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Abortion Care Workforce Compensation Study

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Introduction

Finding and keeping skilled staff has been a long-standing challenge for practices that provide abortion care, and part of this challenge has included wide variation in the compensation, benefits, and employment structures of these practices. The purpose of this study was to assess and document these differences to create opportunities for shared learning within the abortion care community.

In 2024, we fielded an anonymous survey to facilities, organizations, and practices (collectively referred to as “practices” for this report) that provide abortion care in the US. The purpose of the survey was to collect data on compensation, benefits, and issues of recruitment and retention for both clinical and non-clinical staff in the abortion care ecosystem. Practices included both brick-and-mortar and telehealth-only practices and could provide procedural, medication, or both types of abortion. We created an email survey invitation that was distributed via National Abortion Federation (NAF), Planned Parenthood Federation of America (PPFA), and Abortion Care Network (ACN) listservs multiple times during the study period. The target staff to complete the survey was facility administrators, HR directors, or others with detailed knowledge of compensation and benefits.

We developed the survey instrument and survey approach with multiple points of input from advisory council members of Clinical Abortion Staffing Solutions (CASS), a partnership between NAF and PPFA. In accordance with anti-trust regulations, we requested information about salary and benefits that was at least one year old. The survey was open to the field from June through September 2024; we asked for compensation information that was current as of June 2023. We invited survey respondents to complete more than one survey response if there were different compensation or benefits structures in different locations (e.g., different clinic sites, different states) within the same organization. All responses were collected anonymously using Qualtrics.

We also conducted follow-up interviews with 9 representatives of organizations who had completed the survey at least once. Interviews were conducted via Zoom and took approximately 30-45 minutes. We recorded and took notes during interviews and then analyzed these for key themes and unique experiences. Participant names, titles, and organizations are omitted from this report to protect confidentiality.

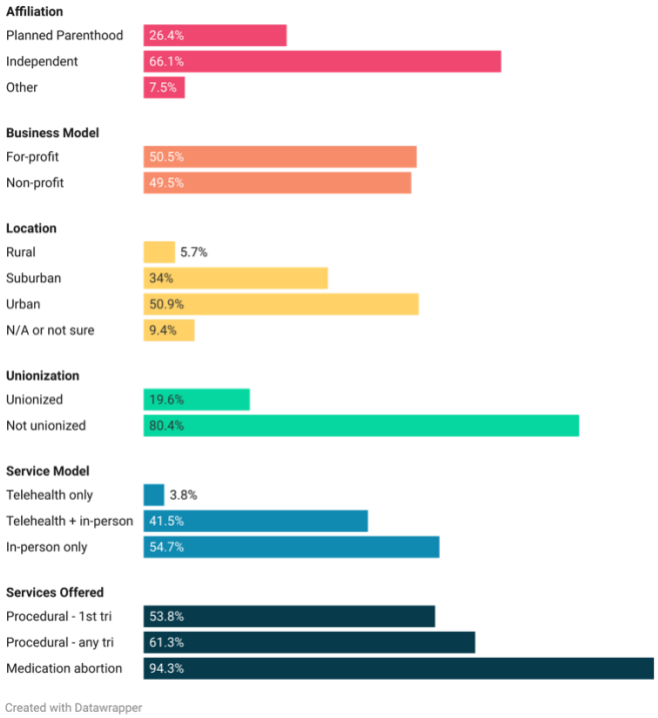
Practice Characteristics

We received detailed survey responses from 106 practices, with another 72 practices (178 total) opening the survey and answering at least one question. For purposes of this report, we analyzed results only from the 106 practices that answered at least the series of questions about staffing. Figure 1 shows the characteristics of participating practices.

Most practices were independent providers (49.1% independent for-profit, 17.0% independent non-profit). Another 26.4% were affiliated with Planned Parenthood; these include responses at both the affiliate level and the site level, given the option to provide multiple responses for multi-site organizations. The rest (7.5%) had a different affiliation, including academic medical center, hospital, or other. This distribution (66.1% Independent, 26.4% Planned Parenthood, 7.5% other) is similar to that of the Abortion Care Network's (ACN) 2024 annual report,[1] which includes 58% Independent, 38% Planned Parenthood, and 4% other. While independent providers may be slightly overrepresented in our sample, this comparison suggests that the sample of practices completing the survey is comparable to the field.

FIGURE 1

Characteristics of Participating Practices

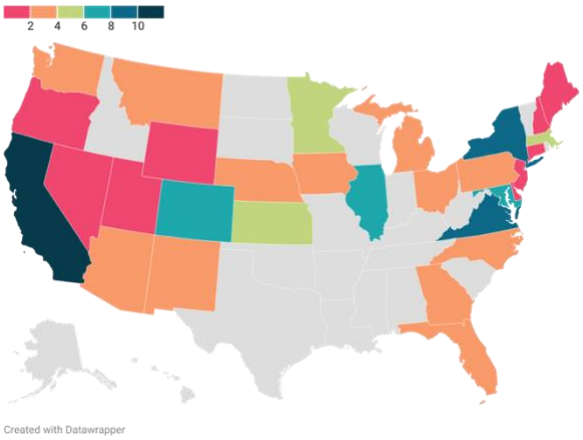


Note: Facilities could offer multiple types of services, so categories under services offered are not mutually exclusive.

About half of survey responses came from for-profit practices (50.5%) and the other half from non-profit (49.5%). The majority (80.4%) were not unionized. Approximately half (50.9%) were in urban locations, 34.0% in suburban, and 5.7% in rural; 9.4% said they were not sure, or the question did not apply. The proportion answering not sure or N/A may be a function of the way that this question was phrased, which was a compromise we made during the IRB approval process. We had originally hoped to obtain practice zip code so that we could classify practices using a more precise measure, but we changed it to self-identification of rural/urban/suburban/not sure because our IRB requested it.

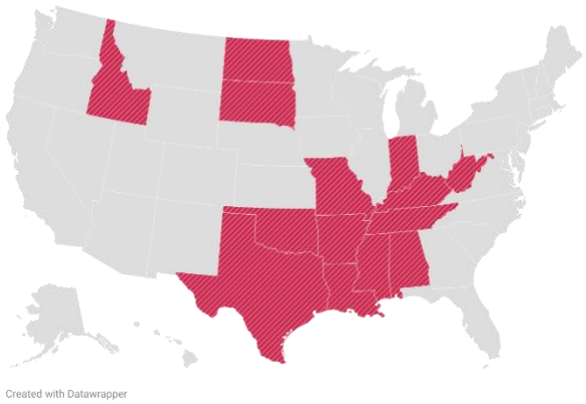
Fewer than half of practices provided telehealth, whether telehealth-only (3.8%) or telehealth and in-person (41.5%); 54.7% did not provide telehealth. Nearly all respondents provided medication abortion (94.3%). Among practices providing procedural abortion, 53.8% provided first-trimester services only, and 61.3% provided services during any trimester.

FIGURE 2
Responses by State



Note: We received 3 responses from DC and 1 response from Puerto Rico (not shown).

FIGURE 3
States with No Clinics Offering Abortion Care, 2024



Source: Abortion Care Network[1]

We received responses from 32 states/territories (Figure 2), nearly all states with abortion clinics. We did not receive responses from Rhode Island, South Carolina, Vermont, or Wisconsin. Other states without responses are those where abortion is banned or without clinics, as noted in the ACN's 2024 Report (Figure 3).[1]

Table 1 shows summary statistics about practice size, including number of patients seen by service model and abortion revenue.

TABLE 1
Practice Size

	N	Average	Median	Minimum	Maximum
Number of patients seen					
In-person abortion care	94	2,639.7	1,428.5	24	30,177
Telehealth abortion care	40	2,612.9	121.5	6	25,920
All services	90	10,405	2,645	32	209,076
Abortion Revenue	70	$2,816,948	$950,000	$0	$32,500,000

Note: This table excludes responses of 0. There were 4 responses reporting 0 in-person patients, 61 responses reporting 0 telehealth patients, and 2 responses reporting $0 in abortion revenues.

Compensation & Benefits

COMPENSATION

We found variability in compensation structures based on staff type (Table 2). Survey respondents identified hourly staffing models (either full-time or part-time) as the most frequently used for all staff types except physicians and management staff. Physicians were compensated most commonly per-procedure (44%), followed by full-time salary (38%). There was significant variability in compensation models for advanced practice providers (APPs), with more than 40% of respondents indicating that they had APPs on staff who were compensated via full-time salary, hourly full-time, and hourly part-time models. Nurses (including both RNs and LPNs; abbreviated as RNs for brevity), medical assistants, ultrasound technicians, paraprofessionals were most commonly compensated hourly. Respondents could also write in answers if there were additional compensation structures used in their practice, which included: contractor (physicians, APPs, and CRNAs); flat rate per day (physicians, CRNAs, and ultrasound technicians); PRN (nurses and MAs); and volunteer (physicians and APPs).

