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Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the Abortion Access and Training Expert Work Group in collaboration with committee member Daniel Grossman, MD.

Increasing Access to Abortion

ABSTRACT: Individuals require access to safe, legal abortion. Abortion, although legal, is increasingly out of reach because of numerous restrictions imposed by the government that target patients seeking abortion and their health care practitioners. Insurance coverage restrictions, which take many forms, constitute a substantial barrier to abortion access and increase reproductive health inequities. Adolescents, people of color, those living in rural areas, those with low incomes, and incarcerated people can face disproportionate effects of restrictions on abortion access. Stigma and fear of violence may be less tangible than legislative and financial restrictions, but are powerful barriers to abortion provision nonetheless. The American College of Obstetricians and Gynecologists, along with other medical organizations, opposes such interference with the patient–clinician relationship, affirming the importance of this relationship in the provision of high-quality medical care. This revision includes updates based on new restrictions and litigation related to abortion.

Recommendations

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

- The federal Hyde amendment and other federal and state restrictions on public and private insurance coverage of abortion should be eliminated. Public and private insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens.
- ACOG calls for the cease and repeal of legislation that creates barriers to abortion access and interferes with the patient–clinician relationship and the practice of medicine, including, for example:
  - bans on abortion at arbitrary gestational ages,
  - requirements that only physicians or obstetrician–gynecologists may provide abortion care,
  - telemedicine bans,
  - restrictions on medication abortion,
  - requirements for mandatory counseling and forced delay before obtaining care,
  - ultrasound requirements,
  - mandated parental involvement, and
  - facility and staffing requirements known as Targeted Regulations of Abortion Provider (TRAP) laws.
- ACOG recommends that 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) be ensured, and governmental restrictions on training programs and funding be removed.
- The pool of clinicians who provide first-trimester medication and aspiration abortion should be expanded to appropriately trained and credentialed advanced-practice clinicians in accordance with individual state licensing requirements.
- Enforcement of the Freedom of Access to Clinic Entrances Act and other criminal and civil provisions and vigilance by local law enforcement to protect patient, clinician, and abortion clinic staff safety should be enhanced.
- Hospitals and other health care institutions should be encouraged to support abortion care as essential

medical care, eliminate barriers to the provision of abortion care in these settings, and preserve availability of comprehensive reproductive health services in communities undergoing hospital mergers.

Introduction

Safe, legal abortion is a necessary component of comprehensive health care. The American College of Obstetricians and Gynecologists supports the availability of high-quality reproductive health services for all patients and is committed to improving access to abortion. Access to abortion is threatened by state and federal government restrictions, limitations on insurance coverage of abortion care, restrictions on funding for training, restrictions imposed by hospitals and health care systems, stigma, violence against clinicians who provide abortions, and a subsequent dearth of clinicians who provide abortions. Legislative restrictions fundamentally interfere with the patient–clinician relationship and decrease access to abortion, particularly for those with low incomes and those living long distances from health care practitioners. The American College of Obstetricians and Gynecologists calls for advocacy to oppose and overturn restrictions, to improve access, and to integrate abortion as a component of health care.

Background

ACOG 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, one quarter of women will obtain an abortion by age 45 years (2). The majority of abortion patients identify as Black, Hispanic, Asian, or Pacific Islander, and 75% of those seeking abortion are living at or below 200% of the federal poverty level (3). People of all genders have sexual and reproductive health needs, including women, transgender people, nonbinary people, and those who are otherwise gender-diverse. This Committee Opinion will use the terms women, patients, individuals, and people interchangeably, and will address specific health needs of transgender, gender nonbinary, and gender-diverse people where appropriate.

Many factors influence or necessitate an individual'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, chorioamnionitis, and cardiac or renal conditions may be so severe that an abortion is the only measure to preserve a patient's health or save their life. All terminations are considered medically indicated.

Individuals require access to safe, legal abortion. Although abortion is legal in the United States, it has become increasingly excluded from its appropriate place in mainstream medical care. It is often the only essential health care service not offered by a patient's usual health care practitioner or health care system. A 2019 national survey of ACOG Fellows and Junior Fellows found that although 72% reported having a patient in the previous year who needed or wanted an abortion, only 24% provided this care (4). Additionally, many hospitals and health care systems limit the scope of reproductive health care for a range of reasons (5).

Abortion is extremely safe (6, 7). The risk of death associated with childbirth is approximately 14 times higher than that with abortion (6). In the United States, 88% of abortions occur within the first trimester, when abortion is safest. Serious complications from abortions are rare at all gestational ages (8).

