

Commentary

Changing Definitions of Women's Health: Implications for Health Care and Policy

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Objectives: To present an overview of how and why normative conceptions of women's health are changing and to discuss some implications of definitional shifts in the context of the changing U.S. health care system. *Method:* The paper describes the historical development of views of women's health and health care, contrasts the biomedical and biopsychosocial perspectives on women's health, and presents some evidence of challenges and opportunities for change in health care and policy. *Results:* While women's health has generally been equated with reproductive functions, expanded definitions focus on health through the life span and in the context of women's multiple roles and diverse social circumstances. This expanded view highlights the limitations of health services and policy based on narrower conceptions and program mandates and the need for strategies for integrated, continuous care. There is evidence of change in women's health care, including in Title V programs. *Conclusions:* New understandings of women's health are particularly relevant to maternal and child health programs, which are positioned to provide model approaches for improving women's health care.

KEY WORDS: Women's health; history of women's health and health care; reproductive functions; women's roles; health services; health policy; Title V.

INTRODUCTION

A paradigm shift is taking place in women's health. This is occurring largely because of the efforts of women in government, academia, the professions, and women's health advocacy and interest groups to draw attention to gender inequities in health care and to improve the health of women. Although the shift can be placed in the context of growing global concern about women's rights and social well-being,

its implications for health care policy and health programs are particularly profound in the United States, where the health care system is undergoing fundamental changes. Because maternal and child health programs, both historically and today, are key components of women's health care and policy, the new understandings of women's health are particularly relevant to them. This paper presents an overview of how normative conceptions of women's health are changing and some implications for women's health care and policy.

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THE SOCIOHISTORICAL CONTEXT OF DEFINITIONAL SHIFTS

The term "women's health" typically connotes reproductive functions and, in particular, women's capacity to produce and nurture children. This focus is

a legacy of the medical conceptions of women's health that emerged in the second half of the 19th century, when ideas about biological determinism and fundamental differences between the sexes were becoming prominent (1). According to the dominant medical theories of the period, the female reproductive organs were not only central to women's reproductive capacity but also controlled women's overall physical and mental condition. At the same time, prevailing gender ideology defined maternity as women's primary social function and moral purpose, thus giving legitimacy to the medical focus on reproduction.

Public policy reflecting and reinforcing the linkage of women's health with reproduction can be traced to the late 1800s, when legislation prohibiting contraception and abortion was justified, in part, on the need to preserve women's health and maternal role. From that period into the Progressive Era, protective labor legislation targeted to women (which, for example, set maximum hours for women's employment outside the home) often was justified as protecting the health of women as actual or potential mothers. Also during the Progressive Era, maternal and child health programs—including maternal education, prenatal care, and child health clinics—were promoted by segments of the health professions, women's organizations, and social welfare workers, who believed that maternal health required both social and medical reforms. These programs were enacted in public policy through the creation of the federal Children's Bureau in 1912 and the Sheppard-Towner Maternity and Infancy Act of 1921, which created federally subsidized programs for maternal and infant health (2). Although women reformers and the medical profession clashed over such issues as who should control the new programs and whether programs should be universal or targeted to the needy, both groups equated women's health with maternity (3).

At the same time, an emerging birth control movement drew attention to the health implications of unplanned and too-frequent pregnancies and to the need for legalized contraception (4). Advocates of legalized birth control, including Margaret Sanger, initially based their arguments both on the need to improve maternal health and on married women's rights to control their sexual and reproductive lives. In part because their views of women's roles were regarded as morally questionable, the birth control advocates did not receive the support of the maternal and child health reformers in the Children's Bureau. (Grace Abbott of the Children's Bureau, for exam-

ple, declared that the purpose of the Sheppard-Towner Act was "not to prevent children from coming into the world but to save the lives of babies and mothers" [3, p. 198]). This early division within the women's health advocacy community foreshadowed subsequent debates about the relative importance of the reproductive rights and maternal-child health agendas. Despite their differences, however, both groups held views of women's health that emphasized reproductive functions.

