Planned Parenthood Federation of America

Abortion Bans Push Care Out of Reach, Fueling Poorer Health Outcomes & Disparities

Introduction

One in three women of reproductive age, plus trans and nonbinary people, are blocked from abortion care in their home state. Since the U.S. Supreme Court took away the federal right to abortion in 2022 and handed states the right to ban abortion, 21 states — and counting — have stripped millions of people of their right to access essential health care.[1]

Abortion bans threaten access to the full range of sexual and reproductive care, as intense medical provider shortages spread. Dozens of health centers — many that provide comprehensive sexual and reproductive health (SRH) services, including life-saving preventive care — have been forced to close, and there have been double-digit declines in applications for OB/GYN medical residencies since the *Dobbs* decision. OB/GYNs and other licensed SRH providers are also retiring or relocating to states where abortion remains legal and they can do their jobs without threats of being criminalized.[2] [3] Now, across the country, already-inequitable health outcomes are worsening — especially for people with low incomes as well as Black, Latino and other communities of color for whom systemic racism such and discrimination have long created barriers to care.

Abortion bans not only cruelly force people to give birth by taking away their right to control their own bodies; people who want to carry pregnancies also suffer devastating loss and hardship. Patients with life-threatening pregnancies and those experiencing miscarriage are being turned away and forced to suffer because they need abortion care to prevent severe infection and death.[4] The providers in states where abortion and reproductive health are protected struggle to keep up with soaring out-of-state patient loads. Some have reported historic increases in abortion patient volume.[5] In Illinois, for example, abortion services have increased by almost 70% since 2020, as thousands of out-of-state patients pour into clinics from restrictive states.[6]

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[1] Fadel, L. (2023, Oct 11). *Billboards supporting women seeking abortions are popping up along I-55 heading north.* NPR. Retrieved: https://www.npr.org/transcripts/1202456541

[2] McCann, A., Walker, A.S. (2023, June). *One Year, 61 Clinics: How Dobbs Changed the Abortion Landscape.* New York Times. Retrieved: https://www.nytimes.com/interactive/2023/06/22/us/abortion-clinics-dobbs-roe-wade.html

[3] Weiner, S. (2023, August). *The fallout of Dobbs on the field of OB-GYN.* American Association of Medical Colleges. Retrieved: https://www.aamc.org/news/fallout-dobbs-field-ob-gyn

[4] Id. *One Year, 61 Clinics.*

[5] Heath, S. (2023, October). *Abortion Access Shifts as States Without Bans Absorb Patient Needs.* Patient Engagement HIT. *Retrieved:* https://patientengagementhit.com/news/abortion-access-shifts-as-states-without-bans-absorb-patient-needs

[6] Chicago Sun Times Editorial Board. (2023, September). *As abortions keep rising in Illinois, support for women seeking care is more important than ever.* Chicago Sun Times. Retrieved: https://chicago.suntimes.com/2023/9/12/23868187/abortion-rights-access-illinois-increase-travel-planned-parenthood-editorial

Abortion bans will worsen existing public health challenges — including: the maternal health crisis, historic surges in sexually transmitted infections (STIs), and advanced cervical cancer incidence — that disproportionately affect Black, Latino, and Indigenous people, LGBTQ+ people and other communities marginalized by inequity. Throughout our country's history, as a result of systemic racism and discrimination that hindered access to economic opportunity, many communities already faced harsh barriers to getting high-quality, affordable the full spectrum of health care, including SRH.[7] The end of abortion rights further erodes access to a full range of SRH, including: birth control, annual wellness exams; gender-affirming care; lifesaving cervical and breast cancer screenings; and STI testing and treatment services.[8] Without a strong and robust network of providers to respond to their growing needs, the U.S. will continue grappling with converging public health crises, including a worsening maternal health crisis.

This issue brief examines how a severe shortage in maternity and SRH care providers — that is intensifying in states with abortion bans — will worsen the U.S. maternal health crisis, which disproportionately affects Black and Indigenous women.