In contrast, historical and contemporary data show that where abortion is illegal or highly restricted, pregnant people may resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, and reliance on unqualified or predatory abortion providers (9, 10). Today, approximately 25 million women around the world resort to unsafe abortions each year, and complications from these unsafe procedures account for as many as 15% of all maternal deaths, approximately 44,000 annually (11, 12).

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 person's decision to have an abortion (13). It is estimated that before 1973, approximately 800,000 U.S. women resorted to illegal abortion each year, resulting in preventable complications and death (14). After the Supreme Court ruling, mortality because of septic unsafe abortion decreased precipitously (15). Similar trends and improvements in women's health have been documented in other countries after the legalization of abortion (16).

Restrictions Limiting Access to Abortion

Abortion, although legal, is increasingly out of reach because of numerous restrictions imposed by the government that target patients seeking abortion and their health care practitioners. Recent years have seen a dramatic increase in the number and scope of legislative measures restricting abortion. In 2019, states enacted 58 restrictions on abortion, of which 25 would ban all, most, or some abortions (17). Several states passed laws banning abortions at 8 weeks of gestation or earlier, and Alabama enacted a law making abortion provision a felony; as of 2020, these laws have been blocked by the courts. Health care practitioners face inappropriate laws unique to the provision of abortion that mandate procedures and counseling that are not evidence-based or ethical and compromise the quality of care (see Box 1). ACOG, along with other medical organizations, opposes

such interference with the patient–clinician relationship, affirming the importance of this relationship in the provision of high-quality medical care (7, 18, 19). ACOG calls for the cease and repeal of legislation that creates barriers to abortion access and interferes with the patient–clinician relationship and the practice of medicine, including, for example: bans on abortion at arbitrary gestational ages, requirements that only physicians or obstetrician–gynecologists may provide abortion care, telemedicine bans, restrictions on medication abortion, requirements for mandatory counseling and forced delay before obtaining care, ultrasound requirements, mandated parental involvement, and facility and staffing requirements known as Targeted Regulations of Abortion Provider (TRAP) laws.

Facility and Staffing 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 unnecessary requirements, such as mandating that:

- facilities meet the physical plant standards of hospitals
- staffing, medications, and equipment be maintained at unnecessary levels
- physicians providing abortions in the clinic setting obtain hospital admitting privileges, with no mechanism to ensure that hospitals will grant such privileges
- the same physician must provide in-person counseling, ultrasonography, and the abortion procedure, resulting in difficulties for patients and clinicians who travel long distances to receive or provide abortion care in rural areas and for multi-day procedures
- clinicians who provide abortion must be board certified obstetrician–gynecologists even though clinicians in many medical specialties can provide safe abortion services

ACOG opposes such requirements because they improperly regulate medical care and do not improve patient safety or quality of care (7, 20).

These laws make abortion more difficult and expensive to obtain, imposing additional costs on the patients who can least afford them (21). Compliance with some of the most onerous regulatory requirements has proved to be so difficult that practices have closed (22). TRAP laws make abortion inaccessible for some people and create delays for others, leading to an increase in abortion after the first trimester (23–25).

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.

Physician and facility requirements—Require that only physicians, sometimes with admitting privileges at a nearby hospital, or only obstetrician–gynecologists, may provide an abortion, and establish certain requirements for the facility where the procedure is performed, which may vary by gestational age.

Gestational age bans—Legislate arbitrary gestational age cutoffs, often 20 weeks of gestation but as early as 6–8 weeks of gestation, beyond which an abortion cannot be performed except to prevent the patient'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 patient. Although "partial-birth abortion" is not a medical term and is vaguely defined in the law, clinicians 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 clinicians who provide abortions in those states.

Biased counseling—Requires scripts mandated by the state to be used in patient counseling, often including inaccurate data and misinformation about pregnancy, fetal development, and abortion. Some states have mandated that clinicians provide information to patients about so-called abortion "reversal," an unproven regimen of progesterone treatment aimed at increasing the likelihood of pregnancy continuation in the rare case that a patient decides to try to continue the pregnancy after taking mifepristone for medication abortion.

Mandated ultrasound—Requires ultrasonography and often additional requirements that the patient receive a detailed description of the image, view the image, or listen to Doppler cardiac tones.