TABLE 2

Compensation Structures by Staff Type

	Staff Type						
	MDs/DOs	**APPs**	**RNs**	**MAs**	**U/S**	**Para.**	**Mgmt**
N	**100**	**57**	**75**	**83**	**33**	**53**	**77**
Salary							
Full-time	38 (38.0%)	23 (40.3%)	15 (20.0%)	12 (14.5%)	0 (0%)	11 (20.8%)	67 (87.0%)
Part-time	13 (13.0%)	5 (8.8%)	4 (5.3%)	2 (2.4%)	2 (6.1%)	3 (5.7%)	5 (6.5%)
Hourly							
Full-time	8 (8.0%)	27 (47.4%)	44 (58.7%)	61 (73.5%)	23 (69.7%)	34 (64.2%)	12 (15.6%)
Part-time	17 (17.0%)	23 (40.3%)	51 (68.0%)	49 (59.0%)	21 (63.6%)	33 (62.2%)	7 (9.1%)
Per-procedure	44 (44.0%)	4 (7.0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

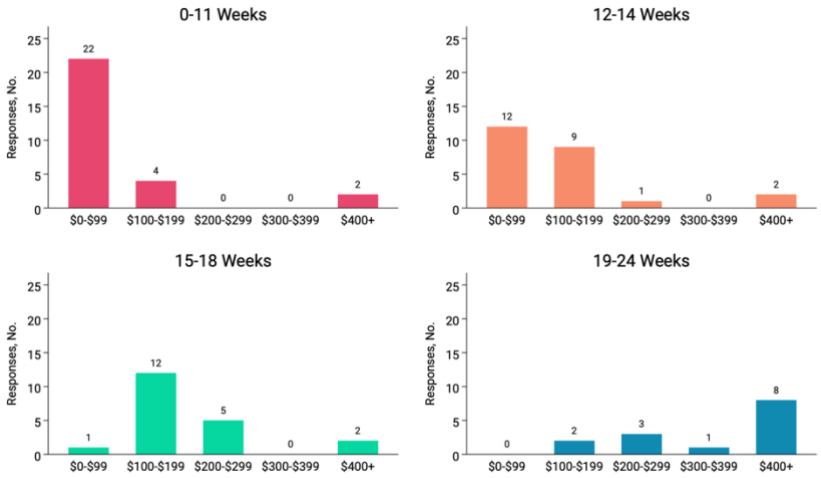
Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; U/S, ultrasound technicians; para., paraprofessionals; mgmt, management

Notes: We collected average hourly wages combined for full-time and part-time and did not request that respondents separate out average hourly wages. N is the number of respondents that indicated that they employ each staff type earlier in the survey. Percents may not sum to 100 as respondents could indicate multiple compensation models for the same types of staff members. We did not include certified registered nurse anesthetists (CRNAs) on this table: salary, 1 full-time and 2 part-time; hourly, 1 full-time and 3 part-time; per-procedure: 3.

Most staff compensated per-procedure were physicians. We noted significant variability in per-procedure compensation rates for physicians, with a few very high outliers. Per-procedure compensation tended to follow the expected trend of higher compensation for later gestation procedures (Figure 4). Open text-responses for per-procedure compensation mentioned: a $1,000 daily minimum, different rates for telehealth and asynchronous medication abortion, and rates determined based on services provide and patient history (e.g. sedation, c-section history, and cervical dilator placement). Table A1 in the appendix shows per-procedure compensation by staff type.

FIGURE 4

Per-Procedure Compensation by Weeks of Gestation

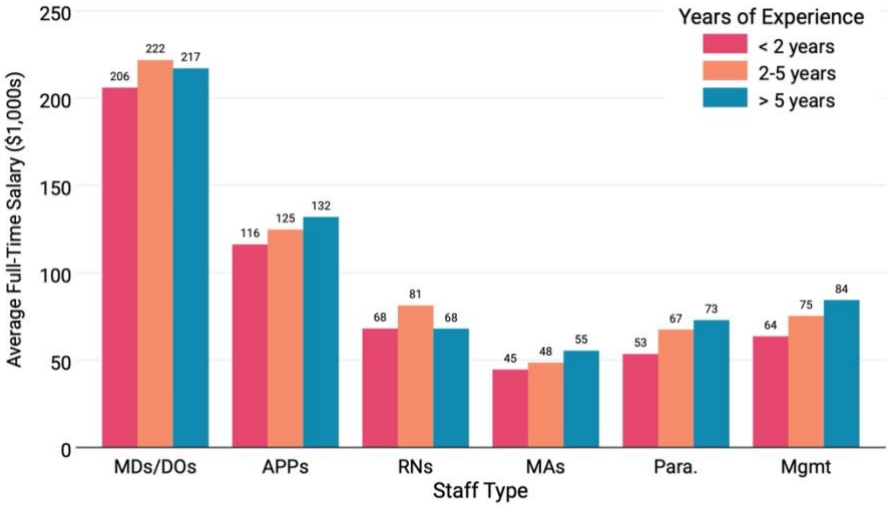


Years of Experience

Figures 5 and 6 show average compensation for each staff type by years of experience for staff members with full-time salary and hourly compensation. For most categories, average salaries were higher within each compensation type with greater years of experience. See Table A2 in the appendix for exact compensation and number of responses.

FIGURE 5

Average Full-Time Salary by Staff Type and Years of Experience

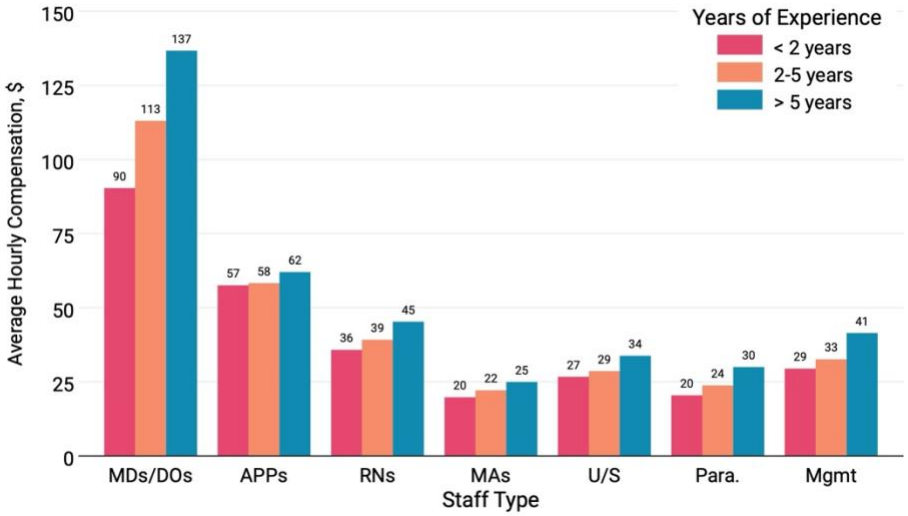


Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; para., paraprofessionals; mgmt, management

Note: Bar labels rounded to nearest thousand.

FIGURE 6

Average Hourly Compensation by Staff Type and Years of Experience



Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; U/S, ultrasound technicians; para., paraprofessionals; mgmt, management

Note: Bar labels rounded to nearest dollar.

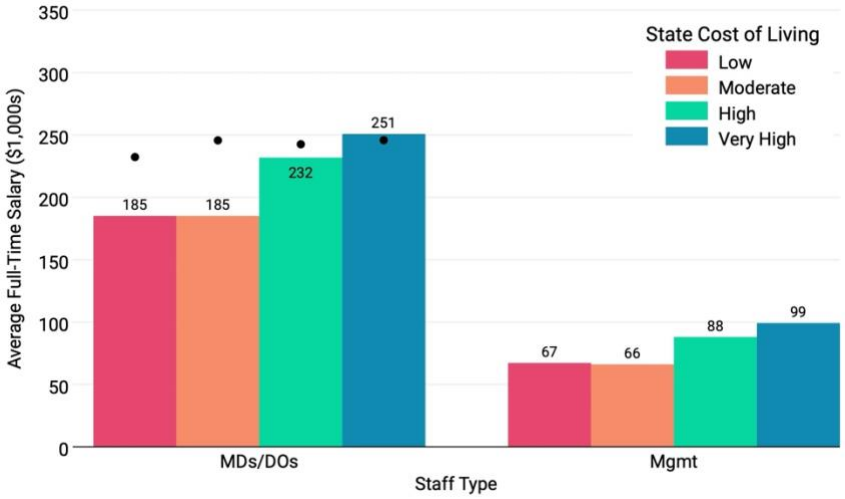
Unsurprisingly, there was a substantial difference between physicians and APPs both for full-time salary (full-time physician average salary was $200K or higher, compared to <$135K for APPs) and hourly compensation models (physicians were paid $90 per hour or more on average, compared to an average of $62 per hour for the most experienced APPs). Both physicians and nurses compensated full-time had the highest salaries for 2-5 years of experience, which may be due to small numbers of responses in these subcategories (see Appendix Table A2).