Abortion Bans Worsen Provider Shortages — Compounding SRH Access Barriers in Restrictive States

To be sure, abortion bans did not cause the maternity care and SRH shortages in restrictive states. But restrictions on abortion care have affected, and will continue to worsen, these crises. Many health care providers are fleeing abortion restrictive states — where maternal mortality rates and other poor health outcomes already far exceed the national average.[9]

Anti-abortion laws are causing more SRH and pregnancy care providers to leave states with the poorest maternal health outcomes

Since 2022, when the Supreme Court ruling triggered state abortion bans going into effect, providers have been retiring or leaving these states — where they could face criminal charges or lose their medical license if they deem abortion care as medically necessary to save the life of their patients.[10] There has also been a precipitous 10% decline in applications for OB/GYN medical residencies in restrictive states — an indicator that staffing challenges and SRH provider shortages are only going to

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[7] Artiga, S., Hill, L., Damico, A. (2022. December). *Health Coverage by Race and Ethnicity, 2010-2021.* Kaiser Family Foundation. Retrieved: https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/#:~:text=For%20example%2C%20between%202010%20and,be%20uninsured%20than%20White%20people.

[8] Zephyrin, L.C., Suennen, L., Viswanathan, P., et al. (2020, July). *Transforming Primary Health Care for Women - Part 1: A Framework for Addressing Gaps and Barriers.* The Commonwealth Fund. Retrieved: https://www.commonwealthfund.org/publications/fund-reports/2020/jul/transforming-primary-health-care-women-part-1-framework

[9] Kaiser Family Foundation. (2022). *Maternal deaths and mortality rates per 100,000 live births.* KFF. Retrieved: https://www.kff.org/other/state-indicator/maternal-deaths-and-mortality-rates-per-100000-live-births/

[10] Declercq, E., Barnard-Mayers, R., Zephyrin, L., et al. (2022, December). *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions.* The Commonwealth Fund. Retrieved: https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes

get worse.[11] Laws that criminalize abortion are causing widespread confusion and panic among OB/GYNs and other SRH providers.

In Idaho, for example, doctors face up to five years in prison for performing an abortion — with very limited exceptions for life endangering circumstances, rape and incest. More than a dozen labor and delivery obstetricians are expected to leave the state or retire in coming months, and one hospital stopped offering labor and delivery services altogether, citing doctor shortages and a hostile "political climate."[12] [13] Other states with similar statutes are: Arkansas,[14] Georgia,[15] Missouri,[16] North Dakota[17] and Tennessee.[18]

With fewer providers, it will be difficult for patients to get essential maternity care, including people who are at higher risk for severe complications.

Some Providers who remain in restrictive states are forced to prioritize restrictive abortion laws over medical best practices — and deny critical care to pregnant patients who are experiencing severe complications

People of reproductive age in the U.S., especially in restrictive states, are dying at alarming rates because they cannot access health care.[19] Carrying an unplanned pregnancy to term is far riskier to a person than abortion care.[20] According to the Turnaway Study, pregnant women seeking abortion who are denied care experience higher risks for life-threatening complications, such as pre-eclampsia and postpartum hemorrhage.[21] Even five years after pregnancy, Turnaway participants who were denied abortion care reported more incidences of chronic pain. Denial of abortion also leads to more severe anxiety, depression and other challenges in their first two trimesters, compared to women who were able to get an abortion.[22]

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[11] Salib, V. (2023, April). *OB/GYN Residency Applications Decreased 10.5% in Abortion Ban States.* Life Sciences Intelligence. Retrieved: https://lifesciencesintelligence.com/news/ob-gyn-residency-applications-decreased-10.5-in-abortion-ban-states
[12] Stolberg, S.G. (2023, Sept). *As Abortion Laws Drive Obstetricians From Red States, Maternity Care Suffers.* New York Times. Retrieved: https://www.nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html
[13] Id.
[14] Arkansas Code § 5-6 (2021) Retrieved: https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2021R%2FPublic%2FACT309.pdf
[15] GA Code § 16-12-140. (2022). Retrieved: https://law.justia.com/codes/georgia/2022/title-16/chapter-12/article-5/section-16-12-140/#:~:text=A%20person%20commits%20the%20offense,produce%20a%20miscarriage%20or%20abortion.
[16] MO Code § 12-188-017. (2022). Retrieved: https://revisor.mo.gov/main/OneSection.aspx?section=188.017#:~:text=Notwithstanding%20any%20other%20provision%20of,in%20cases%20of%20medical%20emergency.
[17] NC Code § 90-21. (2023). Retrieved: https://www.ncleg.gov/Sessions/2023/Bills/Senate/PDF/S20v5.pdf
[18] TN Code § 9-4-5116. (2022). https://www.capitol.tn.gov/Bills/111/Bill/SB1257.pdf
[19] Gunja, M.Z. Seervai, S., Zephyrin, L.C., et al. *Health and Health Care for Women of Reproductive Age.* The Commonwealth Fund. Retrieved: https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/health-and-health-care-women-reproductive-age
[20] Advancing New Standards in Reproductive Health. *Turnaway Study Annotated Bibliography.* University of California in San Francisco. Retrieved: https://www.ansirh.org/sites/default/files/2022-12/turnawaystudyannotatedbibliography122122.pdf
[21] Id.
[22] Id.