The policy linkage of women's health and reproduction was perpetuated in subsequent public programs providing pregnancy-related and/or family planning services. Title V of the 1935 Social Security Act provided funds to support maternal and child health services similar to those under Sheppard-Towner, with special attention to needy women. (Family planning became a permitted service under Title V in 1942.) Title V signaled a policy shift to programs to improve access to pregnancy-related and other reproductive health services for poor and underserved women, rather than for all women regardless of need. Subsequent policies in this tradition included the Emergency Maternity and Infant Care program for the wives and children of men in the lower pay grades in the armed forces during World War II; the Medicaid program, which was established in 1965 and based health benefits for nonelderly, nondisabled needy women on their maternal status; Title X of the Public Health Service Act, established in 1970 to provide funding for family planning programs for poor and underserved groups of women; the Special Supplemental Food Program for Women, Infants, and Children program, established in 1972 to provide nutritional supplements to low-income, nutritionally disadvantaged pregnant and lactating women and to young children; and the Medicaid expansions for pregnant women in the 1980s, which, among other things, contributed to increased Medicaid financing of childbirth and family planning (5-7).

The American medical profession also reinforced the reproductive focus in women's formal health care through the relatively early creation of a specialty board in obstetrics-gynecology (in 1930) (8). The new specialty combined general obstetrics with the surgical field of gynecology and was restricted to physicians who served only women, thus excluding general practitioners from certification in the specialty. Following World War II, the role of obstetrician-gynecologists in the provision of well-woman and preventive care expanded due to the combined

effects of the sexual revolution, the use of Pap smears for cervical cancer screening, and by 1960, the availability of the first oral contraceptive, which required a physician's prescription. By then, obstetrician-gynecologists had become the gatekeepers to medical contraception and to legal abortion. In consequence, women born after World War II came into earlier and more sustained care by obstetrician-gynecologists than any previous generation.

The Women's Health Movement of the 1960s and 1970s provided the first major challenge to the medical profession's view of women's health, and it provided the basis for extending women's health concerns beyond reproduction (9). The post-World War II baby-boom generation of women was then of college age, more sexually active (premaritally) than previous generations, and inclined to view maternity as an optional or peripheral component of their lives. They were highly critical of the male-dominated medical profession's authority to control women's reproductive lives by regulating access to abortion and contraceptives and by managing hospital-based childbirth. (At the time, only about 7% of U.S. physicians and specialists in obstetrics-gynecology were women.) Women also challenged other aspects of their health care, especially practices and products that placed women at risk. Most notably, they drew attention to women's limited access to information about the risks of drugs and medical devices (e.g. oral contraceptives, diethylstilbestrol [DES], intrauterine devices) and to inappropriate informed consent procedures (e.g. in one-step biopsy/mastectomy breast surgery, for sterilization).

The outcomes of this movement had profound impacts on women's health care. The legalization of abortion led to the growth of nonhospital facilities to provide surgical abortions and to an array of controversies and accommodations around abortion services. Alternative forms of health care delivery were created, such as feminist women's health centers and freestanding birth centers, which still exist today. Criticisms of hospital-based childbirth practices led to such reforms as more home-like labor and delivery suites and rooming-in services, which are now widely available in U.S. hospitals. Regulatory innovations such as Food and Drug Administration mandated information inserts in packets of oral contraceptives were implemented.

The movement also helped inspire an influx of women into U.S. medical schools beginning in the mid-1970s, when civil rights legislation prohibited sex

discrimination in educational institutions receiving federal funds. The number of women physicians more than doubled between 1970 and 1980, and by 1995, women were 34% of residents and fellows, 22% of all active U.S. physicians, and 30% of obstetrician-gynecologists (10). In addition, the movement laid the foundations of an organized women's health advocacy community focusing on a wide range of both reproductive and non-reproductive issues. Organizations such as the Boston Women's Health Book Collective and the National Women's Health Network (both of which are still active) enrolled women as members, disseminated health information, and attempted to influence health policy.

