Access to Abortion Services: A Neglected Health Disparity

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Abstract: Minority and low SES women have persistently and disproportionately higher rates of abortion than White and higher SES women, yet have limited access to these services. The response of governmental health agencies to these disparities in abortion has focused solely on decreasing the number of abortions, without attention to access to needed health services. This commentary seeks to build an understanding of how access to abortion care is currently impeded for low-income women and women of color and calls for an end to that omission.

Key words: Abortion, induced; health status disparities; access to health care; women's health.

Introduction

Disparities in abortion rates are well documented, with rates of 11 per 1,000 for non-Hispanic White women, 28 per 1,000 for Hispanic women, and 50 per 1,000 for Black women.[1] From 2000 to 2008 the percentage of abortions to women who were poor rose from 27 to 42 percent.[2] Finally, Black and Hispanic and low income women are more likely to have a second-trimester abortion than their White and more affluent counterparts.[3]

While these disparities in demand for abortion services have appropriately prompted concern, the discussion of these issues tends to be limited in scope. In the public policy arena specifically, these statistics result in a focus exclusively on how to decrease the need for abortion services through, for example, providing greater access to sexuality education, contraception, and economic support.[4–7] While these disparities in abortion are clearly related to known disparities in risk of unintended pregnancy,[8] by focusing only on prevention of the need for abortion, these discussions ignore the question of whether those communities with known need for abortion services have adequate access to these services. This commentary attempts to break that silence.

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Disparities in Access to Abortion

Poor and minority women experience significant barriers to accessing needed abortion services. Healthy People 2020 identifies the four components that encompass access to health services, each of which is relevant to abortion care: coverage, timeliness, services, and workforce.[9]

Lack of financial support for abortion care is a significant barrier for disadvantaged women. The costs associated with abortion are not trivial and increase with gestational age; the mean charge for a non-hospital abortion at 10 weeks is $523 while the mean for a non-hospital abortion at 20 weeks is $1,339.[10] The federal Hyde Amendment, first passed in 1976, prohibits the use of federal Medicaid funds to pay for abortions unless the pregnancy is a result of rape or incest or the pregnant woman's life is in danger. In addition, 32 states and the District of Columbia use the same criteria to limit the use of state funds. Even if a woman does have health insurance, she may not have coverage for abortion, as twelve states restrict abortion coverage in insurance plans for public employees. Prior to federal health care reform, four states restricted coverage of abortion in private insurance plans to situations where the woman's life would be endangered if the pregnancy were carried to term.[11] Rather than redressing this issue, health care reform may make obtaining coverage for abortion more difficult, as the Affordable Care Act includes not only the maintenance of restrictions of funding for women on Medicaid but an expansion of restrictions for women purchasing health care coverage in insurance exchanges. Abortion was the only health care services to be explicitly excluded from coverage expansions under Obama's health care reform efforts. In addition, following the passage of the Affordable Care Act, fourteen states introduced legislation to further restrict abortion insurance coverage in their state; 29 states have legislation set to be introduced in the 2010 and 2011 legislative sessions.[12]

Lack of insurance coverage is not the only financial barrier to abortion services, as state governments are increasingly instituting regulations which require a woman to wait a set period of time between consenting for her abortion and obtaining one. These policies, which most often mandate waiting periods of 24 hours between the counseling and the abortion procedure, exist in 24 states.[13] These waiting periods are a significant obstacle to low-income and geographically-isolated women for whom travel and time represent significant barriers to care. Studies of waiting periods have found that these waiting periods result in some women having abortions at later gestational ages.[14,15] In this way the timeliness of the abortion is directly affected.

With respect to facilities which provide abortion care, 87% of U.S. counties have no known health care facility which provides abortion, and the number of such facilities is declining over time.[10] As a result, women increasingly need to travel long distances to obtain their abortions, a more difficult requirement for vulnerable populations. Even where abortion providers exist, needed services often remain limited, with many states lacking abortion services in the second trimester.[16]

One factor contributing to the lack of facilities providing abortion care is the fact that many states have regulations which impose licensing requirements on facilities where abortions are performed. As an example, a 2004 Texas law required that abortions after 16 weeks gestation be performed in facilities licensed as ambulatory surgical

centers or hospitals. As a result, few providers were able to make the physical plant changes and the number of facilities providing this care dropped dramatically.[16] These regulations do not enhance patient safety and are inconsistent with published standards for similar health care services.[16]

