differently across country contexts and across time: as a form of medical care, as an issue of self-determination, or both. We can expect that this is reflected in whether states prohibit, discourage, allow, or facilitate access of different population groups to different reproductive techniques and services.

3. State Support for Reproductive Equity: Permissiveness and Generosity

Bringing together the perspective of stratified reproduction and the welfare state-reproduction nexus, we propose a framework to compare how welfare states support reproductive equity with reproduction policies. Mirroring the public health notion of health equity (Braveman, 2014), we define reproductive equity as a reduction of *stratification* in reproductive health. By stratification, we refer to health differences between people that are avoidable according to the current state of science and technology, but adversely affect socially and/or economically disadvantaged groups. In turn, reproductive equity is achieved when all the reproductive healthcare services of the highest standard are accessible and affordable, regardless of an individual's characteristics or position in society.

Reproductive equity is therefore a normative concept that puts a spotlight on the question of whether states not only eliminate barriers but also proactively facilitate access to reproductive healthcare services, so that all individuals can realize their reproductive intentions. This conceptual focus adds to the politics of reproduction literature covering the broader spectrum of ideas around reproduction, including ideologies that lack a health- and scientific evidence-orientation, like anti-abortionism or pronatalism. Rather than understanding reproductive equity as a policy goal, we use it as a benchmark concept for the configuration of reproduction policies in different welfare states.

Theoretically, welfare states with high reproductive equity support allow and finance all the available reproductive healthcare services, effectively enabling individuals to decide whether, when, and how to avoid, start, continue, or terminate a pregnancy. For abortion, reproductive equity support can be considered as strong when abortion is free and available upon request and without a waiting period or other

obstacles, such as conscientious objection by physicians. Reproductive equity in MAR requires that individuals and couples be allowed to access different MAR techniques at an affordable cost, regardless of their sexuality or marital status.

Other important concepts largely align with our interest but are not conducive to the analytical aim of this study. Reproductive autonomy, defined as the capacity to make unrestrained decisions associated with reproduction and access to reproductive health services free from interference or coercion (Senderowicz & Higgins, 2020; Upadhyay et al., 2014), is another normative concept that resonates with the notion of reproductive equity. It indirectly implies that states must provide an environment beyond reproduction policies that allows their citizens to make such decisions. Reproductive justice is another powerful term, used as an analytical framework as well as a movement and vision. Coined by feminists of color, it sheds light on the embeddedness of reproductive autonomy in the context of questions of broader social justice, identifying simultaneous oppressions including racism and classism (Luna & Luker, 2013). Because of the holistic vision of the concept, it requires analysis beyond our focus on policies and the welfare state.

In light of the distinction between welfare states that grant access to abortion as a medical entitlement and those that grant it as a body right (O'Connor et al., 1999), reproductive equity support is a cross-cutting concept. Any level of reproductive equity support may theoretically be based on medical entitlement or on body rights, be they defined in an inclusionary or exclusionary way. That means that the medical need vs. body right question is more about *how* welfare states provide reproductive health services, and reproductive equity support is more about *what* is provided.

To capture the institutional provisions that support reproductive equity, we composed a framework with the two dimensions of *permissiveness* and *generosity*. Permissiveness indicates the degree to which policies enable access to reproductive care by establishing who qualifies as a legitimate patient and/or what restrictions are imposed on service delivery. This dimension considers the legality of procedures and services, the presence of limitations on their provision, and whether any criteria exclude certain individuals from being classified as eligible recipients. A lack of restrictions and conditions on accessing these procedures and services can be viewed as permissive and favourable towards reproductive equity.

Generosity reflects how extensively policies provide for the costs of legalized reproductive services to be covered for those recognized as eligible recipients. Policies can promote reproductive equity by subsidizing the expenses associated with reproductive procedures and services within public health systems. Even when a specific reproductive care service is allowed by law, it might not be included in public healthcare coverage. This situation forces people to pay out of their own pockets to obtain these services, discriminating against lower-resourced individuals. Funding reproductive procedures and services enables easier access for disadvantaged socioeconomic groups, thereby promoting reproductive equity.