Another wave of women's health activism emerged around 1990, led by a combination of women's health advocacy groups and women who had attained positions of influence in government, the medical profession, academia, and health care delivery organizations (11). Many of these women had been participants in the earlier Women's Health Movement or had entered their careers as a result of the opportunities opened to women during the 1960s and 1970s. In contrast to the earlier movement, however, this episode reflected a determination by women who had attained positions of influence in government and the professions to work through mainstream institutions and to use public policy to promote equity for women in biomedical research and in health care delivery. The Congressional Caucus for Women's Issues, working in concert with women in the National Institutes of Health (NIH), academia, and throughout the biomedical community, spearheaded the policy initiatives in women's health.

During this episode, activists took a decidedly broad view of women's health. Despite considerable unmet needs for contraception, abortion, and pregnancy-related care among some segments of the female population, women's health advocates focused on issues beyond reproduction. The aging of the baby-boom generation accounts in large part for the 1990s emphasis on women's health through the life span and, in particular, on the health concerns of midlife and older women. Gender politics also helped form the agenda. Both the anti-abortion backlash that escalated during the 1980s and the gender issues raised by Anita Hill's testimony during the Clarence Thomas confirmation hearings in 1991 created a context in which women's health concerns other than abortion became good bipartisan political issues for legislators seeking to be responsive to women constituents.

A number of policy initiatives reflected these developments. The Women's Health Equity Act, an omnibus legislative package addressing women's health research and services, was first introduced in Congress in 1990 and has been reintroduced several times, with enactment of a number of its provisions. The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Title XV of the Public Health Service Act) authorized the Centers for Disease Control and Prevention (CDC) to establish the National Breast and Cervical Cancer Early Detection Program to improve access to screening services for low-income, uninsured, and other underserved women. Federal funding for breast cancer research increased from \$90 million in 1991 to \$500 million in 1995, and a National Action Plan on Breast Cancer was established in 1994 as a public-private partnership. The 14-year Women's Health Initiative, the largest research study ever funded by the NIH, was launched in 1993 and focused on the health of midlife and older women. New positions and offices (such as the NIH Office of Research on Women's Health and the Office on Women's Health in the Department of Health and Human Services) were created in federal agencies to oversee and coordinate the women's health agenda.

A major effort during the 1990s has been to expand the biomedical research agenda on women's health by identifying women's health problems that have been inadequately researched and therefore neglected in clinical practice. Currently, there is a broad consensus among women's health advocates that more public resources should be devoted to research on women's health. There is some disagreement, however, over which problems should get priority, and there are concerns that women's reproductive health not be neglected in the expanded research agenda. A continuing tension between advocates of a reproductive rights agenda and advocates of a broader women's health agenda occasionally surfaces. In addition, some advocates for maternal and child health are concerned that a broadened research agenda in women's health could deflect resources from research and programs to improve the health of pregnant women and infants.

CONTRASTING PERSPECTIVES ON WOMEN'S HEALTH

Women's health advocates worldwide and in the United States recently have promoted expanded con-

ceptions of women's health that include but are not limited to reproductive functions. In this reframing, women's health is conceptualized in terms of the totality of women's experiences throughout the life span. This broadened perspective reflects a number of trends, including women's expanded social and economic roles; growing understanding of how culture, psychosocial factors, social inequalities, and the physical environment impact on health; and the aging of the baby-boomers, who are concerned about health in the perimenopausal years and beyond. The new perspective sometimes is referred to as a "biopsychosocial" model of women's health, in contrast to the traditional "biomedical" model.

