


# The expressivist argument for recent policy changes regarding the provision of prenatal testing in Japan

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## ABSTRACT

The Japanese government and medical professionals have negative attitudes toward the provision of prenatal testing and related information due to social concern regarding discrimination against persons with disabilities. However, with the rapid increase in the number of non-invasive prenatal tests, particularly at non-certificated medical facilities, in response to the growing demand from pregnant women, the Japanese government and medical professional associations have enacted radical changes marking an active commitment to the provision of information on these services. While a major justification for these policy changes is to ensure respect for reproductive autonomy and women's self-determination, they may reinforce the concern regarding discrimination. This article investigated the argument that these new policies may reinforce discrimination and examined three objections to this argument. The results revealed that the recent policy changes, particularly for specific fetal traits, may imply a negative belief about people living with the same traits. Consequently, fundamental institutional changes are necessary.

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## Introduction

In the context of prenatal testing, it is sometimes considered that the rights of persons with disabilities are compromised by respecting, and especially by promoting or enhancing, reproductive autonomy, which refers to women's rights for self-determination concerning their reproduction based on their personal beliefs and aspirations (Gekas et al., 2016; Kato, 2009; Morioka, 2001; Stevens, 2015; Tateiwa, 2016). Some authors have argued that enhancing parents' reproductive autonomy may lead to an increase in the diagnoses of Down syndrome during the prenatal period, which may result in a decreased prevalence of individuals with this trait and raise concerns of stigmatization, discrimination, and decrease in support systems for individuals with disabilities (Gekas et al., 2016). Other authors have observed that permitting women to abort a fetus due to such abnormality entails the rejection of the value of people with disabilities

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or discrimination toward them (Tateiwa, 2016). Especially in Japan, the government and medical professionals hold negative attitudes toward the provision of prenatal testing and related information, largely due to the social concern regarding discrimination against and exclusion of people with disabilities, which have resulted in limitations on women's opportunities for self-determination in this context.

For instance, as several studies have suggested, most pregnant women in Japan are not offered any information about prenatal tests by their obstetricians, which may hinder women's autonomous decisions to undergo prenatal testing (Kato, 2007; Kimura, 2018; Tsuge, 2010). Until very recently, the government and medical professionals in Japan had adopted negative policies about the provision of information regarding these tests (ECEAMT/MHW, 1999; JSOG, 2013, p. 8). Moreover, since all medical professional guidelines for prenatal testing had limited eligibility criteria, not all pregnant women who seek testing were allowed to undergo the same. For instance, guidelines for non-invasive prenatal tests (NIPTs) published by the Japan Society of Obstetrics and Gynaecology (JSOG), a major obstetrician association in Japan, only offered testing for women who had "objective reasons for testing," including advanced maternal age, fetal features of suspicious aneuploidy based on an ultrasound examination, a positive result from maternal serum screening, a history of fetal aneuploidy, or a diagnosis of balanced Robertsonian translocation carrier (JSOG, 2013; Takeda et al., 2016).

One of the major reasons for these negative attitudes is explained in JSOG guidelines as follows:

As medical science has advanced, prenatal diagnostic techniques have improved to chances to diagnose fetal conditions before birth. For some disorders, it is now possible to treat the fetus in utero or the newborn in the early postnatal period based on prenatal diagnosis. However, for some fetal congenital anomalies, for which any treatment is not available, there is concern that prenatal diagnosis will exclude the birth of fetuses with predicted disabilities and eventually lead to the denial of the right to life and respect for the life of persons with disabilities. (JSOG, 2013, p. 1)

However, the Japanese government and medical professionals have recently begun radical changes to these restrictive policies in response to recent issues regarding the provision of NIPTs in Japan. Since the introduction of NIPTs in 2013, the number of medical facilities performing them has rapidly increased, particularly those not certified by the Japan Association of Medical Sciences (JAMS; a relevant medical professional authority for NIPT). Many of these non-certified facilities are neither obstetric nor pediatric, and given that they lack full-time obstetricians and pediatricians, they do not meet certification requirements (JAMS, 2022). It has also been reported that they do not follow JSOG and JAMS's professional guidelines, which establish several requirements such as providing genetic counselling before and after testing and providing NIPT for the three major fetal trisomies (21, 18, 13) only. However, some women have reported that the test results from these non-certified facilities are delivered solely via e-mail and without appropriate explanation (ECNOP/MHLW, 2020; Takahashi et al., 2022). Although this situation seems problematic, especially when considering women's autonomous decision-making, there are no legal or professional regulations in Japan that regulate these pre-natal test implementations. Accordingly, an expert panel of the Japanese

Ministry of Health, Labour and Welfare reported that it is appropriate to provide pregnant women information on prenatal tests to ensure understanding and enable informed decision-making (ECNOP/MHLW, 2021). JAMS has also removed the upper age limit of 35 years to allow pregnant women of all ages to access NIPTs if they have residual anxiety even after receiving genetic counselling (Jinguji & Goto, 2022).

