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Well-woman care barriers and facilitators of low-income women obtaining induced abortion post-Affordable Care Act

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Abstract

Objectives—This study uses the abortion visit as an opportunity to identify women lacking well-woman care and explores factors influencing their ability to obtain well-woman care post-Affordable Care Act implementation.

Methods—We conducted semi-structured interviews with low-income women presenting for induced abortion who lacked a well-woman visit in 12 months or a regular healthcare provider. Dimensions explored included: (1) pre-abortion experiences seeking well-woman care; (2) post-abortion plans for obtaining well-woman care; and (3) perceived barriers and facilitators to obtaining well-woman care. Interviews were transcribed and analyzed using ATLAS.ti.

Results—Thirty-four women completed interviews; three-quarters were insured. Women described interacting psychosocial, interpersonal, and structural barriers hindering well-woman

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care use. Psychosocial barriers included negative healthcare experiences, low self-efficacy, and not prioritizing personal health. Women's caregiver roles were the primary interpersonal barrier. Most prominently, structural challenges, including insurance insecurity, disruptions in patient-provider relationships, and logistical issues, were significant barriers. Perceived facilitators included online insurance procurement, care integration, and social support.

Conclusions—Despite most being insured, participants encountered well-woman care barriers post-Affordable Care Act implementation. Further work is needed to identify and engage women lacking preventive reproductive healthcare.

INTRODUCTION

Low-income women and women of color face many reproductive health disparities, including lower rates of cervical cancer screening and mammography. In pregnancy, low-income women and women of color are more likely to initiate late prenatal care, and to experience higher rates of unintended pregnancy, abortion, preterm birth, and maternal morbidity (Ahmed et al., 2017; Bryant, Worjloh, Caughey, & Washington, 2010; Cheng, Schwarz, Douglas, & Horon, 2009; del Carmen & Avila-Wallace, 2013; Fernandez & Becker, 2017; Finer & Zolna, 2014; Jones & Kavanaugh, 2011; Kost, Landry, & Darroch, 1998; Mohllajee, Curtis, Morrow, & Marchbanks, 2007). Well-woman care (WWC), defined as care that “promotes health over the course of a woman’s lifetime through disease prevention and preventive health care”, aims to address the reproductive health needs of individuals, thereby improving population-level reproductive health disparities (Conry & Brown, 2015). Prior studies have demonstrated a relationship between use of routine reproductive health care and improved reproductive health behaviors (Hall, Dalton, & Johnson, 2014; Hall, Moreau, & Trussell, 2012).

The Affordable Care Act (ACA) sought to increase access to WWC by expanding insurance coverage and mandating coverage for key reproductive health services, including pap smears and breast exams. Despite advancements in expanding access to WWC, some women continue to face challenges accessing these services. Between 2014 and 2016, 19% of African-American women and 24% of Hispanic women had not seen a doctor in the past 12 months due to cost, compared to 12% of white women (Kaiser Foundation, 2017a). During that same period, 17% of African-American women and 32% of Hispanic women did not have a physician/health care provider, compared to 13% of white women (Kaiser Foundation, 2017b).

Women who undergo induced abortion may be more vulnerable to not accessing WWC. Young women, low-income women, and women of color are disproportionately represented among abortion patients (Jones & Kavanaugh, 2011). They are also less likely to have a regular health care provider, identify a clinic where they can obtain health care, or be insured (Salganicoff, Ranji, Beamesderfer, & Kurani, 2014; Kaiser Foundation, 2016). One study prior to the ACA’s major expansions found that 40% of women presenting for induced abortion lacked a regular health care provider (Chor, Bos, Hasselbacher, & Whitaker, 2014). In contrast, a nationally representative survey of 2,907 women in the same period found that 19% of reproductive age women did not have a regular provider (Salganicoff et al, 2014).

Eliciting women's experiences seeking WWC after implementation of the ACA is important to understand the challenges that continue to limit some women's use of WWC. Prior quantitative studies have assessed factors associated with use of preventive reproductive health services since the implementation of the ACA (Arora & Desai, 2016; Hall, Fendrick, Zochowski, & Dalton, 2014; Jones & Sonfield, 2016). However, these studies are limited in their ability to elucidate how women experience these barriers and how individual barriers work together to continue to hinder engagement in WWC. The current study used the abortion visit as a point of contact with low-income women who may otherwise not engage in reproductive health, to qualitatively explore barriers that prevented them from engaging in WWC and consider facilitators that could help marginalized women engage in future care.

