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Women's Health and Managed Care

Michelle Oberman
Santa Clara University School of Law, moberman@scu.edu

Margie Schaps

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WOMEN'S HEALTH AND MANAGED CARE

MICHELLE OBERMAN*  
MARGIE SCHAPS**

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I. INTRODUCTION

During the final decades of the twentieth century, a coalition of activists, academics, attorneys, and others formed around issues relating to women's health. These women's health advocates worked independently and together to identify the myriad ways in which the health care system shortchanges women and to chart out an agenda for enhancing women's health and well-being. The strength of the movement's combined forces is remarkable, and through its advocates' sheer persistence, many changes have occurred. Still, the bulk of the agenda remains incomplete, and those working within the women's health movement today continue the struggle to eradicate forms of gender bias identified over a generation ago.

* Associate Professor, DePaul University College of Law.  
** Executive Director, Health & Medicine Policy Research Group, Chicago, Illinois.  
The authors wish to thank Kimberly Horvath, DePaul Law School Class of 1999, and the staff of the Health & Medicine Policy Research Group for their phenomenal assistance and support.
During this same time frame, there has been a revolution of a different sort in the health care system. The dominant mechanism for financing and structuring health care delivery has shifted from indemnity-based insurance under a fee-for-service system to managed care within a capitated structure. The ramifications of this shift extend far beyond health care finance, however, influencing virtually every aspect of health care delivery and the doctor-patient relationship.

Women's health is no exception, and the shift to managed care has altered, and in many cases rendered obsolete, the original agenda set by women's health advocates. To date, the shift to managed care has gone relatively unnoticed in the legal literature discussing women's health issues. Contemporary women's health scholars tend to ignore the impact of financing mechanisms upon health care providers, their practices, and the context in which health care is delivered. Instead, contemporary women's health scholarship tends to identify women's health dilemmas through a series of issue-specific lenses. This permits those writing in this field to evaluate and critique the underlying legal and ethical elements of a given issue. At the same time, it obscures the structural factors that not only drive the offensive practices, but which, in many cases, will be critical to reversing those practices.

This article undertakes the task of updating and revising the contemporary women's health agenda by considering the impact on women's health of the change to a health care system in which managed care represents the dominant mode of health insurance. Because the full implications of managed care have yet to materialize, this article aims to alert women's health advocates to the emerging body of evidence demonstrating the power of new health care finance mechanisms to reconfigure women's experiences in the health care setting.

The contemporary women's health movement has worked to expose the myriad ways in which the health care system underserves women. Several decades of research has yielded a rich and enormously significant literature, much of which has transcended academic boundaries and has led to revisions in public policy. This broad body of work can be subdivided into

1. John K. Iglehart, The American Health Care System: Managed Care, 327 NEW ENG. J. MED. 742, 742 (1992). Managed care describes such a diverse set of financial arrangements and structures for service delivery that any general discussion of "managed care" risks inaccuracy. On the other hand, a detailed description of the myriad distinctions among managed care entities risks both obsolescence (in today's rapidly changing health care market) and tedium. Thus, the authors have opted for a broad-brush distinction between indemnity-based and managed care plans, and beg the reader's indulgence for their inattention to detail.

four categories: (1) gender bias in the health care finance structure; (2) gender bias in the delivery of health care; (3) gender bias in the medical establishment; and (4) gender bias in health care research. The following sections review the threats to women's health posed by conventional indemnity insurance practices and then explore the manner in which contemporary managed care plans reconfigure these issues.

II. GENDER BIAS IN THE HEALTH CARE FINANCE STRUCTURE

Virtually everything written about traditional, indemnity-based insurance as a mechanism for paying for health care is critical. The system is too costly, inefficient, and, as a result of full-cost reimbursement, fraught with perverse provider incentives to overtreat patients. On the other hand, managed care is fraught with precisely the opposite incentives—for providers to limit access to services, particularly high-cost specialty services, thereby undertreating patients. When it comes to the structure of a health insurance plan, women's health concerns may be undermined both as a result of the manner in which women gain access to the plan, and by the plan's mechanisms for determining which services are covered. Ironically, many of the problems experienced by women under indemnity-based plans are almost the opposite of those experienced by women under managed care plans.

A. Women's Access to Health Care Services

1. Women's Access to Health Insurance

The traditional health insurance system long has had a disproportionately negative impact upon women in terms of access to care. Beginning in the 1930s, traditional health insurance was linked to employment and treated as part of a full-time employee's benefits package. Thus, women who were not employed outside of the home in a full-time capacity had access to insurance only insofar as they were married to men who were employed and


who received a family insurance policy. As New Jersey State Senator Wynona Lipman remarked,

The reality is that women work at least two jobs, and the one they get paid for is often part-time or temporary, because that is all they can get. The reality is that divorce is a normal event in any given life, not an aberration. Given the reality, a health care plan that follows a permanent, full-time job or marriage is an anachronism for women.\footnote{Sex Discrimination in the Health Field and in the Delivery of Women’s Health Care: Public Hearing Before the N.J. Comm’n on Sex Discrimination in the Statutes 2 (N.J. 1994) (testimony of Sen. Wynona Lipman, Chairperson, Comm’n on Sex Discrimination in the Statutes), quoted in Caroline W. Jacobus, Legislative Responses to Discrimination in Women’s Health Care: A Report Prepared for the Commission to Study Sex Discrimination in the Statutes, 16 Women’s Rts. L. Rep. 153, 155 (1995).}