Efforts to define women's health inevitably raise questions about the relevance of gender comparisons. In attempting to articulate what is distinctive about women's health, some definitions of women's health rely on direct gender comparisons and some do not. When women's health is explicitly compared with men's, the definitions are open to the accusation of using men's health as the standard against which women's health is defined, studied, and incorporated into public policy. When the focus is on women, the definitions are open to the "so what?" question—that is, why is a definition of *women's* health, as opposed to *human* health, needed? The answer, from the biopsychosocial perspective, is that gender is a fundamental social variable that affects individuals' social status, access to resources (such as education, income, health care), experiences of health and illness, and interactions with the health care delivery system. The effects of gender on health and illness, furthermore, can be studied for both women and men.

In its attempts to articulate a women's health research agenda, the NIH used a biomedical definition of women's health based on gender comparisons. The NIH defines women's health issues as:

Diseases or conditions *unique* to women or some subgroup of women; diseases or conditions *more prevalent* in women; diseases or conditions *more serious* among women or some subgroup of women; diseases or conditions for which the *risk factors* are different for women or some subgroup of women; and diseases or conditions for which the *interventions* are different for women or some subgroup of women (12).

Many recent explications of women's health problems have used this logic, which has the advantage of focusing attention on conditions that can be readily identified with clinical specialties and programs.

The NIH definition has been criticized, however, for its focus on disease rather than on wellness and for its implicit use of the male norm to define the subject matter of women's health (13).

Women-centered conceptions of health, on the other hand, begin with an understanding of the needs of women and of the social factors that influence their health. While acknowledging biological differences between women and men, they also recognize that society constructs gender differences and that gender-based social inequalities affect health. Examples of inequalities include women's more precarious economic status relative to men, women's greater exposure to domestic violence and coercive sexual encounters, and the stresses associated with women's greater care-giving responsibilities within their families and communities. An understanding of the social causes of health also helps highlight diversity among women in their ability to access such health-producing resources as a safe environment, adequate nutrition, or health care (14).

From this perspective, Rodriguez-Trias proposes two concepts for defining women's health: *centrality* (that is, using women's life experiences as the basis for health research, services, and policy) and *totality* (that is, health understood holistically and in the social context of women's lives) (15). Ruzek argues for an "inclusive social model" of women's health that focuses on the social and economic factors that affect women's health and recognizes the diversity among women in access to health-producing resources (16). In her view, women's health can be improved through interventions in the community, not just in women's bodies. These approaches to understanding women's health also recognize that health is more than the absence of disease or disability; it also includes maintaining bodily integrity and psychological and social well-being. A definition of women's health that reflects these new perspectives was adopted, for example, in the Platform for Action of the Fourth World Conference on Women in Beijing in September 1995:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology (17).

Women's health advocates today generally prefer biopsychosocial definitions of health to biomedical ones. One reason is that notions of biological primacy

often have been used against women. Women's biological functions (for example, menstruation, pregnancy, menopause) have been medicalized and subjected to clinical supervision, and biological arguments have been used historically—as in the case of protective labor legislation—to limit women's social opportunities. In addition, the biomedical model downplays diversity among women and provides a justification for treating all women as biologically equivalent. The special health problems of socioeconomically disadvantaged or minority women, for example, typically are not acknowledged within this framework unless a biological mechanism is discerned. The biomedical model also emphasizes the treatment of disease and neglects health maintenance activities that are important to women (for example, contraceptive practices that enable women to control their fertility).

The expanded view of women's health has raised some concerns, however. The bioethicist Laura Purdy has pointed out that notions of "social health" might encourage the extension of medical authority into social and behavioral realms in which medical professionals have no special expertise (18). Another concern is that definitions emphasizing the social conditions affecting health may deflect attention from more attainable health care reforms to larger social goals that have less likelihood of broad-based political support in the short-term. It is more politically feasible, in other words, to formulate policy to ensure equity in health insurance coverage than to reduce gender inequalities in society at large.

In any event, the new perspective on women's health can be characterized by three features. First, health is viewed as the product of cultural, social, and psychological factors as well as biology, and gender-based social inequalities are understood as a basis for identifying health issues specific to women. Second, women's health is viewed from a life span and multirole perspective, with the implication that overall health includes but is not defined by reproductive health. Third, health is understood as more than the absence of disease and as requiring health promotion and health maintaining strategies by both the individual and society.