State Cost of Living

Compensation for most positions increased with increased state cost of living (COL), especially in highest cost states. To identify state COL, we used the World Population Bureau's publicly available data[2] and then grouped states into 4 categories, with a roughly equal number of survey responses in each group (see Figure A1 in the Appendix). We used this approach rather than the groupings provided in the World Population Bureau data because some states had no responses (largely due to bans or clinic closures) and some states had only 1 or 2 responses, and we wanted to avoid overrepresentation of states without bans and/or a higher number of responses.

FIGURE 7

Average Full-Time by State Cost of Living and Staff Type

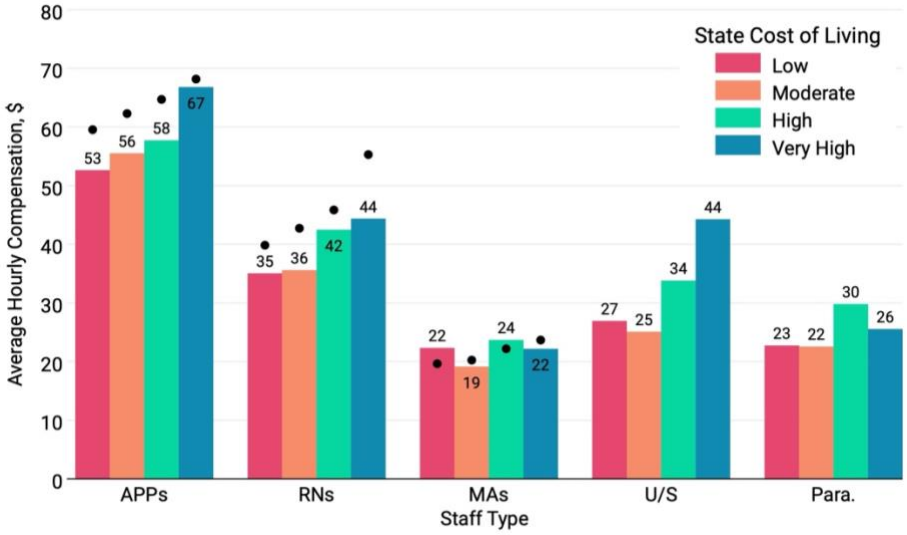


Abbreviations: MDs/DOs, physicians; mgmt., management
Source: World Population Bureau[2]; Bureau of Labor Statistics
Notes: Bar labels rounded to nearest thousand dollars. Black dots indicate average of BLS data for family medicine physicians. Due to BLS data availability, family medicine salary data does not include DC (very high cost of living) or NV (moderate cost of living).

We then analyzed Bureau of Labor Statistics (BLS) wage data and created comparisons for each category with available data using the same state classifications.[3] Figures 7 & 8 show the average full-time salary for physicians (BLS comparison: family medicine) and management, by state COL, and average hourly compensation for APPs (BLS comparison: nurse practitioners and physician assistants), nurses (BLS comparison: nurses), medical assistants (MAs) (BLS comparison, MAs), ultrasound technicians, and paraprofessionals; we selected these because they were the most common compensation type with comparable data available. We found that the compensation by profession type is on par with the compensation identified in the BLS data and that it followed the same pattern, with increasing rates by increasing COL.

FIGURE 8

Average Hourly Compensation by State Cost of Living and Staff Type



Abbreviations: APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; U/S, ultrasound technicians; para., paraprofessionals
Source: World Population Bureau[2]; Bureau of Labor Statistics[3]
Notes: Bar labels rounded to nearest thousand dollar. Black dots indicate average of BLS data for APPs, nurses, and MAs.

Practice Characteristics

We also analyzed salaries by affiliation, business model, and union status (Table 3). Physicians' full-time salary was higher on average in Planned Parenthood practices compared to independent practices, but the opposite was true for management. Similarly, physicians' full-time salary in non-profits was higher on average compared to for-profit practices, but the opposite was true for management. We found higher compensation in unionized practices compared to non-unionized practices for all staff types except for management and APPs.

TABLE 3

Average Compensation by Staff Type and Practice Characteristics

	Average Full-Time		Average Hourly				
	MDs/DOs	**Mgmt**	**APPs**	**RNs**	**MAs**	**U/S**	**Para.**
Affiliation							
PP	$250,915	$68,788	$58.40	$37.88	$22.47	$30.85	$26.16
Independent	$185,150	$81,503	$60.89	$40.23	$21.81	$28.64	$23.34
Business Model							
For-profit	$180,421	$86,046	$59.43	$42.22	$21.67	$29.48	$23.14
Non-profit	$242,643	$72,684	$59.08	$37.81	$22.35	$28.91	$25.62
Location							
Urban	$199,410	$76,517	$53.79	$41.94	$21.32	$29.51	$23.77
Suburban	$233,250	$82,989	$71.43	$39.51	$22.51	$29.88	$24.19
Rural	-	$77,897	$58.08	$34.26	$21.08	-	$17.00
Unionization							
Unionized	$272,280	$70,886	$57.96	$41.61	$22.92	$32.10	$26.56
Not unionized	$193,083	$82,094	$60.32	$39.49	$21.49	$28.15	$23.40

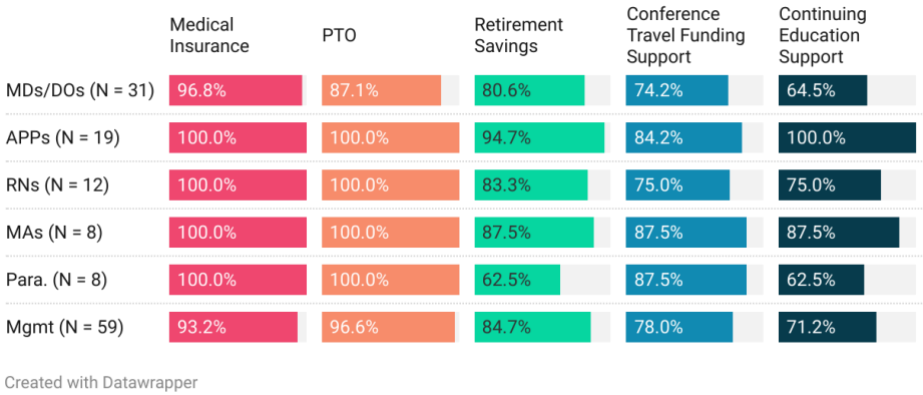
Abbreviations: MDs/DOs, physicians; mgmt; management; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; U/S, ultrasound technicians; para., paraprofessionals; PP, Planned Parenthood
Notes: Data not shown for "other" affiliation not shown.

BENEFITS

Most practices offered some type of benefits, including medical insurance, paid time off (PTO), retirement contribution, conference support, and funds for continuing education for all compensation models (Figures 9-11). Appendix Tables A3 and A4 show benefits offered to part-time salary and per-procedure staff by type. Table 3 shows open-text responses to benefit questions.

FIGURE 9

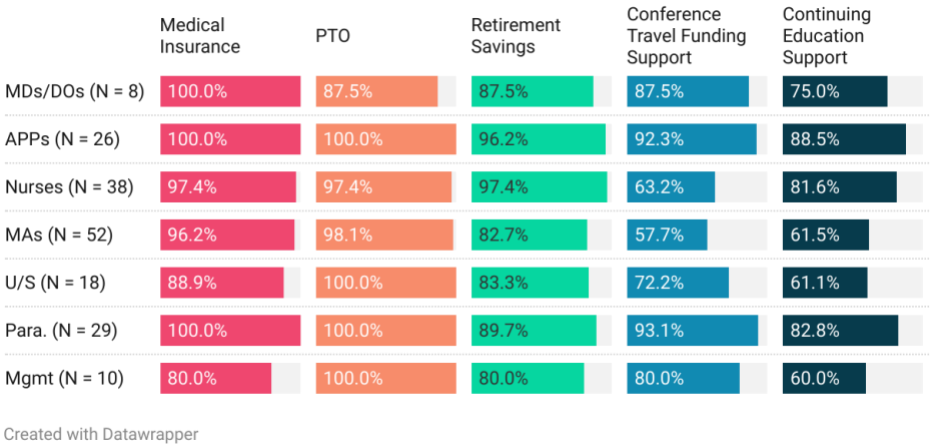
Benefits Offered to Full-Time Salaried Staff



Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; para., paraprofessionals; mgmt, management; PTO, paid time off