State-level mandatory delay requirements—Requires individuals to make two trips for a one-day procedure, typically with a 24- to 72-hour mandated delay between counseling and the abortion procedure. These laws create additional burdens, especially for people in rural areas who often have to travel for many hours to reach a health care practitioner.

(continued)

Box 1. Types of Measures Restricting Abortion *(continued)*

Parental involvement—Requires one or both parents to be notified or give consent before a minor may undergo abortion despite any potential danger to the minor.

This box provides selected examples of types of legislation that restrict access to abortion and is not an exhaustive list. See https://www.guttmacher.org/state-policy/explore/overview-abortion-laws for detailed descriptions of legislation restricting abortion by state.

Insurance Coverage Restrictions

Insurance coverage restrictions, which take many forms, constitute a substantial barrier to abortion access and increase reproductive health inequities. The passage of the federal Hyde amendment in 1977, which denies federal Medicaid coverage for abortions except when a patient's life is endangered or in cases of rape or incest, and the annual renewal of this provision has severely limited Medicaid coverage 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 veterans accessing care through Veterans Affairs, 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 coverage restrictions impede access to safe abortion care, and in some cases function as a de facto abortion ban (26, 27). 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. In addition, 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 coverage-related and payment-related restrictions can be found in Box 2. The federal Hyde amendment and other federal and state restrictions on public and private insurance coverage of abortion should be eliminated. Public and private insurance coverage of abortion care should be considered part of essential health care services and not singled out for exclusion or additional administrative or financial burdens.

Box 2. Abortion Coverage Bans and Funding-Related Restrictions

Hyde Amendment and other federal restrictions—Federal Medicaid covers abortion only when a patient'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; Veterans Affairs prohibits abortion counseling or services in all cases.

State Medicaid coverage—As of 2020, only 16 state Medicaid agencies cover 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 individuals with low and moderate incomes can buy private health insurance. Many of these laws lack exceptions for cases in which an individual'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. New York, NY: Guttmacher Institute; 2020. Available at: https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid. Retrieved August 19, 2020.

Restrictions on Medication Abortion

Medication abortion accounts for approximately 60% of abortions up to 10 weeks of gestation in the U.S., yet federal and state-level restrictions limit the use of this safe and effective method (28, 29). The U.S. Food and Drug Administration's Risk Evaluation and Mitigation Strategy for mifepristone requires that the medication be dispensed in a clinic, medical office, or hospital. Clinicians may not write a prescription for mifepristone for patients to obtain the medication in a pharmacy, which prevents some clinicians from offering the service (4). In addition, as of 2020, 18 states have banned the use of telemedicine to provide medication abortion, despite the evidence that the service is safe and effective and has a high degree of patient satisfaction (30–32); its introduction was also associated with a substantial reduction in second-trimester abortion (33). Most states also prevent advanced practice clinicians from providing medication abortion even though research from several countries indicates that outcomes are similar to those when the service is provided by physicians (34).

Additional Barriers to Abortion Access

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

Stigma and Violence

Stigma, harassment, and violence discourage abortion access and provision and harm patients. Stigma and fear of violence may be less tangible than legislative and financial restrictions, but are powerful barriers to abortion provision nonetheless (35). The stigma of obtaining an abortion and providing abortion may lead to secrecy, marginalization of abortion from routine medical care, delays in care, and increased morbidity from the procedure (35, 36).

Since 1993, anti-abortion violence has led to 11 murders and 26 attempted murders (35, 37, 38). Most abortion clinics report harassment (39). Acts of harassment include picketing, picketing with physical contact or blocking, vandalism, picketing of homes of staff members, bomb threats, harassing phone calls, noise disturbances, taking photos or videos of patients and staff, 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 (39, 40). 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 individuals accessing abortion care or reproductive health care clinicians. However, this federal law requires implementation by local law enforcement, which remains inconsistent (See "The Abortion Fight at Ground Zero: Is the FACE Act Being Enforced?" at https://rewire.news/article/2010/04/30/abortion-fight-ground-zero/). 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. Clinicians who provide abortion care also have been directly targeted with death threats, other threats of harm, and stalking, among other violent acts (38). Enforcement of the Freedom of Access to Clinic Entrances Act and other criminal and civil provisions and vigilance by local law enforcement to protect patient, clinician, and abortion clinic staff safety should be enhanced.