MATERIALS AND METHODS

This qualitative study explores barriers and potential facilitators to engaging in WWC among low-income women presenting for induced abortion. Participants were recruited between June 2015–January 2016 from a clinic that provides first-trimester medical and surgical abortions and second-trimester surgical abortions through 21 weeks and six days gestation. The clinic accepts medical insurance and has a self-pay package for women whose insurance does not cover abortion, who choose not to use insurance, or who lack insurance. The Institutional Review Board of the University of Chicago approved study procedures.

A trained research assistant recruited women after they had completed routine abortion counseling and provided informed consent for abortion, prior to completion of the abortion. Eligibility criteria included: age ≥ 18; having had no interaction with a reproductive healthcare provider in the past 12 months outside of pregnancy, and/or not having a regular health care provider; income at or below 200% of the federal poverty level; ability to understand study procedures; willing and able to sign study consent in English. Exclusion criteria included obtaining abortion for maternal medical or fetal indications. The study aimed to include 25–30 participants *a priori*; however, final sample size was determined by thematic saturation (the point where additional data is unlikely to yield new information). Purposive sampling was used to recruit participants. Factors considered in sampling included: participant age, education, race/ethnicity, insurance status, and obstetric history. Women were compensated \$25 upon completion of the 30-minute interview.

Study personnel met in-person with eligible women to review study procedures and obtain informed consent. Prior to the interview, participants completed a short survey assessing socio-demographic information, obstetric and contraceptive history, and use of health care services. In-depth interviews followed a semi-structured interview guide exploring pre-abortion experiences with WWC care and post-abortion plans for WWC. The initial interview guide was modified after review of the first three interviews. Recognizing the complexity of women's lives, the interview guide and subsequent qualitative analysis were informed by Bronfenbrenner's Ecological Systems Theory, which posits that individuals are anchored within interrelated systems, which interact to influence and contribute to individuals' health and ability to enact health behaviors (Bronfenbrenner, 1977). While this model has been used to understand barriers that low-income women face in engaging in

other forms of care, such as prenatal care, this model has yet to be used to explore the barriers and facilitators that women face in engaging in WWC (Sword, 1999) (Figure 1). Adapting this model for this study, the innermost level consists of psychosocial factors (e.g. self-efficacy), followed by interpersonal factors (e.g. familial responsibilities), and finally broader structural factors that impact individual health behaviors (e.g. insurance).

Interviews were digitally recorded and professionally transcribed, and transcriptions were verified for accuracy and de-identified. Analysis followed a modified template approach, whereby an initial code directory was developed from our review of the literature and the interview guide and was subsequently modified with continued data review (Crabtree & Miller, 1999). Two investigators independently coded the first fifteen transcripts and Cohen's *kappa* scores were calculated for each code to assess inter-rater reliability (Crabtree & Miller, 1999). The investigators met to review and reconcile codes with kappa scores of less than 0.75. Upon reaching consensus regarding codes, one member of the research team coded the remaining interviews. ATLAS.ti® Version 7 (Berlin) was used to apply codes and query the data to retrieve and group comparable text passages from different participants along major themes. The research team met to review and discuss key findings and resolve disagreements through discussion. This analysis presents salient themes regarding psychosocial, interpersonal, and structural barriers and facilitators with regard to WWC care in the context of the ACA.

RESULTS

Demographics

This analysis includes data from 34 women who completed interviews. Women ranged from 18 to 35 years of age (median = 26 years) and were primarily African-American (93.5%) and single (80.6%) (Table 1). Most women were insured (80.6%). Of those insured, 92% were insured under Medicaid. Median gravidity was 3, with 26 women having at least one child and 13 having had at least one prior abortion. Over 58% reported not having seen a women's health provider outside of pregnancy in the two years prior to their interview. The median number of Emergency Department visits over the past two years was zero with a range of 0–20.

Psychosocial Barriers

The most salient theme regarding psychosocial barriers to obtaining WWC related to past negative experiences with health care providers. Some women reported feeling judged by providers for their sexual health behaviors and described having providers undermine their reproductive autonomy. In describing how one health care provider had treated her disrespectfully, one woman explained, "I had came in for an STD checkup. If you have more than one, and then they'd be like, 'Well you need to stop doing this,' ... the way that she was trying to say it to me, like, 'You need to stop doing what you're doing.' She could've reworded it." Other women reported feeling pressured by providers around their reproductive decision-making about contraceptive and pregnancy decisions. One woman recalled, "He was trying to force me to get another form of birth control since he was taking my IUD out." Another woman expressed that her providers made her uncomfortable about

her unintended pregnancy: “They were trying to persuade me to do certain things [...] So it was kind of uncomfortable, and it made me look at them in a certain way because they were so pushy, and it was weird.” A number of women reported that past negative experiences with providers dissuaded them from seeking care. As one participant described, “It was degrading. I know that. I don’t even want to get into it, because it’s emotional. [...] I never went back.”

