Innovative models are needed for equitable abortion access in the USA

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Where an individual lives can have a strong effect on their health and wellbeing. Women living in rural settings or small towns experience poorer health outcomes and have less access to health care than women living in urban settings.[1] They are also more likely to experience poverty.

In *The Lancet Public Health*, Jonathan Bearak and colleagues[2] show that women in the USA experience substantial differences in access to abortion care based on their census tract, with 20% of women having to travel at least 43 miles (69 km) in most states in 2014. Poor access exacerbates inequities—increased travel distance means increased costs for transport, overnight stay, lost wages from time off work, and childcare. For a woman who is economically disadvantaged, having to travel a long distance could put an abortion out of reach, leading her to carry an unwanted pregnancy to term.

This study[2] tells only part of the story, showing the median and 80th percentile distances women must travel to reach a dedicated abortion clinic. But for women seeking specific types of providers, such as those who accept Medicaid,[3] do abortions at later gestations,[4] or are hospital-based,[3] the distance might be even longer. Because provider availability decreases with each week of gestation, even a week's delay can reduce the number of providers substantially.

Living close to a provider means a woman can have her abortion earlier. The earlier a woman can have an abortion, the safer it will be. Research has also shown that the further a woman lives from her original source of abortion care, the more likely she is to visit an emergency department if symptoms arise that she is concerned about,[5] when ideally she would receive follow-up care from a health-care provider who is familiar with post-abortion symptoms.

Bearak and colleagues[2] only examined distance to high-volume abortion providers (offering 400 or more abortions a year) and Planned Parenthood facilities that did at least one abortion. The authors reported that they excluded physicians' offices that do fewer than 400 abortions a year because potential patients might not be aware of the service they provide and because of confidentiality concerns. Yet, the number of these providers is also declining.[6]

To increase the number and distribution of providers in the USA, ending abortion stigma will be crucial. Abortion stigma leads to institutional prohibitions that single out abortion, fear of retribution by protesters, and internalised stigma, which together might act to disincentive providers who would otherwise be willing to offer abortion care to their patients.[7] Ending abortion stigma would help integrate abortion more fully into regular health care, where primary care providers could offer their patients the ability to end unwanted pregnancies. Expanding the types of qualified providers who can offer abortion is also essential. Research has shown that nurse practitioners and certified nurse midwives can safely provide medication and aspiration abortions without physician supervision.[8,9] These providers might serve areas without physicians or where physicians are unwilling to do abortions. Increasing reimbursement could also expand the number of abortion providers across the USA. Studies[10] have shown that private insurance, and the 15 states that use state funds to offer abortions for Medicaid members, reimburse providers at rates that do not cover the full cost of providing abortion care.

Bearak and colleagues[2] discussed the effect of state-level restrictions, particularly those that close clinics and increase distances to a provider. US Food and Drug Administration regulations also prevent wider access to medication abortion by confining its provision to clinical office settings by providers who are registered with the distributor of mifepristone.[11] This requirement, which necessitates health-care providers to identify themselves as abortion providers and maintain a stock of the pills in their offices, is not based on evidence. Removing restrictions on mifepristone would allow more primary care providers to occasionally contact a pharmacy with a prescription for patients with an unwanted pregnancy.

Another approach is telemedicine. The service is feasible; has comparable clinical outcomes to face-to-face provision, is highly acceptable to users, and expands access to abortion in underserved areas, including rural

counties and towns where there are no providers.[12] However, 19 states require abortion providers to be physically present with their patients, thereby banning telemedicine and reducing the feasibility of this approach.[13]

Research is needed to understand how best to innovate models of abortion service delivery to reach women in underserved areas. New models of care could rely less on high-volume abortion clinics and increase access across distance, leading to more equitable reproductive health care across geographical regions in the USA.

Ushma D Upadhyay
University of California, San Francisco, Oakland, CA 94612, USA
ushma.upadhyay@ucsf.edu

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