

The State Based Financial Reality of Women's Health: A Review of Screenings, Treatment & Prevention

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Abstract: Health services available to women and critical to the practice of women's health are historically linked to state funding within the United States. This relationship has been underscored by the overturn of *Roe v. Wade*. Private women's health clinics rely on donations and state based funding. Additionally, organizations such as Planned Parenthood which receive federal money are dependent on state dictated allocation of those funds. This leads to vast differences in the availability and outcomes of women's healthcare by state, which also disproportionately affects women of lower socioeconomic status. This research aims to explore the significance and impact of state funding as it relates to the state total available budget for women's health services. Although each state has their own unique clinics and state-based rules, regulations, and funding sources, grouping into rough tiers of high, medium, and low funding allows for a more holistic analysis while helping minimize geographic biases. Cancer screenings (breast and cervical), STI testing and treatment, contraception availability and use, as well as prenatal care and abortion access are the key aspects of women's health that will be examined. The aim is to highlight the vital correlation between available funding and the quantitative impact on women's health. Disparities have been further widened as a result of funding differences, such as delay of cancer diagnoses, the public health risk of inadequate STI treatment, and the tragic increase in both maternal and fetal death following a lack of proper prenatal care. It is also necessary to acknowledge that all individuals in need of women's health services, regardless of gender identity or sexual orientation, are part of the relevant patient population of this study. Women have a right to knowledge about available health services. It is imperative to know how the state in which one lives affects health care options and thus the health of women and their families.

Keywords: Social determinants of health, Socioeconomic health impact, Gender healthcare access disparity, STD rates, Abortion access

INTRODUCTION

The Women's Health Movement began in the 1960s, just over 60 years ago. Those that founded that movement had the goal to improve health care for all women¹. Unfortunately, a patriarchal society within the United States led to setbacks in the area of reproductive rights during the 1980s; a troubling state of affairs this nation is seeing once again¹. For over 50 years, a network of providers as well as public programs have helped millions of low income women of childbearing age in the USA to gain access to sexual and reproductive health services². These include Medicaid, Title X Family Planning Program, and Section 330 of the Public Health Service Acts which have aided 10,000 safety net clinics across the country²

SERVICES

Planned Parenthood (PP) began as the first birth control clinic in 1916 in Brooklyn, NY³. Since that time they have grown to 600 clinics around the nation that provide numerous services to women and individuals with female genitalia. It represents the largest public women's health organization within the United States. PP provides affordable access to all inclusive sexual and reproductive health services in addition to sexual education to women in all socioeconomic classes nationwide⁴. A majority of Americans predicate their support of public funding for PP based on it being a purveyor of abortion. In reality they provide much more encompassing healthcare; not limited to vaccinating against influenza, hepatitis, and HPV,

smoking cessation counseling, anemia testing, routine health screenings for cholesterol, diabetes, high blood pressure, cervical cancer, and breast cancer⁴.

Planned Parenthood plays a pivotal role in providing healthcare services as well as preventative screenings. They conduct over 250,000 pap tests a year and 350,000 breast exams⁵, ensuring timely diagnoses and better outcomes for patients. These clinics address the access issues that are present for women of lower socioeconomic status. They are able to provide essential services to women, men, and transgender individuals who have no other treatment options due to financial and geographic barriers.

CONTRACEPTIVES

One of the most impactful preventative services offered by Planned Parenthood clinics is access to contraceptives. Contraceptive services are indispensable to women's lives for helping with obstetric and gynecological problems women may face, it also gives women the choice to plan if/when they want to have children and grants bodily autonomy⁵.

In 2015, over 6 million women received publicly funded contraceptive services from safety net health centers which helped avoid 1.3 million unintended pregnancies⁶. Clinics provide: the birth control implant, IUD, birth control shot, vaginal ring, patch, pill, condoms, internal condoms, diaphragm, birth control sponge, spermicide + gel, and cervical caps⁷. They also educate individuals on lifestyle changes if they don't want to use contraceptives such as fertility awareness, withdrawal, breastfeeding, and abstinence. PP also grants access to procedures such as sterilization and vasectomies⁷. In addition to in-clinic education, all of this information is found on the Planned Parenthood website where they provide information on the efficacy, costs, and longevity of various contraceptive methods⁷.