A major justification of these policy changes is to respect or enhance reproductive autonomy (ECNOP/MHLW, 2021; JAMS, 2022) by providing women with appropriate information to enable autonomous decision-making based on their own values and life plans. However, if respecting reproductive autonomy, particularly measures promoting or enhancing it, compromises the rights of persons with disabilities, then the recent policy changes could reinforce social concern regarding discrimination against persons with the disabilities targeted in prenatal testing. Although this concern has significantly affected governmental and professional policies in Japan, discussions of the recent policy changes have not considered how to address this dilemma under the new policies.

How can the government mitigate the risk of disability discrimination while still protecting reproductive autonomy? To address this question, this article focuses on the expressivist argument that prenatal tests for selective abortion express a negative or discriminatory belief about people living with disabilities. Although the expressivist argument has received theoretical criticism, for instance that prenatal testing does not actually express negative beliefs (Buchanan, 1996; Nelson, 1998, 2000; Shakespeare, 2009), since the advent of NIPTs several authors have tried to develop the theory underlying this argument to clarify certain ethical issues posed by this technology (Hofmann, 2017; Perez Gomez, 2020; Reed, 2020).

This article examines three major objections to the expressivist argument and investigates whether this argument holds for the recent policy changes regarding prenatal testing in Japan.

## **Current institutions and historical background related to abortion and prenatal testing in Japan**

Japanese society has been considered unique in its history, current institutions, and situations surrounding abortion and prenatal testing (especially the low prevalence of prenatal testing; Tsuge, 2015). The Japanese Penal Code criminalizes abortion, with some exemptions stipulated in the Maternal Health Act. Under this Act, an authorized obstetrician may perform an induced abortion with the consent of the woman and her spouse within 21 gestation weeks if (1) the continuation of pregnancy or delivery may significantly harm the woman's health owing to physical reasons (medical reason clause), (2) for economic reasons (economic reason clause), or (3) if the pregnancy is a result of rape or other conditions under which the woman could not refuse intercourse (Kai et al., 2017). It is noteworthy that the Act does not directly provide for women's right to self-determination for abortion; women are required to gain consent from their sexual partner to have an abortion. Moreover, this Act does not directly allow selective abortion. The economic reason clause has been interpreted to cover selective abortion (ECNOP/MHLW, 2021). In other words, selective abortion can be permitted not because a woman chooses to have an abortion due to fetal disability, but because the woman's health is seriously compromised by the birth or upbringing of a child with a

disability. The number of formally reported abortions in Japan has been decreasing since the 1950s. In 2022, it was 122,275 accounting for 5.1% of women of reproductive age (MHLW, 2022).

Before undergoing an abortion procedure in Japan, a woman is no longer required to undergo a legal approval review process by medical professionals, which was required by the Act until 1952 (Norgren, 2001, p. 48). Furthermore, obstetricians performing the procedure do not usually verify whether the woman meets any of the three conditions mentioned above (Kai et al., 2017; Norgren, 2001). Therefore, it seems that women may have abortions freely (Goto, 2021; Kai et al., 2017). In reality, women, especially socially disadvantaged women, experience barriers to accessing abortion procedures. Since abortion procedures are not covered by national health insurance, women seeking abortions must pay out of their own pocket, which usually costs about 200,000–300,000 JY (1,300–2,000 USD; Yamamoto et al., 2022). Until recently, the major medical abortion method was curettage, which has been reported to have rare but significant risks. An oral abortion pill was only approved by the Japanese government in April 2023 (Kaneda, 2023). Additionally, although the Act does not require a sexual partner's consent when a woman seeking an abortion is not married, clinics usually require it nonetheless. Thus, women who cannot obtain their partners' consent may miss the legally permissible abortion period (Yamamoto & Akuzawa, 2021). Moreover, as there is no clear legal foundation for permitting selective abortion, medical professionals are not legally obliged to provide information on prenatal testing, which is essential to ensure women's autonomous decisions regarding testing and abortion (Kobayashi, 2021).

Prenatal testing for certain fetal abnormalities is offered via publicly funded screening programmes in many countries, though NIPTs are not covered in all countries/ states (Boyd et al., 2008; Steffensen et al., 2023; Vanstone et al., 2019). No prenatal tests are covered by national health insurance, and except for ultrasound scanning, no prenatal tests in Japan are funded by local governments (Sasaki et al., 2011; Yamamoto et al., 2022). For example, NIPT for the three trisomies costs approximately 1,500–2,000 USD in Japan (Yamamoto et al., 2022). As mentioned before, the government and medical professionals had adopted negative policies regarding the provision of information about these tests. When prenatal serum markers were first introduced and spread in Japan in 1994, an expert panel of the Japanese Ministry of Health and Welfare published an official statement stating that “obstetricians are not required to provide information regarding prenatal serum marker screening to pregnant women, and they should not recommend testing” (ECEAMT/MHW, 1999). Aside from the social concern about discrimination against people with disabilities mentioned above, major reasons for this cautious policy include limited genetic counselling services, raising concerns about women's autonomy. Because maternal serum marker screening results are only shown on the probability forms, these results can be misunderstood without genetic counselling (ECEAMT/MHW, 1999; Tsuge, 2015).