Women are more likely to be insured than men simply because they are more likely to receive Medicaid assistance. This is particularly true for young and elderly women.\footnote{See The Commonwealth Fund, Survey of Women’s Health 5 (1993).} Those women who are insured, however, are more likely to receive inadequate health care and fail to receive preventive care.\footnote{Id.} Women who work outside of the home tend to be employed in a part-time, intermittent capacity and, as a result, are seldom eligible for insurance benefits.\footnote{Id.} In 1994, two million women of working age, or fifteen percent of adult women, had no health insurance of any kind.\footnote{Young-Hee Yoon et al., Women’s Access to Health Insurance 8 (1994).} Women who seek to purchase a single policy are hampered by high prices, which may be even higher if they have a “pre-existing condition.”\footnote{One of the most perverse aspects of the U.S. health care financing system is that it is structured to deny coverage to those who are most in need. Under the rubric of “pre-existing conditions,” insurers raise premiums to the point where women are effectively priced out of the market for health care. Insurers’ notions of “pre-existing conditions” are remarkably comprehensive, including, in an extreme example, a woman’s status as a victim of domestic violence. Jacobus, supra note 7, at 165.} For example, comprehensive coverage for a twenty-five-year-old female non-smoker is approximately $150 per month.\footnote{These figures are based on Blue Cross/Blue Shield comprehensive coverage with a $250 deductible for a non-smoker with no pre-existing conditions. Comprehensive coverage includes 100% coverage of hospital care and 80% coverage of doctor visits, outpatient care, and prescriptions. A 64-year-old woman will pay approximately $375 per month. Comprehensive coverage with a $250 deductible for a 25 year-old male non-smoker costs $110 per month. Telephone Interview with anonymous insurance agent, Blue Cross/Blue Shield of Illinois (Aug. 1997).} For maternity coverage, the same woman’s premium jumps to approximately $310 per month.\footnote{See supra note 13 and accompanying text.}
they are pregnant or raising small children, poor women can obtain health care free of charge through the Medicaid program; however, Medicaid is available only to the poorest of the poor, and it does not cover the working poor. Moreover, services covered by Medicaid vary by jurisdiction and tend to be focused on reproductive health care. As such, even a Medicaid card does not guarantee access to primary care physicians, mental health services, or a host of other health care needs.

The lack of access to health care has direct, negative health consequences for women. The uninsured frequently neglect smaller health problems, seeking treatment only when those problems become severe. Thus, one finds that uninsured or Medicaid-insured women “face [significantly] greater risks of dying after breast cancer is detected than women covered by private health insurance.” The threat of losing health insurance also generates perverse and damaging consequences for women in abusive or otherwise dangerous or unhappy marriages.

2. Women’s Enrollment in Managed Care Plans

To the extent that individuals gain access to managed care plans as an employment benefit for full-time employees, women are equally as disadvantaged in terms of access to managed care as they are under conventional insurance plans. However, in one particular sector of the population—that of government-sponsored health insurance—women are not at all disadvantaged in terms of access. On the contrary, women are being aggressively recruited into managed care plans.

16. See id. at 812.
19. See Art Charlton, Forum on Health Care Costs Encounters Widespread Concern in Warren: Roukema Finds Ailment Easier to Diagnose Than Cure, STAR-LEDGER (Newark, N.J.), June 4, 1993, at 32 (noting that women often “return to abusive spouses so as not to lose health insurance for themselves and their children”).
20. Although the following remarks pertain to the Medicaid population, it is worth noting that the Medicare population, which is also overwhelmingly female, see Elizabeth M. Clark, Women in the Healthcare System Part I: As Patients, 83 J. MED. ASS’N GA. 189, 189 (1994), is opting into managed care in growing numbers, see Frank Ceme, Rehabbing Medicare: Is Managed Care a Cure-All or Just a Crutch?, 69 HOSPITALS 21, 21-22 (1995).
Managed care operates under a capitated structure. This means that a fixed cost is paid into the system annually by each enrollee in exchange for complete coverage of the entire range of the enrollee’s health care needs for the coming year. The plan survives, and even thrives, to the extent that it successfully manages or limits the expenses generated in caring for its individual patients. In order to do this, it must find a large enough pool of relatively healthy patients to offset the costs of treating those individuals who require extensive and/or expensive health care services. Additionally, when treating patients, it must insure that the costliest of services and treatments are rendered only when medically necessary.

Managed care offers the promise of cost savings through coordinated and well-planned health care delivery. As such, states are increasingly turning to this structure to help resolve the budgetary strains that grow out of their role in funding the Medicaid program. Specifically, managed care quickly is becoming the health care financing mechanism for the nation’s Medicaid population. Because the vast majority of Medicaid recipients are women and children, the transformation of the Medicaid system will necessarily have a disproportionate impact on women.

When a state adopts a managed care model for insuring its Medicaid population, it generally offers to pay managed care plans set capitation rates for all Medicaid-eligible individuals. Thus, the only barrier to access to care becomes finding the eligible individuals. With millions of dollars at stake, however, managed care plans have begun to compete aggressively for enrollees among the Medicaid population.

In the short years since the advent of Medicaid managed care, there have been numerous accounts of exploitative and predatory marketing practices by managed care entities eager for a share of the Medicaid market. For example, sales abuses range from forging names on HMO applications to misleading clients about the types of services that the HMO covers.

21. Note that this is a generalization, and that there are managed care entities that opt for a non-capitated or partially-capitated structure.


23. Richard J. Manski et al., Medicaid, Managed Care, and America’s Health Safety Net, 25 J.L. MED. & ETHICS 30, 30 (1997) (“Almost every state has introduced some form of managed care for a subset of their Medicaid beneficiary population.”).


25. Some states’ plans are more of a hybrid, in which states provide managed care for the Medicaid population by paying certain primary care physicians a discount fee-for-service rate in exchange for their agreement to function as gatekeepers by controlling the patients’ utilization of health care services. Colleen A. Foley, The Doctor Will See You Now: Medicaid Managed Care and Indigent Children, 21 SETON HALL LEGIS. J. 93, 121-22 (1997).

Not only does this aggressive marketing result in fraudulent enrollment figures, thereby squandering precious state health care funds, but perhaps more importantly, it has a devastating impact on the Medicaid population. Once enrolled, a Medicaid recipient is unable to change plans for a fixed ineligibility period. Yet, changing plans is precisely what many enrollees will seek to do, in large part in response to provider dissatisfaction. This problem is exacerbated by the unethical practices of those who recruit new enrollees to a plan by falsely reassuring them that they can continue receiving care from their current health care providers.

States have made belated efforts to check these predatory practices, for example, by banning high-pressure enrollment tactics such as door-to-door marketing. Yet such limited measures can scarcely compensate for the confusion generated by the rapid dismantling of the system under which millions of individuals have received health care for decades. The de-linking of Medicaid and welfare, coupled with the sudden transfer from an indemnity-based system to a managed care system has left many individuals understandably confused about their eligibility for health care benefits.