It is important to capture the institutional support for reproductive equity along these two distinct dimensions. A policy may be permissive without being generous—a service could be legalized, but without funding being provided for it. In this pattern, the service is legitimized as a market good but omitted from the package covered by the welfare state. Conversely, policy provision might be generous but not permissive, such as when a service is financed that can only be accessed under strict conditions. In these cases, welfare states narrowly define legal services or recipients but assure the designated recipients to the legalized services as part of the state mandate.

Our permissiveness–generosity framework adds a perspective that is distinct from existing comparative approaches analysing reproduction policy. For example, in the field of MAR, a strand of political science research has proposed a framework based on the notion of autonomy, distinguishing who is granted autonomy by the state, i.e., professionals and recipients (Bleiklie et al., 2004; Engeli, 2009; Engeli & Rothmayr Allison, 2013; Varone et al., 2006). In their framework, treatment eligibility and cost coverage are indiscriminately listed as factors to determine patients' autonomy. This blurs an important distinction between different sets of inequalities (e.g., sexuality and socioeconomic status) as well as whether welfare states conceive access to MAR as a matter of self-determination or as a right to healthcare, and for whom. In the field of abortion, most comparative studies account for changes and differences in abortion policy in terms of liberalization, measured by the breadth of grounds for legal abortion and the availability of abortion upon request (Boyle et al., 2015; Fernández, 2021; Forman-Rabinovici & Sommer, 2018). Even in those studies that consider financial aspects of abortion policy, cost coverage is merely conceptualized as one of the measures by which the state erects barriers for people to obtain abortion (Budde & Heichel, 2017). This also fails to capture the different models of how welfare states address inequalities in abortion access.

4. Reproductive Equity Support in 30 High-Income Countries in 2020

In this section, we apply our proposed two-dimensional framework to empirical data on 30 high-income countries and explore how welfare states provide reproductive equity support in the fields of MAR and abortion.

4.1. Data

We used the most recent available policy data on abortion and MAR from the novel IRPD (Zagel et al., 2025). The IRPD includes policy indicators for 33 countries from 1980–2020 in the policy fields of sex education, contraception, abortion, MAR, and pregnancy care. The database was built in the scope of the research group Varieties of Reproduction Regimes, based at the WZB Berlin Social Science Center, Germany (2022–2028), and is provided in a data archive to the scientific community. Data collection was carried out from 2022 to 2024 with a standardized online survey of policy experts. The questionnaire included measurements of carefully selected reproduction policies used in previous studies and additional indicators. Pretests were run separately for each policy field by researchers with expertise in the respective field. One expert per country filled in the questionnaire, providing data through desk research and drawing on their network. Country experts were selected from academics and reproductive rights professionals, each with extensive expertise in at least one of the policy fields.

For this article, we used data on abortion and MAR policy. Our final sample for this step of the analysis consisted of 30 countries: Australia, Austria, Belgium, Bulgaria, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Japan, Latvia, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, South Korea, Spain, Sweden, Switzerland, Türkiye, and the United Kingdom. We excluded the United States because of its strong subnational variation in most of the indicators we consider.

4.2. Index Building

To map reproductive equity support, we created one composite index for each of the two dimensions (permissiveness and generosity) using variables measuring abortion policy and MAR policy. This was to provide an overview of overall reproductive equity support across fields. We used eight policy indicators from the IRPD to operationalize the permissiveness dimension (four for each policy field) and four policy indicators to operationalize the generosity dimension (two for each policy field).