In 2013, NIPT implementation for the major trisomies was first approved as screening tests in clinical research in Japan. Although NIPT for trisomy 21 has been reported to have higher sensitivity than maternal serum screening (according to EBM clinical practice guidelines established by JSOG in 2014, they were 99% and 81%, respectively (JSOG, 2014, p. 82); a more recent study conducted in Japan reported the former as 99.78% (Sasaki et al., 2021)), it is still a screening test, not a diagnostic test (Table 1). Medical

**Table 1.** Main prenatal screening/diagnostic tests mentioned in this article.

	Maternal Serum Maker Screening	Non-Invasive Prenatal Tests (NIPTs)	Amniocentesis
Type of test		Screening	Diagnostic
Technically detectable conditions	Trisomy 18, 21, possible neural tube defects	Trisomy 13, 18, 21, other chromosome anomalies including SCAs, fetal sex, a few microdeletions (Birko et al., 2019; Steffensen et al., 2023)	Trisomy 13, 18, 21, other chromosome anomalies including SCAs, neural tube defects, fetal sex (Birko et al., 2019; Steffensen et al., 2023)
Timing of testing	15th–20th week of pregnancy	Available after 10 <sup>th</sup> week of pregnancy	Available after 15th–16th week of pregnancy
Sensitivity	81% for trisomy 21	99% for trisomy 21	Almost 100% in detecting trisomy 21
Specificity	92% for trisomy 21 (Sekizawa, 2019)	More than 99.9% for trisomies 21, 18, and 13 (Sasaki et al., 2021)	Almost 100% in detecting trisomy 21
Risks	No increased risk of miscarriage	No increased risk of miscarriage	Risk of miscarriage around 1 in 200–400 (0.3–0.5%)

Note: Information and data without references were cited from the JSOG Clinical Guidelines (JSOG, 2014).

professionals and the government maintained the prior, cautious policy regarding provision of information (JSOG, 2013, p. 8).

Over the past decade, the rate of prenatal testing followed by selective abortion in Japan has been low. In 2016, the total number of prenatal tests (maternal serum marker screenings, amniocentesis procedures, chorionic villus samplings, and NIPTs conducted at certified facilities) was equivalent to 7.2% of the total number of births (977,000; Sasaki et al., 2018). A report estimated that the annual projected number of births of babies with trisomy 21 has remained steady at around 2,200 (22 per 10,000 births) from 2010 to 2017 (Sasaki & Sago, 2019).

History of eugenic policies in Japan and public debates over it have clearly had a significant effect on the current attitudes and policies surrounding abortion and prenatal testing. In 1940, during World War II, Japan first enacted a eugenic law named the National Eugenic Act authorizing sterilizations for eugenic reason. However, it was not until after the war that the government enacted eugenic policies outright. In 1948, the Eugenic Protection Act was passed, with a purpose of preventing the birth of inferior offspring for eugenic reasons. The law authorized enforced sterilizations for eugenic reasons and permitted abortions for multiple conditions (Norgren, 2001; Tsuge, 2015). It is estimated that 25,000 compulsory sterilizations were performed until the law was repealed in 1996 (Higuchi et al., 2019). From the late 1960s to the early 1970s, there were political movements to amend this law. On the one hand, there was a movement to introduce the so-called fetal clause allowing abortions for the reason of fetal disabilities; on the other hand, there was the movement to repeal the economic reason clause mentioned earlier. These movements triggered a public controversy over selective abortion, especially between disability rights activists and feminist groups in Japan. Finally, they came to an agreement on the seemingly contradictory idea that selective abortion is not a woman's right, but access to abortion should be allowed as a woman's right (Kato, 2009; Norgren, 2001; Tsuge, 2015).

Amniocentesis was increasingly promoted in the early 1970s in line with the eugenic policies of some Japanese local governments (Tsuchiya, 2007); however, disability rights activists subsequently protested that not only were prenatal testing and abortion eugenic, they also implied discrimination against people with disabilities. This claim had some

impact on both the public debate over selective abortion and the policies concerning the provision of prenatal tests and their information, in particular the negative policies by medical professionals and the government mentioned earlier (Kato, 2009). This claim appears to align with the expressivist argument. Thus, the next section will explore this similarity.

## The expressivist argument

There are several formulations of the expressivist argument (Hofmann, 2017; Holm, 2008; Perez Gomez, 2020). The typical formulation is that prenatal tests to select against disabling traits express a negative belief about or attitude toward people living with these traits (Hofmann, 2017; Parens & Asch, 2000; Perez Gomez, 2020; Reed, 2020; Shakespeare, 2009). Another formulation states that prenatal tests and selective abortions send demeaning or hurtful messages to people with these traits (Edwards, 2004; Nelson, 2000; Parens & Asch, 2000). Some advocates of this argument claim that the practice of prenatal testing or selective abortion embodies discrimination against these groups of people (Asch, 1989, 2000; Parens & Asch, 2000).