Even more troublesome than the issue of predatory enrollment tactics are the systemic problems that result from the poor fit between managed care's cost-saving mechanisms and the health care realities of the Medicaid population. The cost-containment mechanisms of managed care were designed to correct the excesses of the fee-for-service system, which included problems such as the over-reliance on specialty care and expensive technology. Even when it operated under a fee-for-service model, however, Medicaid did not experience these particular problems. Instead, Medicaid's problems were of an entirely different nature: "episodic patient eligibility, insufficient numbers of providers in areas of highest need, declining reimbursement rates, . . . inappropriate use of hospital emergency rooms for routine care, and a high incidence of potentially preventable acute or urgent conditions." As the authors of one thoughtful essay on the Medicaid managed care trend conclude:

> Even at their best, when emphasizing primary and preventive care and savings over time, today's managed care systems are not intended to provide basic access to the health care system for the poor and vulnerable. Nor are they meant to support the needs for income, housing, food, rehabilitation, and long-term care that safety nets like Medicaid and its associated Great Society programs provide.

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27. As of Fall 1997, there are at least eight states that have passed such legislation. Telephone Interview with Cheryl Fish-Parcham, Families USA (1997).
29. Manski et al., supra note 23, at 32.
30. Id.
As a result of this poor fit, it is not surprising, yet critically important, to observe that contemporary studies of Medicaid managed care reveal no increased access to care and no significant reduction in health care costs.  

B. Breadth of Coverage and Women's Health Needs

1. Covered Services Under Traditional Indemnity Plans

The second major problem arising under the category of health care plan structure is the lack of coverage for health care services critical to women's well-being. This is particularly true in the areas of prevention and primary care, which represent health care services that are essential to maintaining women's health, yet routinely have been excluded from insurance benefits packages. For example, consider the lack of coverage for basic reproductive health care, ranging from periodic pap smears, to mammograms, contraception, and abortion. The failure to recognize and account for these costs as part of any basic health care package indicates a cynical attitude toward women's lives and welfare. Finally, traditional insurance plans seldom cover home-health aides, who are critical to relieving the burden of providing ongoing care for ailing family members. Because this burden falls overwhelmingly upon women, particularly older and working women, the absence of coverage constitutes a de facto private tax upon this population.

2. Managed Care, Covered Services, and Women's Health

To the extent that it would cover all of an individual's health care needs, particularly those relating to preventive care and wellness, managed care has the potential to solve many of the above problems. Unfortunately, the reality is that managed care's goal of cost savings has led plans to limit access to many services that are utilized disproportionately by women. For example, many of the services targeted for cost savings by managed care plans are those primarily used by women, such as mental health services. Access to appropriate mental health services is particularly

31. Salganicoff, supra note 28, at 79.
32. For a comprehensive list of services routinely excluded by insurers, yet critical to women’s health, see Jacobus, supra note 7, at 168-69.
33. Id. at 169.
34. See Dorothy P. Rice et al., The Economic Burden of Alzheimer's Disease Care, 12 Health Aff. 164, 168 (1993). The Older Women’s League found that three out of four caregivers for the elderly are women. Suzanne Gordon, The Impact of Managed Care on Female Caregivers in the Hospital and Home, 52 J. Am. Med. Women's Ass'n 75, 76 (1997) (citing Older Women’s League, Failing America’s Caregivers: A Status Report on Women Who Care (1989)).
important to women given that depression is twice as common in women as men, and generalized anxiety disorder and panic disorders are more prevalent in women than men. However, inadequacies in the detection, diagnosis, and treatment of mental health and psychosocial problems by primary care clinicians is compounded by the economic incentives in most managed care contracts not to refer patients for specialty services. When patients are referred for mental health services, managed care systems are likely to severely limit the number and type of visits and encourage less expensive medication treatment rather than more expensive psychotherapy. This is done despite the evidence that a combination of psychotherapy and medication often is the most effective long-term treatment for many conditions that disproportionately affect women, such as eating disorders, panic attacks, obsessive-compulsive disorders, and depression.

The efforts of managed care entities to distinguish mental from physical well-being, and to limit access to the former, marks a tragic perpetuation of the false dichotomy between physical and mental health. It also hints at the more profound limitations of a health care system that is financed by third-party payors—employers or the government—regardless of whether it is capitated or indemnity-based. To the extent that third-party payors negotiate with providers over how much and what sort of care will be provided at what cost, women's health and well-being forever will be held hostage to the negotiating entities' desires to limit costs and, as a result, to these same entities' estimations of women's health care needs and priorities. Moreover, to the degree that these decision-makers hold mistaken or biased beliefs about women's health care needs, these estimations will be inaccurate and quite likely detrimental to women's long-term well-being.

The subsequent sections of this article illustrate three additional parameters of systemic bias against women—providing evidence of (1) the express and implied biases against women that pervade the health care...
setting, (2) the undermining of the quality of care women receive, and (3) the limited extent to which a change from fee-for-service to managed care can be expected to enhance women’s health status.

III. GENDER BIAS IN DELIVERY OF HEALTH CARE

In the late 1960s, a grass-roots women’s health movement emerged as women began to talk to one another about their experiences of frustration and anger toward physicians and the health care system as a whole.39 Women’s stories of condescending, judgmental treatment, and of being lied to, sexually abused, overtreated, and ignored by their doctors are recorded in several early histories of the women’s health movement.40 They went unacknowledged by the medical establishment until 1991, however, when the American Medical Association (AMA) published a report on gender disparities in clinical decision-making. This report reviewed the existing literature on the impact of gender in the health care setting and concluded:

Historically, societal perceptions regarding women’s health status have often disadvantaged women. Throughout the mid-19th and well into the 20th century, women’s perceived disposition toward both physical and mental illness was used as a rationale for keeping them from worldly spheres such as politics, science, medicine, and law. For women, behavior that violated expected gender-role norms was frequently attributed to various physical or mental illnesses . . . .