CANCER SCREENING

In the United States, female cancers (breast and cervical) are in the top 5 cancers in both incidence and death rate⁸. Regular screening is recommended for both breast and cervical cancers to ensure timely diagnosis and initiation of treatment. In regards to breast cancer, there is documented variation in incidence rate based on state⁹. There also is discrepancy in

breast cancer mortality rate as it relates to race, with non-hispanic black women having a mortality rate of 28%, in comparison to non-hispanic white women having a mortality rate of 19.9%, even though the incidence rate of breast cancer is greater in white women in comparison to black women.⁹ This information spotlights vast discrepancies, especially in regards to women's health with breast and cervical cancer screenings. Roughly 80% of the women in the United States report receiving a diagnosis or screening at a private doctor's office. However, up to 17% of women 18-64 years of age state that they utilize health centers and clinics.¹⁰ Even more, about 25% or more of those uninsured or receiving Medicaid, utilize health care centers and clinics¹⁰.

Although there are many complicating factors in terms of each state's individual Medicaid budget based on population statistics, it is apparent that the states falling within the top tercile of Medicaid spending matched the top 15 states who were closest to the National Cancer Institute (NCI) goal of 81% of women receiving a mammogram at least every two years between the ages of 50-74.¹¹ In regards to cervical cancer screenings through pap smears, the NCI has a set goal of 93% of women within each state receiving a pap smear within the past three years between the ages of 21 and 65. Unfortunately, no states have met this goal, with only ten states reaching a Pap smear rate of 80% or more with the latest statistics from 2020.¹¹ Therefore, an expansion of screening in general is needed, with the average national screening rate for women over 18 who had a Pap smear within the past three years was only 66% in 2018¹¹. 77% of planned parenthood's budget is spent on contraception and STI treatment and prevention while 13% is spent on cancer screenings and prevention.¹¹ The budget provides insufficient financial resources to provide Pap Smears or breast exams at the level NCI deems is a necessary public health service. Women delayed in proper screenings or diagnoses seek medical care likely upon appearance of symptoms. This increases the cost and necessity for private insurance, creating a barrier to access for those in states without proper public funding for more affordable women's health screenings.

SEXUALLY-TRANSMITTED INFECTION/DISEASE TESTING:

STI surveillance funding falls squarely in the balance of cooperative federalism where state-federal funding relies on federal direction that attempts to achieve uniform action across states with conditional federal funding, and state implementation based on voluntary acceptance of federal funds. There are, however, some specific examples of national epidemics which showcase the use of the Constitution's Commerce Clause which grants federal authority over public health threats and infectious disease transmission across state lines. The balance of federal compulsion and state autonomy is currently hotly debated in the public health arena as data shows a consistent rise in STI rates while federal and state funding remains stagnant. Increased federal funding for public screening programs and consequent increased access to STI screenings were credited for the lowest recorded rates of STIs in the US in the early 2000s.

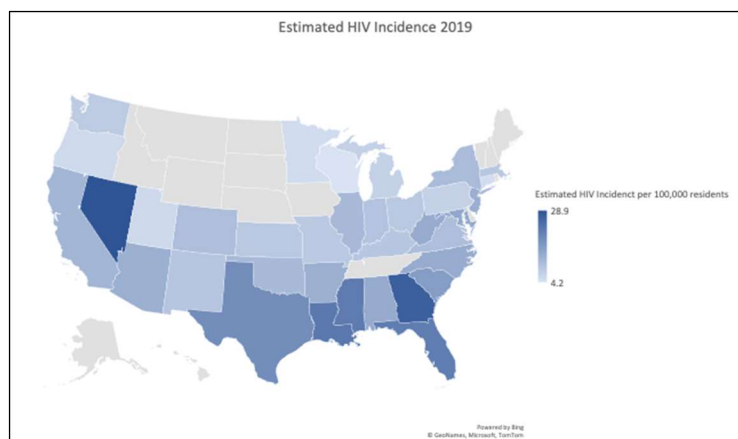


Figure 1: United States estimated incidence of HIV in 2019 per 100,000 residents by state. *Data not extrapolated gray states

However, federal funding for these programs have seen a 40% decrease since 2003¹². A reported one-half of state and local programs have since cut their budgets, laying off staff and reducing clinic hours¹³. Many of these programs included on-site testing and partner care intervention that offered critical access for several groups without routine care providers¹². Testing helps expand clinics' impact and reach to the broader community, regardless of gender or sexual orientation. CDC data shows a 45% increase in reported cases of gonorrhea between 2016 and 2019, and a 50% increase in primary syphilis for those same years. Although a decrease of reported chlamydia cases was seen from 2019 to 2020, researchers point towards reduced diagnosis, which is typically only

possible, early in the course of the disease, through screening. A reported 84% of females and 94% of males with a chlamydia diagnosis didn't report symptoms within the first 12 months of infection. Over 40% of new HIV infections are attributed to transmission by those unaware of their HIV status.¹⁴ This means there may be an increasing number of cases that will go undiagnosed, increasing the risk of severe complications and long-term sequelae. One example of the possible impacts of reduced surveillance is the 15% increase in congenital syphilis since 2016 which can be attributed to a lack of testing for the mothers. At least 143 stillbirths in 2020 were attributed to this rise¹⁴.