FIGURE 10

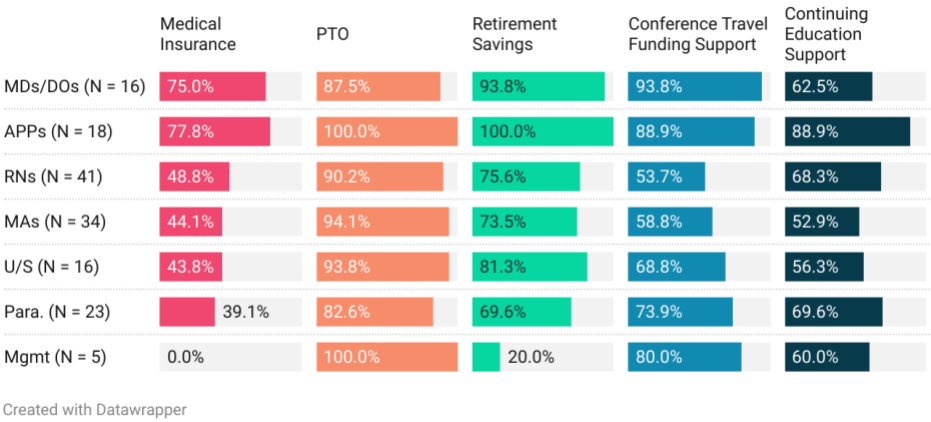
Benefits Offered to Full-Time Hourly Staff



Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; para., paraprofessionals; mgmt, management; PTO, paid time off

FIGURE 11

Benefits Offered to Part-Time Hourly Staff



Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; para., paraprofessionals; mgmt, management; PTO, paid time off

TABLE 4
Open-Text Responses: Benefits

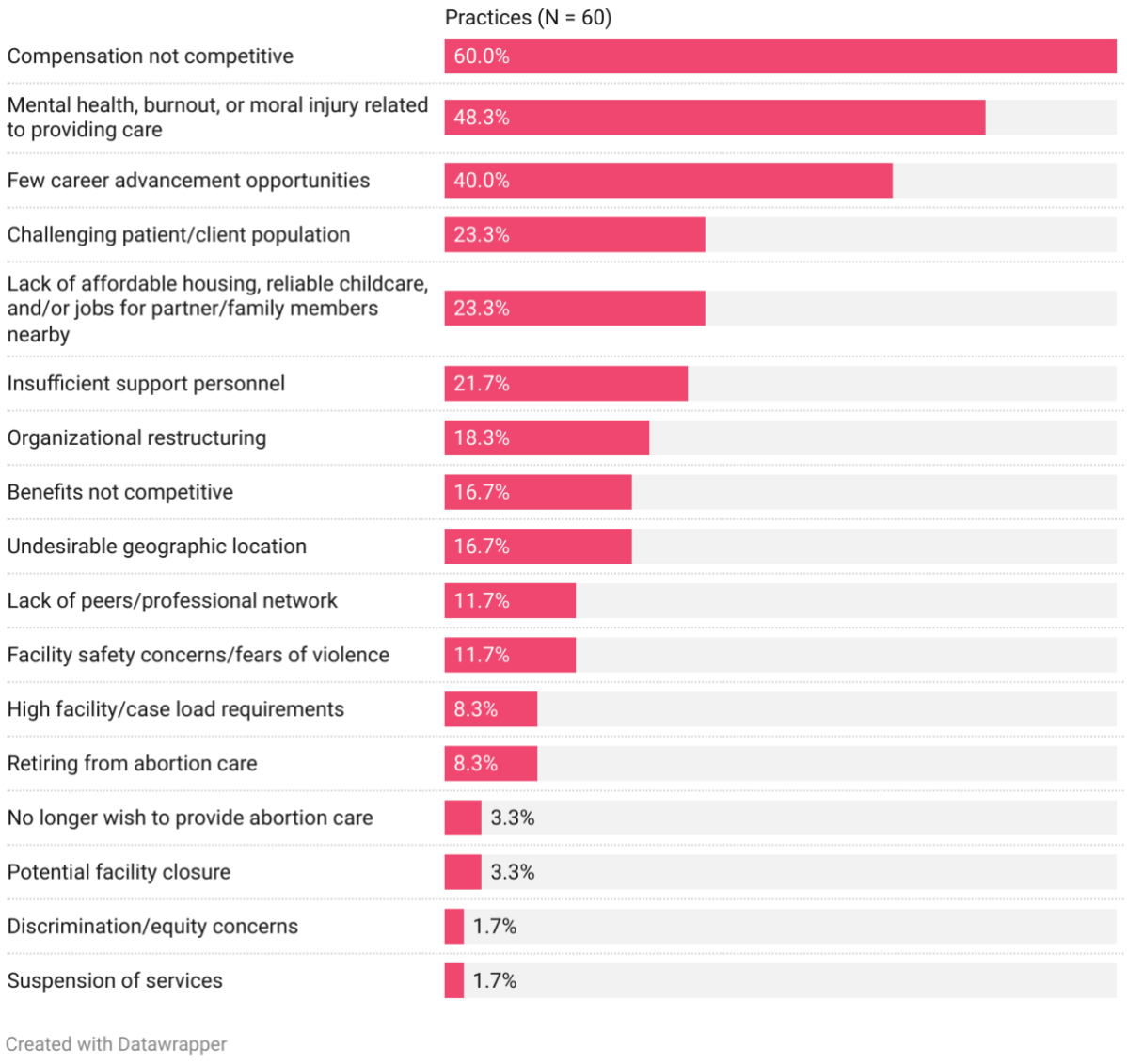
	Staff Type					
	MD/DOs	**APPs**	**RNs**	**MAs**	**Para.**	**Mgmt**
Insurance & Medical						
Dental, vision, life, & disability	X	X	X	X	X	X
Accidental death & dismemberment	X	X	X	X	X	X
Paid family medical leave	X	X	X	X	X	X
Non-Salary Compensation						
Equity		X			X	
Bonuses	X	X				X
Reimbursement						
Licensure	X	X	X	X	X	X
Tuition		X	X	X	X	X
Scrubs/uniforms		X	X	X	X	X
Wellness						
Employee Assistance Program	X	X	X	X	X	X
Stipend/benefit	X	X	X	X	X	X
Other						
Lodging	X	X				
Entertainment discounts		X	X	X	X	X

Abbreviations: MD/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; para., paraprofessionals; mgmt, management
Note: Additional responses included: loans and advances for paraprofessionals, administrative time pay for physicians, and travel expenses for physicians.

Recruitment & Retention

The most common reason for recruitment and retention challenges was compensation (Figure 12). A high proportion of responses reported issues with moral injury, mental health, and burnout.

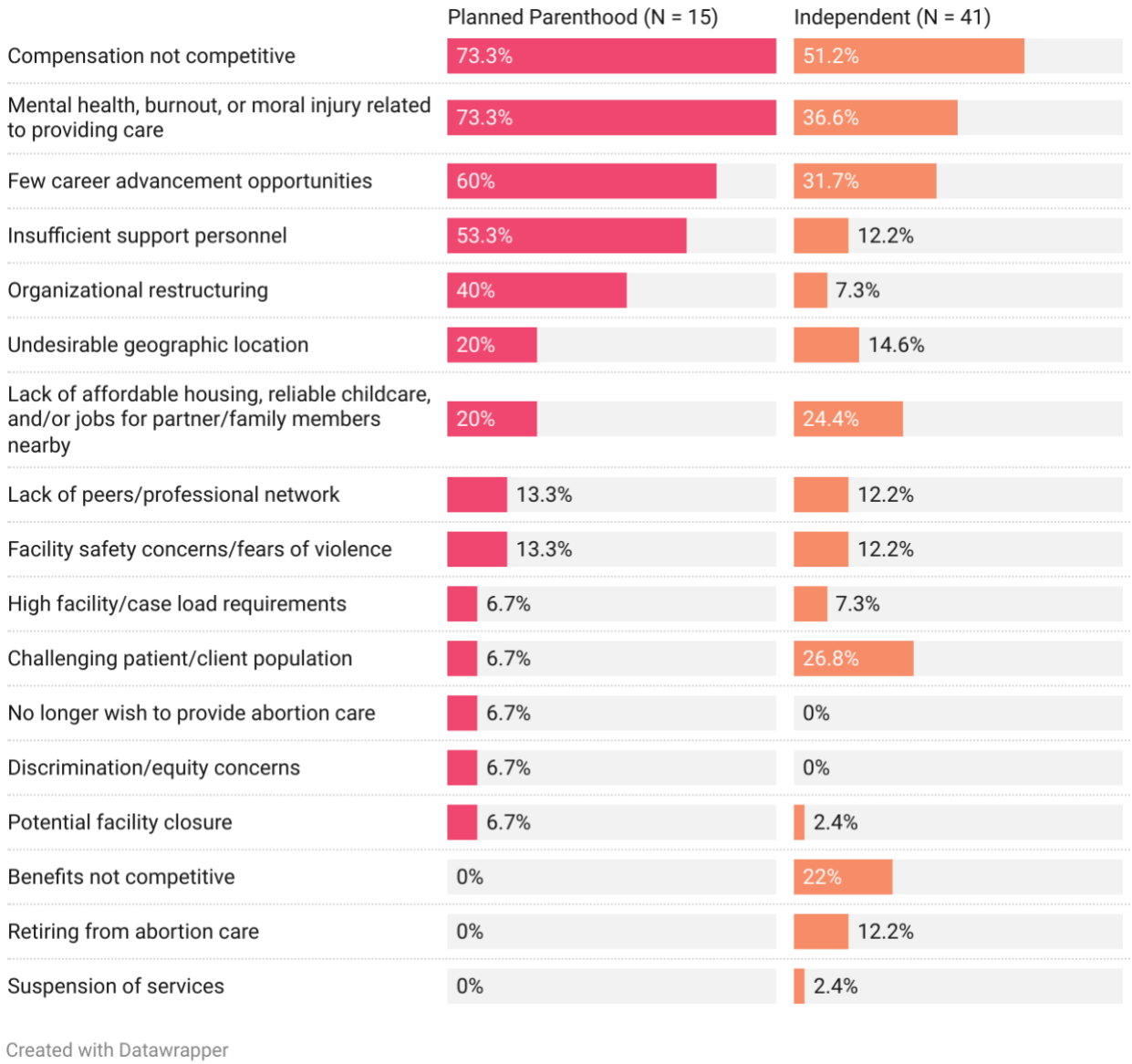
FIGURE 12
Recruitment & Retention Challenges



Insufficient support for personnel and organizational restructuring were of much greater concern for Planned Parenthood practices compared to independent practices (Figure 13), whereas challenging patient/client population and noncompetitive benefits were of greater concern for independent practices compared to Planned Parenthood practices.

