BARRIERS TO PLANNED PARENTHOOD ABBORTION CARE IN THE U.S. IN 2019, AND PROPOSED SITES FOR EXPANDING CARE

Background

1 in 4 women in the U.S. will have an abortion by the age of 45, yet significant barriers exist to this common procedure. Geographic access is not uniform across the U.S. Political, religious, and cultural objections have created a scarcity of resources and imposed barriers to access. A variety of factors influence an individual’s access to abortion care: geographic distance, political barriers such as policies that restrict or prohibit access, and affordability of care based on types of providers and insurance status. These are the primary focus of this analysis, but no means the only barriers to accessing abortion care. Past literature suggests that these barriers and other lead patients to travel out-of-state for care, or may prohibit them from obtaining the care they need altogether.

Planned Parenthood Federation of America is the largest provider of reproductive health care in the U.S, including abortions. Planned Parenthood sites refer to low-income patients, including those who do not have health insurance, making them an important provider for these populations.

Purpose

The purpose of this project was to understand the spatiality of barriers to abortion care. Ultimately, these analyses were used to make recommendations about where future Planned Parenthood clinic locations may be most valuable. This was determined by assessing which states were most vulnerable based on restrictive abortion policies and financial barriers, and then by locating the Census tracts with the highest density of women of reproductive age in each of these two states. Texas and Mississippi. Data on spatial, political, and financial factors were used to map abortion access. Insurance status was the primary indicator of financial access to abortion care, and state-wide uninsurance rate was chosen as an indicator for poor financial access. This analysis sought to answer questions about how each of these barriers to accessing abortion care presents differently across the U.S, and which regions are particularly burdened with barriers to care.

Past Literature on Barriers to Access and Current Applications:

Geographic Barriers:

In 2008, abortion recipients reported traveling an average of 30 miles one way for their abortion care. This analysis is based around a map of Planned Parenthood clinics nationwide, up to as of April 2019. These data were obtained using Python and the Scraps library to create Planned Parenthood’s list of health centers by state and the contact information for each clinic. Addresses were geocoded using Geocoding, and mapped across the U.S. A kernel density map of clinic locations was produced to visualize areas of scarcity around the U.S, shown above. This data was also used in the state maps to create population density maps with buffered regions of access to clinics.

Financial Barriers:

In recent years, abortions have become increasingly concentrated among low-income populations. In 2014, 75% of abortion patients were low-income. Nonetheless, financial barriers persist, and often, lack of insurance coverage prevents patients from accessing abortions. Using state-by-state uninsurance data, Texas was identified as the state with the highest uninsured rate (18%), and was subsequently used in analyses to determine where new clinics would be most valuable.

Political Barriers:

In 2014, 51% of women lived in a state that was considered “hostile” or “extremely hostile” towards abortion rights based on restrictive abortion policies in place. These restrictions were considered when identifying the two states for analysis. Mississippi is one of 8 states with all four of the policies considered below in place, and is notoriously anti-abortion. Consequently, Mississippi was chosen as the focus for further analysis.

Discussion of Results:

Across the U.S, major disparities in geographic access were identified. A large portion of the center of the country has extremely limited access to Planned Parenthood clinics, indicating a low density of accessible, affordable abortion providers. In contrast, regions in the Northeast and West coast had the highest density of Planned Parenthood clinics. Many states have at least one of the four key policy barriers to abortion in effect as of 2017, though new policies come in and out of effect regularly. When geographic access is considered within the political context of these barriers, it becomes apparent how necessary financial access is for these “abortion hostile” states in particular.

Texas and Mississippi, there are large swaths of the population who reside over 50 miles away from the nearest Planned Parenthood Clinic. When broken down into women of reproductive age, many dense regions were served by at least one Planned Parenthood clinic. However, several densely populated areas were not. “Reproductive age” was defined as women ages 15-54, average age of menarche in the U.S is 12.5 and the average age of menopause is 51. For the sake of this analysis, the entire categories of women 15-45 and 45-54 were included, as Census tract data were not broken down more granularly, causing a probable overestimation. The regions identified as potential sites for new Planned Parenthood clinics account for density of the population of reproductive age and distance to the nearest Planned Parenthood Clinic. The final sites displayed are only the two or three highest density tracts overlapped substantially, the buffer that accounted for these three density tracts overlapped substantially, the buffer that accounted for these three highest density tracts was used. Estimated New Service Regions

The Guttmacher Institute, a research and policy organization with a focus in reproductive and sexual health, provides an online tool that estimates the potential impact of expanded access to various forms of reproductive healthcare by state and number of new patients and services. This tool was utilized to estimate the number of abortions and unintended pregnancies prevented in each region identified from analyses of Texas and Mississippi with expanded access to care. The number of patients was estimated using Census tract data on women of reproductive age, and the number of services were calculated using the current rates of abortion and unintended pregnancy per 100 reproductive age women. Additional data was added to these numbers in order to estimate the impact of slightly higher density of women of reproductive age was calculated by tract. 50 mile buffers were created around each Planned Parenthood clinic in each state, and tracts outside of these buffers are shown in grey. All tracts outside of these 50 mile buffers were considered as sites for a new clinic. 50 mile buffers were built for the highest density tracts in each state. Census tract data including numbers of unreported women of reproductive age were spatially joined with these new buffers to identify high-value service regions that could be created with these potential new clinics. In regions where multiple high-density tracts overlapped substantially, the buffer that accounted for the highest density was included. On the right are the service regions with the highest density of women of reproductive age. These populations were used in the Guttmacher tool to calculate the benefits in the table below.

Population Density of Women of Reproductive Age without Health Insurance

<table>
<thead>
<tr>
<th>Zone</th>
<th>Population</th>
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<th>Unintended Pregnancies Prevented</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
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The Guttmacher tool was utilized to calculate the benefits in the table below.

### Conclusion and Outlook

While no state has perfect access to abortion care, this analysis offers recommendations for two particularly vulnerable states by identifying key areas with a high population of need. This analysis provides very modest recommendations for expanding access in states that are currently underserved. Abortion access can be expanded in other regions of the states and across the U.S.

Future work in this area ought to examine not just Planned Parenthood clinics, but all clinics that provide low cost abortions to uninsured or low income individuals. This exclusion limited the reliability of the current analysis. Furthermore, future analyses ought to consider factors besides Euclidean buffer distance, such as travel, driving conditions, and other travel barriers and costs. Additionally, other policies may become relevant, particularly if political changes further jeopardize access to safe, legal abortion care at the state or national level.

### References

- https://www.guttmacher.org/article/2015/01/just
- Restrictions. Guttmacher Institute. 2015
- Perspectives on Sexual and Reproductive Health (March 1, 2017). 304042
- Conclusions and Outlook:

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### Policy Access:

- **Policy in Place**
- **No Policy in Place**
- Mandatory Wait Period
- Parental Consent
- Must Return for Second Trip
- Institution May Refuse Abortion

### Table 1: Guttmacher estimates of cost savings and potential outcomes calculated for each potential new clinic service region.

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