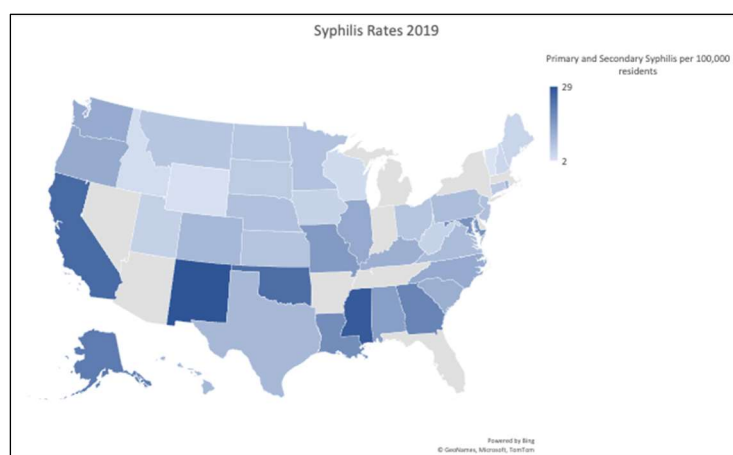


Figure 2: 2019 US syphilis rate per 100,000 residents by state. *Data not extrapolated gray states

Although screening and treatment for STIs is often paid for by private insurance, public coverage programs like Medicaid, and out-of-pocket expense, much of the cost of screening and treatment for the under- and uninsured is provided by community and safety-net services funded by federal dollars. Federal funding specifically for STI prevention is codified by Section 318 of the Public Health Services Act (PHSA)¹⁵. The Division of STD Prevention (DSTDP) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at CDC is the principal administrator for the distribution and directions of these funds and funding efforts. One such program is the Strengthening STD Prevention and Control for Health Departments' program which awards grants to state, local, and territorial health departments to screen for and treat chlamydia, gonorrhea, and syphilis¹⁵.

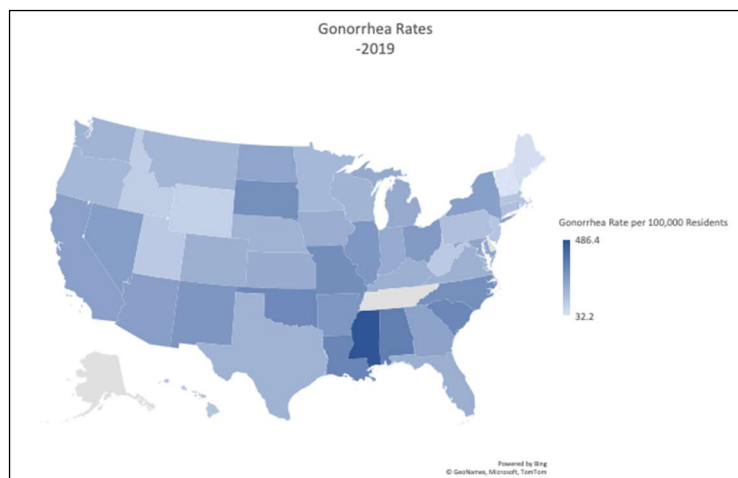


Figure 3: 2019 US gonorrhea rates per 100,000 residents by state. *Data not extrapolated gray states

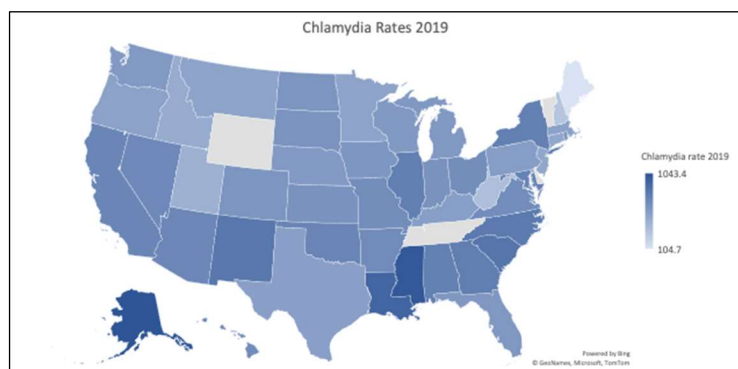


Figure 4: 2019 US Chlamydia rates per 100,000 residents by state. *Data not extrapolated gray states

In 2019, 58% of the CDC's total budget was allocated to government health operations, the majority of which were state and local governments. The total budget of the CDC, however, was cut by 40% from 2003 to 2018, impacting the availability of capital to support critical programs¹⁶. Another source of federal funds that are used for state and local programs come from the Title X Family Planning program, which awards grants to comprehensive family planning providers who offer preventive health services including STI testing and treatment. Nationwide networks of health clinics that provide no or low-cost sexual health services like Planned Parenthood have historically received significant support through Title X grants. An estimated 4 million people in the US relied on Title X funded healthcare services in 2016. During that year, Planned Parenthood served 41%, approximately 1.6 million of that population.

With continued stagnation of state and federal funding for surveillance, screening, and treatment, several specific examples of direct population impacts have emerged. The Planned Parenthood Advocates of Iowa published a 2020 report on rise in STI rates from 2017-2019 in counties where clinics faced forced-closure in 2017 following the Iowa Legislature defunding of these clinics¹⁷. The Iowa department of health reported a 21% increase in STI rates in Scott County, which was one of four counties where Planned Parenthood clinics were located. In fact, data from IDH shows that all four counties that had previously benefited from closer proximity to Planned Parenthood clinics experienced increases in STI rates following their closure. The most staggering of these impacts were seen in Woodbury County where there was a 74% increase in reported STIs between 2017 and 2019¹⁷.

California is another state that has seen staggering increases in STI incidence following an \$8 million reduction in funding to its Title X program. This comes as California is reporting a 30 year high in STI rates, including a 600% increase in congenital syphilis and 200% increase in gonorrhea since 2010. Budget constraints have forced large operation reductions or closure of a reported 150 health centers providing free or low-cost STI testing and treatment in California alone.¹⁷

Beyond a net reduction in the Title X Family Planning budget, recent changes to the rules that govern funding eligibility of health clinics has forced closure of health care centers across the country. In 2019, a domestic gag rule was put in place to prevent healthcare centers receiving funds from Title X grants from giving information or referring patients to abortion providers. This forced an estimated 50% reduction in patients that received care from Title X funded clinics, regardless of their reason for utilizing clinic services¹⁸. Title X eligibility was previously based on the capability to provide broad and comprehensive services related to family planning. For patients seeking contraception, well-woman visits, or health education, additional screenings were provided including STI screenings and treatment. A 50 % reduction in the capacity to care for the 4 million people reliant on these services has and will continue to have devastating impacts on our ability to fight the rise in STIs.

PRENATAL/ABORTION CARE

Prenatal care and abortion access are necessary elements in a woman's health care plan. In 2021, the U.S Department of Health & Human Services (HHS) awarded \$350 million to each state to support pregnant females and fetal/newborn health through the Health Resources and Services Administration (HRSA)¹⁹. America's maternal mortality rates are disproportionately high in comparison amongst developed nations. This is especially true amongst Black and Native American women. The HRSA Maternal and Child Health, Healthy Start program invests in communities with infant mortality rates that are at least one and half times the U.S. average. Some of the local projects that HRSA conducts include prenatal, post-partum, well-baby, youth care, reproductive life planning, and women's health, screening and referrals for mental health, parenting skills, transportation, immunizations, and health education¹⁹.

Each Healthy Start project has a Community Action Network (CAN), which collaborates with established social support entities such as Medicaid, Maternal, Infant, and Early Childhood Home Visiting Program, and Children's Health Insurance Program (CHIP). Since 2021, the HRSA has awarded over \$100 million to more than 100 recipients in 35 states²⁰.

The HHS also awards Title X Family Planning Service Grants, which supports providing low cost birth control and reproductive health care. Some of the services provided include wellness exams, cervical and breast cancer screening assessments, birth control/education for contraception, and STI testing²¹. In 2016, more than 4 million people utilized these services provided through Title X. In 2019, the Trump administration's Title X gag rule caused Planned Parenthood health centers, which served 41% of the 4 million patients, to withdraw from the Title X program leaving many women without access to sexual and reproductive health care. This lack of care may have contributed to the rise in abortions in 2019. People of color, LGBTQ+, and people in rural areas were disproportionately affected. In 2021, the Biden administration signed a memorandum reversing Trump abortion access restrictions²¹.