FIGURE 13

Recruitment & Retention Challenges by Affiliation

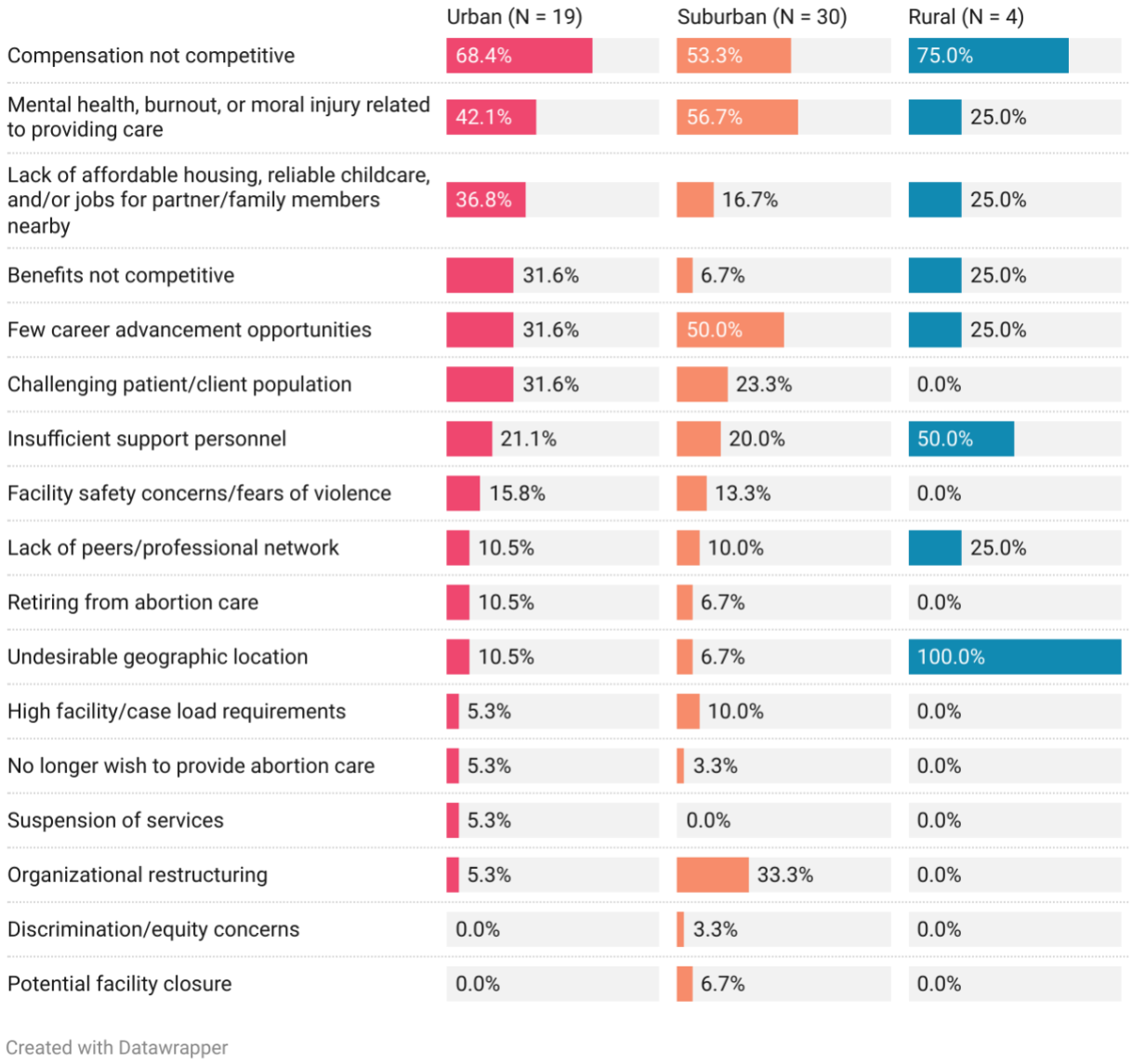


Note: "Other" affiliation (N = 3) not shown.

We only received 4 responses from rural practices, but 100% of those 4 identified undesirable geographic location as a factor in recruitment and retention challenges (Figure 14). Recruitment and retention challenges by business model, service model, and unionization can be found in Appendix Figures A2, A3, and A4.

FIGURE 14

Recruitment & Retention Challenges by Location

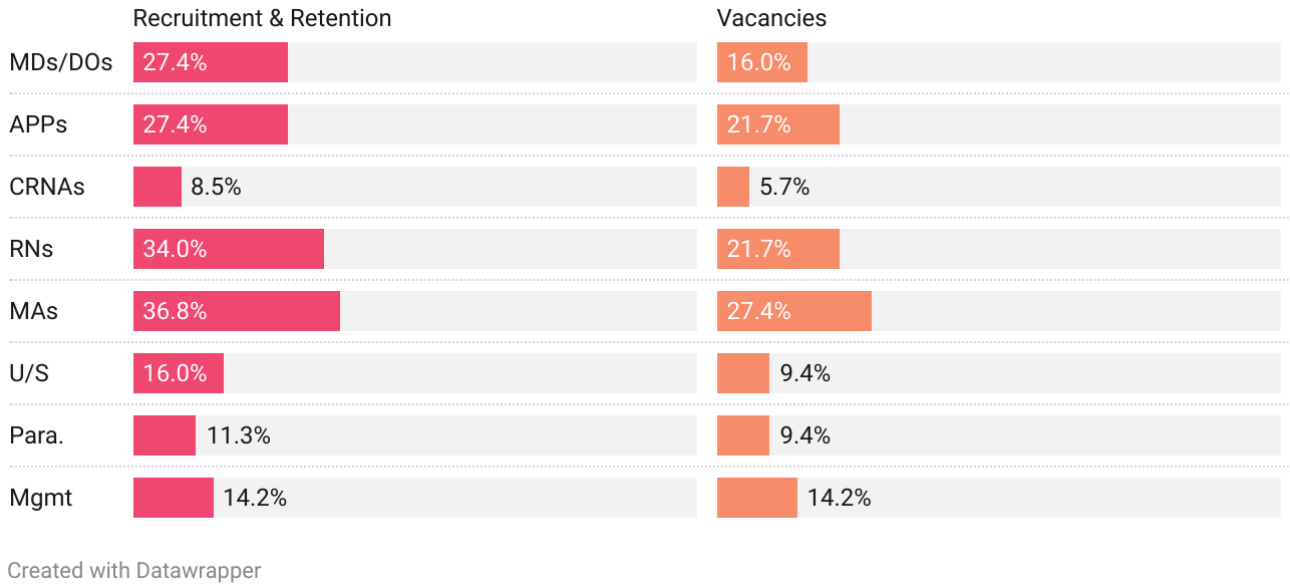


Created with Datawrapper

MAs (36.8% of responses) and nurses (34%) were the roles for which survey respondents most often identified recruitment and retention challenges (Figure 15). MAs were also the role for which respondents most often stated they had current vacancies (27.4%, Figure 15). We explored recruitment and retention challenges in greater depth during the key informant interviews.

FIGURE 15

Practices Reporting Recruitment & Retention Challenges and/or Vacancies by Staff Type



Abbreviations: MDs/DOs, physicians; APPs, advanced practice providers; CRNAs, certified registered nurse anesthetists; RNs, nurses; MAs, medical assistants; U/S, ultrasound technicians; para., paraprofessional; mgmt, management

Key Informant Interview Themes

COMPENSATION

There was high variability across the practices that we interviewed, but many participants noted that they struggled to balance providing abortions at the lowest cost for their patients while also paying their staff livable wages. One participant noted that their organization conducted an annual assessment comparing wages in their organization to others in the state using resources such as Payfactor, Indeed, and Glassdoor. They felt that this was a successful approach to ensuring that their compensation was as competitive as possible.