IMPLICATIONS FOR HEALTH CARE AND POLICY

The reframing of women's health has some important implications for the organization and delivery

of women's health care. The implied policy objective of the expanded view of women's health is the need to ensure all women's access to comprehensive medical and psychosocial services that incorporate both reproductive and nonreproductive services in a continuum of care across life stages. Currently, the U.S. health care system is undergoing a major transformation characterized by the growth of increasingly diverse managed care organizations serving enrolled populations, growing enrollment in managed care among both privately and publicly insured persons, increased government regulation of managed care, restructuring of Medicaid and Medicare, and declining federal investment in the health care "safety net" for the growing number of uninsured and other underserved persons. This is the context within which women's health care is being reframed.

The current state of women's health care is highly fragmented. Although fragmentation has been defined in many ways, in women's health care it generally refers to the tendency to separate delivery of reproductive³ and nonreproductive services without provisions for coordination of total care (19). This separation reflects both medical specialization and organization and financing issues. Public programs in women's health are targeted to needy women and focus on services related to reproduction and the reproductive system (e.g., Title X family planning programs, Title V prenatal care programs, Title XV CDC breast and cervical cancer screening programs, recent Medicaid expansions for pregnant women). These programs undoubtedly extend access to at least a limited set of services for underserved segments of the female population. They also may contribute to system-level fragmentation, however, by sustaining programs that are not linked with other services or are temporary in nature and do not provide for transitioning women to other sources of care when their eligibility for benefits expires. Given the absence of universal health insurance and growth in the number of uninsured Americans, the need for Medicaid expansions, for targeted public programs, and for maintaining safety-net women's health services remains great. A key policy issue in women's health care is how to preserve the safety net for un-

derserved women while simultaneously improving the availability of comprehensive, integrated services.

In order to obtain both reproductive and nonreproductive care, many women use more than one health care provider, and most women do not have access to the type of "primary care" that is characterized by proponents as first-contact, comprehensive, coordinated care based on a sustained partnership between provider and patient (20). In the 1993 Commonwealth Fund Survey of Women's Health, women ages 18 and over reported various patterns of care seeking: 33% of women reported seeing both a family practitioner or internist and an obstetrician-gynecologist for their regular care, 39% saw only a family practitioner or internist, 16% saw only an obstetrician-gynecologist, 3% saw only other specialists, and 10% had no regular physician (21). These various pathways of entry to the health care system, furthermore, affect the care women receive. Women seeing two types of physicians—both a generalist and an obstetrician-gynecologist—made, on average, 25% more annual physician visits and received more clinical preventive services than women seeing only a generalist. Women who saw only a generalist were less likely than women seeing an obstetrician-gynecologist (as either the primary physician or in combination with a generalist) to receive Pap smears, mammograms, and cholesterol screenings (22).

The overlay of publicly supported programs for women's health care further complicates women's utilization patterns. For example, according to the 1995 National Survey of Family Growth, 26% of women ages 15–24 reported using a family planning clinic for their first contraception-related visit, and 15% of women ages 15 to 19 years and 21% of women ages 20–24 years received a family planning or other medical service in a publicly funded family planning clinic during the 12 months prior to the interview (23). Although most of the over 4000 Title X funded family planning clinics nationwide provide services in addition to contraception (e.g., screening for sexually transmitted diseases, Pap smears, pregnancy tests), their resources to expand services are limited, and they are not typically integrated into service systems to link women with other providers. Little is known about how women who use family planning clinics obtain their basic health care, either within these settings or elsewhere, about the comprehensiveness of the health care they receive, or about their risks if additional providers are not aware

³There is no standard definition of reproductive health care. Here the term is used broadly to refer to pregnancy prevention services, abortion services, infertility services, pregnancy-related care, sexually transmitted diseases services, and care of the female reproductive system throughout life.

of their contraceptive histories (e.g., use of oral contraceptives).