Limited feelings of self-efficacy, one’s confidence in achieving behavioral goals, also inhibited use of WWC. Some women described being overwhelmed by the process of finding a provider. One woman anticipated that finding a provider would be “hard, because you don’t just want any doctor, you really want a good doctor who’s going to really take care of you, and know what they’re doing, and not just any[one].” Another participant explained, “Just not knowing where to start, and not knowing whether you just go to the hospital saying you need a doctor, and who to talk to in order to establish that. I just don’t know.”

Several women indicated that they simply did not prioritize WWC, often due to competing priorities and hectic schedules. One woman described her hesitancy to book appointments due to “concerns about scheduling, because sometimes I have things to do, and I’m thinking, ‘Okay. I’ll call them back later,’ and then later never comes around.” Another woman prioritized acute care visits over preventive visits: “I just never followed through with it [finding a primary care provider], I never did. I’d see the doctor for that day, and that would be it, unless I felt something was wrong.”

Interpersonal Barriers

Women’s roles as caregivers emerged as the dominant theme regarding interpersonal barriers to WWC. Most study participants were parents, and many spent significant time caring for parents with medical problems. Addressing personal reproductive health needs took a back seat to addressing the health needs of children and/or adult family members. Several women described difficulties making appointments due to concerns about childcare, “I’ve got no time. I’ve got five kids at home, it’s more about taking them to the doctors. I don’t have time to take myself to the doctor. If I do, I have to take five kids with me, so it’s an inconvenience for me, to tell you the truth.” One woman caring for her father described how his illness impeded her ability to seek WWC she had intended to obtain. “I was planning on getting another doctor. I just haven’t been in too much of a rush, because I’ve been dealing with a lot with my dad. He got really, really sick, and involved me to be in the hospital almost every other day.” This same participant explained that while caring for her ailing father, “I didn’t really have time to worry about me.” For some women, however, their role as caregivers motivated them to seek self-care. One woman with a young child explained, “Since I’ve had my three-year-old, I really focus all my energy on her that I hadn’t really focused any on myself. I’m trying to learn how to better that with my health and things like that, because I realized that if I’m not healthy, then it’s going to affect how I’m able to provide for her.”

Structural Barriers

Most women identified at least one structural barrier to engaging in WWC. Narratives about structural barriers centered mainly around three themes: insurance and cost, navigating providers and clinics, and geography and transportation. Though this study took place several years into the ACA's expansion of Medicaid and insurance exchanges, many women experienced or perceived instability around insurance coverage. In the two years prior to participating in this study, 15 women (44%) had gained or switched insurance and nine women (26%) had lost insurance. Accordingly, many women cited insurance disruptions as a barrier to WWC, whether due to changes in employment, clerical errors, or "aging out" of parental coverage. One woman described, "I was working at a job. They didn't offer insurance, and I couldn't...they say I made too much, so I couldn't get insurance through Medicaid. I was without insurance for so long, for a long period of time.... I'm working part time, so I was able to get the insurance then." Some women with insurance continued to weigh the cost of insurance premiums against other important family expenses. One woman described decision-making around paying for her insurance or her utility bills, "Your light bill, your gas bill, could be like 200 bucks. I know insurance is important, but you're like in a win-win situation sometimes. Insurance is something else."

Many women described structural challenges to establishing consistent relationships with trusted health care providers. Some expressed frustration attempting to switch providers and clinics assigned to them by their insurance company. One participant summarized, "You know, 9 times out of 10, I would be comfortable with whoever I picked. If [I] was comfortable with who I picked, I wouldn't keep switching insurance. It's just the problem that you can't get an appointment, or can't find a doctor that you like, or a doctor won't take your insurance." Another explained that being assigned a new physician by her insurance meant she and her daughter were no longer able to see the same provider, "Me and my daughter can't go to the same doctor, because [my insurance plan] is not covered for her, it's more for women, so now we have to go to two different doctors." Women with assigned providers encountered additional frustrations. One woman explained, "Every time you call, the doctors are always full. I don't care what doctor you call. Well, it's January now, but he's booked up until April. By that time, I could be dead waiting on an appointment. So, it's easier to go to an emergency room."

