



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Increasing Access to Abortion

ABSTRACT: Safe, legal abortion is a necessary component of women's health care. The American College of Obstetricians and Gynecologists supports the availability of high-quality reproductive health services for all women and is committed to improving access to abortion. Access to abortion is threatened by state and federal government restrictions, limitations on public funding for abortion services and training, stigma, violence against abortion providers, and a dearth of abortion providers. Legislative restrictions fundamentally interfere with the patient-provider relationship and decrease access to abortion for all women, and particularly for low-income women and those living long distances from health care providers. The American College of Obstetricians and Gynecologists calls for advocacy to oppose and overturn restrictions, improve access, and mainstream abortion as an integral component of women's health care.

Recommendations

The American College of Obstetricians and Gynecologists (the College) recommends the following to ensure the availability of safe, legal, and accessible abortion services free from harmful legal or financial restrictions:

- Eliminate the federal Hyde amendment and other federal and state restrictions on public and private insurance coverage of abortion. Public and private insurance coverage of abortion care should be comparable to that of other essential health care services and not singled out for exclusion or additional administrative or financial burdens.
- Cease and repeal legislation that creates barriers to abortion access and interferes with the patient-provider relationship and the practice of medicine, including for example
 - telemedicine bans,
 - medication abortion restrictions,
 - mandatory counseling and delays, and
 - Targeted Regulations of Abortion Provider (TRAP) laws.
- Ensure public funding for opt-out abortion training for medical student, resident, and advanced practice clinician education (where training is routinely integrated but those with religious or moral objection can opt-out of participation), and remove

governmental restrictions on training programs and funding.

- Expand the pool of first-trimester medication and aspiration abortion providers to appropriately trained and credentialed advanced practice clinicians in accordance with individual state licensing requirements.
- Enhance enforcement of Freedom of Access to Clinic Entrances and other criminal and civil provisions and vigilance by local law enforcement to protect patient and abortion provider safety.
- Encourage hospitals and women's health care providers to support abortion care as essential medical care for women, eliminate barriers to the provision of abortion care in these settings, and preserve availability of comprehensive reproductive health services in communities undergoing hospital mergers.

Background

The College supports women's right to decide whether to have children, the number and spacing of their children, and to have the information, education, and access to health services to make these choices (1). In the United States, where one half of all pregnancies are unintended, almost one third of women will seek an abortion by age 45 years (2). Underserved women, including those who are low-income, experience the highest rates of

unintended pregnancy and abortion (3). The most effective way to reduce abortion rates is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception.

Many factors influence or necessitate a woman's decision to have an abortion. They include, but are not limited to, contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, and exposure to teratogenic medications. Additionally, pregnancy complications, such as placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, and cardiac or renal conditions, may be so severe that an abortion is the only measure to preserve a woman's health or save her life.

Women require access to safe, legal abortion. Although abortion is legal in the United States, it has become increasingly marginalized from mainstream medical care. It is often the only essential health care service not offered by a woman's usual health care provider and within a woman's usual health care system.

Where abortion is legal, it is extremely safe (4). The risk of death associated with childbirth is approximately 14 times higher than that with abortion (4). In the United States, 88% of abortions occur within the first trimester, when abortion is safest. Serious complications from abortions at all gestational ages are rare.

In contrast, historical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers (5, 6). Today, approximately 21 million women around the world obtain unsafe, illegal abortions each year, and complications from these unsafe procedures account for approximately 13% of all maternal deaths, nearly 50,000 annually (5, 6).

In 1973, the U.S. Supreme Court decision, *Roe v Wade*, established that the legal right to privacy under the due process clause of the 14th Amendment extends to a woman's decision to have an abortion. It is estimated that before 1973, 1.2 million U.S. women resorted to illegal abortion each year and that unsafe abortions caused as many as 5,000 annual deaths. After the Supreme Court ruling, mortality due to septic illegal abortion decreased precipitously (7). Similar trends and improvements in women's health have been documented in other countries after the legalization of abortion (8).