To measure permissiveness, we used the following four (a–d) abortion policy indicators: (a) whether abortion was available on request (1/0), (b) whether medication abortion was legal (1/0), (c) whether doctors were allowed to object to providing an abortion (0/1), and (d) whether there were mandatory waiting periods between counseling and abortion (0/1). Permissiveness in MAR policy was operationalized with three (i–iii) indicators that indicated whether the following treatment methods were legal for (i) different-sex couples, (ii) lesbian couples, and (iii) single women (each 1/0): intra-uterine insemination—a procedure to place laboratory-processed sperm in the uterus with the use of donor semen (IUI-D) and in vitro fertilization (IVF)—a sequence of procedures to fertilize gametes extracorporeally alongside intracytoplasmic sperm injection (ICSI)—a procedure to directly inject a single sperm into the cytoplasm of an egg. For each of the patient groups, we assigned 1 if at least one of the two methods (IUI-D and IVF/ICSI) was legal, and in the case of IVF/ICSI, if at least one of the gamete configurations (own/donated) was legal. A fourth MAR indicator (iv) that we included in the permissiveness index was whether surrogacy (any arrangement) was legal (1/0).

In the generosity index, we included two indicators of abortion policy: whether costs for an abortion were *covered fully*, *partially*, or *not at all* (1/.5/0), and whether costs for post-abortion care were *covered fully*, *partially*, or *not at all* (1/.5/0). MAR policy was also measured with two indicators in the generosity index: whether costs for MAR treatments were *covered fully*, *partially*, or *not at all* (1/.5/0), and the number of cycles that were covered at least partially (count).

To build the index, we first coded each individual indicator so that a higher value was in the direction of more permissiveness and generosity, respectively; the higher the value, the higher the support for reproductive equity. For example, we coded countries as 0 which allowed doctors to object to performing an abortion on a patient. Our coding shows variation in support for reproductive equity, but does not allow us to conclude how restrictive countries are, which previous studies have considered as the opposite end of permissiveness. In our data, the coding of 0 cannot be interpreted as restrictiveness, since it can include regulations with other implications, such as when there was no national regulation at all or the indicator was not applicable. One example of when we coded an indicator as 0 with a *not applicable* meaning was cost coverage of MAR treatments in countries where MAR was not permitted.

Next, we standardized the indicators that were not measured as 0/1 to have comparative measures. We follow earlier examples in comparative policy research (e.g., Gornick & Meyers, 2003) and standardized by dividing the values by the observed maximum. Finally, we created additive indices for permissiveness and generosity. To give equal weight to each policy field, we applied an equal weighting strategy (x*0.5). Equal weighting is applied in index building when all the indicators included in the measure are considered equally important or when no evidence supports a different scheme (Gan et al., 2017). Since there was no evidence that any of the indicators for abortion and MAR respectively should receive a higher weight in the unchartered field

of comparative reproduction policy indexing, equal weighting appeared to be the apt strategy. With this, the theoretical range of the permissiveness index is 0–4, and for generosity index it is 0–2.

4.3. Results

Table 1 shows descriptive statistics for the two composite indices of permissiveness and generosity. Our weighted permissiveness index has an empirical range from 1 for Italy, France, and Poland to 3.5 for Sweden and Australia in 2020 (mean 2.21). Generosity ranges from 0 for Canada, Japan, and Australia to 1.75 for Belgium (mean .84) in that year.

Table 1. Descriptive statistics for policy indices.

	Permissiveness	Generosity
Mean	2.21	0.84
SD	0.67	0.47
Min	1	0
Max	3.5	1.75

Figure 1 shows the countries' 2020 index scores in the two-dimensional space of permissiveness and generosity. Countries vary widely on our measures, reflecting a broad range of approaches to reproductive

