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The Provision of Comprehensive Reproductive Health Services in Los Angeles: A Physician's Perspective

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Abstract

There are very few legal restrictions to obtaining an abortion in the state of California.

However, women who reside in the highly populated and diverse county of Los Angeles may face barriers to obtaining comprehensive reproductive health services. In particular, women may face linguistic, cultural, and socioeconomic barriers, among others, that contribute to disparities in reproductive health and to access to safe abortion.

In the era of health care reform, opportunities to address these health disparities exist, but access to abortion remains a challenge.

With approximately 10 million residents, Los Angeles is one of the most populous counties in the United States. As the nation's major immigration port of entry, Los Angeles County also has unrivaled racial and ethnic diversity with the largest populations of Filipinos, Guatemalans, Koreans, Mexicans, Salvadorans, and Thais outside their native countries.[1] Approximately 48% of Los Angeles county's population is Hispanic or Latino, 27% is White, 15% is Asian/Pacific Islander, 9% is Black, and less than 1% identifies themselves as "other."[2] Aside from the large population and unmatched diversity, Los Angeles County has long been considered a place of haves and have-nots. There exists the glamorous Hollywood lifestyle centered around a multibillion-dollar motion picture industry and the bleak reality of Skid Row, a roughly four-square-mile area of downtown that houses the area's largest population of homeless residents.[2] Approximately one in three residents of Los Angeles county lives in economic hardship (below twice the federal poverty level), and 15% live in extreme poverty (below federal poverty level) with a disproportionate number of these residents being Black or Latino.[3] Regarding health care, 30% of Angelinos are uninsured, and this prevalence is twice the national prevalence.[3,4]

With these unique demographics, it is not surprising that Angelinos face multiple health challenges. It is well established that a multitude of factors contribute to one's overall health. As an obstetrician–gynecologist at a large academic institution in Los Angeles, I see striking differences in race/ethnicity, education, income, insurance status, and access to basic health care among the patients we care for at our university's private hospital and its affiliated public safety-net teaching hospital. These differences contribute to disparities in the health of the women I see, including their reproductive health.

In our academic faculty practice, more than 90% of the patients I see have preferred provider organization health insurance plans. The majority of these women are affluent, highly educated, White, and generally healthy. Most are able to schedule appointments with relative ease and have the ability to find my e-mail online or page me off hours to address issues of concern. These patients have at least some basic knowledge of their bodies and health and this knowledge is enhanced if they perform independent online research. Most become active participants in their health and are able to carry on a savvy conversation regarding their reproductive health needs and desires. These women come to proactively discuss their reproductive plans. Some come to discuss how to prepare for a healthy pregnancy and the majority of women who are not actively seeking pregnancy are already using an effective contraceptive method. I also see a subset of women who specifically come to discuss switching to a highly effective long-acting reversible contraceptive method, in the form of intrauterine devices or the contraceptive implant. As such, I infrequently see regular patients of mine with unintended pregnancies. However, the moment a patient misses her period or finds out she is pregnant, an appointment is readily scheduled to discuss her pregnancy options. Should a patient choose to have an abortion, the procedure is scheduled as soon as insurance authorization is obtained and it can be fit into the operating room schedule.

California is one of the few states unaffected by the growing pieces of legislation proposed or passed across the United States designed to restrict women's reproductive choices and their ability to obtain an abortion. Women who seek abortions in California are not subject to 24-hour waiting periods, mandatory ultrasound viewing, or scientifically incorrect medical counseling scripted by politicians. In contrast with many states, second-trimester abortions remain largely unrestricted in California. Whereas the privately insured women in my practice face relatively few barriers for obtaining an abortion, the uninsured and publicly insured patients I see at the university-affiliated county hospital face barriers related to difficulty accessing care through the public health care system. Some of these patients report not knowing how to make an appointment, whom to call, or even if abortion services are available to them.

The Los Angeles County hospital is the largest single provider of health care to the low-income, uninsured, or underinsured population of Los Angeles County and serves as the regional referral center for some of the sickest patients. Our family planning service sees a wide range of patients who seek abortions, from women whose medical condition may place them at high risk for morbidity and mortality during pregnancy to women referred from the outskirts of the county who were too far along in pregnancy to find a local physician trained to perform later abortion procedures.