Restrictions Limiting Access to Abortion

Abortion, although still legal, is increasingly out of reach because of numerous government-imposed restrictions targeting women and their health care providers. Recent years have seen a dramatic increase in the number and scope of legislative measures restricting abortion, with 22 states enacting 70 measures restricting abortion care

in 2013. The greatest number of state-level restrictions ever enacted in 1 year was in 2011, with 92 restrictions (9). Health care providers face laws inappropriately unique to the provision of abortion that mandate procedures and counseling that are not evidence-based or ethical (see Box 1). The College, along with other medical organizations, opposes such interference with the patient-provider relationship, confirming the importance of this relationship in the provision of high-quality medical care (10).

Box 1. Types of Measures Restricting Abortion ←

“Personhood” measures—Establish fertilized eggs as separate legal individuals subject to laws of the state and would likely criminalize abortion, embryonic stem cell research, infertility treatments, cancer treatments, and some methods of contraception.

Gestational age bans—Legislate arbitrary gestational age cutoffs, often 20 weeks of gestation, beyond which an abortion cannot be performed except to prevent the woman's death or irreversible morbidity, often with no exception for fetal anomalies.

“Partial-birth” abortion bans—The federal Partial-Birth Abortion Ban Act of 2003 (upheld by the Supreme Court in 2007) makes it a federal crime to perform procedures that fall within the definition of so-called “partial-birth abortion” contained in the statute, with no exception for procedures necessary to preserve the health of the woman. Although “partial-birth abortion” is not a medical term and is vaguely defined in the law, physicians and lawyers have interpreted the banned procedures as including intact dilation and evacuation unless fetal demise occurs before surgery. Several states also have passed bans on so-called “partial-birth abortions,” which impose additional restrictions and penalties on abortion providers in those states.

Biased counseling—Require state-mandated scripts to be used in patient counseling, often including inaccurate data and misinformation about pregnancy, fetal development, and abortion.

Mandated ultrasounds—Requires ultrasonography and that the patient receives a detailed description of the image, views the image, and/or listens to Doppler heart tones.

State-imposed waiting periods—Require a woman to make two trips for a 1-day procedure with a 24–72-hour mandated delay between counseling and the abortion procedure. These laws create additional burdens, especially for women in rural areas who often have to travel for many hours to reach a health care provider.

Parental involvement—Require one or both parents to be notified and/or give consent before a minor may undergo abortion despite the danger to the minor in circumstances of abuse.

This box provides selected examples of types of legislation that restrict access to abortion and is not an exhaustive list. See www.guttmacher.org/statecenter/spibs/spib_OAL.pdf for detailed descriptions of legislation restricting abortion by state.

Medically Unnecessary Abortion Facility and Staff Requirements

Facility and staffing requirements enacted in some states, under the guise of promoting patient safety, single out abortion from other outpatient procedures and impose medically unnecessary requirements designed to reduce access to abortion. Also known as TRAP laws, these measures have included needless requirements such as mandating that facilities meet the physical plant standards of hospitals; that staffing, drug, equipment, and medical records be maintained at unnecessary levels; that physicians performing abortions in the clinic setting obtain hospital admitting privileges, with no mechanism to ensure that hospitals will grant such privileges; that the same physician perform in-person counseling, ultrasonography, and the abortion procedure, resulting in difficulties for physicians who travel long distances to provide abortion care in rural states and for multi-day procedures; and that clinic physicians be board certified obstetrician-gynecologists despite the fact that clinicians in many medical specialties can provide safe abortion services. The College opposes such requirements because they improperly regulate medical care and do not improve patient safety or quality of care.

These laws make abortion more difficult and expensive to obtain, imposing new costs on the women who can least afford them (11). Compliance with some of the most onerous regulatory requirements has proved to be so difficult that some practices have closed. In states with few abortion providers, TRAP laws can make abortion essentially inaccessible (12).