UNIONIZATION

Participants expressed differing views on how unionization affected operations. In one practice, compensation had been drastically higher since unionization. This was particularly beneficial to MAs and nurses. Pre-unionization, the practice paid less than hospitals, so many MAs and nurses sought employment elsewhere. After unionization, the higher pay encouraged people to stay.

For another practice, there was a lot of tension surrounding unionization. Paying the staff more would require charging more for abortions, which was not feasible for many patients. Practice leadership had to balance providing the cheapest abortion possible but also creating a staffing environment that was supportive and met the needs of staff.

> *"I think there's a real tension between.... **the more you pay staff, the more you have to charge patients.** Some of the costs of abortion, even though they haven't gone up a lot in the last two decades are still unachievable for a lot of people. How do you balance that tension between you wanting to **give the cheapest abortion possible** but not at the **expense of unhappy staff**, and not at **the expense of an unhappy experience?**"*

BENEFITS

Benefits were highly variable across practices interviewed; however, many participants stated that their organizations wanted to expand their benefits but did not have the funds to do so. Particularly, participants noted that they would like to expand health insurance and parental leave for their staff.

Participants also stated that it was important to acknowledge the difficulty of the work and to respect time off, so they encouraged many practice staff to take time off with no expectation of responding to emails or checking in while on PTO.

RECRUITMENT & RETENTION

Many participants noted challenges regarding recruitment and retention that differed by staff type. Some practices had difficulty hiring front-desk employees, nurses, and MAs. Since the work could be difficult and mundane, participants said that many nurses wanted to develop new skills and could not do so with such redundancy (unlike a full-scope family practice). Given the competitive job market for nurses and MAs, participants noted challenges with retaining these staff and stated that hospitals pay better.

> *"It's just so different now. I have so many residents, and they all want to come back and work. They all want this... I've turned away probably 5 doctors that wanted to travel and work here... I have to say **'I'm sorry. I have enough doctors, which is crazy'**. Things are **changing for the better** in that way."*

Effects of the Dobbs Decision

Participants also varied in their comments on how the *Dobbs* decision affected recruitment and retention. Some practices found that staff did not have a particular commitment to reproductive health and only a handful of staff wanted specifically to work in abortion facilities because of the passion for the work: "It's a job. Not a passion." However, others experienced the opposite, even turning away doctors interested in working for their practices in some cases. For another, abortion care work was not popular pre-*Dobbs*, but post-*Dobbs* they received "tons of applicants" who were passionate about this work.

> *"When I started, there was a tremendous amount of feminism… I would put an ad in for a job and **I would have 50 applicants in 24 hours.** Now, I get applicants that have no interest in reproductive rights. They have no ongoing commitment to working in this field. I think if I went through my staff now in my two offices, I would say that maybe there's a handful of people that I feel are really dedicated to this. Back years ago, all of my offices would go to march in Washington, all of the staff. We'd have 30-40 from each office going. **Now, there's nothing like that.**"*

Techniques for Recruitment

Participants adopted new and innovative techniques to recruit staff, in addition to recruiting through professional groups (e.g., CASS) and word-of-mouth. One practice purchased a seat on Indeed so that they could reach out to candidates rather than waiting for potential workers to reach out to them. At the same time, artificial intelligence (AI) technology complicated recruitment because applications were auto-submitted by AI based on keywords regardless of interest in the position.

> *"The other challenge, too, is AI, because folks put their resume in Indeed and say 'apply for me.' We call people and they're like 'I didn't apply.' **That's a lot of resources we're using**, because they matched a certain word, so the vendor just automatically applied for them... Our talent acquisition coordinator speaks with people all the time that have no idea that they've applied for our positions. **They have no idea what we've done or what we do.**"*

STATE POLICY LANDSCAPE

The challenges with compensation, recruitment, and retention were, not surprisingly, taking place within a continuously changing state policy landscape. Participants noted that both current staff and job applicants were often concerned about their safety working in an abortion practice, particularly in abortion-hostile states, and many participants noted the challenges with being unable to promise job security.

Changing Business Models

Participants described various business models that were created in response to *Dobbs*. One practice was started after the decision. Originally, physicians were flown in from other states and were paid very high rates. They later changed their model for physicians to work entirely remotely and do telehealth visits. Another practice employed people in multiple states (both in-person and telehealth services) but would not hire in states that they perceived as too expensive to live (e.g., NY). One participant had to close practice locations in multiple states post-*Dobbs* and reassigned staff to call centers or growth and acquisition. Despite these reorganization successes, they reported that they still lost about 60% of their staff.

Job Security

Interview participants expressed that job security could not be promised due to the changing landscape, injunctions, and not knowing if they might have to stop providing abortion care. Lack of job security also caused burnout and high turnover rates, as one participant shared that for individuals working in abortion-hostile states, "there are laws now that we have to turn away approximately 40% of our clients because they can no longer receive care under the law changes in the state… these are high anxiety jobs."

"I've had a lot of conversations with people essentially asking them for job security, and I have to tell them 'we don't see ourselves going anywhere, ***but there are a lot of things that are out of my hands*** *at times.' Abortion care is so unpredictable, especially now that* Roe *has been overturned. We can't give someone definite job security like they're asking me for. I'd love to be able to do that.* ***I'd love to be able to tell you that 'abortion's going to be fine,' but I've been proven wrong apparently.****"*

FUNDING STRUCTURES

Funding appeared as a very common and particularly challenging theme throughout interviews with participants. Many participants reported that their practices struggled after funding cuts in July 2024. Participants noted that with reduced funding, practice staff had to devote a significant amount of time to securing funding for their patients, particularly relying on donations, fundraising, and local abortion funds. In some cases, these shifts in the funding environment had a direct effect on staffing, with a possible reduction in employee retention, as some staff members had been hired with one set of professional responsibilities and those had shifted to include funding-related tasks that were outside of their original roles. One participant noted that staff was spending significant time securing funding which was not their intended role or what they wanted out of their role, affecting morale. Another said that when they had the funding to assist with practical support, they guided one patient who had never flown in an airplane or stayed in a hotel through the entire travel process. Now, "[that kind] of extensive service is no longer available, and that is disappointing."

*"****I'm spending all my time on funding.*** *I'm not taking care of patients. All of my staff who are usually counseling and working with the patients are all on the phones trying to get money to get the procedures done. It's not like we're making money on this.* ***I just can't sustain the practice without it****… Why would [the staff] want to do that? I mean, if they really wanted to be in social services and be a social worker, then that's where they would have gone. They wouldn't have gone to work in a facility like this* ***then spend 80% of their time running around trying to get money for people.****"*

Conclusion

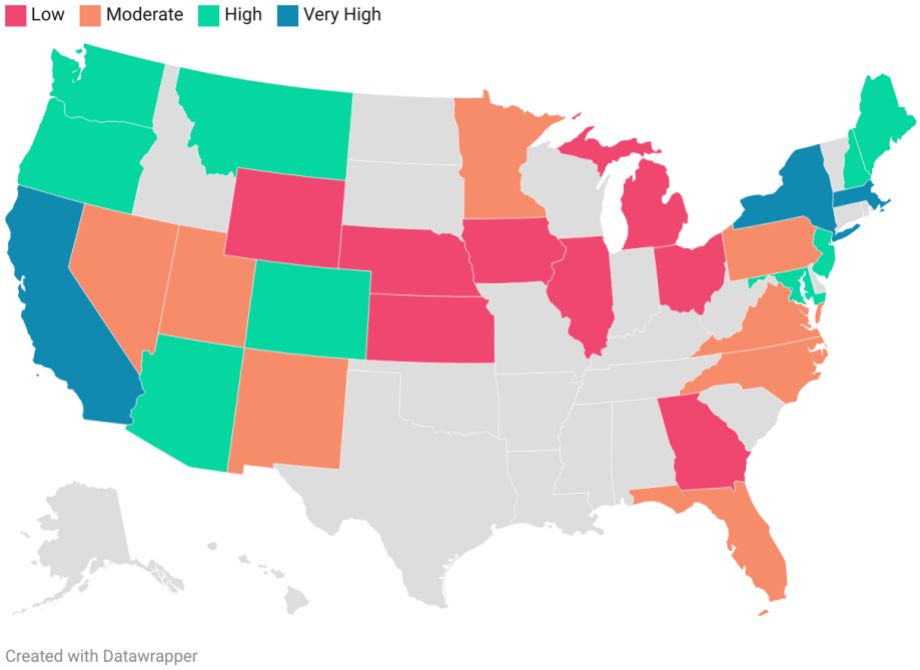
This report describes the staffing, compensation, and benefits considerations of practices in the abortion care ecosystem. Our sample included a mix of independent practices, Planned Parenthood practices, and others, and they represented nearly all states with at least one abortion clinic, based on ACN's 2024 report.[1] We received responses from few rural practices, which may limit generalizability to rural settings. The most common compensation model for physicians was per-procedure, and the most common compensation model for most other professions was hourly (APPs, nurses, MAs, ultrasound technicians, and paraprofessionals). Compared to national data from BLS, we found that compensation in the abortion ecosystem aligned with compensation for similar professions across the US.