Similarly, little is known about how women who receive pregnancy-related services under the Medicaid program obtain health care when their Medicaid eligibility expires or the extent to which prenatal and postnatal care are coordinated for these women. (Benefits expire 60 days following childbirth unless the woman qualifies for welfare assistance.) Currently, Medicaid covers about 40% of all U.S. births (24), but the program is not required to provide mechanisms for ensuring continuity of care for women following childbirth, even if the woman has a chronic condition such as diabetes that requires monitoring. A recent analysis found that nearly two-thirds of women who leave the Medicaid program become uninsured (25).

Strategies for Change

A number of strategies are available for redesigning women's health care to be more consistent with new conceptions of women's health. In medical education, several initiatives are underway to provide better training for physicians in the expanded domain of women's health, but their outcome for care delivery is far from certain. Curriculum reforms that are intended to improve the training of medical students and residents in the content of women's health have been implemented in several specialties (e.g., internal medicine, obstetrics-gynecology, family practice) (26). Four-year residency programs in obstetrics-gynecology now are required to provide a minimum of six months of primary care. A recent survey of the directors of these programs found some skepticism about expanded training in primary care: while 53% agreed with the primary care requirement, 43% disagreed with it, and 60% believed that educational deficiencies would develop in obstetrics-gynecology as a result of the requirement (27).

Efforts also are underway to develop a new interdisciplinary primary care medical specialty in women's health, as exemplified by the founding in 1996 of the American College of Women's Health Physicians, which now has over 170 members and student chapters in two states. Proponents of the new specialty argue that it will produce experts in women's health and will encourage medical institutions to take women's health seriously; critics argue that it will marginalize women's health rather than integrating it into other specialties (28). In nursing,

there are proposals to increase the supply of advanced practice nurses (including, for example, nurse practitioners and clinical nurse specialists) capable of providing women's primary care; key barriers to an expanded role for nurses in women's primary care include physicians' opposition and state nurse practice acts that limit nurses' functions and ability to receive third-party reimbursement (29).

In health care delivery, innovative models for women's health services abound and provide possible organizational models for change. One interesting phenomenon is the growth of new types of women's health centers. The 1994 National Survey of Women's Health Centers estimated that there were 3600 organizational entities nationwide providing services designed for and marketed to women; over 400 of these identified themselves as primary care centers. Comprehensive primary care women's health centers attempt to integrate reproductive and nonreproductive care for women using a "one-stop shopping" model in which basic services are available on site, a well-woman visit includes a comprehensive examination including a gynecologic exam, and overall care (including referrals for obstetrics) is coordinated by a primary care provider (usually an internist or obstetrician-gynecologist) or a multidisciplinary team (30).

Primary care women's health centers currently are of three types: (1) hospital-owned or -operated centers, including new primary care centers for women in Veterans Administration medical centers and centers in community hospitals and academic medical centers, such as Women's Health Associates at Massachusetts General Hospital in Boston; (2) independent for-profit centers founded by physicians, advanced practice nurses, or lay entrepreneurs, and marketed to privately insured women, such as the Spence Centers for Women's Health, which were founded in 1995 and combine traditional and non-traditional therapies; and (3) community-based not-for-profit centers, including feminist women's health centers and former reproductive health centers, such as some Planned Parenthood affiliates, which have recently expanded into primary care. Although all of these centers may serve women enrolled in Medicaid, the community-based primary care centers serve more Medicaid, uninsured, and underinsured women than the other types of centers.

Six case studies of these types of comprehensive primary care women's health centers around the country found that although some are experiencing financial difficulties, they generally are functioning at

full capacity, require little marketing to attract patients, and have highly satisfied patients who prefer the centers to other sites where they previously had obtained care. Administrators and clinicians believe the centers are efficient, because they provide well-woman care in fewer annual visits per patient, and that they provide high quality care tailored to women's clinical and psychosocial needs. Research comparing these centers with traditional models of primary care delivery for women is needed to demonstrate the "value added" of centers. One recent study comparing three primary care women's health centers with three internal medicine practices in one city found that women served in centers received more clinical preventive services from their primary physicians (without additional visits), more preventive counseling services, and reported higher levels of satisfaction with patient-provider interactions than women in internal medicine practices (31). These findings suggest that centers may provide efficiencies and higher quality, at least with regard to prevention.