The diverse formulations for the expressivist argument share several features. First, they focus on selective abortion based on fetal traits, particularly disabilities, following prenatal testing, rather than abortion in general (particularly referring to abortion performed based on a woman's self-determination). Second, they tend to focus on the implications of testing and selective abortion on the lives of people living with disabilities, rather than on fetuses subjected to testing and abortion. Finally, they tend to concern the *psychological, logical, or theoretical implications*, rather than the *causal results*, of testing and abortion on the lives of people living with disabilities.

The claim made in the 1970s in Japan also shares these features. Mainly, this claim has been widely accepted by not only disability rights advocates but also other groups such as feminists (Tateiwa, 2016; Toshimitsu, 2012), whereas the expressivist argument was primarily developed by disability rights advocates (Buchanan, 1996; Hofmann, 2017; Nelson, 1998, 2000).

As mentioned in the previous section, the claim that prenatal testing for selective abortion implies discrimination against people living with disabilities has had an impact in Japanese society. However, this claim seems to have been eclipsed by the debate over the recent policy changes regarding prenatal tests in Japan. This article examines three objections to the expressivist argument and explores whether this argument holds true in the current Japanese context.

## Objections against the expressivist argument

### *Policy changes do not express negative beliefs*

The first objection is that prenatal testing and selective abortion do not actually express negative beliefs or attitudes (Buchanan, 1996; Nelson, 1998, 2000; Shakespeare, 2009). Parents “may feel that having a disabled child will damage their partnership, or impact negatively on their other children. They may fear economic hardship” (Shakespeare, 2009, pp. 127–128). Women who choose selective abortion may be motivated by the

belief that, considering their circumstances, they should not bring a child with disabilities into the world. However, Buchanan (1996) argued that this belief does not necessarily entail the idea that people with disabilities in general should not be born. According to Buchanan, only if a woman subscribes to that idea and it also motivates her decision to have an abortion does her decision express a negative belief about people with disabilities in general. Nelson (1998) expanded on this objection by focusing on prenatal testing and selective abortion as social practices. Nelson argued that if an act is considered a socially settled practice rather than an individual choice, the relationship between the meaning of the act and the belief that a person holds may not be direct (Nelson, 1998). Furthermore, the meaning of a symbol depends on how it is used in a publicly shareable system of symbols (Nelson, 1998). Therefore, a social practice may convey certain beliefs, even if the individual engaging in the practice does not personally hold those beliefs (Nelson, 2000). Nevertheless, the meaning attached to prenatal testing and selective abortion is too vague and ambiguous to be regarded as sending any particular message about people with disabilities; this is because testing and selective abortion do not occur against the background of “a settled practice of seeing them as expressing what a community is and with what it identifies” (Nelson, 1998, p. 179).

Although several authors have responded to these objections (Hofmann, 2017; Mills, 2011; Perez Gomez, 2020), I shall focus on whether these objections are valid for the expressivist argument regarding the recent policy changes in Japan. Before doing so, however, it is important to introduce and modify Holm’s (2008) distinction between expressivist arguments, as objections that are valid against one type of argument may not hold against others. There are at least three expressivist arguments depending on what constitutes a negative belief: social practices of prenatal testing and selective abortion in the abstract, the social practice of prenatal testing and selective abortion implemented in a particular society, and an individual choice made by pregnant women or couples (Holm, 2008). A further distinction must be made between social practices accepted by many individuals and those publicly endorsed by the government. The expressivist argument “may be especially strong when it is directed toward applications of technologies of genetic selection that are socially sanctioned and state funded” (Sparrow, 2008, p. 121).

Considering these distinctions, the first objection that prenatal testing for abortion does not actually express negative beliefs might not be valid for the recent policy changes in Japan. Since the question here concerns a politically endorsed practice in a society rather than the practice of prenatal testing for selective abortion or individual choice, it is not sufficient to consider only the purposes, intentions, and motivations behind the policies. Many public policies and social institutions result from a compromise between diverse views, and the intention to support a policy is not necessarily obvious. As Hofmann (2017, p. 510) correctly noted, “actions (facilitated by social institutions, such as legislations, health care provision, and technological armamentarium) may frame and form certain values which may be detrimental to societal attitudes and individual members of these societies.” If a publicly endorsed policy and the institutional structure behind it consistently presuppose a certain belief or assessment about specific members’ way of life, this can deeply affect their self-evaluation and evaluation by other members. In explaining this, we may refer to Rawlsian concept of social bases of self-respect, which he regards as the most important primary social good (Rawls, 2001a,

pp. 57–58). According to Rawls (1996, p. 318ff), “self-respect depends upon and is encouraged by certain public features of basic social institutions, how they work together and how people who accept these arrangements are expected to (and normally do) regard and treat one another.” This could also apply to negative evaluations that occur in the form of discrimination. That is, publicly endorsed institutions or policies that presuppose negative evaluations of certain members may undermine their self-esteem.

