

Women's Health Care: A National Health Care Issue

This forum was held in New York City on April 26, 2005. Below are edited transcripts of the remarks of the speakers, Martha Livingston, PhD and Linda Prine, MD.

Martha Livingston, PhD

Women's health care is an issue of national health care in three ways. The first two are broadly known and discussed; the third is less well known outside the women's health movement.

1. Health care is a window on our whole social contract. Because our social support system is less generous than that of many other countries, women are more dependent on men as breadwinners to obtain health care coverage. Because women's employment is more episodic, we are more vulnerable to the loss of health insurance, and we often work in jobs that don't provide insurance.

2. Because caring is considered women's work, women do the lion's share — about three-quarters — of long-term caregiving, paid and unpaid, both in long term care facilities and in the family. The demands of family caregiving often force women into nightmare situations of 'round-the-clock work, or out of the work force altogether. Long term care, like child care, is a women's issue.

3. As important as the first two issues, but less well known outside the women's health movement, are women's concerns about the content and quality of medical care. The culture of medicine has been a macho culture in which doctors, even women doctors, have not been trained to talk to or listen to women, to respect and support women's concerns and decisions. Many in mainstream medicine have been woefully ignorant about women's bodies. The human female has been seen, in standard medical education, not as a variation of the human norm (the 70-kilogram white male), but as a complication. Normal female anatomy and physiology have been medicalized, seen as requiring medical intervention for normal female physiological functions such as menstruation, birth, and menopause. Too often, doctors hold themselves as experts on issues about which they have not been adequately trained, often lecturing women about "lifestyle" issues related to sexuality and sexual orientation.

Because women's bodies are seen as problematic and complicated, women especially need a health care system in which we can choose practitioners who really

understand how women's bodies work. Examples of the "overdoctoring" that results from mainstream medicine's poor understanding of women's health include

- Over-use of episiotomies in birth, which can be damaging to women's sexual response;
- Over-prescription of hormones during menopause, until the release of the 2002 study showing an increased incidence of reproductive cancers and heart disease associated with hormone use, and no benefit except as a short-term treatment for menopausal discomforts;

- Interference in normal labor, denying the normal physiology of birth and leading to an epidemic of cesarean sections (26% nationwide);

- An epidemic of hysterectomies, with 33 to 97% of the 750,000 performed annually considered unnecessary. Long-term effects include increased risk of heart disease and interference with women's sexual response.

- The excessive use of Halsted's radical mastectomy in breast cancer treatment, leading to lifelong disability. It took women's health activist Rose Kushner and others to change this norm. Now, lumpectomy is a common option, providing outcomes as good as mastectomy for many women.

On the other hand, women also face "underdoctoring," under treatment for conditions not related to the reproductive system. An example that has received much recent attention is heart disease, long considered a men's disease and studied primarily in men, resulting in mis-diagnosis or late diagnosis in women, mistreatment (for example, heart valve replacement surgery with inappropriately-sized valves tested only in men), and late diagnosis or no treatment (heart attacks unrecognized because symptom presentation is "atypical," or not the way men present with heart attacks).

Women's vision of health care calls for a radical reshaping of the health care system, including medical education and training

- In the content of what doctors are taught about the female body;

- In how doctors and their patients can work together as partners for health;

- In humanizing medical education and residency training so that doctors — including women doctors — don't come out socialized into a macho style of practice.

This presentation has been a snapshot of some of the most pressing current concerns about women's health care. Since the rise of the modern women's

(over)

health movement, much has changed in medical education, including a dramatic rise in the number of women medical students, from around 10% to over 50% in most US medical schools. But merely bringing women into medicine without a change in the underlying culture and ideology of mainstream medicine is not sufficient to guarantee more appropriate health care for women. How to transform the culture of medicine in order to institutionalize changes in women's health care is an ongoing concern.

Martha Livingston is Associate Professor of Health and Society at SUNY Old Westbury and Certified Childbirth Educator and midwifery advocate who has written and spoken on women's health issues in several countries.