From our interviews, we noted, unsurprisingly, that state legislation and the associated practice closures created significant uncertainty for practice managers, staff, and patients. Some interview participants noted that unionization improved compensation and recruitment/retention, but others felt that it wasn't a feasible option for them to pursue. We heard both that some practices had more applicants than positions for both clinical and support staff, and that other practices were having a hard time recruiting and/or retaining certain positions, especially front desk and nurses. This variation mirrors our survey findings, which suggest that practices experienced different recruitment and retention challenges based on affiliation, location, and other factors.

The results of this study can be used as a baseline measure of the compensation and staffing issues facing abortion care practices in 2023 and 2024. As the abortion care landscape continues to shift in response to growing threats to access, there is a need for ongoing research on this topic, and we suggest repeating this study in the coming years. It is also essential to understand perspectives from clinicians and support staff directly, with a particular focus on nurses, medical assistants, and administrative staff, in addition to the information we report here at the practice level. We also recognize that the abortion care workforce includes not only the professions studied here but also the staff and volunteers at abortion funds and practical support organizations, and future studies should include these workers as well.

Appendix

FIGURE A1
State Cost of Living Groups



Source: World Population Bureau[2]
Note: DC is in the "very high" cost of living category.

TABLE A1

Per-Procedure Compensation by Weeks of Gestation and Staff Type

	Weeks of Gestation				
	0-11	**12-14**	**15-18**	**19-24**	**25+**
MD/DOs					
Median	$76.25	$100	$150	$400	$712.50
Range	$30-$750	$50-$900	$80 -$4,050	$150 -$3,750	$200-$7,500
N	32	26	20	14	4
APPs					
Median	$50.00	-	-	-	-
Range	$30-$94	-	-	-	-
N	3	0	0	0	0
CRNAs					
Median	100	$100	$137.50	$300	$300
Range	$75-$125	$75-$125	$100-$175	$300	$300
N	2	2	2	1	1

Abbreviations: MD/DOs, physicians; APPs, advanced practice providers; CRNAs, certified registered nurse anesthetists

TABLE A2

Average Compensation by Years of Experience and Staff Type

	< 2 Years		2-5 Years		> 5 Years	
	Average	**N**	**Average**	**N**	**Average**	**N**
MD/DOs						
Full-time salary	$205,883	16	$221,632	5	$216,925.00	20
Part-time salary	$159,631	5	$193,800	5	$193,200.00	6
Hourly	$90.31	2	$113	1	$136.67	3
APPs						
Full-time salary	$116,165	11	$124,685	12	$131,886.00	13
Part-time salary	$52,500	1	$54,000	1	$81,333.00	3
Hourly	$57.52	23	$58.25	17	$61.98	19
RNs						
Full-time salary	$68,000	5	$81,250	4	$67,918	5
Part-time salary	$27,500	1	-	0	$40,750	2
Hourly	$35.75	42	$39.14	34	$45.24	39
MAs						
Full-time salary	$44,544	7	$48,491	7	$55,349	2
Part-time salary	-	0	-	0	-	0
Hourly	$19.75	49	$22.11	42	$24.91	36
U/S						
Full-time salary	-	0	-	0	-	0
Part-time salary	-	0	-	0	$3,600	1
Hourly	$26.65	17	$28.59	14	$33.73	12
Para.						
Full-time salary	$53,400	4	$67,400	5	$72,833	6
Part-time salary	$35,800	2	$52,500	2	$65,000	2
Hourly	$20.40	31	$23.73	27	$29.93	24
Mgmt						
Full-time salary	$63,377	34	$75,237	30	$94,274	37
Part-time salary	$32,500	1	-	0	$21,250	2
Hourly	$29.42	11	$32.57	9	$41.42	9

Abbreviations: MD/DOs, physicians; APPs, advanced practice providers; RNs, nurses; MAs, medical assistants; U/S, ultrasound technicians; para., paraprofessionals; mgmt, management

Note: The only responses for certified registered nurse anesthetists (CRNAs) were for hourly rate (< 2 years of experience, $57.50; 2-5 years of experience, $58.50; > 5 years of experience, $59.00).

TABLE A3
Benefits Offered to Part-Time Salaried Staff

	Medical Insurance	PTO	Retirement Savings	Conference Travel Funding Support	Continuing Education Support
MDs/DOs (N = 12)	9 (75.0%)	6 (50.0%)	9 (75.0%)	9 (75.0%)	7 (58.3%)
APPs (N = 3)	1 (33.3%)	3 (100%)	2 (66.7%)	3 (100%)	3 (100%)
CRNAs (N = 1)	1 (100%)	1 (100%)	1 (100%)	1 (100%)	1 (100%)
RNs (N = 4)	4 (100%)	4 (100%)	4 (100%)	2 (50%)	3 (75%)
U/S (N = 1)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)
Para. (N = 2)	1 (50.0%)	2 (100%)	1 (50.0%)	2 (100%)	2 (100%)
Mgmt (N = 3)	2 (66.7%)	3 (100%)	2 (66.7%)	2 (66.7%)	1 (33.3%)

Abbreviations: MD/DOs, physicians; APPs, advanced practice providers; CRNAs, certified nurse anesthetists; RNs, nurses; U/S, ultrasound technicians; para., paraprofessionals; mgmt, management; PTO, paid time off

TABLE A4
Benefits Offered to Per-Procedure Staff

	Medical Insurance	PTO	Retirement Savings	Conference Travel Funding Support	Continuing Education Support
MDs/DOs (N = 23)	4 (17.4%)	5 (21.7%)	4 (17.4%)	18 (78.3%)	18 (78.3%)
APPs (N = 3)	1 (33.3%)	0 (0%)	0 (0%)	1 (33.3%)	2 (66.7%)
CRNAs (N = 1)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)

Abbreviations: MD/DOs, physicians; APPs, advanced practice providers; CRNAs, certified registered nurse anesthetists; PTO, paid time off