Therefore, to explore whether a policy has implications for persons with disabilities, we need to consider the logical implications of the institutional structures, social systems, and norms on which the policy is based. As such, we should first consider legal regulations on abortion in Japan, for policies on prenatal testing might be meaningless if any case of abortion is illegal. Next, we should consider professional regulations regarding prenatal testing.

As mentioned earlier, NIPT guidelines in Japan limit the test strictly to the three major trisomies (JAMS, 2022), yet it is impossible to determine which fetal traits should be institutionally included in NIPT based solely on medical or scientific facts, such as sensitivity and specificity. Since the advent of NIPTs, many countries, particularly those with public prenatal screening programmes, have considered the moral dilemma of which of the *technically* detectable fetal traits should be *institutionally* allowed to be included in clinical tests (Dondorp et al., 2015). In Japan, the JAMS guidelines for certifying NIPT provider facilities state that

in order to determine the expansion of fetal traits tested in NIPT, analytical and clinical validity must first be evaluated by clinical research and other studies, and then not only their medical significance but also their ethical and social implications should be carefully considered for admitting its clinical use. (JAMS, 2022)

Yet, before approving clinical research for estimating the NIPT accuracy of some fetal traits, a research ethics committee must first consider both its clinical value as suggested by previous research and also its social value (Emanuel et al., 2000).

Consider, for instance, fetal sex chromosome aneuploidies (SCAs; Table 2). NIPT for SCAs is becoming widely available in many countries (Johnston et al., 2023; Steffensen et al., 2023), although their positive predictive values are reported to be lower than those for the major trisomies (Bussolaro et al., 2023; Guo et al., 2022; Lu et al., 2022), and national guidelines in some countries do not support informing women or couples about SCA results (Steffensen et al., 2023). In Japan, though some non-certified facilities offer NIPT for SCAs (ECNOP/MHLW, 2020), professional guidelines do not permit including SCAs in NIPT (JAMS, 2022; JSOG, 2013). To consider such an inclusion, it would be essential to evaluate their analytical performance, especially for targeted populations in Japan. However, it might be difficult or almost impossible for an institution’s ethics committee alone to determine whether to approve clinical research evaluating such factors concerning NIPT for SCAs. At least in Japan, such research is approved by a committee only after considering whether it is institutionally consistent with the regulations on abortion. Considering the history and institutions in Japan mentioned earlier, decisions on this issue will arouse social controversy, for detection of fetus SCAs can lead to an abortion (Guo et al., 2022; Lu et al., 2022). Abortion for SCAs could be considered a violation of the Maternal Protection Act (enacted 1948, revised 1996), under which selective abortion is only permitted on the basis that the woman’s health



**Table 2.** Post-natal characteristics of major trisomies and SCAs (Johnston et al., 2023; Nuffield Council on Bioethics, 2017; Office for Health Improvement & Disparities, NHS England, 2022; So et al., 2017).

	Major trisomies		Sex chromosome aneuploidies (SCAs)
	Trisomy 21 (Down's syndrome)	Trisomy 18 (Edwards' syndrome), Trisomy 13 (Patau's syndrome)	45,X (Turner syndrome), 47,XXY (Klinefelter syndrome), 47,XXX(triple X syndrome), and 47,XYY (Jacobs syndrome)
Main characteristics	<p>Around 5% of babies will not live past their first birthday; for babies without serious health problems, survival is similar to that of other children. People with Down's syndrome will have some level of learning disability that can vary from mild to severe. The main health problems they may have include heart conditions, problems with digestive system, hearing and vision, and Alzheimer's disease later in life. Some of these problems can be treated, and today some people with Down's syndrome will live into their 60s or longer. With support, many more people with Down's syndrome are able to get jobs, have relationships, and live semi-independently in adulthood.</p>	<p>The survival rates of babies with these conditions are low and of those babies born alive only around 13% with Edwards' syndrome and 11% with Patau's syndrome will live past their first birthday. Major health problems of those with these conditions include a severe leaning disability, cardiac defects, deafing difficulties, cleft lip, and palate. Active treatment (e.g. to repair heart defects) can increase life expectancy, after which some babies may survive to adulthood, but this is rare.</p>	<p>People with these conditions (in particular those with 47,XXX; 47,XYY; and mosaic SCA) may not have life-threatening health conditions, then some of them are not identified throughout their lifetimes. Major health problems reported for those with these traits include short stature(45,X), tall stature (47, XXY; 47,XXX; 47,XYY), infertility (45,X; 47,XXY), heart defects, and modest reduction in IQ (people with 47,XXX are reported to have a reduction in IQ of 20 points).</p>

is seriously compromised by the birth or upbringing of a child with a disability. Then, if fetal disability is sufficiently mild and/or manageable such that the birth will not seriously compromise the woman's health (though that is difficult to determine prenatally), abortion could not be allowed under the Act.

