Women's Health Issues xxx-xx (2017) 1–7

ELSEVIER

WOMEN'S HEALTH ISSUES

www.whijournal.com

Original article

Differences in Abortion Service Delivery in Hostile, Middle-ground and Supportive States in 2014

Rachel K. Jones, PhD *, Meghan Ingerick, BA, Jenna Jerman, MPH

Guttmacher Institute, New York, New York

Article history: Received 20 September 2017; Received in revised form 20 November 2017; Accepted 11 December 2017

A B S T R A C T

Objectives: In 2013, the majority of women lived in states considered hostile to abortion rights, or states with numerous abortion restrictions. By comparison, 31% lived in supportive states. This study examined differences in abortion service delivery according to the policy climate in which clinics must operate.

Methods: Data come from the 2014 Abortion Provider Census, which contains information about all known abortion-providing facilities in the United States. In addition to number and type of facility, we examine several aspects of abortion care: provision of only early medication abortion (EMA-only) whether an advanced practice clinician provided abortions, gestational parameters, and average charge for procedure. All indicators were examined nationally and according to whether the clinic was in a state that was hostile, middle ground, or supportive of abortion rights.

Results: In 2014, hostile and supportive states accounted for the same proportion of all U.S. abortions—44% (each)—although 57% of women age 15 to 44 lived in hostile states. Hostile states had one-half as many abortion-providing facilities as supportive ones. EMA-only facilities accounted for 37% of clinics in supportive states compared with 8% in hostile states. Sixty-five percent of clinics in supportive states reported that advanced practice clinicians provided abortion care, compared with 3% in hostile states. After cost of living adjustments, a first-trimester surgical abortion was most expensive in middle-ground states ($470) and least expensive in supportive states ($402).

Conclusions: The distribution of abortion services, the type of facility in which they are provided, and the amount a facility charges all vary according to the abortion policy climate.

Over the last decade states have passed an unprecedented number of laws regulating abortion. In 2013, 56% of U.S. women lived in a state considered hostile to abortion rights, up from 31% in 2000 (Boonstra & Nash, 2014). During this same time period, the proportion of women living in states considered to be supportive of abortion rights decreased from 40% to 31%.

Between 2011 and 2014, the U.S. abortion rate decreased by 14%, and the number of clinics providing abortion care in the United States decreased by 6% (Jones & Jerman, 2017). Decreases in clinic numbers were greatest in those regions of the United States that passed the most abortion laws (the Midwest and the South); associations between abortion restrictions, number of clinics, and abortion rates were not uniform across states (Jones & Jerman, 2017). The decline in unintended pregnancy also contributed to the decrease in abortion (Finer & Zolna, 2016) and, likely, the decrease in clinic numbers; this may be one reason abortion incidence and number of clinics declined in states that are supportive of abortion rights. But state abortion policies influence more than the number of clinics in a state. Many abortion restrictions are not necessarily meant to close clinics, but to limit service options; these include laws pertaining to health insurance, early medication abortion (EMA), and those designating which health care professionals can provide abortion care. Thus, the types of abortion care offered may vary according to policy climate, because some regulations are specifically intended to impact service delivery.

In 2014, there were 1,671 facilities known to provide abortion care (Jones & Jerman, 2017). Clinics accounted for the largest share, 47%, followed by hospitals and physicians' offices, at 38% and 15% respectively. Prior research has found that there were fewer hospitals and doctors' offices providing abortion in the Midwest and the South in 2011, and it is likely that the

* Correspondence to: Rachel K. Jones, PhD, Guttmacher Institute, 125 Maiden Lane, Floor 7, New York, NY 10038. Phone: 212-248-1111, extension 2262; fax: 212-248-1951.

E-mail address: rjones@guttmacher.org (R.K. Jones).

1049-3867/$ - see front matter
https://doi.org/10.1016/j.whi.2017.12.003

distribution of abortion-providing facilities also varies across policy climates (Jerman & Jones, 2014). For example, physicians in private practice in hostile states with numerous regulations may not have the resources to meet all these requirements, and there may be fewer of them providing abortions.

The last decade has seen the emergence of a new type of clinic. EMA is offered by the overwhelming majority of clinics providing abortion care and accounted for 31% of abortions in 2014 (Jones & Jerman, 2017). That same year, 23% of nonhospital abortion providers offered only EMA (EMA-only; Jones & Jerman, 2017), although little else is known about these clinics. A majority of states have passed laws intended to make medication abortion more difficult to access. For example, 34 states mandate that only licensed physicians can provide medication abortion, and 19 require that the clinician be physically present when the primary abortion drug is administered (Guttmacher Institute, 2017). In turn, we expect EMA-only facilities will be less common in hostile states.