Finally, some women identified that inconvenient provider locations or transportation challenges posed barriers to accessing care. When asked if there was a clinic close to home that she would consider for WWC, one participant replied, "I don't think so." Another participant stated: "That's going to be my main concern, where is [a doctor] going to accept me at? Where are they going to send me? If it's going to be far from my house, I've got twin babies, so it's hard for me to go. That's about it. Where is it going to be at? If it's going to be close, or an inconvenience for me."

Facilitators

By design, study participants were not actively engaged in WWC; however, they were able to identify facilitators that had helped in the past or that they believed would help them obtain WWC going forward. These facilitators included strong patient-provider

relationships, insurance procurement, family support, and integration of care with other services. A strong patient-provider relationship was a common facilitator. Many reported ease of scheduling and comfort with the provider as helpful to getting to their appointment. Reflecting on a physician she saw in the past, one woman stated, “She always remembered us. She remembered why we were there, or why we were coming. The office was a pretty big office, but it was just good to know that they knew who you were and stuff like that. You can call them for any problem that you may have. They’ll actually help you and tell you what you need to do to fix it.” Another woman echoed, “I go to the doctor recently with my mother because she just got diagnosed with cancer, and so I’ve been going to her doctor for about a year now. I have an easier transition in order to find one, because I go to the hospital all the time.”

Ease of obtaining insurance was also seen as a facilitator, with several women commenting on the ease of obtaining insurance online. For example, “Because I applied online, and they sent me a letter for an interview or whatnot.” Another woman commented, “It was easy. All I had to do was go on the website and fill out my information, and they sent me some papers to fill out. Then I sent the papers back, and they sent me my card. It was easy to do it.” Participants identified family support and the integration of health care with other services as facilitators to obtaining WWC. One woman explained how her mother’s guidance helped her enter the health care system, “My mom. She always, like, “Have you been to get a checkup?” and, “Everything OK?” My mom helped me a lot, too, to check on myself and make sure I’m OK.” Women also described the ease of obtaining care when in school “When I was in college it was convenient because it’s right on campus. When I left work or something, I just went over there and then went home. It was convenient, and that always works for me.” Finally, one woman appreciated the ease of following up with her obstetrician when she was able to obtain care for her son at the same visit, “Yeah, and then it’s convenient. Everything is in one spot. I can go for OB. I can go for regular checkups. My son can go. We can go for dental and everything.”

DISCUSSION

This study sought to understand women’s experiences navigating reproductive health care after implementation of the Affordable Care Act. Our sample of women, most of whom had insurance, reported encountering a variety of psychosocial, interpersonal, and structural barriers to obtaining WWC. Women described negative past experiences with reproductive healthcare providers that deterred some from seeking future care. Women spoke of prioritizing the needs of their children or adult family members over their own personal health needs. Most prominently, structural challenges, including insurance insecurity, insurance-based disruptions in patient-provider relationships, and logistical issues, posed significant barriers to women seeking WWC. These findings demonstrate that insurance alone is not sufficient to ensure women’s access to WWC. That the median number of Emergency Department visits over two years was zero also may indicate that these barriers potentially impede some women from also using more acute care.

Many barriers elicited in these interviews parallel prior quantitative studies evaluating the prevalence of individual barriers to WWC after ACA implementation (Arora & Desai, 2016;

Hall et al., 2014; Jones & Sonfield, 2016). This study moved beyond prevalence to explore the ways in which psychosocial, interpersonal, and structural barriers influenced women's reproductive health care seeking behaviors. Furthermore, the qualitative nature of this study allowed women to describe the interaction of barriers to WWC post-ACA implementation. The struggles of participants with small children in particular demonstrate this interaction. That over 75% of this study's participants were mothers is not surprising, given national data showing that the majority of abortion patients have children (Jerman, Jones, & Onda, 2016). At the interpersonal level, participants described prioritizing their children's health needs over their own health needs. At the structural level, participants with small children described struggles stemming from being assigned different health care providers than their children and from lacking transportation and childcare needed to attend WWC visits.

Many women described signing up for insurance online as a relatively smooth process, which may be one of the reasons that so many of our study's participants were insured (largely through Medicaid). This speaks to one successful strategy of the ACA in trying to expand women's access to care. However, women did not mention other services or innovative programs available through Medicaid that could mitigate some barriers to accessing care, such as using transportation services available through Medicaid to get to appointments. Existing research has found that, compared to socially advantaged women, less educated, lower-income, and uninsured women have greater gaps in knowledge about how the ACA affects their ability to use WWC and contraception (Hall et al., 2014). These gaps in knowledge underscore the need for further outreach and education about resources that can help women utilize WWC.