This reflection in turn shows the following: The fact that a certain range of fetal traits is institutionally approved as a target of NIPTs in Japan represents a type of public endorsement of the belief that the birth of children with these traits has a sufficient impact such that the economic reason clause is applicable.

Moreover, it is also noteworthy that information about fetal traits provided through testing is useless for an abortion decision unless it is connected to knowledge regarding how people with the same traits live in a society, for the information directly provided through prenatal testing solely concerns the fetus' chromosomes and genes. However, this type of information cannot in itself constitute the basis for the decision to abort, as people have "no experiences of chromosomes" and "do not have preferences for specific types of chromosomes per se" (Hofmann, 2017, p. 512). This holds true for the professional determination of which fetal traits should be institutionally targeted by NIPTs. Without referring to any information about persons with the same traits as those targeted by NIPTs, medical professionals cannot judge which fetal disabilities are sufficiently serious to be deemed adequate grounds for an institutionally approved abortion under the economic reason clause. Information includes not only medical and scientific facts but also negative evaluations of people with these disabilities. Therefore, policies limiting the range of fetal traits that can be institutionally detected and providing information about prenatal testing only for these traits imply a negative belief regarding persons with the same traits, as stated by the expressivist argument. As such, the term *express* in the expressivist argument can be understood to *logically imply in the light of institutional consistency*.

### ***Distinction between abortion and other measures to prevent fetal disability***

The second objection states that if the expressivist argument about prenatal testing is true, it must also apply to other attempts to prevent fetal disability (Buchanan, 1996; Nelson, 2000; Shakespeare, 2009; Steinbock, 2000), such as promoting maternal supplements, refraining from medication that is known to impede fetal growth, immunization, and therapeutic measures. If the argument targets only prenatal testing for selective abortion, it must explain the moral distinction between prenatal testing and other measures. However, according to the objection, advocates of the expressivist argument fail to explain this distinction.

Shakespeare noted that defenders of the expressivist argument must be able to explain the moral difference between preventing the birth of a fetus with disabilities, which entails destroying that fetus' life, and preventing a disabling trait from occurring in the fetus (Shakespeare, 2009). In trying to explain this difference, the expressivist argument contradicts itself, as it commits to reproductive autonomy regarding abortion in general, stating that to respect a woman's autonomy, abortion should be permitted if the woman makes the decision on her own (Asch, 1989, 2000). However, the fact that "it is acceptable to have an abortion for social reasons, for example, the timing of the pregnancy is inconvenient, [...] but not for the morally significant

reason that the foetus is affected by an impairment” does not make sense (Shakespeare, 2009, p. 123).

To explore potential contradictions between accepting women’s right to abortion in general and rejecting selective abortion based on prenatal testing, it is necessary to clarify my position on the moral status of the fetus and abortion. I agree with Shakespeare in adopting the gradualist position (Steinbock, 2015), according to which “the developing foetus should be regarded as having increasing moral status as pregnancy progresses” (Shakespeare, 2009, p. 124). Therefore, while it is permissible to support general access to early-stage termination, it is morally contentious to permit late termination of pregnancy, regardless of the reason (Shakespeare, 2009). “All termination or loss of pregnancy, at any stage, may be sad and regrettable, because it involves the extinction of a growing human life, full of potential and promise” (Shakespeare, 2009, p. 124). However, “abortion is neither a tragedy (as many anti-abortionists claim) nor an insignificant clinical procedure (as some pro-choice activists claim)” (Shakespeare, 2009, p. 124).

Nevertheless, even if we agree with Shakespeare’s position on abortion, it is possible to morally distinguish between allowing access to (safe) abortion procedures (ensuring negative rights about abortion) and supporting abortion decisions through interventions (ensuring positive ones). The former requires others not to interfere with an individual woman’s decision about abortion, whereas the latter requires involvement in such a decision. This difference could be more clearly explained with reference to O’Neill’s argument about the distinction between obligations corresponding to liberty rights and those corresponding to welfare rights (that is, obligations to the rights to goods and services; Enzo et al., 2021). The former are obligations carried by all agents, not only governments and medical professionals but also passers-by, whereas the latter are “distributed” among or “allocated” to specific agents and agencies, such as governments or medical professionals (O’Neill, 1999, pp. 60–64). Considering this distinction regarding the right to abortion, it is not contradictory to adopt a policy allowing a safe pregnancy while simultaneously rejecting a policy supporting women’s abortion decisions (such as providing public funds or allowing some service and technologies to be covered by national health insurance).