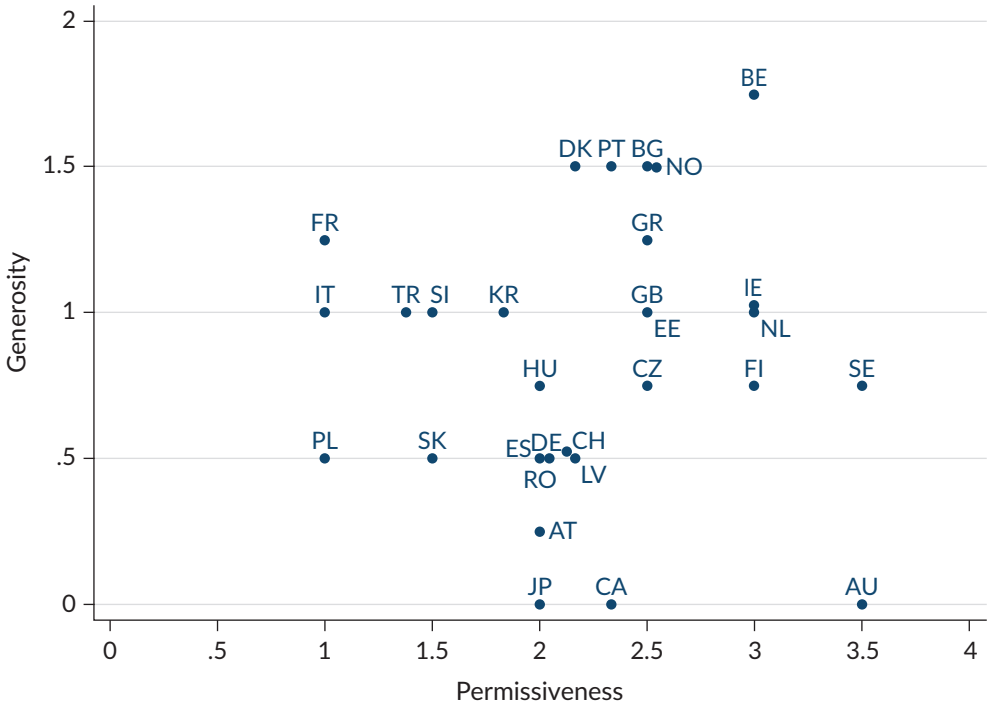

Figure 1. Reproductive equity support by generosity and permissiveness across countries, 2020. Source: IRPD v1.0.0 data (Zagel et al., 2025). Notes: AU: Australia; AT: Austria; BE: Belgium; BG: Bulgaria; CA: Canada; CZ: Czech Republic; DK: Denmark; EE: Estonia; FI: Finland; FR: France; DE: Germany; GR: Greece; HU: Hungary, IE: Ireland; IT: Italy; JP: Japan; LV: Latvia; NL: the Netherlands; NO: Norway; PL: Poland; PT: Portugal; RO: Romania; SK: Slovakia; SI: Slovenia; KR: South Korea; ES: Spain; SE: Sweden; CH: Switzerland; TR: Türkiye; GB: the United Kingdom.

equity support in abortion and MAR. Australia sticks out as particularly permissive and particularly low on generosity from the central government. Japan and Canada are on a par with Australia in terms of generosity, but have lower levels of permissiveness. Belgium, Bulgaria, Denmark, Norway, Greece, and Portugal score high on both dimensions. By contrast, Poland scores low on both dimensions, in line with recent research on the dire situation for reproductive rights in Poland (Kaminska, 2024). Italy and France have similarly low levels of permissiveness as Poland, but score higher on generosity. Among the countries with a level of generosity similar to Poland but somewhat higher permissiveness are the three German-speaking countries of Austria, Germany, and Switzerland, as well as Latvia, Slovakia, Romania, and Spain.

5. Reproductive Equity Support in Austria, Germany, and Switzerland

In this section, we extend our comparative analysis of reproductive equity support with a case-study approach, focusing on Austria, Germany, and Switzerland. The analysis draws on the two dimensions of permissiveness and generosity and focuses on important changes in MAR and abortion regulations in recent decades. The aim is to better understand the countries' positions in the range of reproductive equity support models (answering *what* is provided) while also considering the distinction between medical entitlement and body right approaches proposed by O'Connor et al. (1999; addressing *how* rights are provided for).

In mainstream comparative welfare state research, Germany and Austria have predominantly been categorized as conservative welfare states, characterized by an intermediate level of decommodification of labour and a high level of stratification (for a systematic review, see Ferragina & Seeleib-Kaiser, 2011), not least in terms of gender inequalities in paid and unpaid work (Leitner, 2010). Switzerland is often deemed as an outlier in that literature, with direct democracy and federalism significantly impacting the development of the Swiss welfare system (Obinger, 1998).