This study has a number of limitations. The vast majority of this study's participants were insured, primarily through Medicaid, which afforded the opportunity to understand barriers to care for insured women that continue post-ACA. However, this limited the ability to understand barriers that continue to hinder access to insurance post-ACA implementation. Additionally, our study participants comprised of a specific population – low-income, reproductive age women presenting for abortion. Women who have a higher income or who have never been pregnant may not share challenges described in this study. However, this study's findings likely have implications for other vulnerable populations and may inform interventions to help engage at-risk individuals in preventive health care.

IMPLICATIONS FOR PRACTICE AND/OR POLICY

That some women continue to face interacting, multi-level challenges to obtaining WWC despite expanded access under the ACA is concerning. Further, women's access to this care under the ACA is currently being eroded. Therefore, it is essential to develop innovative approaches to identify women who lack care and help them overcome multi-level barriers to WWC. This study illustrates the important role that patient-provider interactions can have in influencing whether or not women engage in WWC. Negative interactions that participants perceived to be judgmental and proscriptive, especially around reproductive decision making, dissuaded some participants from seeking further care. Conversely, some women experienced positive patient-provider relationships that fostered health care seeking behaviors. These findings echo prior research demonstrating the important relationship

between high quality interpersonal care and reproductive health seeking behaviors and underscore the need to foster strong interpersonal skills among healthcare providers (Dehlendorf, et al., 2016). Models exist to help providers engage in more open and supportive communication with patients (ACOG, 2014; Holt, Dehlendorf, & Langer, 2017). Shared decision making, for example, encourages patients and providers to share information, discuss treatment preferences, and arrive on an agreed upon treatment plan (ACOG, 2014). Incorporating models such as shared decision making into medical education, starting early in undergraduate medical education and continuing through continuing medical education, is essential to help providers engage in effective patient-centered care.

Integrating health services into points of contact with women who do not obtain WWC also has the potential to address several challenges illustrated in this study, including women prioritizing their families' care above their own, logistical challenges, and discomfort with healthcare settings. The abortion visit is one opportunity to reach women who do not otherwise not engage in WWC and to help them link to preventive reproductive health care after the abortion. The well-child visit is another such setting. One study of mothers attending their children's well-child visits with family medicine physicians found that almost 95% of mothers were willing to accept health advice from their child's physician (Rosener et al., 2016). The study found that well-child visits might, therefore, offer an opportunity to provide interconception care by advising mothers about 1) smoking cessation, 2) depression screening, 3) contraception and 4) folic acid supplementation (Rosener et al., 2016). Future interventions must focus on helping address and overcome barriers at different levels (psychosocial, interpersonal, and structural), by focusing on the individual and tailoring the intervention to her needs.

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Figure 1.
Conceptual Model for Women's Engagement in Reproductive Health Care as adapted from Bronfenbrenner's Ecological Systems Theory Model

Table 1

Socio-demographic and insurance factors for study participants

	Interview participants n=34
Age (years) *	
18–25	15 (48.4)
26–35	16 (51.6)
Education *	
High School	17 (54.8)
Some College	13 (41.9)
Other **	1 (3.2)
Race/Ethnicity *	
African-American	29 (93.5)
Hispanic/Latina	1 (3.2)
White	1 (3.2)
Other ***	0 (0)
Gestational age (weeks) *	
9 0/7	12 (38.7)
9 1/7 to 13 6/7	5 (16.1)
14 0/7	12 (38.7)
Trimester *	
First	18 (58.1)
Second	12 (38.7)
Abortion Type *	
Medical	10 (32.3)
Surgical	21 (67.7)
Gravidity (median, range) *	3 (1–8)
Parity (median, range) *	1 (0–5)
Number of ER visits in the past two years (median, range) *	0 (0–20)
Number of visits to a women's health provider outside of pregnancy in the past two years (median, range) *	0 (0–12)
Insurance Status	
Yes	26 (76.5)
No	8 (23.5)
Insurance Type	
Medicaid	24 (70.6)

	Interview participants n=34
Private	2 (5.9)
None	8 (23.5)
Gained or switched insurance in the past two years	
Yes	15 (44.1)
No	19 (55.9)
Lost insurance in the past two years	
Yes	9 (26.5)
No	25 (73.5)

Data are n (column%) unless otherwise specified.

* Data missing for first three study participants.

** Trade school

*** Other includes Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and Other.