As for the former obligations to ensure liberty (negative) rights regarding abortion, since past unjust policies deprived women and couples of opportunities to make reproductive decisions, we clearly can agree that it is morally important to respect that right, by, for instance, allowing access to safe abortion procedures, with which Shakespeare (2009) would certainly agree. As for the latter obligations to ensure welfare (positive) rights regarding abortion, we must determine to whom and to what extent this obligation should be allocated; to do that, we need to consider the real capabilities, available resources, vulnerabilities, and other obligations and responsibilities of those who bear the obligations (O’Neill, 1999, p. 68). For instance, considering the current situation in Japan, where many women seeking prenatal tests for selective abortion at non-certified facilities can not be provided with appropriate counselling services, a change in governmental policy toward active involvement to facilitate the provision of appropriate information may seem crucial to ameliorate the situation. However, it is unclear to what extent the scope of governmental obligation to ensure positive rights should be expanded in the context of abortion, as by providing publicly funded screening programmes.

Addressing this question is pressing, for in our age, the rapid development of reproductive technology is furthering the demand for positive rights to use reproductive technologies. In this respect, a contradiction does not necessarily exist between accepting access to abortion procedures and refusing some public support to promote selective abortion.

Considering this distinction, we could explain the moral difference between preventing the birth of a disabled fetus and preventing disabling traits from occurring in a fetus without contradictions. Regardless of whether the fetus is considered a person, abortions at any stage involve “the extinction of a growing human life, full of potential and promise” (Shakespeare, 2009, p. 124), and may involve sadness and regret. Therefore, preventing the birth of a disabled fetus by abortion is a moral concern (in this regard, we might be required to modify a part of the expressivist argument), whereas preventing disabling traits from occurring in a fetus by, for instance, recommending folic acid or prenatal care, is less problematic in that it does not entail destruction of life.

Thus, preventing fetal disabilities through abortion, particularly by providing social support for individual choices through the provision of technology and information, is morally different from preventing fetal disabilities using other measures. The expressivist argument developed here does not necessarily apply to methods such as recommending folic acid or administering prenatal care.

### ***Distinction between selective and other abortions***

Finally, the expressivist argument may fail to explain the distinction between selective and other abortions. As mentioned above, proponents of the expressivist argument usually commit to the view that abortion should be permitted if a woman makes the decision (Asch, 1989, 2000). According to this argument, abortion on the grounds of fetal disability alone is morally problematic, as it has social implications and is not merely a private affair. However, critics such as Nelson and Shakespeare have argued that this view cannot be sustained. I focus on Nelson’s criticism based on the analogy between abortion on the grounds of fetal disabilities and poverty, since this criticism can be valid at least for the application of the expressivist argument in the current context in Japan.

According to Nelson (1998), if selective abortion expresses a negative belief about people with disabilities, the same holds true for abortions for other reasons, such as poverty and family size. To advance this claim, Nelson rejected both the any/particular distinction offered by Asch (1989, 2000) and the intrinsic/non-intrinsic distinction presented by Press (2000). According to the first distinction, while most abortions represent a decision not to bear and rear any child at a particular time because the pregnancy itself is unwanted, selective abortions involve the decision not to bear and rear a particular child due to its traits, although it is an otherwise-wanted pregnancy (Asch, 1989, 2000; Parens & Asch, 2000). For Asch, terminating a once-wanted pregnancy based on only one piece of information (the existence of a disability) about the fetus is tantamount to saying that the disability is inimical to the life that a woman or a couple wants to have (Asch, 2000). However, Nelson contended that this distinction is insufficient. He provided the example of a woman who decides to abort her fetus because she believes her family is too poor to have more children. In this case, the fetus’ trait of being indigent becomes the reason for abortion. According to Nelson, the first distinction cannot be

sustained because her decision to abort can be regarded as being based on the characteristics of this particular fetus, rather than on her circumstances. The mindset of many women who contemplate terminating their affected pregnancies is ambiguous, which makes it challenging to assert with certainty that they do not want only fetuses with specific traits.

In response to this criticism, Press (2000) presented the intrinsic/non-intrinsic distinction. According to this distinction, indigence, which could be the reason for an abortion, is not an intrinsic characteristic of the possible child but of the pregnancy, which is contingent on circumstances. By contrast, in the case of selective abortion, the disability is intrinsic to the child (Press, 2000). According to Asch and Press, abortions on the grounds of fetal disabilities have a morally different meaning from those on the grounds of poverty. Nelson criticized this second distinction by referring to the social model of disability. According to this model, impairments are physical and mental characteristics, whereas disabilities are social constructs wherein people with such characteristics are excluded from major domains of social life. That is, this model suggests that it is not a person's mental or physical condition that is disabling the person but rather the social limitations imposed on them (Steinbock, 2000; Wasserman et al., 2011). Although this model has received widely support among disability rights advocates, Nelson suggests that considering a fetal disability inherent is incompatible with this model and thus dismissed the intrinsic/non-intrinsic distinction. For him, if selective abortion expresses a negative belief regarding a person who possesses certain traits, this also holds true for abortion on the grounds of poverty (Nelson, 2000).

Several authors have responded to this criticism (Asch, 2000; Mills, 2011, pp. 72–83; Press, 2000); however, I only consider whether, if the recent policy changes in Japan regarding prenatal testing for selective abortion express negative beliefs, the same holds true for abortion on the grounds of poverty. That is, I focus not on individual decisions but on social policies concerning abortions.