Funding Restrictions

Funding restrictions, which take many forms, constitute a significant barrier to abortion access and increase reproductive health inequities. Passage of the federal Hyde amendment in 1977, which denies federal Medicaid funds to pay for abortions except when a woman's life is endangered or in cases of rape or incest, and the annual renewal of this provision has severely limited Medicaid funding for abortion; a majority of states also restrict state Medicaid coverage of abortion. Restrictions on abortion coverage also exist for military personnel, retirees, and their dependents through the TRICARE military health care system; for federal employees and their dependents insured through the Federal Employees Health Benefits Program; and for those receiving care through the Indian Health Service. These funding restrictions impede access to safe abortion care and, in some cases, function as a de facto abortion ban (13, 14). Legislative bans on private insurance coverage of abortion further marginalize abortion and represent a departure from the insurance industry's usual practice of covering abortion services equitably with other procedures. Further, restrictions attached to appropriations and other public monies hospitals receive can jeopardize medical education and training programs for all clinicians, as well as

affect patient care. A list of funding-related and payment-related restrictions can be found in [Box 2](#).

Restrictions on Medication Abortion

Restrictions on medication abortion burden doctors' ability to practice medicine, criminalize physicians who follow evidence-based guidelines, and threaten women's ability to access safe, confidential abortion care in a timely manner. Some states have prohibited or have attempted to prohibit evidence-based best practices for medication abortion either by outlawing use of the necessary medications or by threatening physicians with criminal penalties unless they use a legislatively mandated, outdated protocol. Innovations in the medication-abortion regimen have occurred since the FDA approval of mifepristone

Box 2. Abortion Coverage Bans and Funding-Related Restrictions ↩

Hyde Amendment and other federal restrictions—Federal Medicaid funds cannot be used to pay for abortion except when a woman's life is endangered or in cases of rape or incest. Legislated in 1977 and renewed annually as a rider to federal appropriation bills. It was amended in 1994 to add rape and incest as exceptions. Restrictions also exist through the TRICARE military health care system, the Federal Employees Health Benefits Program, and within the Indian Health Service.

State Medicaid funding—Only 17 states currently allow state Medicaid funds to be used for medically necessary abortions beyond those allowed under the Hyde amendment. South Dakota is the only state not in compliance with the minimum federal Hyde exceptions and excludes coverage even in cases of rape and incest*.

Private insurance coverage—A number of states have banned abortion coverage in the private insurance market, including in new exchanges being established under the Patient Protection and Affordable Care Act where low- and moderate-income individuals can buy private health insurance. Many of these laws lack exceptions for cases in which a woman's health is jeopardized or in cases of fetal anomaly.

Residency training funding—Some states restrict state monies from being used to support or subsidize abortion training at public universities or hospitals.

Affiliation bans—Some states prohibit any medical or educational institution that provides abortion care, referrals, or training from participating in public health programs or from receiving public funding of any sort, including Medicaid reimbursements or family planning grants.

Punitive tax policies—Some states deny tax-exempt status to any nonprofit organization, hospital, or health center that provides, refers for, or covers abortion care.

*Guttmacher Institute. State funding of abortion under Medicaid. State Policies in Brief. New York (NY): GI; 2014. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf. Retrieved July 29, 2014.

in 2000, and today, most medication abortions are accomplished with a revised, evidence-based regimen that provides superior efficacy and adverse-effect profile compared with the original FDA protocol (15). Yet states have legislated the practice of medicine by dictating specific dosages, method of use, timing, and location of administration for the medication, precluding health care providers' ability to provide quality care. Some states also criminalize the use of telemedicine to prescribe medication abortion, despite the fact that telemedicine is safe, effective, highly acceptable to patients, and facilitates access to care for women in rural areas (15).

Social, Cultural, and Administrative Obstacles to Abortion Access

Other formidable obstacles to abortion access include the stigma associated with obtaining and providing abortion services, a lack of abortion providers, and "crisis pregnancy centers" that use misinformation to divert women from appropriate care. These nonlegislative barriers can be exacerbated by or result from restrictive legislation and can further isolate vulnerable populations from timely medical care.

Stigma and Violence

Stigma, harassment, and violence discourage abortion access and provision. Stigma and fear of violence may be less tangible than legislative and financial restrictions, but are powerful barriers to abortion provision nonetheless (16). The stigma of obtaining an abortion, as well as for providing an abortion, may lead to secrecy, marginalization of abortion from routine medical care, delays in care, and increased morbidity from the procedure (16, 17).