In sum, the effective diagnosis and treatment of women’s ailments has been sabotaged by gender bias.42 Gynecologists have served as women’s primary care physicians, and many have professed expertise in diagnosing and treating conditions that extend far beyond their medical competence.43

42. One 1958 textbook notes that “[a] woman is a uterus surrounded by a supporting organism.” Iago Gladstone, Other Aspects of the Abortion Problem, in ABORTION IN THE UNITED STATES 117, 118 (1958); see also Mary C. Howell, What Medical Schools Teach About Women, 291 NEW ENG. J. MED. 304, 304-07 (1974) (discussing discrimination within the medical community against women both as students and as patients).
Social or cultural biases have shaped not only the interaction between doctor and patient, but have influenced every aspect of the care that women patients have received.  

There is little reason to believe that the shift to managed care has altered health care providers' preconceived gender biases. Indeed, the structure and financial incentives inherent in managed care further reinforce physician proclivity toward practicing medicine outside their areas of expertise in ways that inure to the detriment of women. For example, research already has demonstrated that primary care clinicians, operating under incentives to limit costs by avoiding referrals to mental health experts, are less likely to diagnose and secure specialty care for patients with mental health disorders.  

A. Diagnosis and Treatment

Gender bias in health care delivery has led to a seemingly contradictory set of results: missed diagnoses, undertreatment, and overtreatment of women patients. Missed diagnoses may result from bias in the individual practitioner as well as from a more diffuse, systemic bias. Several examples illustrate this point.

Studies have shown that doctors are more likely to attribute the health complaints of their female patients to emotional rather than physical causes. As a result, studies indicate that, despite the fact that cardiovascular disease is the leading killer of both women and men, women's symptoms are often either ignored or treated too late. Sometimes bias impairs clinical judgment in a more general sense, as seen in studies documenting the widespread failure of doctors to diagnose domestic violence in their female patients. Finally, there are missed diagnoses caused by a scientific bias against women, as demonstrated by the fact that until 1993,  

44. See generally Barbara Bernstein & Robert Kane, Physicians' Attitudes Toward Female Patients, 19 Med. Care 600 (1981) (discussing results of an experiment conducted to assess physicians' attitudes toward female patients).
45. See supra notes 36-37 and accompanying text.
47. Id. at 1211-18.
48. In 1993, the Commonwealth Fund released a study of health care experiences of 2500 women and 1000 men. The Commonwealth Fund, supra note 8, at title page. The results were that 25% of women, compared to 12% of men, said that they had been “talked down to” or treated like a child by their physician. Id. at 7. Nearly 1 in 5 women, compared to 7% of men, had been told that a reported medical condition was “all in your head.” Id.
49. In a recent study, 40% of the men with abnormal exercise radio nuclide scans were referred for cardiac catheterization versus 4% of the women. Gender Disparities, supra note 41, at 561; see also Jacobus, supra note 7, at 272.
50. Jacobus, supra note 7, at 208.
the Centers for Disease Control's presumptive diagnosis for AIDS was based on male patients, and therefore excluded cervical cancer, chronic vaginal yeast infections, and other symptoms common to females with AIDS.\(^5\)

The problem of undertreatment is related to that of missed diagnosis because individual practitioner bias inappropriately influences clinical decision-making. This result is ironic since, overall, women receive more health care than men.\(^5\) Numerous studies demonstrate, however, that "women's health care tends to be comprised of drug prescriptions and routine checks whereas major diagnostic and therapeutic interventions are more frequently performed on men."\(^5\) This phenomenon is illustrated by studies finding that men are six and one-half times more likely than women to receive tests for lung cancer, kidney transplants, and cardiac catheterization.\(^5\)

Within managed care systems, the issue of undertreatment is of great concern to women. The most comprehensive interview study comparing women's experiences within managed care and fee-for-service systems was completed by the Commonwealth Fund in 1995 and showed that women in HMOs were more likely than their fee-for-service counterparts to report lack of access to needed medical care in the last year. The reasons women cited for this included cost, lack of coverage, and inability to get an appointment. Because providing service within a capitated managed care system is costly for the system rather than the patient, there is a clear incentive to place barriers between the patient and access to the system. This is evidenced again in the 1995 Commonwealth Fund survey, which found that managed care enrollees were more likely than fee-for-service members to rate as fair or poor their access to specialty care—twenty-three percent versus eight percent.\(^5\) This result is driven in part by the tendency of managed care plans to structure primary care clinicians' salaries with incentives that are in part based on how few referrals they make to specialists, how few days their patients spend in the hospital, and how few emergency room visits their patients make.\(^5\)

51. *Id.* at 273; see LESLIE LAURENCE & BETH WEINHOUSE, OUTRAGEOUS PRACTICES: THE ALARMING TRUTH ABOUT HOW MEDICINE MISTREATS WOMEN 148-49 (1994).


53. *Id.; see Gender Disparities*, *supra* note 41, at 561 ("Societal value judgments placed on gender or gender roles may . . . put women at a disadvantage in the context of receiving certain major diagnostic and therapeutic interventions, such as kidney transplantation and cardiac catheterization.").


The incentive under managed care to avoid referrals to specialists is gender-neutral on its face. If women seek access to specialists who have received advanced training in women’s health, however, their limited access to expert care relegates them to treatment by those who historically have misdiagnosed, mistreated, and misunderstood women’s concerns.

An additional disparate impact relating to the incentive to avoid referrals to specialists derives from the impact such policies have on the doctor-patient relationship. Research has established a direct correlation between the quality of the doctor-patient relationship and a positive health outcome. For example, research into the diagnosis and treatment of victims of domestic violence indicates that, unless providers take the time to counsel women and ask them directly about such abuse, women will not disclose it. Thus, the fact that women are less likely to trust their doctors and report less positive relationships with their providers than do men reveals a potential threat to the health outcomes of women who seek medical care.

As several health law experts have noted, managed care policies that discourage physicians from referring patients to specialists in effect divide the physician’s loyalty between the patient and the managed care entity. As such, these policies pose a direct threat to the physician’s fiduciary duty to the patient. To the extent that the patient is aware of the physician’s incentives, the trust that is essential to the doctor-patient relationship will be undermined. It stands to reason that the growing climate of mistrust and divided loyalties between doctors and patients will further diminish the quality of the relationship between women and their doctors.


59. See, e.g., Warshaw, supra note 58, at 132-33 (describing structural constraints on time and diagnosis that impinge upon physicians’ abilities to diagnose domestic violence).