FIGURE A2

Recruitment & Retention Challenges by Business Model

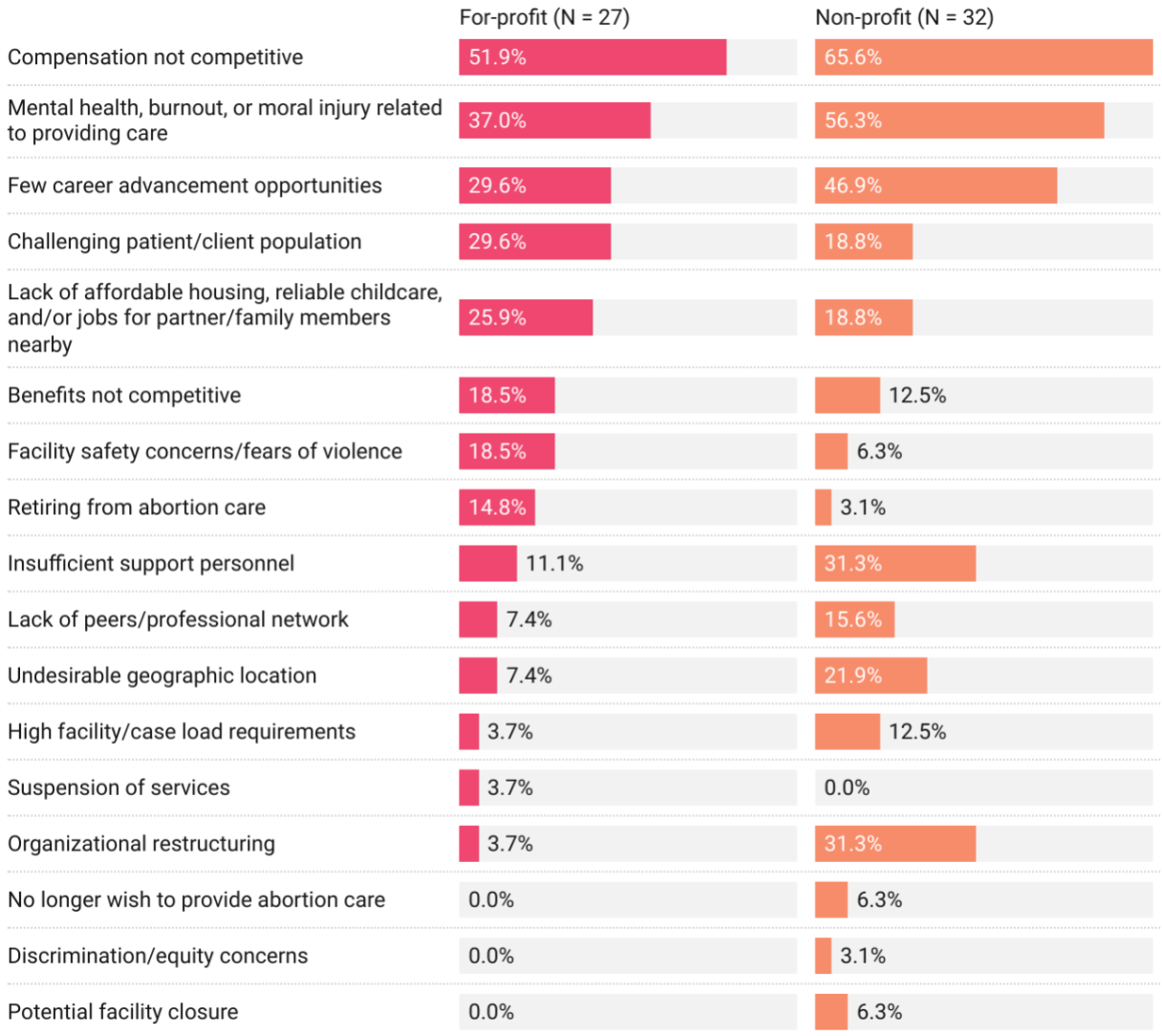


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FIGURE A3

Recruitment & Retention Challenges by Service Model

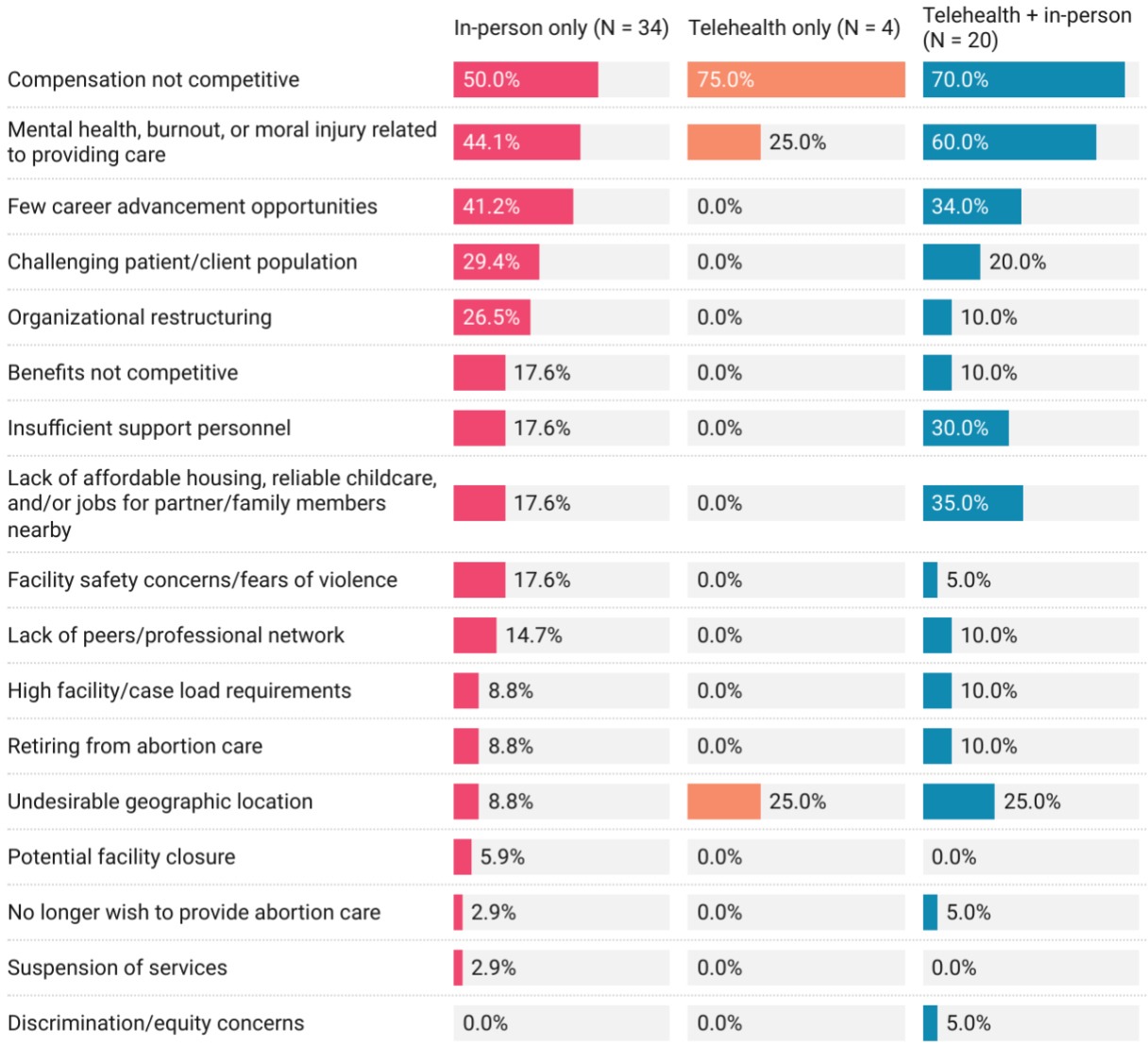
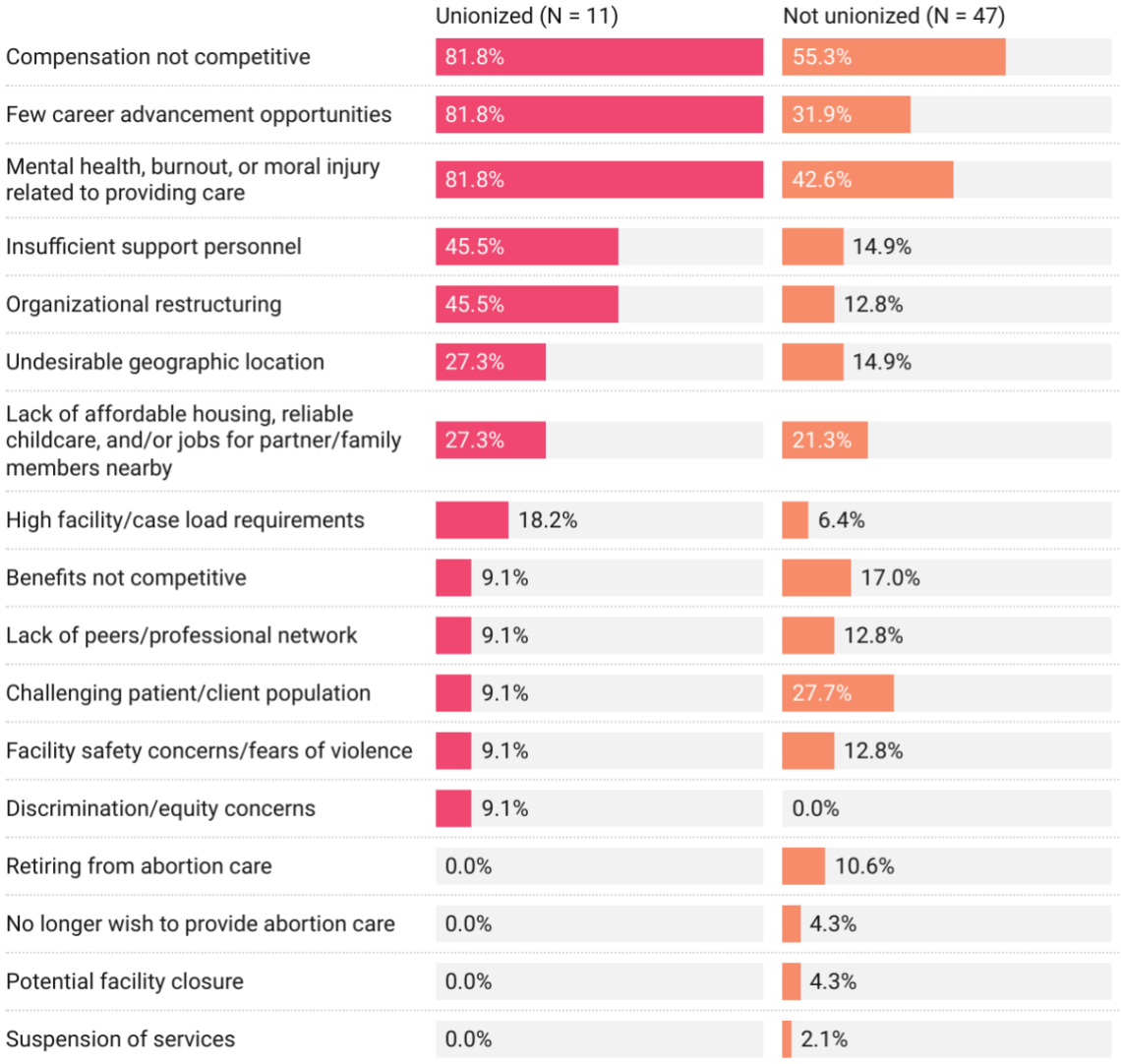


FIGURE A4

Recruitment & Retention Challenges by Unionization



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