Although Nelson's criticisms are directly targeted at individual self-determination, his point seems to have some validity, at least regarding the recent policy changes in Japan. From the individual perspective, the disability an impaired person faces may deeply impact their self-esteem and identity, as well as their family, to such an extent that they might regard the disability as almost intrinsic to people with the same trait. Individual efforts to change the surrounding environment cannot easily eliminate this impact, though they can reduce it. Thus, from the individual perspective, it might be important to question whether abortions due to fetal disability differ from abortions due to poverty. However, from the social perspective, whether a woman's reason for abortion stems from injustice is a more important issue. As suggested by the Rawlsian "difference principle," mitigating the influence of social contingencies and natural fortune on distributive shares, which cannot be affected by individual efforts, is one of the important tasks of justice (Rawls, 2001b). Particularly from the perspective of social justice, it is clearly unjust to abandon an individual in either situation, that is, being born poor or having a disability. Thus, these two situations are indistinguishable.

In addition, at least in Japan, it is difficult to institutionally distinguish abortion on the grounds of fetal disability from that of abortion due to poverty. As mentioned above, under the Japanese legal system, selective abortion is permitted only if it falls under the economic reason clause. This means that selective abortion can be permitted only

if the woman's health is economically compromised by the birth or upbringing of a child with a disability, rather than because she chooses to have an abortion due to a fetal disability. Thus, if a policy on the provision of prenatal tests and information on abortion implies negative beliefs about persons with disabilities, the same could hold true for abortion on the grounds of poverty. Institutional support for abortion due to poverty can imply the belief that the life of a child likely to be born in indigent circumstances deserves termination before birth depending on parental decision, rather than deserving social support to live as a member of a society.

Nevertheless, this does not necessarily imply that abortion on the grounds of poverty should be prohibited. As noted above, there is a morally significant difference between allowing access to abortion procedures and supporting (or promoting) abortion decisions through interventions. The expressivist argument developed in this article clearly applies to the latter. Therefore, if active social support was provided for individual self-determination about abortion but only on limited grounds, such as poverty or certain fetal disabilities, then such support would have negative implications for persons with the same characteristics – that is individuals in poverty and with disabilities. In other words, the provision of social support (rather than mere permission) for abortion only on specific grounds may express negative beliefs.

## Discussion

This article examined three objections to the expressivist argument applied to the current context in Japan. Recent policy changes in Japan regarding active commitment to the provision of testing and information, particularly for specific fetal traits, may imply a negative belief about people living with the same traits. However, this argument does not claim that prenatal testing and provision of information always imply a negative belief. I do argue, however, that this implication does hold true for recent policy changes in Japan. How then can we address the long lingering social concern regarding discrimination against persons with disabilities under these new policies, which are crucial for protecting reproductive autonomy? It is possible to draw some conclusions regarding the institutional changes required to alleviate the expressivist argument.

First, it is necessary to develop comprehensive institutional arrangements to support people with disabilities and their families. The expressivist argument developed here targets only the practice of prenatal testing for selective abortion and does not include providing the test or information on future children. However, if prenatal tests to prepare for childbearing were common and did not necessarily lead to abortion, then the expressivist argument might not apply to this situation. Nevertheless, this may cause other issues, such as an infringement of future children's rights.

Second, it is necessary to change regulations regarding abortion and prenatal testing. As argued above, recent policy changes under the current regulatory system in Japan have negative implications for persons with the targeted disabilities. Among technically detectable fetal traits, only certain disabilities are institutionally targeted in NIPTs. In addition, determining which fetal traits are targeted may depend on an assessment of whether the birth of children with the traits in question is sufficiently serious that the economic reason clause of the Maternal Protection Act is applicable. Under regulatory systems that permit abortion for any reason and determine the range of institutionally

targeted fetal traits without negative assessments of people living with the same traits, policies of active information provision may not necessarily have these negative implications. In 2016, the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) recommended that the Japanese government amend the Penal Code and Maternal Protection Act to ensure the legalization of abortion in all cases and revise the Maternal Protection Act to remove the requirement of spousal consent for pregnant women to abort (CEDAW, 2016). Although these recommendations were made from the perspective of women's autonomy, this article suggests that such legal changes are also essential to avoid discrimination. Thus, to alleviate the expressivist argument in Japan, fundamental institutional changes are required beyond the medical field, including the development of counselling systems.

The changes mentioned above are necessary not only to avoid discrimination against persons with disabilities but also to respect autonomy. Focusing on autonomy in the limited context of prenatal testing without considering the limitation of self-determination regarding abortion and child-rearing hinders women's autonomy over their lives. In this respect, although recent policy changes can enhance reproductive autonomy in the context of prenatal testing, they minimally improve autonomy over women's whole lives. In conclusion, eliminating restrictions on accessing abortion is essential to ensure that recent policy changes for prenatal testing alleviate the expressivist argument. Therefore, avoiding discrimination and respecting autonomy are not necessarily contradictory.

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