61. Id.

62. See Jaklevic, supra note 57, at 34.

63. See id.
From its inception, the women's health movement has fought against the overtreatment of women, demonstrating in case after case the way in which "[m]edicine can and has been used as an institution of social control over women." 64 The history of the medicalization of pregnancy provides perhaps the best example of the way in which women have been subjected to unnecessary, invasive, and harmful therapies in the name of health care.65 From the start of the twentieth century, doctors have sought to control pregnancy, and therefore, pregnant women, by way of medical interventions.66 One needs only a passing familiarity with the consequences of prenatal x-rays, Thalidomide, and DES to recognize how deleterious such interventions can be.67 It is only recently that many medical practices associated with the routine treatment of pregnancy have been identified as scientifically unproven and therefore worthless.68 It has taken several decades for lawyers, academics, and activists to expose doctors' unlawful practice of threatening or resorting to judicial intervention in order to force women to undergo caesarean sections.69 The law still tolerates certain health care practices that undermine women's autonomy, such as the HIV testing of pregnant women without their consent.70

64. Rodwin, supra note 60, at 159 (citing Irving K. Zola, Medicine as an Institution of Social Control, 20 SOc. REV. 487 (1972)).
65. Id. at 158, 160.
66. See id. at 158.
67. E.g., Rodwin, supra note 60, at 157-58. See generally BARBARA EHNREICH & DEIRDRE ENGLISH, FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS' ADVICE TO WOMEN (1978) (discussing the historical development of women's health issues).
Although much of the literature in women's health continues to address problems stemming from overtreatment or inappropriate treatment, the reality is that as women move into managed care entities, the problem of undertreatment is likely to be far more menacing to their health. The routine overtreatment of women was enabled by a fee-for-service financing mechanism which provided that the more doctors treated their patients, the more money they made. In addition to the financial incentive, the trend toward overtreatment was driven by physicians' fear of medical malpractice and their mistaken belief that the best protection against liability lay in running every possible test and offering every possible treatment. Thus, it did not matter that so few of the treatments surrounding pregnancy were medically effective or helpful to the patient's well-being. Rather, they came to represent a sort of self-perpetuating standard of care as doctors became afraid to practice without using all potentially useful forms of treatment.

Managed care, with its capitated financing mechanism, has partially reversed these incentives. Although malpractice liability remains a threat, it is no longer financially prudent to respond to that threat by overtreatment. Because each additional test represents a net loss to the managed care entity, whether it is deducted from the pocket of the provider or from that of the entity as a whole, the practice of running unnecessary tests is fast becoming obsolete. Indeed, the capitated system thrives only to the extent that its providers differentiate essential from non-essential treatment, offering the former and limiting the latter.

B. Non-Integrated Services for the Delivery of Health Care

In addition to these identified patterns of gender bias in health care delivery, the traditional structure for the delivery of health care services is poorly tailored to women's health needs. From a woman's perspective, the health care system is a fragmented one, in which her health care needs seldom can be met in a single visit to a provider. As the author of a comprehensive review of women's health concludes:

71. See, e.g., sources cited supra note 69 (discussing the legal and ethical issues raised by caesarean sections); see also Margaret M. Donohoe, Our Epidemic of Unnecessary Cesarean Sections: The Role of the Law in Creating It, the Role of the Law in Stopping It, 11 Wis. Women's L.J. 197 (1996) (discussing the underlying causes of the startlingly high rate of these surgical interventions in the United States).

72. Jonathan J. Frankel, Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures, 103 Yale L.J. 1297, 1298 (1994) (estimating that approximately $15 billion is spent on defensive medical procedures each year).

73. Id.

74. See, e.g., id. at 1298 n.4.

75. Id. at 1318.

76. Id.
Even the wealthiest woman must go to a gynecologist for reproductive concerns, an obstetrician for the delivery of her children, a mammography center for breast cancer screenings, an internist or family physician for “general ailments,” and specialists in the diseases of elderly/post-menopausal women if she hopes to have those concerns taken seriously. If all internists are trained to offer “one-stop shopping” to adult males, why are they not trained to deal with the common medical needs of the other 52 percent of the population?77

For poor women, many of whom lack adequate health insurance, available health care is even more fragmented.78 Because their care is provided at emergency rooms or community clinics, poor women seldom see the same doctor more than once.79 Rarely are there adequate medical records to guide a physician in providing appropriate treatment.80 Preventive care, such as mammography or pap smears, becomes a luxury that these women simply cannot afford.81

The impact of the lack of integrated services extends far beyond mere inconvenience. For example, an internist may prescribe antibiotics to treat a woman’s sinus infection, and these antibiotics may interfere with the efficacy of the birth control pills she is taking. Unless the internist thinks to ask the woman whether she is taking birth control pills, the woman’s diligence in obtaining treatment for her infection may result in an unexpected pregnancy. In addition to the bio-medical consequences of fragmentation, the lack of integration permits doctors to conceive of patients on a male model, with the result that much of the treatment women receive is inappropriate or ill-tailored to meet their needs.82 This is seen in the area of substance abuse where, despite the well-documented fact that the etiology and treatment of addiction in women is entirely different from that of men, services for women, and particularly pregnant women, are in scarce supply.83

By virtue of its gatekeeper structure and its primary care focus, managed care holds the promise of providing a far more comprehensive, integrated approach to patient well-being than that provided under a fee-for-service structure. The success of this system, however, rests upon the diligence of

77. Jacobus, supra note 7, at 174.
78. Id.
79. Id.
80. Id.
81. Id.
82. Id. at 174-75.
83. See generally Michelle Oberman, Sex, Drugs, Pregnancy, and the Law: Rethinking the Problems of Pregnant Women Who Use Drugs, 43 HASTINGS L.J. 505 (1992) (describing the various ways in which substance abuse treatment for women is different than for men, including issues ranging from women’s need for day care services to the tendency of female addicts to use substances to self-medicate, rather than as a form of recreation).
the individual provider in assuring that each patient receives the services she needs. For example, one study questioned women about their failure to obtain a mammogram in spite of the fact that it was covered under their health insurance plans. The researchers found that the main reasons women offered were that their doctors never told them to get one or that they did not know that they needed one. Although the streamlining and integration of the structure for accessing specialized services represents the promise of improved health care status, if women are to receive better care their primary care doctors must be trained carefully to assure that their health care needs are met.