Abortion bans put lifesaving care out of reach for a growing number of people who are forced to carry their pregnancies under extreme circumstances — with few options for medical care that would save their lives. A mounting number of reports confirm that since abortion bans have gone into effect, pregnant women with life-threatening emergencies are being turned away at hospitals, deterred by the legal risks of providing abortion care in their restrictive state.[23] Among those being turned away are people experiencing a miscarriage and other pregnancy-related emergencies. Miscarriages, in particular, are extremely common, and account for up to 30% of pregnancies.[24] Without abortion-related services, or miscarriage management care, patients are at risk for serious infections that can quickly progress to septic shock and even death.[25] The set of services that are administered to safely end a patient's pregnancy and manage pregnancy loss are identical — regardless of the underlying reason — and many doctors and pharmacists have chosen to err on the side of extra caution, due to concerns with the applicable laws.

States with restricted access to abortion have the poorest maternal health outcomes for women of color, particularly Black and Indigenous women

The majority of Black women and many Indigenous people now live in a state that has banned abortion, and they also have the worst pregnancy outcomes.[26] [27] Black women are three times as likely — and Indigenous women, more than twice as likely — to die from pregnancy-related causes than white women.[28] The majority of these deaths are preventable. Systemic racism is a fundamental driver of these disparities, and they exist across traditional socio-economic indicators (e.g. educational attainment, income level).[29] Compared to white women, Black, Indigenous and Latino populations also have much higher uninsured rates, especially in states that did not expand Medicaid.[30] This makes it harder for these communities to get the full range of sexual and reproductive health care, including birth control, preventive screenings for chronic conditions and other care that contributes to healthier pregnancies.

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[23] Stolberg, S.G. (2023, Sept). *As Abortion Laws Drive Obstetricians From Red States, Maternity Care Suffers.* New York Times. Retrieved: https://www.nytimes.com/2023/09/06/us/politics/abortion-obstetricians-maternity-care.html

[24] March of Dimes. *Healthy Moms. Strong Babies.* MOD. Retrieved: https://www.marchofdimes.org/find-support/topics/miscarriage-loss-grief/miscarriage

[25] Dulay, A.T. (2022, October). *Septic Abortion.* Merck Manual Consumer Version. Retrieved: https://www.merckmanuals.com/home/women-s-health-issues/complications-of-pregnancy/septic-abortion#:~:text=Septic%20abortions%20usually%20develop%20when,an%20abortion%20or%20a%20miscarriage.

[26] Tamir, C. (2021, March). *The Growing Diversity of Black America.* Pew Research Center. Retrieved: https://www.pewresearch.org/social-trends/2021/03/25/the-growing-diversity-of-black-america/

[27] Sanchez-Rivera, A.I., Jacobs, P., Spence, C. (2023, October). *A Look at the Largest American Indian and Alaska Native Tribes and Villages in the Nation, Tribal Areas and States.* U.S. Census Bureau. Retrieved: https://www.census.gov/library/stories/2023/10/2020-census-dhc-a-aian-population.html

[28] Trost, S., Beauregard, J., Chandra, G., Njie, F., et al. (2022). *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S., 2017-2019.* CDC. Retrieved: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

[29] https://www.ahajournals.org/doi/10.1161/CIR.0000000000000936

[30] Uninsured Rates for Nonelderly by Race/Ethnicity. (2022). Kaiser Family Foundation. https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?dataView=1&activeTab=map&currentTimeframe=0&selectedDistributions=hispanic&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Even prior to the rise of abortion bans put in place across the country, people of color made up 60% of abortion patients in the U.S. — and three in four with low-incomes.[31] Our new restrictive landscape — where abortion access has been eliminated in almost half of U.S. states — is especially harmful to Black communities and other women of color, who historically — and at present — face more barriers to gaining economic opportunity and basic health care, including abortion and SRH care.