Regarding reproduction policy, the three countries share the common pathway of having introduced rather restrictive MAR policies in the 1990s. These reforms seemed to have been influenced by the radical feminist discourses at the time that viewed assisted reproductive technologies as tools for further exploitation of the female body by patriarchal science (Engeli & Rothmayr Allison, 2016). These policies banned various techniques associated with MAR from medical practice and privileged married heterosexual couples. However, there have been important regulatory changes in the past decade. In contrast to MAR policy, the three countries have experienced different trajectories in abortion policy, such as in how abortion upon request has become available at different times in the three countries.

5.1. Austria

In Austria, state support for reproductive equity has taken diverging pathways in the fields of MAR and abortion. Austrian MAR policy used to be one of the most restrictive in Western Europe, when legislative control of the domain began with the passage of the Reproductive Medicine Act in 1992 (*Fortpflanzungsmedizingesetz: FMedG*). However, it became significantly more permissive through a reform in 2015 (*Fortpflanzungsmedizinrechts-Änderungsgesetz 2015: FMedRÄG 2015*). The revision legalized certain MAR techniques that were previously prohibited. These include the use of donated sperm for IVF, which used to be only allowed for intra-uterine insemination (IUI), and the use of donated oocyte. This amendment opened up treatment options for those who cannot use their own gametes. It also expanded the patient

definition and included female same-sex couples, although MAR access for single women and male same-sex couples, via surrogacy prohibition, has remained illegal. In terms of generosity, the Austrian state started financing MAR costs under the IVF Fund Act in 2000. Under this law, patients receive reimbursement for 70% of the costs for IVF treatments for a maximum of four cycles. This also applies to the patient groups that were newly added in the 2015 reform.

Meanwhile, Austria has had a permissive abortion policy since the 1970s, based on the framing of abortion as a woman's liberation, though with a low level of generosity. Abortion has been legal upon request within the first trimester of pregnancy since 1975. The Austrian Social Democratic Party, advocating for a reform of the restrictive 19th-century law since the 1920s, had linked the issue of abortion to class struggle; abortion restrictions only negatively affected poorer women who, unlike their affluent counterparts, could not afford to find a legal loophole or other ways to access abortion (Köpl, 2001). However, in the wake of the second-wave feminist movement in Europe and the formation of autonomous feminist groups during the 1970s, women's groups within the Austrian Social Democratic Party and other established institutions incorporated the radical feminists' frame of abortion as an issue of women's self-determination and emancipation (Griessler & Hadolt, 2006). Although abortion remained on the criminal code, it became available upon request; Austria was the second country in Western Europe after Denmark, and the first Catholic country to introduce an upon-request model (Knill et al., 2014). The parliamentary discussions led to this reform, framing abortion as an issue of women's individual rights and liberation. This framing was largely kept in subsequent parliamentary and governmental discussions. When the abortion medication Mifegyne was authorized in 1998, most Austrian parties viewed it as an extension of a woman's right to decide about their own pregnancy (Köpl, 2001). Meanwhile, reproductive equity support is limited in its generosity. The costs for abortion (whether surgical or by medication) and abortion-related care have never been covered in Austria.

In summary, Austrian reproductive equity support has taken two diverging paths in the fields of MAR and abortion. The MAR regulation was transformed from a restrictive *but* generous policy to a permissive *and* generous one. Once defined as lawful, MAR treatments have consistently been financed and the range of treatments and patients deemed legitimate has expanded in the last decade. In contrast, Austrian abortion policy has always been permissive *but* not generous; abortion became available upon request in the 1970s while incorporating a radical feminist perspective, yet the policy lacks generosity as individuals are responsible for bearing the costs associated with abortion.