Provider training is not the only factor relevant to managed care's integration of services and the capacity to influence women's health. Equally significant are current industry trends of exempting or limiting access to services, such as mental health services, which are used disproportionately by women. Obviously, the benefits flowing from integration of services will be significantly undermined if necessary health care services are not included in the package. Furthermore, managed care plans have attempted to limit costs for these specialized services by requiring copayments from enrollees who seek to access them. This requirement has been shown to deter many women, and particularly low-income women, from seeking treatment for these fairly basic health care needs.

Surprisingly, recent studies indicate that women in managed care plans are not accessing treatment even for basic preventive care—covered services that represent the principle advantage that managed care offers over traditional indemnity insurance plans. Despite the fact that managed care plans may cover more of women's basic health care needs, the most recent study to look at women's use of these services within managed care settings

84. Amy Bernstein, Women's Health in HMOs: What We Know and What We Need To Find Out, 6 WOMEN'S HEALTH ISSUES 51, 55 (1996) (citing Nancy Breen & Larry Kessler, Changes in the Use of Screening Mammography: Evidence from the 1987 and 1990 National Health Interview Surveys, 84 AM. J. PUB. HEALTH 62, 65 (1994)).

85. Id.

86. See THE COMMONWEALTH FUND, supra note 8, at 8 (noting that women consume more mental health services than do their male counterparts); see also Newell & Saltzman, supra note 37, at 79 (discussing the managed care industry's efforts to limit psychotherapy in favor of short-term drug treatment responses to mental health ailments); Treatment for Depression, supra note 36, at 8.


88. Women who were enrolled in HMOs in 1987 were more likely to receive pap smears and breast exams within the previous year than women in fee-for-service plans. Robert H. Miller & Harold S. Luft, Managed Care Plan Performance Since 1980: A Literature Analysis, 271 JAMA 1512, 1512-19 (1994). By 1992, however, HMOs had lost this comparative advantage. Id.
showed a decline in the percentages of women using these services and reported significantly higher numbers of women who felt they were not getting needed care and had difficulty reaching their physicians when they needed them. These results are echoed by a study of the impact of managed care on the Medicaid population, which found little increase in access to preventive services for low-income women in Medicaid managed care plans. As yet, the managed care industry has not explained these puzzling findings. To the extent that they represent a consistent pattern, however, they may indicate that women's health is unlikely to fare any better under a system of managed care than it has under one of fee-for-service.

IV. GENDER BIAS IN THE MEDICAL ESTABLISHMENT

A. Provider Dissatisfaction

Provider dissatisfaction has long been one of women’s chief complaints about the health care system. This dissatisfaction encompasses issues ranging from providers' insensitivity to the context of their female patients' lives, to problems stemming from inappropriate and inadequate training and expertise in handling specific health concerns, to women's fears that disclosing anything but physical complaints will result in the physician telling them that their symptoms are imaginary or insignificant. One example of this emerges from a 1993 Commonwealth Fund study, which found that over ninety percent of women who were physically abused by their partners did not disclose that fact to their providers even though such abuse can result in closed head injuries, fractures, substance abuse, and an array of other physical health problems.
The problems associated with provider insensitivity are compounded for women who deviate from the white, middle-class, heterosexual, able-bodied norm. Many authors have exposed the negative health care experiences of subpopulations of women, such as lesbian women, women with disabilities, and/or women from cultural or racial minority backgrounds. Barriers ranging from the physician’s inability to communicate in the patient’s language to a more subtle, yet equally profound, inability to understand a patient’s value system prevent the quality of honest, open communication thought to be necessary to the integrity of the doctor-patient relationship. As a result, women from cultural, ethnic, and other subpopulations tend to report even higher rates of provider dissatisfaction, and for many such groups of women, a marked tendency to avoid the health care system altogether.

When women are insured through fee-for-service plans, they can respond to provider insensitivity by switching providers and can continue to do so until they find someone with whom they can establish a sound doctor-patient relationship. Women insured under managed care plans are, by definition, limited in their ability to switch providers. Although most managed care plans offer a choice of primary care doctors, patients can only select doctors who participate in the plan. The unsurprising result of this structure is that managed care enrollees are more likely than fee-for-service members to rate as fair or poor their ease of changing physicians—twenty-five percent versus six percent—and their choice of physicians—twenty-five percent versus five percent.

This is troubling information in view of women’s long history of well-founded dissatisfaction with health care providers. Moreover, there are negative health implications inherent in these results. Poor doctor-patient

94. Jaklevic, supra note 57, at 34 (study demonstrated that good clinician-patient communication results in better outcomes and higher patient satisfaction).
95. For example, lesbian women report that they do not seek medical attention because of the demeaning way they are treated by providers. See Jocelyn C. White & Valerie T. Dull, Health Risk Factors and Health-Seeking Behavior in Lesbians, 6 J. WOMEN’S HEALTH 103, 103 (1997). Provider dissatisfaction can also result in an “overutilization” of the system, as demonstrated at a 1996 conference on urban women’s health held in Chicago, where Latino women reported that Latinas often go to the doctor many times for the same illness. When asked why, they reported that they are never taken seriously by providers so they must return several times at which point they finally may be treated. HEALTH & MEDICINE POLICY RESEARCH GROUP, IMPROVING THE HEALTH OF URBAN WOMEN: MODELS FOR THE FUTURE 62 (forthcoming May 1998).
96. THE COMMONWEALTH FUND, supra note 56, at 7.
97. See THE COMMONWEALTH FUND, supra note 8, at 7-8 (discussing women’s higher rates of provider dissatisfaction, their history of having health concerns dismissed by providers, and their increased reports of feeling patronized by their health care providers).
communication undermines the health care relationship, creating a tendency for women to avoid seeking needed medical attention.\textsuperscript{98}

\textbf{B. Gender Bias in the Training of Medical Professionals}

To a certain extent, provider dissatisfaction reflects the demeaning cultural biases against women, many of which have been perpetuated through the process of training health care professionals. This is particularly evident in the tendency to diminish women by treating them in a pejorative and often sexual manner.\textsuperscript{99} For example, a 1979 medical textbook for obstetricians and gynecologists suggests the following:

The evaluation of the patient’s personality need not be a lengthy matter. It begins as she enters the consultation room and sits down. Character traits are expressed in her walk, her dress, her makeup. . . . The observant physician can quickly make a judgment as to whether she is overcompliant, overdemanding, aggressive, passive, erotic, or infantile.\textsuperscript{100}

No less blatant, and certainly more ubiquitous today, are the off-hand remarks of medical instructors. One doctor, trained at a prestigious medical school in the late 1980s, recalls the following remarks during a lecture from her former gynecology professor: “One always begins an annual exam with the breasts, because, if the breast examination is done properly, you won’t need to use any lubrication for the pelvic exam.”\textsuperscript{101}

Even more striking than the evidence that doctors’ training may include lessons that undermine their respect for women patients is the fact that medical training often excludes issues that will be critical to the doctors’ ability to treat many of their patients. For example, despite the fact that abortion is the most common outpatient gynecological surgery for women, only twelve percent of the nation’s residency programs in obstetrics and gynecology train their physicians to perform routine abortions.\textsuperscript{102} Likewise, despite the fact that gynecologists are likely to treat women over the full course of their life cycles, few are trained in issues relating to the health care needs of older women.\textsuperscript{103} This means that they are ill-equipped to counsel their patients not only regarding the obvious issues of menopause and hormone replacement therapy, but also regarding their more general health concerns, such as cardiovascular disease, osteoporosis, and the impact

\textsuperscript{98} Jaklevic, supra note 57, at 34 (discussing a study demonstrating that good clinician-patient communication resulted in better outcomes and higher patient satisfaction).
\textsuperscript{99} J. ROBERT WILLSON & ELSIE REID CARRINGTON, OBSTETRICS AND GYNECOLOGY 51 (6th ed. 1979); Howell, supra note 42, at 304-05.
\textsuperscript{100} WILLSON & CARRINGTON, supra note 99, at 51.
\textsuperscript{101} Interview with D.M., in Chicago, Ill. (1987).
\textsuperscript{103} See Jacobus, supra note 7, at 278.
of chronic conditions on women with relatively little social support. Finally, despite the fact that a significant percentage of women's visits to health care providers are triggered by incidents of domestic violence, to date few medical schools educate their students about this issue. As such, it is almost inevitable that domestic violence goes largely undetected by doctors.

In an effort to redress the current gender bias in the training of physicians, the Council on Medical Education, the Federated Council on Internal Medicine, the American College of Obstetricians and Gynecologists, the American Association of Family Practice, and the National Academy of Women's Health in Medical Education have delineated competencies in women's primary care that cross traditional professional boundaries. In addition, the American Medical Women's Association has drafted a model curriculum that would "feminize" the medical school curriculum by incorporating women's health issues in a comprehensive manner. Others, more sanguine about the slow pace of medical school curricular reform, would risk perpetuating the marginalization of women's health concerns by creating a "new medical specialty devoted to women's health." These women's health specialists would provide the full spectrum of routine women's health care and, in particular, "would be trained in such areas as how to manage menopause, spot physical and sexual abuse, prevent and treat osteoporosis, and incorporate the growing body of research on how diseases and drugs act on women, as opposed to men." While this debate rages, a growing number of medical education programs are now offering special training programs and continuing education courses in women's health.

Regardless of the relative merits of these proposals, it is evident that reform will require a serious commitment from those at the highest levels of the medical profession. The contemporary medical establishment is so overwhelmingly male-dominated that such a commitment is unlikely to be forthcoming anytime soon. Despite the rapid growth of female medical

104. See id.
105. Id. at 208-09. One in three women seeking care at an emergency room is there as a result of abuse. Id. The American Medical Association estimates that medical care as a result of domestic violence costs between $5 and $10 billion per year. Id. at 206.
106. See generally Eileen Hoffman et al., The Women-Centered Health Care Team: Integrating Perspectives from Managed Care, Women's Health, and the Health Professional Workforce, 7 WOMEN'S HEALTH ISSUES 362 (1997).
108. Jacobus, supra note 7, at 181.
109. Id. at 181-82.
110. These programs attempt to integrate reproductive, medical, and mental health care and include sex-specific and gender-specific curricula. Lila A. Wallis, Why a Curriculum on Women's Health?, in REFRAMING WOMEN'S HEALTH 13, 21-23 (Alice J. Dan ed., 1994).
school enrollment, women remain dramatically under-represented in the academic medical establishment. On 1991 and 1992, twenty-two percent of full-time medical school faculty were women, but only nine and one-half percent were full professors. On average, male faculty are promoted twice as fast as women. There are currently only seven female medical school deans in the nation, and according to the American Association of Medical Colleges, only five percent of department chairs are women. Moreover, a number of studies indicate that harassment and gender discrimination remain prevalent in the medical profession, constituting a de facto bar to women’s ability and willingness to assume leadership positions.

C. Women’s Health Centers: An Effort at Structural Reform

One major effort to enhance provider sensitivity and women’s comfort with and confidence in the medical treatment they receive is the development, beginning in the 1980s, of hundreds of women’s health centers. Many of these centers are hospital-based and arguably predominantly developed as marketing tools for the hospital. Nonetheless, they give providers with an interest in and commitment to a holistic approach to women’s health issues an opportunity to develop their expertise in an atmosphere of support and offer some level of integrated service. These centers generally offer care that encompasses internal medicine, obstetrics and gynecology, mental health, nutrition, nurse practitioners and midwives, and an array of educational programs.