The transformation of some family planning clinics into primary care centers has been motivated by a combination of changing conceptions of women's health, patient demand, and the pressures of competition with managed care plans for Medicaid patients. Administrators of family planning centers in the National Survey of Women's Health Centers were reconsidering their missions and service mixes. Most notably, 26% reported planning to expand primary care services within the next two years, and 22% planned to add midlife women's services (e.g., menopause counseling). Some of the challenges encountered by family planning centers in transitioning to primary care include recruiting primary care physicians, reorienting and expanding the technical skills of staff, preserving adequate time for patient education and counseling, partnering with local providers for backup and referral services, safeguarding client confidentiality, and upgrading information systems to monitor and assess quality of care (32). An alternative to transitioning to primary care is contracting with managed care plans to provide specialty services in which family planning providers have developed expertise (e.g., routine gynecology for disabled women or abortion services), thus expanding the service mix for plan enrollees (33).

Within the managed care industry generally, there is increasing interest in identifying areas for improvement and "best practices" in women's health

care. Because managed care plans are accountable for enrolled populations, often assign gatekeeping primary care providers, and emphasize preventive care, their potential for improving the delivery of comprehensive primary care services to women is great. Managed care plans vary widely, however, in how they organize women's primary care (e.g., the types of clinicians who may serve as primary care providers for enrolled women or provide key components of women's basic care), in the benefits structures for women (e.g., whether or not contraceptives are covered, the periodicity with which clinical preventive services such as Pap smears and mammograms are covered), and in quality of care for women (e.g., percentages of women receiving preventive services and early prenatal care) (34). Incentives within managed care that encourage physicians to reduce utilization or to decrease time during office visits for patient education and counseling may harm women if specialty services or informational services are curtailed. Research has yet to identify the characteristics of managed care plans that are associated with more comprehensive services or with better health outcomes for women.

Implications for Maternal and Child Health Programs

Title V maternal and child health programs are likely to be increasingly affected by changing patterns of women's health care delivery, particularly the growth of Medicaid managed care. Advocates for these programs may be challenged to defend their traditional focus on women's health primarily in relation to children's health, and on prenatal care and other pregnancy-related services rather than a continuum of care for women. Title V programs are strategically positioned, however, to help policymakers define appropriate women's health care, particularly for underserved populations, consistent with new definitions of women's health.

Maternal and child health personnel could be credible advocates for the proposition that women's reproductive health and overall health are inextricably linked, and that separating services for women according to body parts or temporary conditions such as pregnancy does not ensure the health of women or their families. Furthermore, since preventing unintended pregnancies is an important strategy for improving birth outcomes, women's health, and the health of women's families, integrating pregnancy

prevention and pregnancy-related services at the clinical and programmatic levels is sound public policy. Specific roles for maternal and child health personnel might include articulating for the public and policymakers how normative conceptions of women's health are changing; defining a continuum of care for women (regardless of pregnancy status) that includes comprehensive preventive services (e.g., pregnancy prevention, sexually transmitted disease and AIDS prevention, nutrition counseling, smoking cessation programs, breast and cervical cancer screening); identifying the components of women's health (prepregnancy, during pregnancy, and postpregnancy) that impact on the health of children; assessing women's unmet needs for services in communities; providing expertise in culturally sensitive care for disadvantaged minority populations of women; developing and evaluating innovative models of comprehensive care for women; and helping preserve and strengthen the health care safety net for uninsured, underinsured, and other underserved women.

