

VIEWPOINT

HEALTH CARE POLICY AND LAW

The Use of Public Health Evidence in *Whole Woman's Health v Hellerstedt*

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Enacted in 2013, Texas's House Bill 2 (HB 2) was one of the most restrictive abortion laws in the country. The law had 4 provisions: (1) physicians providing abortion had to have admitting privileges at nearby hospitals, (2) medication abortion had to be provided according to the protocol described in the US Food and Drug Administration (FDA)-approved labeling of mifepristone, (3) most abortions at 20 weeks postfertilization or later were banned, and (4) facilities providing abortion had to meet the standards of ambulatory surgical centers. The first 3 provisions went into effect by November 2013; the fourth provision, meeting the standards of ambulatory surgical centers, was enforced only briefly in October 2014 before the US Supreme Court issued a stay.

The most immediate impact of HB 2 was the closure of clinics—first because physicians could not obtain or maintain admitting privileges, and in October 2014 because they did not meet the surgical center standards. In April 2013, before the introduction of HB 2, there were 41 facilities providing abortion in Texas; when the ambulatory surgical center provision was enforced, there were only 10 facilities serving a population of 5.4 million women of reproductive age.^{1,2}

Several abortion providers challenged the admitting privileges and the ambulatory surgical center provisions of HB 2 in the case of *Whole Woman's Health v Hellerstedt*, which was argued before the US Supreme Court earlier this year. The Court ruled 5 to 3 that these provisions were unconstitutional because they imposed an undue burden on women's access to abortion.³ In particular, the Court weighed the evidence regarding the potential benefit of HB 2 against the evidence of its harm and found the latter to be more compelling. To reach this conclusion, the Court relied on considerable public health evidence, highlighting the important role that clinical and social science research can play in informing health policy.

Since 2011, I have collaborated with colleagues at the University of Texas at Austin and other institutions in the Texas Policy Evaluation Project, which aims to study the impact of reproductive health legislation in the state. In 2011, the legislature voted to cut public funding for contraceptive services by two-thirds and excluded providers affiliated with Planned Parenthood from a state-funded replacement program for the Texas Medicaid fee-for-service family planning program. These changes effectively dismantled the state's family planning safety net and likely increased pregnancy among low-income Texan women.⁴

Although the contraceptive budget cuts closed family planning clinics in Texas, HB 2 closed abortion clin-

ics. On the day the admitting privileges provision went into effect, 11 facilities closed because physicians had been unable to obtain privileges.² Obtaining and maintaining privileges was difficult for abortion providers who rarely—if ever—admit patients to a hospital.

The closure of facilities affected women's access in 2 ways. First, the closures reduced the geographic distribution of facilities, concentrating services in larger cities and increasing distances to the nearest clinic. For example, in April 2013, about 400 000 women of reproductive age in Texas lived more than 100 miles from the nearest abortion clinic in the state.² By May 2014, that number had increased to approximately 1 000 000. Second, as clinics closed, the reduced capacity of the remaining facilities increased wait times to get an appointment.⁵ For example, in Dallas and Fort Worth, the wait times had stabilized around 5 days by early 2015. When a large-volume provider there closed in June 2015, the wait times at the remaining facilities increased to 21 days or longer.

To evaluate the impact of HB 2, it was critical to document the changes in abortion service delivery after it went into effect. The usual way to perform this type of research is to analyze official abortion statistics. However, because Texas releases these data 2 years after they are collected, it became clear we needed to collect the data ourselves to inform this policy debate.

In early 2014, we contacted the 41 abortion providers that were open at the end of 2012—including those that subsequently closed—to obtain information on the services they provided through April 2014.² We compared the abortion numbers for the period November 2013 to April 2014—the first 6 months after HB 2 went into effect—to the same period 1 year prior. We found that the total number of abortions performed in Texas declined by 13% (a reduction of about 9000 procedures annually), which was a steeper drop than had been reported in the state or nationally in recent years. Given the cuts in family planning services that had taken place in Texas in the preceding years, it was highly unlikely that this decline was due to a reduction in unintended pregnancy. The official Texas statistics for 2014, which were released 3 days after the Supreme Court ruling in June 2016, confirmed our earlier estimates and indicated that few women (<2% of Texas residents obtaining abortion) traveled out of state for services.⁶

One of the most alarming findings of our research was that there was a small but significant increase in the proportion of abortions performed after 12 weeks gestation.² The official statistics for 2014 indicated there was a 27% increase in second-trimester abortion com-

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pared with 2013 (from 4814 to 6117 procedures) after adjusting for the fact that the state changed how gestational duration was reported (from weeks since last menstrual period in 2013, to weeks since fertilization in 2014).⁷ This increase in later abortion is a particular cause for concern from a public health perspective because second-trimester abortion, although very safe, is associated with a higher risk of complications, such as hemorrhage, compared with first-trimester abortion.⁸ It is also more expensive for women, and there are fewer physicians who perform second-trimester abortions. Of note, the provisions of HB 2 banning most abortions after 20 weeks and restricting medication abortion are still in effect, although the latter is essentially moot since the FDA approved updated labeling for mifepristone in March 2016. Before the labeling change, however, there was a 70% reduction in medication abortion statewide.²

To document the impact of clinic closures on women, we surveyed abortion patients throughout the state in 2014.⁷ We compared the experiences of women whose nearest clinic closed between 2013 and 2014 with those of women whose nearest clinic remained open. We found that women whose nearest clinic had closed traveled 4 times farther to obtain an abortion—85 miles on average each way—compared with those whose nearest clinic remained open. In addition, more women whose nearest clinic closed had out-of-pocket expenditures greater than \$100 (32% vs 20%).

We also conducted in-depth interviews with 23 women affected by HB 2.³ We spoke with women who were turned away from clinics that closed and heard how it took time and money to find another open clinic and arrange transportation. For some, these obstacles created delays that pushed them into the second trimester before they could obtain care. A few women we interviewed were unable to obtain the abortion they desired at all. They were forced

to continue the pregnancy because it was too logistically complicated and expensive to travel to a more distant clinic.

In contrast to the harms we documented of HB 2, during the legal proceedings Texas offered little evidence of benefit for the challenged provisions. Instead, the Supreme Court cited the evidence that abortion as currently practiced in the United States is exceedingly safe—safer than continuing the pregnancy to term and safer than or similar to other outpatient procedures, such as colonoscopy or dental or plastic surgery, that are not similarly regulated.⁹ Friend-of-the-court briefs submitted by social scientists and by professional medical groups, including the American College of Obstetricians and Gynecologists and the American Medical Association, cited numerous peer-reviewed articles documenting the safety of abortion.

With regard to the ambulatory surgical center provision of HB 2, a recent systematic review¹⁰ found that major complications, such as those requiring hospitalization or transfusion, occurred in less than 0.5% of first-trimester abortions. These rates were similar among studies performed in outpatient clinics, ambulatory surgical centers, or hospitals.¹⁰ Our research also indicated that the existing ambulatory surgical centers in Texas were unlikely to be able to meet the demand for services statewide if all the clinics that were not ambulatory surgical centers closed.²

The Supreme Court decision in the *Whole Woman's Health* case provides a clearer judicial standard related to undue burden on women seeking abortion. The Court said laws restricting abortion cannot be considered in the abstract—or just because a legislature says they would be beneficial. Instead, courts must compare the benefit the law is likely to provide with the burden the law will impose on women. The Court's decision shows that evidence matters, which hopefully heralds a new emphasis on data-driven policies for reproductive health.

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