Lack of Abortion Care Facilities and Practitioners

The number of facilities providing abortion in the United States decreased 38% from 1982 to 2000, and continues to decrease (40, 41). 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 (28, 42). A 2017 study identified 27 U.S. cities with populations of 50,000 or more where people have to travel more than 100 miles to the nearest clinician who provides abortions (43). This dearth of abortion services also derives from a lack of health care practitioner 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 obstetrics and gynecology residency programs include abortion training, programs widely vary in the scope and type of training offered (44–46). State laws, regulations, institutional restrictions, and funding restrictions also may influence administrative decisions to disallow abortion training and may ultimately jeopardize the accreditation of medical education programs (45). ACOG recommends that 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) be ensured, and governmental restrictions on training programs and funding be removed.

Further, many religiously affiliated institutions, especially Catholic health care facilities, do not offer reproductive health services, including contraception, sterilization, and abortion (47, 48). Mergers of secular hospitals with religiously affiliated health systems can result in the elimination of previously available reproductive health services (49, 50). In other cases, hospitals cease to offer services not based on legal restrictions or religious opposition, but because of the associated stigma. Hospitals and other health care institutions should be encouraged to support abortion care as essential medical care, eliminate barriers to the provision of abortion care in these settings, and preserve availability of comprehensive reproductive health services in communities undergoing hospital mergers.

Laws that unnecessarily curtail scope of practice diminish the number of qualified medical professionals who can provide abortion care. The vast majority of states require that abortions be provided only by physicians, which limits the practice of advanced practice clinicians (51). However, several reports show no differences in outcomes in first-trimester medication and aspiration abortion by health care practitioner type and indicate that trained advanced practice clinicians can safely provide abortion services (34, 52–58). The pool of clinicians who provide first-trimester medication and aspiration abortion should be expanded to appropriately trained and credentialed advanced practice clinicians in accordance with individual state licensing requirements.

People Facing More Barriers

Adolescents, people of color, those living in rural areas, those with low incomes, and incarcerated people can face

disproportionate effects of restrictions on abortion access. As of 2020, parental involvement of some kind in a minor's decision to access abortion is required in 37 states and may contribute to delays accessing care (59, 60). Restrictions and requirements of clinicians who provide abortions, restrictions on the use of telemedicine, and legislatively imposed mandatory delay all have a disproportionate effect on rural people's access to abortion (61). People living on low incomes most acutely 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.

Although incarcerated people possess the legal right to abortion, accessibility varies widely (62, 63). A survey of prison and jail health care practitioners found that only 68% of respondents enabled incarcerated people to obtain abortion care (62), and a 2019 study representing nearly 60% of all U.S. incarcerated women reported only 11 abortions in 1 year, representing 1% of all pregnancy outcomes (63).

Immigrants also may face difficulties accessing abortion care, including language and financial barriers, as well as limited knowledge of available services (64). There have been cases of unaccompanied minor immigrants in detention who have been prevented by federal authorities from accessing abortion care, a policy that has been successfully challenged in court (65)

Transgender men and gender-diverse individuals also may face barriers accessing abortion services (66). Transgender individuals report experiencing discrimination and mistreatment when seeking health care, and clinicians providing abortion care should ensure their practices are welcoming to transgender patients (67, 68). More research is needed to understand the experiences of transgender men and gender-diverse individuals seeking abortion care.

Crisis Pregnancy Centers

Crisis pregnancy centers present themselves as health clinics offering pregnancy options services, but operate to dissuade individuals from seeking abortion care (69). They often provide inaccurate medical information, asserting false links between abortion and breast cancer, infertility, mental illness, and other misinformation (70). These efforts to misinform can divert pregnant people from accessing comprehensive and timely care from appropriately trained and licensed medical practitioners (70).

Summary

When restrictions are placed on abortion access, patients and families suffer. Abortion access is increasingly limited; research shows that restrictions dictate whether or not care is safely obtained, as well as the quality of care (7, 71). Restrictions disrupt the patient–clinician relationship, create substantial obstacles to the provision of safe medical care, and disproportionately affect those with low incomes and those living long distances from clinicians who provide abortion care (72, 73). Additionally, clinicians who provide abortions may face stigma in the workplace, in their communities, and from colleagues. Clinicians who provide abortions face violence and threats to themselves, their staff, and their families. Finally, patients are prevented from or experience delays in obtaining abortion care because of inadequate health coverage, insurance coverage restrictions imposed by the state, or waiting periods, and are subject to stigma and shame. Individuals who are unable to obtain a wanted abortion report worse physical health and more economic insecurity compared to those obtaining the abortion (74, 75). These obstacles marginalize abortion services from routine clinical care and are harmful to people's health and well-being.

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