A majority of states only allow licensed physicians to perform abortions (Guttmacher Institute, 2014a). Many physician-only laws were implemented shortly after abortion was legalized to prevent unlicensed health care providers from performing abortions. However, since that time, nurse practitioners, nurse-midwives, and physician assistants (referred to as advanced practice clinicians [APCs]), have become integrated into the U.S. health care system, including the field of family planning (Auerbach et al., 2012; Fowler, Gable, Wang, & Lasater, 2016). Recent years have seen increased efforts to involve APCs in abortion care (Barry & Rugg, 2015; Weitz et al., 2013; Weitz, Anderson, & Taylor, 2009), and the availability of medication abortion may have bolstered these efforts. Although only five states currently allow APCs to perform surgical abortions, at least 12 additional states allow them to provide medication abortion (Barry & Rugg, 2015; Guttmacher Institute, 2014a). No national study has examined the involvement of APCs in abortion care. Still, because a majority of states mandate that abortion, including medication abortion, can be provided only by a licensed physician, we expect that APC involvement in abortion care will be more common in supportive states.

How much women have to pay for abortion care may also be influenced by state policy climate. Restrictions such as waiting periods or ones that require major structural changes to a clinic can result in substantial expenses (Colman & Joyce, 2011; Mercier, Buchbinder, Bryant, & Britton, 2015; Mercier, Buchbinder, & Bryant, 2016), and facilities located in states with numerous restrictions might have to charge more for care to compensate for these costs. Some 75% of patients who obtain abortions are poor or low income (Jones, Jerman, & Onda, 2016). In 2011 and 2012 the average patient paid $480 for a first-trimester surgical procedure (Jerman & Jones, 2014). Because many patients are uninsured or have insurance that does not cover abortion, the majority pay out of pocket (Jones et al., 2016). Women who are unable to come up with this money may not be able to obtain abortions.

Finally, a majority of states, including some considered supportive of abortion rights, have imposed gestational limits on abortion, typically between 20 and 24 weeks (Guttmacher Institute, 2014b). Thus, it is unclear whether we might expect variations in the availability of abortion at later gestations by policy context. At the other end of the spectrum, more providers have been able to offer abortions at very early gestations over the last decade, in part owing to the integration of EMA (Hammond & Chasen, 2009, p. 11; Henshaw, 2009). We might expect greater availability of very early abortion in states with fewer restrictions and greater availability of EMA-only facilities.

This study uses data from all known U.S. abortion-providing facilities to examine several indicators of abortion care according to whether the facility was in a state that was characterized as hostile, middle ground, or supportive on abortion rights. The information from this study expands on the absolute number of clinics as a measure of access, and provides a more nuanced examination of abortion service delivery.

Methods

Data for this cross-sectional study come from the Guttmacher Institute's 2014 Abortion Provider Census. Since 1973, the census has surveyed the known universe of abortion-providing facilities in the United States, and constitutes the most comprehensive information on abortion incidence. We obtained approval for the census through expedited review by the Guttmacher Institute's federally registered institutional review board. Detailed information on methodology has been documented elsewhere (Jones & Jerman, 2017), but we provide a brief description.

Paper questionnaires were mailed to all known abortion providing facilities in March 2015. Completed questionnaires were collected through April 2016 via mail and, during nonresponse follow-up, by telephone, fax, and email. Questionnaires included items about the number of abortions provided in 2013 and 2014 (with separate questions for number of medication abortions), the minimum and maximum gestations at which abortions were provided in 2014, and the typical fee schedules for EMA and surgical procedures at 10 and 20 weeks in 2014. For the first time we asked facilities, "In 2014, were any abortions at this facility provided by an APC, such as a physician assistant, nurse practitioner, family nurse practitioner, women's health nurse practitioner, or certified midwife?" and this measure is included in the current analysis.

Data on number of abortions was provided by 58% of all facilities. Health department data were used to determine abortion caseloads for an additional 20% of facilities, and estimates were made for the remaining 17%. The vast majority of counted abortions—88%—came from information given to us directly by abortion providers.

Although we surveyed all known abortion providing facilities and were able to obtain, or estimate, information on number of abortions for all of them, questionnaires were sometimes incomplete. For some facilities, we were able to obtain additional information over the phone and from facility websites (e.g., fee schedules). We acquired at least some information on gestational limits from 85% of clinics and information on charges from 84% of clinics. We constructed nonresponse weights that accounted for these differences based on facility type and caseload, assuming that nonresponding facilities resembled those that provided the relevant information.

The weight used for amount a facility charged for first-trimester abortions was adjusted for clinic caseload as well as nonresponse. A small number of clinics charge substantially higher prices for abortions (Jerman & Jones, 2014), and these facilities typically serve a small number of clients. The inclusion of facility caseload into the weight prevented these facilities from skewing the amount charged; the measure used in the analysis represents the amount women paid for an abortion. Because abortions at 20 weeks are much less common than those