Restrictions on who can perform an abortion further limit the abortion care workforce. While efforts to expand the number of obstetrician/gynecologists trained to provide abortion services are underway, the effects of these new training opportunities on abortion provision after residency remains modest.[17] An additional means of improving access is the use of family physicians, nurse practitioners, midwives, or physician assistants, as there is ample documentation that these health care clinicians can perform early abortion safely.[18–22] However, policies in several states limit abortion care to only obstetrician/gynecologists and in most states to only physicians, without evidence that such restrictions improve abortion safety.[11,23]

In addition to these state-based restrictions, clinicians who wish to provide abortions can face difficulty obtaining medical liability coverage. Non-obstetrician/gynecologists may be refused such coverage based on their specialty alone,[24] thus making it impossible to offer this care. In addition, many community health centers access malpractice insurance for their clinicians through the federal program for federally-qualified health centers (FQHC). As this program specifically excludes malpractice coverage for abortion procedures, providers working in these clinics are often unable to provide this service. This limitation on services from these safety net providers are a substantive barrier to care for the 16 million medically underserved Americans who receive their primary care at these sites.[25]

Effects of Limited Access to Abortion Services

The effect of limited access to abortion services results in significant consequences for some women,[26] including women in vulnerable populations having abortions at later gestational ages.[27,28] While having an abortion is safer for the pregnant woman than continuing a pregnancy to term regardless of the gestational age, the earlier an abortion is performed the safer it is. For each week of gestation after 8 weeks, the risk of mortality increases and most abortion-related mortalities could be eliminated if women obtained their abortions prior to 8 weeks of pregnancy.[29] As such, there are significant health consequences from delayed access to care.

Poor women are also more likely to carry an unintended pregnancy to term,[8] which may be partially due to their difficulty accessing and paying for abortion services.[30] The most recent study to investigate the effect of financial barriers to abortion on pregnancy outcomes used data from North Carolina during years where there was inconsistent public funding of abortion. During periods in which abortion funding was not available, a third of all pregnancies which would have been aborted were carried to term. This effect was noted to be particularly strong among Black women and all women with lower levels of education.[31] This finding is problematic from a women's rights perspective, as women without financial access to abortion services are being denied the ability to make the decision they desire regarding their fertility. In addition, continuing a pregnancy which is undesired can have health consequences, as women

with unintended pregnancies that are continued are less likely to receive appropriate prenatal care and have poorer health outcomes.[32–35] In addition, studies have found that there are negative effects for the children resulting from unplanned pregnancies, including an increased risk of infant mortality and child abuse.[35]

Where Are the Calls for Decreased Disparities in Access?

Poor and minority women experience both greater need for and reduced access to abortion services than their White and more affluent counterparts, and have negative health and social consequences as a result. With other chronic conditions with similar disparities—such as diabetes and HIV—there is the recognition that it is necessary not only to work to prevent the onset of the disease but also to ensure access to and eliminate disparities in health care services for whom prevention is not successful. No one would argue, for example, that individuals diagnosed with diabetes should be denied access to diabetes-related care because they did not adhere to diabetes prevention strategies such as exercise and improved nutrition. In contrast, governmental health agencies invested in women's reproductive health and health disparities have addressed only prevention of unintended pregnancy, thereby ignoring the need for access to abortion care as one option for treatment of this condition.[7,36]

We propose that a new public policy approach would address the issue of undesired fertility as a condition requiring not only prevention but also treatment. This approach allows consideration of access to all reproductive health services, including abortion, as a health disparities issue. Concrete steps which governmental health agencies could institute with this altered perspective on abortion disparities include removing the exclusion of health care coverage for abortion in both the private and the public sectors. Further, health care regulations which specifically target abortion facilities should be eliminated, and trained providers should be allowed to provide these services without barriers associated with licensure or medical liability insurance.

We acknowledge that the shift in focus that we are proposing may seem unlikely in the current political climate, in which Republican lawmakers have the majority in the House of Representatives and increased power in many state governments, and in which there has already been numerous bills introduced in the federal legislature to further limit access to abortion.[37] However, it is in exactly these circumstances that a rational, public health oriented approach to women's reproductive health generally, and abortion specifically, is most needed. By drawing attention to the importance of coupling attention to prevention of unintended pregnancy with attention to access to safe abortion care, those invested in advancing public health can ensure that public policy is harnessed to improve the health and well-being of all women, rather than to promoting a particular ideological perspective.

Notes

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