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# Health Care Services and Systems for Women of Reproductive Age

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Recent attention to women's health issues reveals that women's care is based on insufficient research and is fragmented in its delivery, particularly with regard to the separation of reproductive and non-reproductive services. Women in the United States obtain health care services from a wide variety of sources, and they frequently enter the health care delivery system for either pregnancy-prevention or pregnancy-related services. The array of health service organizations serving women include both public and private entities, and some women may use a combination of both. Unless a woman is enrolled in a managed care plan of some type, her use of multiple sources of health care is unlikely to be coordinated by any provider or payer. The current health care delivery system for women therefore results in both redundancies and gaps in services, with the potential for discontinuities as women age and change providers or health insurance plans.

Because health care providers have not traditionally been trained in, or responsible for, all aspects of women's care, some women's health problems have been neglected in both research and clinical practice. These include eating disorders, domestic violence, sexual abuse, depression, sexual dysfunction, chemical dependency, the menopause transition, and gender-specific aspects of such chronic conditions as heart disease and diabetes. Many women do not have access to the type of "primary care" that is comprehensive, coordinated, and based on sustained partnerships between provider and patient.<sup>1,2</sup>

## Utilization Patterns

Women make greater use of the health care system than men, and their utilization patterns are more complex.

- While constituting approximately one-half of the population, in 1994 women made 60% of all visits to physicians and hospital outpatient departments. Sixty-one percent of all hospital stays were made by women, even when excluding obstetrical stays.<sup>3,4</sup>

- Eighty percent of women typically report having a usual source of care -- predominantly physicians' offices. Many women, however, obtain specialty reproductive health services or routine care in the public sector, or from private organizations that rely heavily on public funds (e.g., Planned Parenthood centers, or school-based health centers).
- According to a 1993 survey, 33% of women over the age of 18 use both an obstetrician/gynecologist and another primary care physician.<sup>4</sup> Types of physicians women see influence the services they receive: women who do not see obstetricians/gynecologists are more likely not to receive key preventive services according to established guidelines.<sup>5,6</sup>
- Visits to obstetricians/gynecologists account for about 1/3 of office visits made by women ages 15 to 44.<sup>7</sup> And while there are reported to be approximately 100,000 advanced practice nurses involved in providing primary care,<sup>8</sup> less than 2% of women use providers other than physicians as a regular source of care,<sup>6</sup> and only 5% of all in-hospital births are attended by certified nurse midwives.<sup>9</sup>
- Potential use of alternative providers is often constrained by state regulations limiting prescribing, admitting privileges, restrictions related to third-party reimbursement, and physician resistance.

Women of reproductive age use a diverse array of providers of health care, sometimes concurrently, and issues of comprehensiveness and continuity of care are critically important for this age group. New types of women's health centers are emerging which may help address both coordination and utilization concerns. These centers are hospital- or community-based. In 1993, there were an estimated 3,600 women's health centers nationwide, serving 14.5 million women.<sup>10</sup> Twelve percent of the centers provide comprehensive primary care. Many of these are models for innovative provision of primary care, but they have rarely been evaluated to determine their impact on quality or costs.

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## Barriers to Women's Health Care Access

Despite women's greater overall use of care, they face a number of barriers to receipt of care -- both financial, and non-financial.

- Financial barriers include lack of health insurance and inadequate insurance.
  - women are more frequently insured as dependents of spouses or other relatives
  - women more often undertake part-time employment, where insurance benefits are limited
  - women spend more out-of-pocket for health services, particularly poor women
  - although Medicaid is a key source of insurance for women, nearly one-third of poor and near-poor women remain uninsured<sup>11</sup>
  - low-income women's Medicaid coverage primarily involves only pregnancy-related services
  - recent welfare policy changes create new challenges in enrolling in Medicaid and leave most immigrant women without health care coverage.<sup>12</sup>
  - In addition, access to public prenatal care programs and family planning clinics are threatened by limitations in government funding streams and by competition from managed care plans for Medicaid clients which also reduces the financial base of these organizations.<sup>13</sup>
- Women face many non-financial barriers as well, including:
  - lack of availability of health services, or appropriate service providers. For example, in 1989, 1/4 of counties were found to have no prenatal clinic services;<sup>14</sup> in 1992, 84% of U.S. counties were without any providers of surgical abortions.<sup>15</sup>
  - limited availability of enabling services such as child care, transportation, and translation services.

## Challenges and Opportunities Related to Managed Care

The growth of managed care implies both benefits and risks to women. Although the term "managed care" is increasingly vague, its emphasis on cost control, coordination of services, and preventive care has the potential

to improve prevention and screening, provide more effective prenatal care, lower out-of-pocket costs, and foster better integration of reproductive and non-reproductive care for women. Managed care might result in fewer unnecessary interventions for women, such as cesarean sections and hysterectomies. And because health maintenance organizations have low copayments and do not have coinsurance or deductibles, out-of-pocket costs to women should be lower and more predictable.<sup>16</sup>

However, potential risks associated with managed care include possible reduced access to specialists, incentives to underserve, reduced time during visits for provider-patient communication, and discontinuities in care associated with voluntary or involuntary plan switching. Also, some managed care plans serving Medicaid enrollees may be unprepared to address the special needs of low-income women and their children, specifically chronic conditions, disabilities, mental illness and substance abuse, and also to provide linkages with needed social services.<sup>17</sup>

## Quality Issues in Women's Health Care

Currently there is no consensus on a definition of quality in women's health. Two general categories of issues are particularly relevant to quality: increasing the knowledge base on the effectiveness of specific services; and evaluating the effects of alternative health care delivery models.