5.2. Germany

German reproductive equity support has shown a modest increase in permissiveness while remaining low or declining in terms of generosity in MAR and abortion. Since the first legislation addressing MAR (*Embryonenschutzgesetz: EschG*) in 1990, certain techniques (including egg donation) have been prohibited and remain so until today, though the patient definition has broadened. The official physician guidelines, binding for all practitioners, used to limit MAR access to married different-sex couples and, in exceptional cases, unmarried different-sex couples in a stable relationship (Bundesärztekammer, 1994). This restriction was lifted when the guidelines were updated in 2018, effectively opening up MAR for lesbian couples and single individuals. Male same-sex couples remained excluded through a total ban on surrogacy. The generosity of MAR policy was partially decreased in 2004 due to a general reform of the German

healthcare system. Up to 2003, statutory health insurance funds fully covered all expenses for ART, including doctor visits and the prescribed medications required for conception and a successful pregnancy. In 2004, the Act to Modernize Statutory Health Insurance (*GKV-Modernisierungsgesetz: GMG*) introduced a limit of three cycles and established age restrictions (40 years for women) for accessing IVF under statutory health insurance. Patients were also required to contribute 50% of the associated costs through a co-payment system (Hilland, 2011).

For abortion, the German federal government provides little reproductive equity support, both in terms of permissiveness and generosity. Since 1993, abortion has been available on demand within the first 12 weeks of pregnancy in Germany. However, it remains regulated in the criminal code (*Strafgesetzbuch:StGB*), with conditions that the person seeking abortion must undergo mandatory counseling at least three days prior to the abortion. This requirement also applies to medication abortion, which became available in 1999 in Germany following the authorization of Mifegyne by the European Union (Hemmerling et al., 2005). Regarding generosity, abortion costs and costs related to post-abortion care are never covered, except for medical and criminological exceptions. This shows that abortion is not considered part of the healthcare package that the welfare state is obliged to provide unless medically or criminologically certified.

In summary, German reproductive equity support has increased to a limited extent in permissiveness and remained low or decreased in generosity. The patient definition for MAR was expanded in 2018, but many techniques remain prohibited, including egg donation. Permissiveness of abortion increased in 1993 via legalization of abortion upon request, with dissuasive measures introduced. In terms of generosity, the cost coverage of MAR has decreased, while abortion upon request has never been financed.

5.3. Switzerland

In Switzerland, state support for reproductive equity has been considerably restricted for MAR, while it has increased for abortion. State equity support of MAR is extremely limited both in terms of permissiveness and generosity. The first federal legislation of MAR, the Reproductive Medicine Act (*Fortpflanzungsmedizingesetz: FMedG*), was passed in 1998 and came into force in 2001 (Rothmayr & Serdült, 2004). The law has not significantly changed until today, except for a revision in 2017, which authorized pre-implantation genetic diagnosis. Under the law, sperm donation is allowed only for married couples and egg donation is entirely prohibited. By confining MAR involving sperm donation to married couples, the law automatically excluded lesbian couples until same-sex marriage was legalized in 2022, and single women altogether. Gay men are also excluded from the MAR through the surrogacy ban; unlike other techniques, this has been stipulated in the Federal Constitution since 1992. The Reproductive Medicine Act also imposes restrictive measures on the process of accessing legal procedures. In contrast to other countries, it mandates a counseling and reflection period of four weeks for the couple between the initial counseling with a physician and the actual treatment. There is little reproductive equity support in terms of generosity. Public healthcare barely covers any expenses for MAR treatments, regardless of an individual's characteristics or medical diagnosis of infertility.

Swiss reproductive equity support for abortion was low but has widened over time. Abortion became illegal under the Swiss Penal Code in 1942, except for medical reasons certified by two doctors (Rey, 1994). The law was revised in 2002, with abortion becoming effectively available upon request within the first

twelve weeks of pregnancy. Although it is stipulated that the person must be in a state of distress, the definition of that state is up to the individual who requests an abortion. There have been a series of attempts to decriminalize abortion since the early 1970s, but the deep political divide in public opinion as well as in parliament has led to non-decisions for more than three decades (Engeli, 2009). Despite the relatively late increase in permissiveness, abortion costs have always been covered by compulsory health insurance, both before and after liberalization in 2002 (Engeli & Varone, 2012; Rey, 1994). This is perhaps because abortion had long been available only within the medical framework, instead of as an issue of women's body rights, as in the Austrian and German cases. Indeed, the medical entitlement framing was not entirely eliminated by the 2002 amendment, which demanded the person be in a "state of distress" to obtain an abortion. The long-standing medical framework over three decades and failures to decriminalize abortion may have paradoxically led to the cost coverage of abortion as a norm.