I recall a young patient named Ana with hypertension, diabetes, and renal failure who became pregnant accidentally. She had migrated from Central America, and in her limited amount of English, described her difficulties with keeping track of her appointments and care plans with different specialists. She was a single mother caring for her three young children at home while working full-time as a housekeeper and did not have enough money to afford all of her medication. With her social and economic situation, she found setting time aside to care for herself or see a doctor challenging. Ana's care was fragmented. In addition, because of her missed appointments, her physicians seemed to focus on managing the acute issues related to her medical conditions and discussions surrounding her reproductive plans were limited. She was then faced with an unintended pregnancy. Because of her multiple medical conditions, limited finances, and already having three children at home, Ana decided

not to continue her pregnancy. She told me she could not afford another child and knew she had to focus on caring for herself and the children she already had. According to the Guttmacher Institute, vulnerable populations such as Black, Latina, poor, and young women have disproportionately higher rates of unintended pregnancies and abortions.[5] This patient, Ana, helps me understand why this is so.

Women face many barriers that lead to delays in obtaining abortion care. Ninety percent of counties in the United States lack an abortion provider.[6] Women who had difficulty finding an abortion provider or who may have initially been referred to another clinic that could not perform her procedure are among factors associated with presenting for an abortion in the second trimester.[7] Finances may play another role because costs are a well-known barrier to accessing medical care. Patients at the county hospital often remind me they have to take time off work, travel long distances by bus, and find childcare when they schedule appointments. Even though Medicaid covers abortion procedures in the state of California for those who qualify, difficulty obtaining state insurance is another factor for woman having to seek a later abortion.[7] Besides these factors, the decision to have an abortion is highly personal.

In large metropolitan areas such as Los Angeles, social, cultural, and economic diversity presents challenges to providing high-quality comprehensive health care to all women. As such, developing ways to decrease health inequities between marginalized and privileged populations and to promote the health of marginalized groups of women is essential. Lack of access to abortion care, and women's health services in general, may be rectified through efforts aimed at improving the health literacy of vulnerable populations. Delays in obtaining care may be averted through education programs aimed at improving patients' as well as health care providers' knowledge of locally available reproductive health services. Strengthening the linguistic and cultural competence of health care providers can ensure that diverse populations obtain the care they need. These suggestions for improvement in health care delivery represent the beginning of a dialogue on how we can reduce inequities in access to reproductive health services even where abortion is legal.

The Affordable Care Act (ACA) presents an opportunity to improve the delivery of reproductive health services for many women. According to the Congressional Budget Office, there will be 30 million fewer Americans expected to be uninsured in 2016 if the ACA is implemented as designed through the successful expansions of both Medicaid and private insurance coverage.[8] Through the Medicaid expansion, it is anticipated that more low-income and uninsured women will be able to access the family planning services that are essential for helping women avoid unintended pregnancies and abortions. Many women accessing care through the expanded private insurance market will have strong reproductive health care coverage. The ACA has mandated that most private insurance plans provide essential preventive services free of cost, some of which include contraceptive counseling, provision of contraceptive methods, sexually transmitted infection testing and treatment, breast and cervical cancer screening, pregnancy tests and maternity care, and well-woman visits.

However, the ACA prohibits abortion coverage from being required as part of the federally established essential benefits package, so abortion coverage will depend on policies enacted at the state level.[9] As such, insurance companies, policymakers, and legislators must be encouraged to include abortion coverage in their state's public and private insurance policies. Many states have already enacted laws restricting abortion coverage in plans offered through such policies, for example where public funds are used to insure employees.[10] California is one of a minority of states that use state Medicaid funds to cover abortions, and the state's policies do not currently place limits on private insurance companies' abortion coverage.[11] Recent actions by California Governor Jerry Brown indicate support for expanding access to abortion in the current political climate.[12]

Overall, the ACA represents a victory for women's reproductive health even as challenges lie in its implementation, and for the delivery of abortion services specifically. Special efforts should be made to help vulnerable groups learn about available coverage options, the enrollment system, and how to access care. Only then can the reproductive health of marginalized women be improved through the services available from the ACA. In an ideal world, all pregnancies would be timed, healthy, and desired. However, the rate of unintended pregnancies in the United States is 50%.[13] The ACA's preventive health services for women, such as coverage for contraceptive counseling and methods, are essential to preventing unintended pregnancies, but they are not enough. Even in places such as Los Angeles where abortion is safe, legal, and available, challenges to access remain. Until all women can access the services they need, a woman's right to abortion must be supported.

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