The life span perspective on women's health, furthermore, provides a rationale for extending the population served beyond the traditionally defined "reproductive years" (ages 15-44) to include preadolescence through the transition to menopause or beyond. This is based on the reasoning that prepregnancy health status affects pregnancy outcomes, and for many women, prenatal care is provided *after* their health already has been compromised by such problems as obesity, smoking, or chronic conditions that can influence reproductive outcomes. In addition, women are giving birth at later ages, and because caregiving responsibilities do not end with menopause, are responsible for child health beyond the years when they are capable of pregnancy. At a minimum, maternal and child health programs could incorporate information and services that assist women who are transitioning into or out of childbearing (e.g., preconception services, perimenopause services).

The prospect of providing extended services for women may seem daunting given increasingly constrained resources in Title V and other publicly funded health services programs. In addition, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which severed the automatic linkage between welfare and Medicaid enrollment, raises the possibility of greater numbers of low-income women without health insurance in some states and increased demands on Title V programs for serv-

ices traditionally provided within their mandate. Programs are unlikely to have the capacity to provide comprehensive women's health services by themselves, nor are they likely to have the information system capability to track and coordinate services clients receive from other sources of care. The realities of the health care marketplace, however, provide incentives to reconsider traditional mandates and to forge linkages with other programs and organizations.

In many states, Title V programs already provide a variety of women's health services beyond pregnancy-related care through a variety of contracting and grants mechanisms. A 1992 survey by the Women's Access to Comprehensive Health Services Project of the Association of Maternal and Child Health Programs (AMCHP) found that over three-fourths of states used Title V funds to support family planning services (some states integrate Title V and Title X funds or programs), a majority of state MCH units were administering preconception care and breast and cervical cancer screening services, and about one-third of state MCH units were administering screening and treatment of sexually transmitted diseases and smoking cessation programs (35). Other areas that were of interest to Title V programs but less well developed included lifestyle programs (e.g., nutrition, exercise), substance abuse prevention, domestic violence programs, and screening and treatment of depression (for which risk factors in women include pregnancy and the stresses associated with care giving [36]). A 1996 AMCHP survey of 22 state Title V programs found that nonpregnancy-related areas in which programs would like to become involved included rape prevention/crisis services, development of a women's health agenda, women's preventive health services, and domestic violence (37).

AMCHP surveys found little evidence, however, of comprehensive approaches to women's overall health care among Title V programs. Although eighteen states had established women's health units by 1992, they tended to be limited to reproductive health services (e.g., family planning, prenatal care). The current status of Title V programs nevertheless suggests a recognition of the issues and a readiness to seek ways to expand the service mix and continuity of care for women. A better understanding of the factors that account for variation across states in the scope and structure of Title V programs' involvement in women's health services would be helpful for promoting a broader women's health agenda.

As key components of the women's health care safety net, Title V programs are positioned to partner with other providers to ensure preventive services, referrals, follow-up, and coordination of continuous care for women whose changing eligibility for public programs or limited economic resources are barriers to care seeking. A variety of mechanisms is available for such linkages, including pooling grant funding, developing referral networks with other programs in both the public and private sectors, and contracting with other providers such as family planning programs (particularly those that have expanded primary care services) and managed care plans. Specialty services for managed care contracting by Title V programs might include wrap-around prenatal services (e.g., nutritional services, social services) for low-income and disadvantaged minority women. Because Title V programs traditionally have served these populations, they are likely to have greater expertise in their care than many newer Medicaid managed care plans.

CONCLUSION

New conceptions of women's health challenge consumers, purchasers, providers, and policymakers to rethink traditional assumptions about women's health care and public health programs. The evolving health care delivery system and policy climate provide opportunities for innovation in women's health care and public programs, but they also set the boundaries within which changes will be made and implemented. Within this context, those responsible for maternal and child health programs will be challenged to reconcile traditional mandates with changing expectations about women's health care. Because of their long experience in pregnancy and perinatal care, Title V programs are positioned to provide leadership in the development of model approaches to coordinated prevention, clinical care, and social services for underserved women and, potentially, for all women.

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