Linda Prine, MD

Reproductive health care is an area that will be politically problematic during our struggle for a just national health care system and once we have national health insurance, because many powerful forces, including those who now control the federal government, oppose both abortion and reproductive health care for women. In 87% of U.S. counties, where 28% of women reside, there are no abortion providers; in some entire states, there are no providers. Half of U.S. pregnancies last year were unintended, and half of those led to abortions, about 1.3 million. Half of those women used no birth control; the other half used birth control that failed them. And these are young women; the women most likely to need abortions are between ages 15 to 24.

The U.S. has the highest abortion rate among the rich industrialized nations, largely because women have such poor access to contraception. While the number of abortions has been declining, the cause of the decline is unclear: is it a result of better access to contraceptives, or worse access to abortion care? Studies demonstrate that the decline in the abortion rate is only minimally influenced by the abstinence movement. In fact, teens practicing abstinence have been shown to end up with higher rates of sexually transmitted diseases because of their lack of preparation when they do end up having sex. Contraceptives are not covered by health insurance plans to the same extent as other pharmaceuticals are, and the right wing has recently been promoting "conscience clauses" that anti-choice pharmacists can use to avoid filling contraceptive prescriptions for women. In addition, contraception use is not perfect, so that the need for abortion access would remain, even if contra-

ceptives were widely available in a national health program.

The many barriers to reproductive health care for women include the fact that 20% of U.S. hospitals are religiously-affiliated, often not providing contracep-

tives or abortions. The vast majority of gynecologists are not taught how to perform abortions, and other advanced practice providers such as nurse-practitioners and nurse-midwives, who are capable of performing abortions, are not legally able to do so in many states. Over-the-counter emergency contraception is another preventive means capable of reducing the need for abortion, but it has not been granted over-the-counter status despite a positive recommendation from the FDA's own scientific advisory panel. It would appear that the right wing's focus on reproductive health issues is not strictly about limiting abortions, since they are also opposed to women's access to contraception. But it is not about opposition to sexuality either, since the right has not demanded a conscience clause against Viagra; it appears to be about controlling women.

With access to contraception, as with good health care overall, women will have more access to education, jobs, and financial security; children will have better health and better parenting; society will benefit overall. But that view is not shared by many on the extreme right.

Linda Prine is Associate Professor of Family Medicine at the Albert Einstein College of Medicine and Co-founder of the Reproductive Health Access Project. She is an abortion provider and trainer of other doctors in abortion care at Planned Parenthood of NYC.

Conclusion

National health insurance will not automatically solve many of the women's health problems discussed at this forum. It will improve women's access to health care by leveling the playing field with men. But women will need to continue to demand humane, respectful care from providers who are knowledgeable about our bodies and our health care needs. Real progress cannot be made toward the women's health movement's vision of appropriate health care for all until there is universal access to health care through a single payer national health insurance program.

PNHP-NY Metro FORUM REPORT

Physicians for a
National Health Program
New York Metro Chapter
2753 Broadway #198, New
York, NY 10025
Tel: (212) 666-4001
Fax: (212) 866-5847
E-mail pnhpnyc@igc.org
Web www.pnhpnyc.org



THE LUKOMNIK FORUM SERIES

This Forum was the fourth sponsored by the Joanne Lukomnik Fund for Health Care Reform. Joanne, who died at the age of 51 in 1998, served as medical director and consultant to community health centers in New York City and was one of the founders of PNHP. The Lukomnik Fund was created to continue her activism toward the kind of compassionate health care she fought for and that we believe is a basic human right.

This forum was sponsored by the NY Metro Chapter of Physicians for a National Health Program and co-sponsored by Metro NY Health Care for All Campaign, Public Health Assn of New York City, Student National Medical Assn, Region IX, American Medical Student Assn, Region 2, Queens College Urban Studies Dept.

The views expressed in forum reports are those of the speakers and are not necessarily those of the forum sponsors. Contact us for other forum reports.