Termination of pregnancy for medical reasons in France: to what extent healthcare services ensure access to abortion across the national territory?

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Extended Abstract

Context

Termination of pregnancy for medical reasons (TPMR) were tolerated since the mid-19th century in France, but it had been fully legalized in 1975 along with elective abortion. Today, the latter is possible on woman's request up to 14 weeks of pregnancy, while the former can be performed only in case of a "serious danger for the woman's health" or if there is a "probability that the unborn child will suffer from a particularly serious condition recognized as incurable at the time of diagnosis" (art. L2213-1 of the French Code of Public Health). When a woman who wants a TPMR must obtain an authorisation from a multidisciplinary medical team. While elective abortion beneficiates from a rather liberal legal framework TPMR is much more constrained. Thus, about 225 000 elective abortions and 9000 TPMR are performed each year.

Most of TPMR receive an authorisation from physicians who are members of a Multidisciplinary centre for prenatal diagnosis (MCPD). However, despite their central position in TPMR access, these centres are spread across only 38 of the 101 French *départements*. The French Agency of biomedicine mentions a possibly inequal access to these centres depending on the region but without exploring the effective consequences on the care provided (Agence de la biomédecine, 2020). Indeed, little is known about TPMR, whereas elective abortion is studied annually at Ined (Breton et al., 2022) and Drees (Vilain & Fresson, 2023): these researches have documented barriers and inequalities of access, including in terms of territorial disparities. Thus, despite the plurality of places, healthcare providers and methods legally allowed, the structure of elective abortion services strongly varies depending on the *département*, therefore limiting women's possibility to choose the type of their abortion (Chaput et al., 2022). The importance of abortion services all over the territory to ensure access to elective abortion incites to explore the territorial repartition of TPMR services and its consequences on the moment and the place of abortion. In other words, to what extent can healthcare structure ensure access to TPMR for all women who would want or need one?

Material and methods

This research relies on the French national health insurance database which includes all reimbursements of drugs, medical tests and care performed in France, and few socio-demographic information on patients. As it covers all reimbursements, this database covers 99 % of the French population (Tuppin et al., 2017). All women who carried out a TPMR, in a public or private hospital, between March 2019 and December 2021 are included in this study – data of 2022 will certainly be included to enrich the results.

Analyses are led at the *département* level to ensure a minimum number of TPMR by territorial entity. We use the TPMR rate in the feminine population to study the territorial disparities. The

proportion of TPMR performed outside the *département* of residence is used to express inter-*département* mobility; it is then studied through the presence of MCPD, the moment of the year and the duration of pregnancy to explore how the care services repartition affects the moment (of the pregnancy and of the year) and the place where abortion if performed. A cartography of abortion care centres and MCPD will provide a more precise view on TPMR services across the French territory.

Expected findings

In France, between March 2019 and December 2021, the TPMR rate was 13.9 for 10 000 women aged 15 to 54 years. The rate varied strongly between *départements*: from 0.8 in La Creuse to 36.3 in Paris. Besides, the proportion of TPMR performed outside the *département* of residence also varied widely – from 90 % in La Creuse to 0.3 % in La Réunion. In the *départements* where the proportion was higher than 60 %, the TPMR rate was below 7.5.

Also, as mentioned earlier, despite the importance of MCPD to obtain an authorisation to perform a TPMR, only one third of the *départements* (38 in 101) had one of these centres, leaving the two other thirds devoid of these healthcare services. Except in Ile-de-France (around Paris region), among the 45 *départements* where at least 30 % of TPMR were performed in another *département*, none had a MCPD. Thus, women living in a *département* without a MCPD had to move more to obtain their abortion. Yet, long distance can make TPMR access more difficult: arduousness of the trip especially with an advanced pregnancy, taking a day off work, organizing babysitting etc. A cartography of MCPD and hospitals where TPMR were performed will enlighten with more precision the disparities of healthcare services.

As the number of elective abortions varies with holidays period (Breton et al., 2018), it was also the case for TPMR performed in the *département* of residence: between March 2019 and December 2021, it decreased strongly during summer, All saints and Christmas holidays, and a bit less during winter and Easter holidays. Indeed, healthcare providers are less available therefore services have less capacity to perform abortions during holiday periods. These variations suggest that, like elective abortions, TPMR are planned according to healthcare services availability, potentially to the detriment of women's needs or preferences.

However, these seasonal variations did not occur for TPMR performed outside the *département* of residence, which can suppose that these abortions were more difficult to plan due to the distance. They could also be emergency situations which could not wait the closest abortion services to be available.

Finally, TPMR performed outside the *département* of residence had a longer duration of pregnancy than those performed inside: they are on average 1.5 week later. This result is consistent with the precedent hypothesis: TPMR services may be too distant from certain remoted areas, especially in the absence of MCPD in the *département*, which would explain the wide disparities of TPMR rate. This inequal repartition of TPMR services may imply that women who have to travel to carry out an abortion face supplementary difficulties produced by the lengthening of the procedure which increases the duration of pregnancy. It certainly also impacts the moment of the procedure, as planning can be more complicated with long distance.

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Abstract

In France, while elective abortions can be performed on the women's request up to 14 weeks, terminations of pregnancy for medical reasons (TPMR) are possible with no time limit but only in case of a "serious danger for the woman's health" or if there is a "probability that the unborn child will suffer from a particularly serious condition recognized as incurable at the time of diagnosis" (art. L2213-1 of the French Code of Public Health). A TPMR necessitates an authorization of a medical team, often the one of a Multidisciplinary centre for prenatal diagnosis (MCPD). However, these centres exist only in 38 of the 101 French *départements*. This communication explores inter-*départments* mobility for TPMR, as well as its effects on the care provided (lengthening of the procedure and duration of pregnancy).

Based on the French national health insurance database, this research includes all women who had a TPMR between March 2019 and December 2022 in France. TPMR rates varied widely across the national territory. *Départements* with a smaller TPMR rate had a bigger proportion of TPMR performed outside the *département* of residence and more often had a MCPD. While TPMR performed in the *département* of residence varied with the holiday period, it is not the case for abortions performed outside. These results suggest that TPMR access may be restricted by the distance between the place of residence and of abortion, which certainly delays healthcare, as the duration of pregnancy increased when TPMR were performed outside the *department* of residence.