States that have banned abortion and restricted other publicly funded SRH care have 62% higher maternal mortality rates than states with SRH protections. This is in part because of more severe provider shortages in these states, despite much higher volumes of community need. States where abortion has been banned have 32% fewer OB/GYNs per birth, and almost 60% fewer midwives. Because of the systemic inequities in health care, Black and Indigenous women are more likely to have a high-risk pregnancy that requires more medical attention and maternity care from these maternity providers, and the unavailability of these providers puts women from such communities at an even greater risk for severe complications, and even death. The Centers for Disease Control and Prevention (CDC) estimates that with comprehensive, timely and compassionate delivery of care, 84% of all maternal deaths that occur in the U.S. are preventable.[32]

Indeed, in its State Strategies for Preventing Pregnancy-Related Deaths, the CDC's Division of Reproductive Health reports, "maternal health outcomes are dependent on access to care across a person's life course — including pre-pregnancy, prenatal, labor and delivery, emergency obstetric and postpartum health and care in the interconception period."[33] Preconception or pre-pregnancy care includes: birth control counseling, screenings and management of chronic diseases, STI and HIV services, vaccinations, behavioral health screenings, interpersonal violence and social risk screenings, and other essential care that contribute to healthier pregnancies and outcomes across the lifespan.[34]

In states with no Medicaid -expansion states, many women of reproductive age cannot access Medicaid until they become pregnant, owing to more generous income criteria (138% FPL) that is mandated by federal statute. Medicaid covers 42% of births in the U.S., including: almost 65% of Black births, more than 58% of Latina births, and over 65% of Indigenous births.[35] Not only are substantial numbers of these individuals entering pregnancy with poorer outcomes because they were unable to access preconception services and other essential care, but they also may not be receiving the full scope of prenatal care necessary for healthier pregnancies. Being uninsured during pregnancy is associated with later initiation of prenatal care or not receiving this essential care at all. In restrictive

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[31] Jerman, J., Jones, R.K., Onda, T. (2016). *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008.* Guttmacher Institute. Retrieved: https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014
[32] Trost, S., Beauregard, J., Chandra, G., Njie, F., et al. (2022). *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S., 2017-2019.* CDC. Retrieved: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html
[33] Id.
[34] Women's Health Practice Bulletin (2020. *Preconception Health + Health Care Initiative.* Before and Beyond. Retrieved: https://beforeandbeyond.org/wp-content/uploads/2021/02/phc-bulletin-0223211.pdf
[35] March of Dimes. *Healthy Moms. Strong Babies.* MOD. Retrieved: https://www.marchofdimes.org/find-support/topics/miscarriage-loss-grief/miscarriage

states, the number of individuals who received late or no prenatal care is 62% higher compared to states that have expanded Medicaid and bolstered access to abortion and SRH care.[36]

Abortion bans combined with the pervasive effects of systemic racism and other harmful health care decisions will continue to worsen outcomes for Black and Indigenous women — especially, as barriers mount to comprehensive health care across their lifespan, including maternity and abortion care.

Conclusion

It has been almost two years since the Supreme Court decision stripped millions of people of the right to access fundamental health care and control their own bodies. The freedom of self-determination should include health care, and encompass the full range of reproductive care services that maintain health and well-being across a person's lifespan. However, today, far fewer people are able to get the care they need. The barriers have only grown worse to prevent unplanned pregnancies, and get the essential health care needed to live full lives. This is especially tragic for populations marginalized by systemic racism and communities with deep inequities. Many states with abortion bans abortion and have historically rejected opportunities to improve safety-net health care access for the populations in need. The legacy of these attacks have further weakened our SRH infrastructure — even in states where abortion is legal and providers are struggling to meet demand with scarce public resources and federal investment.

[36] Declercq, E., Barnard-Mayers, R., et al. (2022, December). *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes