Racism and lack of social services: The status of women's health care in the US

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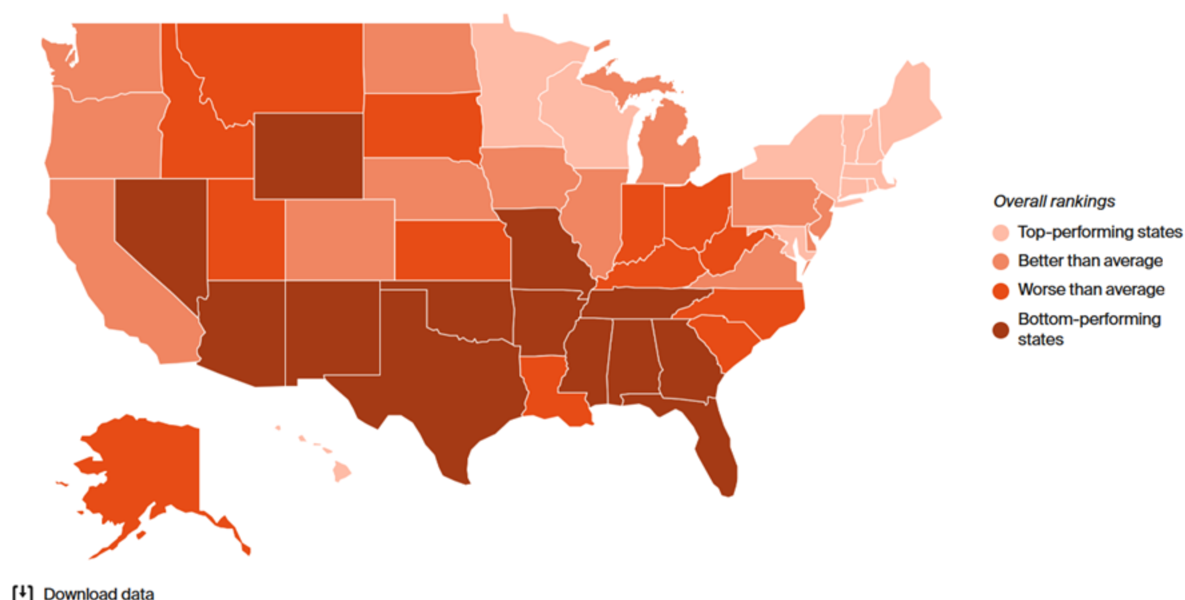
A recent publication from the Commonwealth Fund is the 2024 State Scorecard on Women's Health and Reproductive Care in which they rank all the states (plus DC) for how well that care is provided and the health status of women that results. The map below gives an overall sense (darker is worse), and the entire ranked list can be found in an interactive table in the document.

The first thing that we see is that there are no real surprises. Massachusetts is at the top and Mississippi is at the bottom. The other top and bottom states are the usual suspects for almost anything that is beneficial to people, with the Northeast doing best and the old Confederacy doing the worst. There are always some minor shifts within those groups, and in this ranking we see that Louisiana* and South Carolina are only "worse than average" not in the "bottom performing states", while disappointing to me, Arizona and New Mexico are in the lowest group. The reasons are a little different in different states; the Arizona legislature is (narrowly; we hope to flip it this year) controlled by Republicans who are as mean and nasty as those in the deep south. New Mexico is controlled by Democrats, but it is very poor. Poor is a big component of health status, and its fingerprints are all over this data on women's health. 'Despite a small rebound in women's life expectancy in 2022, it remains at its lowest since 2006,' says the report.

Abortion care – access to it and the quality of it – has dominated the national political discussion. I don't want to minimize it; it is incredibly important that women can have abortions, it is a privacy issue, and it will hopefully have major negative repercussions for the party whose agenda is to limit it. That the greatest restrictions on abortion are in the same states that have the worst women's health status is neither a coincidence nor a surprise; the people who control these states and are anti-abortion are also racists and are unwilling to provide funds to improve the health standards of people who are women, minority, or poor – and especially all three. But it goes far beyond abortion:

> For health outcomes, we measured all-cause mortality, maternal and infant mortality, preterm birth rates, syphilis among women of reproductive age, infants born with congenital syphilis, self-reported health status, postpartum depression, breast and cervical cancer deaths, poor mental health, and intimate partner violence.

Abortion is not the major component of poor reproductive health status. Maternal mortality rates are shockingly high in the southeast, and worst in the Mississippi Delta. The US overall does not do very well in this area, especially as it is the richest country in the world. Data from the CIA (!) shows that in 2020, the US maternal mortality rate overall was 21/100,000, tied with Lebanon, Grenada, and Malaysia and just slightly worse than the West Bank or (pre-war) Gaza Strip. This was (and



Data: Overall performance scores from the Commonwealth Fund 2024 State Scorecard on Women's Health and Reproductive Care.

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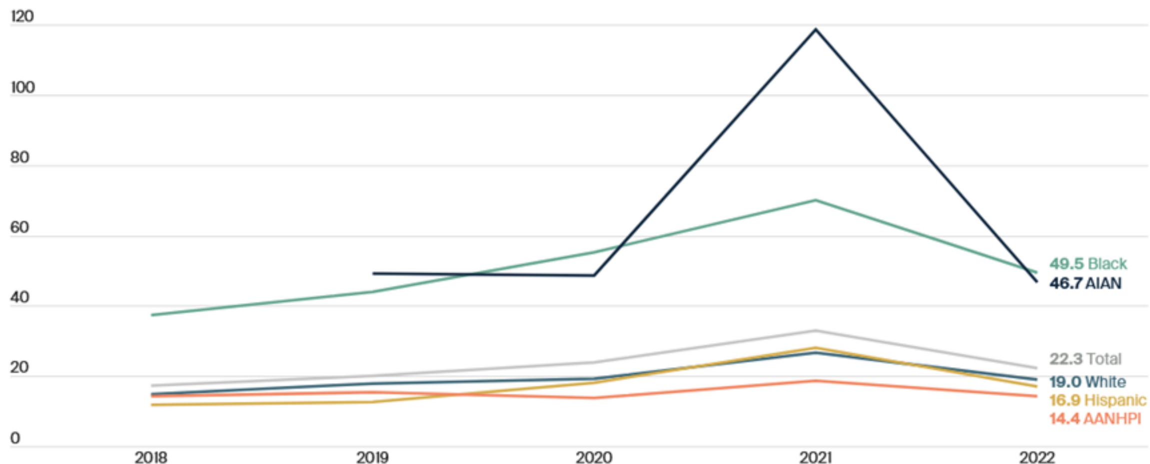
The maternal mortality rate nearly doubled between 2018 and 2022, with rates for Black and American Indian and Alaska Native women increasing the most.

Maternal mortality rate per 100,000 live births, 2018–2022



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Note: Maternal deaths include those assigned to ICD-10 codes A34, O00–O95, and O98–O99 and occur while pregnant or within 42 days of being pregnant. Rates shown are for American Indian/Alaska Native (AIAN; non-Hispanic); Asian American, Native Hawaiian and Pacific Islander (AANHPI; non-Hispanic); Black (non-Hispanic); white (non-Hispanic); and Hispanic (any race) people, based on information from decedent's death certificate. 2018 AIAN rate is not available because of CDC data suppression standards for small numbers of deaths. AA and NHPI data are combined because NHPI data alone are not available for 2018–2022 because of CDC data suppression standards for small numbers of deaths.

Data: Donna L. Hoyert, *Health E-stat: Maternal Mortality Rates in the United States, 2022* (National Center for Health Statistics, May 2024); and authors' calculations using data from the National Vital Statistics System (NVSS), Natality and Mortality, via CDC WONDER, 2018–2022.

Source: Sara R. Collins et al., *2024 State Scorecard on Women's Health and Reproductive Care* (Commonwealth Fund, July 2024). https://doi.org/10.26099/6gr0-t974

remains) much higher than Canada (11), UK (10), and most of Europe, including eastern Europe at 5 or less! (Note, showing the same dramatic racist differences as in the US, Israel is at 3). Of course, this overall rate in the US is driven by the states with the highest rates, with the worst states having a range of 34.1-51.7! While this is largely the result of excessively high rates in minority women, it is worth noting that the maternal mortality rate for white women in the US is over 19!

This is a good time to discuss the segmentation of results for maternal mortality (and all-cause mortality, and really most things) by race or ethnicity. In the bizarre, perverted, and of course racist excuse provided by many (racists) for why the US' maternal mortality is so high compared to civilized countries, it is often said "it's the minorities that drive the rate up". In addition to ignoring the excessively high rate for US whites (19) it is scarcely an excuse; indeed, it is an indictment. It is not only that the US, unlike civilized countries, does not provide health care for everyone, essentially free of charge at the time of service (that is, paid for by tax revenues, as well as costing a lot less because of the elimination of the incredible profits extracted by middlemen such as insurance companies in the US). It also provides lousy social services of all kinds, not ensuring, as civilized countries do, housing, food, and education for everyone. These (the "social determinants of health") are even more important than medical care in creating improved health status. And, while other countries do spend much more money than we do on providing them, the total cost per capita is probably less than what the US spends on health care alone! Of course, much of the spending (particularly on social services and health care for the poor, like Medicaid) is on a state basis; that is why there are such differences between the Massachusetts' and Mississippi's in this Commonwealth Fund study. And what are the practices that work? Again, no surprise:

> In our scorecard, states with the lowest rates of maternal mortality had:
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> - more maternity care providers (Vermont #2, Connecticut #3)
> - fewer women with no prenatal care (Vermont #1, California #3, Connecticut #5)
> - fewer women with no postpartum checkups (Vermont #1)
> - fewer uninsured women ages 19–64 (Vermont #3)

It cannot be stated too strongly that public funds should support a public social safety net, not bloat the profits of private companies as they do here in the US! This is most well-documented for the piggish pharmaceutical

industry and the entirely unnecessary (indeed, far worse than unnecessary, destructive and evil) for-profit health insurance industry, which I have discussed many times. But it is also the other parts of the health care industry, particularly delivery systems (e.g., hospitals). Yes, the for-profits, hospitals and nursing homes and other facilities, especially those run by corporations. But it is also the ostensible "non-profits", which do their best to emulate for-profits by doing everything possible to exclude patients without insurance or with Medicaid, pay their CEOs (and other C-suite executives) exorbitant salaries, and channel huge earnings into subsidiaries that actually own or invest in for-profit enterprises! This is documented in Why many nonprofit (wink, wink) hospitals are rolling in money by Elisabeth Rosenthal (Washington Post, July 29, 2024) and discussed by Don McCanne in Health Justice Monitor 'Not-for-profit care begets profits'. Dr. McCanne cites a study by KFF showing even a program providing "street medicine", healthcare for the homeless, in California is making money by getting huge amounts of Medicaid funds. Providing health care to homeless people is a good thing, something we need more of. If I had my druthers, I would rather see them making money than huge "non-profit" hospital systems (or of course straight for-profits, although those at least pay taxes), but they shouldn't be either.

In health care, and in all social service, all the public money should go to providing direct care (OK, maybe with a 2% overhead, like Medicare – but NOT Medicare (Dis) Advantage – has). Zero dollars should go to profits (or "excess" income that can be invested for profit), bloated salaries, and the like.

We have too many people, women and others, dying because of the lack of such care.

*Louisiana just put the two drugs used for medication abortion, mifepristone and misoprostol, on its state's controlled dangerous substances list, like narcotics. So look for LA's ranking to drop!