After *Roe v. Wade* was legalized in 1973, the annual number of abortions in the U.S. rose until reaching peak levels (over one million) around the early 1990s²². Since then, this number has steadily declined until 2018-2019, where there was a 2% increase. The Centers for Disease Control and Prevention (CDC) and the Guttmacher Institute are two organizations that

aim to measure the number of abortions per year within the United States. However they each have their own distinct methods²³. The CDC requests data from the central health agencies for each of the 50 states and the District of Columbia. In 2019, a total of 629,989 abortions were reported nationally to the CDC²³.

The Guttmacher Institute, founded in 1968, compiles its figures through contacting known providers of abortions including clinics, hospitals, and physicians' offices all throughout the country. The institute additionally utilizes questionnaires and health department data to provide estimates for abortion providers that do not respond to its inquiries. In part because Guttmacher includes figures and some estimates, its totals are higher than the CDC's. In 2020, they reported 930,160 abortions in the United States which was an 8% increase from 862,320 abortion in 2017²⁴.

In a study conducted by the CDC on abortion surveillance in the United States for the year 2019, women in their 20s accounted for the majority of abortions (56.9%)²². Non-Hispanic White women and non-Hispanic Black women represented the largest percentage within 2019²². Some factors causing this disparity include unequal access to family planning services, economic disadvantage, and distrust of the medical system²². The study also concluded that the national fatality rate for legal abortions within 2013-2018 was 0.41 deaths per 100,000 abortions. This is in stark contrast with the approximately 68,000 (13%) of women that will die annually worldwide due to unsafe abortion²². Another 5 million women will suffer long-term health complications from unsafe abortions²². The rise in abortion rates across the United States can be attributed to several factors. Many states expanded Medicaid coverage to include abortion care. The majority of people who obtain an abortion are low income, and this coverage meant that many who previously could not afford an abortion could now receive access. Local and national abortion funds also increased their capacity to help people pay for abortions²⁵.

In 2019, New York (78,587), Florida (71,914), and Texas (57,275) were the top three states in regards to the number of abortions performed²². A study published in 2018 conducted a systematic outline search for abortion facilities in every state, the results identified 780 facilities. The lowest gestational limit at which services were provided was found to be 12 weeks in the state of Wyoming. The highest was 28 weeks in the states of New Mexico. People in 27 midsize

labeled US cities must travel over 100 miles to even reach a facility that provides abortions²⁶.

CONCLUSION

Although there are numerous resources that provide statistics and information regarding women's health as it relates to state spending in various categories, no research is without its limitations. Many women who are homeless or without access to any form of healthcare, private or otherwise, are not included in many reported statistics. Homeless women frequently deal with the obstacles of transportation and internet access compounded by a lack of financial resources. This heightens the hurdle to accessing any form of medical care. An additional research shortcoming was the accuracy of self reported women's healthcare spending. Many women prefer no record made of their medical care, especially if they receive abortion services. This is accomplished through cash payments or the use of names such as "Jane Doe". This creates difficulties in formulating an accurate and complete representation of spending and utilization of medical care per state. Therefore, the Medicaid budget per capita was examined to determine if there was correlation with state funding availability. Furthermore, many resources and statistics utilized are from the years 2019-2021. During this time, the COVID-19 pandemic resulted in inaccurate data due to social isolation recommendations. Americans decreased the number of visits outside of their home for any circumstance, including healthcare related reasons.

The Women's Health Movement is not even 100 years old and the country is regressing to ideology disseminated to the American public before the movement's inception. Women's health care is not limited to endometriosis, PCOS, menstrual cramps, UTIs, and osteoporosis, but all aspects contributing to women's wellbeing. Preventative screenings are vital as they can help detect different cancers that can ultimately lead to death if not cared for, impacting women and their loved ones.

A Note from The Authors

As female medical students we are immersed in learning the science behind anatomy and physiology of women's health as well as those with female genitalia. We hope to bring awareness to women clinics and how they exist to do more than abortions.

We want to provide equity in the care we give to all of our patients regardless of socioeconomic status. The goal of our research is to educate policy makers and healthcare

professionals on the reality of the impact in changes for funding for women's health.

We advocate for expanded access and funding for women's clinics not just for the minority of the budget that is used for abortions, but for screening and prevention of numerous communicable diseases, infections, and cancers.

Conflict of interest and funding

No conflicts of interest are present, financial or otherwise.

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