

## Spotlight

# Abortion bans and their impacts: A view from the United States

Laura J. Frye<sup>1,\*</sup> and Beverly Winikoff<sup>1</sup><sup>1</sup>Gynuity Health Projects, New York, NY, USA\*Correspondence: [lfrye@gynuity.org](mailto:lfrye@gynuity.org)<https://doi.org/10.1016/j.xcr.2022.100905>

A retrospective study of abortion facilities in and around Texas by White et al.<sup>1</sup> and a spatial analysis by Rader et al.<sup>2</sup> are combined to illustrate the detrimental effects of abortion bans enacted in the United States.

Abortion restrictions have been introduced in various forms across many states for years, but since June 2022, when the right to abortion was no longer federally protected, we have seen a rapid increase in these restrictions. We are just starting to quantify and qualify their effects. Two recent studies published in JAMA offer early indications of the effects of draconian bans.

In “Association of Texas’ 2021 Ban on Abortion in Early Pregnancy with the Number of Facility-Based Abortion in Texas and Surrounding States,” White et al. used a large dataset containing information before and after the passage of SB8 in September 2021.<sup>1</sup> This bill banned most abortions after 6 weeks in the state of Texas. The data presented in this article allow for a careful examination of the law’s effects, and the authors paint a picture of how rapidly destabilizing such bans can be. The study clearly shows that, in the immediate aftermath of SB8’s implementation, there was both an absolute drop in documented abortions and a shift in the location of abortions as Texans went to neighboring states for medical care.

The paper explicitly examines abortions after 12 weeks as an important indicator of change, not because of the small decrease in safety and efficacy with increasing gestational durations, but rather because of the major increase in burdens to affected individuals (cost, time, travel) and to clinics (resources, scheduling) with gestations beyond this point.

A clearer and more detailed sense of how these patient travel dynamics play out can be found in the “Estimated Travel Time and Spatial Access to Abortion Fa-

ilities in the US Before and After the *Dobbs v Jackson Women’s Health Decision*” by Rader et al., which uses simulation and spatial analysis to measure changes in surface travel time to the closest abortion facility before and after the June 2022 Dobbs decision.<sup>2</sup>

The average travel time to reach the nearest abortion facility significantly increased in the simulated post-Dobbs world, and, while the median change from 11 to 17 min is not jaw dropping, the spread of the data and the extremes of the curve are where the biggest problems lie. The authors show a doubling of the number of individuals who must travel more than 60 min to access abortion care. Then, through sensitivity analyses on geographic heterogeneity, they illustrate some of the extreme increases in travel time for people in the South, as in Texas, with a mean increase of over 7 h.

While the White paper notes that their data did not include individual-level demographic information (and thus was not able to explore the disparate effects of the ban on various subpopulations), the Raden paper is able to shed some light on the disproportionate impacts of abortion restrictions by use of census data. The latter paper shows that longer travel times occur more frequently in populations without insurance, with lower incomes, and who are racial and ethnic minorities. Documentation of these effects is important for advocacy, policy change, and resource allocation.

The White et al. paper wisely uses care in describing the data they have as “documented facility-based abortions,” acknowledging the now-frequent practice of non-facility-based self-managed abortion with pills. Similarly, Rader et al. note

that their data are predicated on the idea of traveling to a physical facility and do not account for the mailing of pills to a person’s home. The TelAbortion study from 2016 to 2021 provided evidence on the safety and efficacy of direct-to-patient telemedicine abortion with mailing of pills,<sup>3,4</sup> and the FDA now allows for this method of abortion pill provision. We also know that self-managed abortion can be a safe and effective option<sup>5</sup> and is currently common in the United States.<sup>6,7</sup> There is increasing interest in determining its role in the care landscape.<sup>8–10</sup> Moving forward, it would be beneficial to see more information on how remote provision of care and self-management play into the dynamics illustrated in these articles.

These two papers, used together, can help prepare clinics in protective states for the influx of affected individuals as additional oppressive laws are passed in other states. The lessons documented only grow in relevance as the map of the United States darkens with more and more states passing restrictive abortion laws. We can use these data both to decry the negative and disproportionate effect of these bans and to call for action to prepare receiving clinics in protective states as they take on the care of more people who are denied medical services in their home states.

## DECLARATION OF INTERESTS

The authors declare no competing interests.

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