In summary, Swiss state support for reproductive equity has been significantly limited in MAR but has increased in abortion. Since MAR was first legislated for, the policy has shown low degrees of both permissiveness and generosity. Meanwhile, the regulation of abortion has changed from a restrictive *but* generous policy to a permissive *and* generous one since the liberalization in 2002, maintaining a medical entitlement framework.

6. Conclusion

This article provides a comprehensive framework to classify and measure state support for reproductive equity across countries. We focused on MAR and abortion as two subjects of intense political controversy. By integrating the conceptual perspectives of stratified reproduction and comparative welfare state research, we propose a two-dimensional framework to capture how policies can shape different sets of inequalities as well as how access to reproductive care is conceived of in these policies. The first dimension of permissiveness reflects the degree to which policies enable access to reproductive care by legalizing services, defining who qualifies as a patient, and/or refraining from imposing restrictive measures on service delivery. The second dimension of generosity measures the extent to which policies subsidize the costs of authorized services for individuals deemed eligible recipients. The empirical application of this framework across 30 high-income countries, as well as case studies from Austria, Germany, and Switzerland, highlights the diverse ways in which state policies either mitigate or exacerbate inequalities in reproductive care access.

Two main take-aways emerge from mapping a broad range of countries on permissiveness and generosity in reproductive equity support of abortion and MAR. First, countries vary widely in the way they support reproductive equity in abortion and MAR, with few countries providing permissive and generous support and many others putting a focus on either permissiveness or generosity. A number of countries provide limited support in both dimensions. Second, there is some overlap with mainstream welfare state model typologies' groupings of countries, but overall, divergence is the more obvious pattern. For example, while the Nordic European countries are commonly classified as universal and comprehensive welfare systems attuned to moderating inequalities, Finland and Sweden score intermediate on our generosity measure. Among the countries that are categorized as conservative continental European in other typologies, only Austria and Germany group together in our analysis, while countries such as France, the Netherlands, and Belgium are scattered.

We focused on the three German-speaking countries that cluster together in our overall mapping for a more in-depth analysis of the two regulatory fields of abortion and MAR. The comparison of the three cases reveals that while countries have enhanced reproductive equity by increasing permissiveness or generosity in recent decades, state support for individuals' equal access to MAR and abortion remains limited and has taken different pathways for this group. Austria shows a dual approach, where MAR policies have become more permissive and generous, contrasting with abortion policies that have long been permissive but not generous. Germany shows a modest increase in permissiveness regarding MAR but continues to impose restrictive measures on abortion access and provides no financing. Switzerland presents a configuration of contrasting approaches to the two fields, with little equity support for MAR while maintaining greater access to abortion by framing it as a form of medical care.

This study has limitations and potential room for further research. Our analysis of reproductive equity support across 30 countries employs composite indices; as we demonstrated in the in-depth analysis of three German-speaking countries, further studies could assess reproductive equity support in a disaggregated manner by looking into individual reproductive fields to explore convergence and contradictions in light of reproductive equity within a country. Furthermore, both of our empirical analyses are limited to abortion and MAR. Our two-dimensional framework of permissiveness and generosity could be extended to cover other domains of reproduction policy, such as contraception and pregnancy care.

This article takes a novel perspective on how different countries regulate reproduction. By analysing state interventions in different aspects of reproductive care, we were able to investigate how state policies shape reproductive processes as a whole. Our proposed permissiveness–generosity framework enables us to distinguish the implications for the different sets of inequalities that policies may shape, as well as how access to different reproductive care services is conceived of in relation to welfare provision. The case-based analysis supplements the more broad-brush multi-country analysis by carving out the different policy trajectories that otherwise similar countries have taken in their reproductive equity support. Such cross-country comparisons are useful for understanding and informing how state policies support equal access to reproductive care and ultimately allow individuals to achieve the reproductive pathways they desire, regardless of their characteristics or socioeconomic positions.

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Conflict of Interests

The author declares no conflict of interests.

Data Availability

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