Although attention has been devoted recently to outcomes research that focuses on disease management, it is important to note that much of women's health care is not disease-related but is concerned instead with prevention and health maintenance.

Measures of quality currently being utilized under HEDIS for commercially insured women are: breast and cervical cancer screening, early prenatal care, ongoing prenatal care, Cesarean-section and VBAC rates, birth-related average length of stay, and post-partum checkups. HEDIS measures monitored for women enrolled in Medicaid incorporate additional indicators related to pregnancy and childbirth, and to linkages with social services. Additional measures of quality in women's health are under development within National Committee for Quality Assurance.

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## Issues for Policy, Practice and Research\*

Public policy to improve perinatal health and the overall health of women must address two broad issues:

1. The need for all women to have access to a basic standard of health care in their communities at an affordable cost; and
2. The need to ensure that health services provided to women are comprehensive, integrated, and of high quality.

Policy related to health insurance, managed care, availability of safety-net programs, and other issues also must focus on issues specific to women. Public funding streams that support specialized reproductive services without providing for their integration into comprehensive, continuous women's health care programs help perpetuate fragmentation and inadequate care.

Research needs involve addressing how women's health care utilization and quality differ by provider type and by organizational context. Research is needed to determine how receiving care from different types of primary care providers affects the quality of care; how the coordination of reproductive and non-reproductive care in different types of organizations impacts on outcomes; and how the physician-patient communication process in different types of settings affects satisfaction and other outcomes. Despite the massive changes underway in our health care system, little is known about how new organizational forms such as comprehensive primary care women's health centers and the various types of managed care organizations (including mental health and substance abuse "carve outs") are affecting women's health care.

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\* Given the formative nature of our research on this topic, this material does not reflect an exhaustive list of potential issues of concern. Rather, the material below reflects selected preliminary ideas generated to stimulate dialogue and further study. In addition, certain issues may have been intentionally omitted from this section in favor of their incorporation in other materials prepared as part of a broader initiative to review the state of the field of perinatal and women's health.

## References

- 1 Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds., 1996. *Primary Care: America's Health in a New Era*. Washington, DC: National Academy Press.
- 2 Starfield B, 1992. *Primary Care: Concept, Evaluation, and Policy*. New York.
- 3 Horton J, 1995. *The Women's Health Data Book (2nd edition)*. Washington, DC: Jacobs Institute of Women's Health.
- 4 Weisman CS, 1996. Women's use of health care. In: Falik MM, Collins KS, eds. *Women's Health: The Commonwealth Fund Survey*. Baltimore: Johns Hopkins University Press.
- 5 Weisman CS, Cassard SD, Plichta SB, 1995. Types of physicians used by women for regular health care: Implications for services received. *Journal of Women's Health* 4:407-416.
- 6 Wyn R, Brown ER, Yu H, 1996. Women's use of preventive health services. In: Falik MM, Collins KS, eds. *Women's Health: The Commonwealth Fund Survey*. Baltimore: Johns Hopkins University Press.
- 7 National Center for Health Statistics, 1995. *Health, United States, 1994*. Hyattsville, MD: Public Health Service.
- 8 American Academy of Nursing, 1997. Women's health and women's health care: Recommendations of the 1996 AAN Expert Panel on Women's Health. *Nursing Outlook* 45:7-15.
- 9 Gabay M, Wolfe SM, 1997. Nurse-midwifery: The beneficial alternative. *Public Health Reports* 112:386-394.
- 10 Weisman CS, Curbow B, Khoury AJ, 1995. The National Survey of Women's Health Centers: Current models of women-centered care. *Women's Health Issues* 5:103-117.
- 11 Short PF, 1996. *Medicaid's Role in Insuring Low-Income Women*. New York: The Commonwealth Fund.
- 12 Rosenbaum S, Darnell J, 1997. *An Analysis of the Medicaid and Health-Related Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)*. Washington, DC: Kaiser Commission on the Future of Medicaid.
- 13 Henshaw SK, Van Vort J, 1994. Abortions services in the United States, 1991 and 1992. *Family Planning Perspectives* 26:100-106,112.
- 14 Singh S, Forrest JD, 1989. Torres A, *Prenatal Care in the United States: A State and County Inventory, Volume I*. New York: Alan Guttmacher Institute.
- 15 Davis K, 1997. Uninsured in an era of managed care. *Health Services Research* 31:641-649.
- 16 Bernstein AB, 1996. Women's health in HMOs: What do we know and what do we need to find out? *Women's Health Issues* 6:51-59.
- 17 Salganicoff A, 1997. Medicaid and managed care: Implications for low-income women. *Journal of the American Medical Women's Association* 52:78-80.

This **Issue Summary** is one in a set of thirteen, prepared as part of an initiative -- Perinatal and Women's Health: Charting a Course for the Future -- sponsored by the Maternal and Child Health Bureau in partnership with the Women's and Children's Health Policy Center at the Johns Hopkins School of Public Health. The intent of this work is to highlight policy and program areas needing to be addressed to ensure the continuous improvement of health care and services related to perinatal and women's health over the coming decade.

Copies of this and the additional Issue Summaries listed below can be accessed by contacting: National Maternal and Child Health Clearinghouse at 703/356-1964.

- 1 The Social Context of Women's Health**
- 2 Women's Reproductive Health and Their Overall Well-being**
- 3 Women's Experience of Chronic Disease**
- 4 Depression in Women**
- 5 Abuse Against Women by Their Intimate Partners**
- 6 The Nutritional Status and Needs of Women of Reproductive Age**
- 7 Women's Physical Activity in Leisure, Occupational and Daily Living Activities**
- 8 Effects of Drug and Alcohol Use on Perinatal and Women's Health**
- 9 Effects of Smoking on Perinatal and Women's Health**
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