In the past 20 years, 13 physicians and clinic staff at abortion facilities have been either murdered or seriously harmed (16, 18). Most abortion clinics report harassment (19). Acts of harassment include taking photos or videos of patients, tampering with garbage, placing glue in locks or nails on the driveway of clinics, breaking windows, interfering with phone lines, approaching cars, and recording license plates (19). The Freedom of Access to Clinic Entrances Act became law in 1994 in response to clinic violence and specifically prohibits the use of force against women accessing abortion care or reproductive health care providers. However, this federal law requires implementation by local law enforcement, which remains inconsistent (20). In addition, a 2014 Supreme Court ruling striking down a state law that established a fixed "buffer zone" around abortion clinics has resulted in other jurisdictions repealing or abandoning enforcement of similar laws.

Lack of Abortion Providers and Facilities

Stigma, harassment, and violence, in combination with legal and administrative barriers, contribute to a scarcity of abortion services throughout much of the United States. The number of facilities providing abortion in the

United States decreased 38% from 1982 to 2000, and continues to decrease (19, 21). More than one third of U.S. women live in the 89% of counties that lack an abortion care facility, and more than 17% of women obtaining an abortion in 2008 traveled more than 50 miles to obtain the procedure (22). This dearth of abortion services also derives from a lack of health care provider training, institutional policies against abortion provision, and a restricted pool of health professionals qualified and willing to provide abortion care.

Despite the Accreditation Council for Graduate Medical Education (ACGME) requirement that obstetric and gynecology residency programs include abortion training, programs widely vary in the scope and type of training offered (23). State laws, regulations, and funding restrictions also may influence and drive administrative decisions to disallow abortion provision and training, and may ultimately jeopardize the accreditation of medical education programs (23).

Further, many religiously affiliated institutions do not offer reproductive health services, including contraception, sterilization, and abortion. Mergers of secular hospitals with religiously affiliated health systems can result in the elimination of previously available reproductive health services (24). In other cases, hospitals cease to offer services not based on legal restrictions or religious opposition, but because of the associated controversy.

Laws that unnecessarily curtail scope of practice diminish the number of qualified medical professionals who can provide abortion care. Currently, only five states allow advanced practice clinicians to provide first-trimester medication and aspiration abortions (25, 26). Yet, several reports show no differences in outcomes in first-trimester medication and aspiration abortion by health care provider type and indicate that trained advanced practice clinicians can safely provide abortion services (25–31).

Vulnerable Populations

Adolescent, rural, poor, and incarcerated women can face additional restrictions on access to abortion as well as disproportionate effects from other barriers. Parental involvement of some kind in a minor's decision to access abortion is currently required in 38 states (32). Abortion provider-related restrictions and requirements, restrictions on the use of telemedicine, and legislatively imposed waiting periods all have a disproportionate effect on rural women's access to abortion (33). Low-income women face federal and state restrictions on public and private insurance coverage of abortion, including plans offered through the insurance exchanges established under health care reform, most acutely. And although women retain their legal right to abortion while incarcerated, accessibility varies widely (34). A survey of correctional health care providers found that only 68% of facilities enable inmates to obtain abortion care (34).

Crisis Pregnancy Centers

Crisis pregnancy centers present themselves as health clinics offering pregnancy options services, but operate to dissuade women from seeking abortion care (35). They often provide inaccurate medical information, asserting false links between abortion and breast cancer, infertility, mental illness, and other misinformation (36). These efforts to misinform can divert women from accessing comprehensive and timely care from appropriately trained and licensed medical providers (36).

Summary

When restrictions are placed on abortion access, women's health suffers. Abortion access is increasingly limited; research shows that restrictions dictate whether or not care is safely obtained (37). Restrictions disrupt the patient-provider relationship, create substantial obstacles to the provision of safe medical care, and disproportionately affect low-income women and those living long distances from abortion providers (38, 39). Additionally, abortion providers may face stigmatization in the workplace, in their communities, and from colleagues. Abortion providers face violence and threats to themselves, their staff, and their families. Finally, women are prevented from or experience delays in obtaining abortion care because of inadequate health coverage, state-imposed funding restrictions, or waiting periods, and are subject to stigma and shame. These obstacles marginalize abortion services from routine clinical care and are harmful to women's health.

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