111. Bernadine Healy, Women in Science: From Panes to Ceilings, 255 SCIENCE 1333, 1333 (1992). Of course, the same under-representation occurs throughout the scientific community, and is particularly relevant in the areas of clinical research design and funding. See Rothenberg, supra note 46, at 1210.
112. Healy, supra note 111, at 1333.
113. Council on Ethical & Judicial Affairs, Gender Discrimination in the Medical Profession, 4 WOMEN’S HEALTH ISSUES 1, 2-3 (1994).
114. Id.; Telephone Interview with Chuck Elliot, Director of Faculty Reporter System, Association of American Medical Colleges (1997).
115. See generally THE OUTER CIRCLE: WOMEN IN THE SCIENTIFIC COMMUNITY (Harriet Zuckerman et al. eds., 1991). Remember “the case of Dr. Frances Conley, the prominent neurosurgeon who resigned her tenured position at Stanford University Medical School’ in protest over the University’s failure to check the continual sexual harassment directed at both herself and her female colleagues. Joan Libman, Sudden End to a Trailblazing Career, L.A. TIMES, June 7, 1991, at E1.
116. E.g., Carol S. Weisman et al., The National Survey of Women’s Health Centers: Current Models of Women-Centered Care, 5 WOMEN’S HEALTH ISSUES 103, 104 (1995).
117. Id.
118. Jane Linker, A Center of One’s Own: Specialized Facilities, Planned for and by Women, Allay Their Fears Associated with Medical Settings, JEWISH WK., Jan. 24, 1997, at
There are now hundreds of these centers around the country.\(^\text{119}\) The most comprehensive study to date evaluating women's health centers found that they served more than fourteen million women in 1993 and approximately half of those women used "these centers as their usual source of care."\(^\text{120}\) However, many of these centers are threatened by restrictive managed care networks. As a growing number of women enroll in managed care plans, these centers are losing their patients because they are excluded from managed care networks. Thus, despite the remarkable success of this initiative at enhancing women's satisfaction with their health care, women's health centers are likely to become a relic of the past.

V. GENDER BIAS IN HEALTH CARE RESEARCH.

Closely related to the problem of gender bias in the medical establishment is the issue of gender bias in health care research. Beginning in the late 1960s, the federal government began to articulate guidelines for research on human subjects, which in 1975 were codified into regulations that mandated the exclusion of women of childbearing age from participation in bio-medical research.\(^\text{121}\) Ostensibly designed to protect women and fetuses from the risks of experimental treatment, the result of this policy is that women's health needs have gone largely unexamined, both in terms of the allocation of resources for biomedical research and in terms of the safety and efficacy of treatments administered to women. Professor Karen Rothenberg, former Special Assistant to the Director of the Office of Research on Women's Health, concluded, "In study after study of health issues important to women, women have been excluded or seriously under-represented."\(^\text{122}\)

The consequences of this exclusionary policy are as ludicrous as they are far-reaching. One of the more stunning results is a study that examined the impact of obesity on breast and uterine cancer, using participants who were all male.\(^\text{123}\) With respect to HIV, despite the fact that women represent the fastest growing population with HIV, they have been

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40. available in 1997 WL 11661766.
119. Weisman et al., supra note 116, at 105-06.
120. Id.
122. Rothenberg, supra note 46, at 1207. In 1985, "the United States Public Health Service Task Force on Women's Health Issues concluded that the exclusion of women in clinical research has significantly affected the quality of health care available to women." Id. at 1203 (discussing Task Force on Women's Health Issues, U.S. Public Health Service, Women's Health: Report of the Public Health Service Task Force on Women's Health Issues, 100 PUB. HEALTH REP. 73 (1985)).
123. Rothenberg, supra note 46, at 1208.
overwhelmingly excluded from studies of experimental AIDS therapies.\(^\text{124}\) The Multiple Risk Factor Intervention Trial Group involved a long-term study of coronary heart disease, the greatest killer of women and men alike.\(^\text{125}\) It studied 12,866 men and no women.\(^\text{126}\) The Health Professionals Follow-Up Study examined the link between caffeine consumption and heart disease by studying 45,589 men and no women.\(^\text{127}\) The Physician's Health Study found that one aspirin per day reduced the risk of myocardial infarction in 22,071 men. No women were studied.\(^\text{128}\)

In retrospect, it may seem incredible that scientists and researchers ever presumed that research which excluded women could yield scientifically meaningful results for women. In essence, women were viewed as being both so different from men that they could not be included as research subjects, and yet so similar to men that any research findings could be generalized to women. In part, this "logic" may have resulted from the "gender blinders" worn by an overwhelmingly male scientific establishment. As Professor Vanessa Merton notes in her comprehensive critique of the government's exclusionary policy, "Arguably, among the most significant practical reasons for this exclusion has been the gender identity of those conducting and funding clinical research, and their preoccupation, not always conscious, with medical problems that resonate for them."\(^\text{129}\)

In addition to simply having "overlooked" women's health concerns, there are a host of cost-related justifications for excluding women. These "costs" reflect researchers' awareness that a treatment's efficacy may be influenced by women's menstrual cycles and by their use of synthetic hormones. Furthermore, although women represent more than one-third of all cases of AIDS globally and die significantly sooner after diagnosis than men with AIDS, and despite important gender differences in all phases of the disease process, from prevention and exposure to diagnosis and treatment, women are still excluded from most biomedical and psychosocial research.


124. *Id.* (noting that of the 28 AIDS trials of experimental drugs, only 131 of 2634 participants were women). Furthermore, although women represent more than one-third of all cases of AIDS globally and die significantly sooner after diagnosis than men with AIDS, and despite important gender differences in all phases of the disease process, from prevention and exposure to diagnosis and treatment, women are still excluded from most biomedical and psychosocial research.


126. *Id.*

127. *Id.*

128. *Id.*

hormones such as oral contraceptives. Designing clinical trials that account for these factors would be more costly than excluding women altogether.

Without doubt, however, from the industry’s perspective, the more significant “cost” of including women in clinical trials derives from their reproductive capacity and the concern that women will become pregnant while participating in an experimental protocol and eventually bear children who will be abnormal. As Professor Merton points out, the fear of liability on the part of trial sponsors is wildly disproportionate to the reality of the risks they face, since the women will have signed consent forms that will curtail their capacity to sue and their offspring’s ability to recover will be limited by the challenge of demonstrating that the harm they suffered was in fact caused by the experimental agent.

The consequence of excluding women from research for decades is a dearth of information regarding safe and effective treatments for women patients, and a world in which doctors must proceed in treating women on the basis of a false assumption that they are essentially like men. The extent to which any efforts to remedy the problem of women’s exclusion from research will succeed depends upon whether the proposed reforms take into account all of the factors that have motivated exclusion in the first place.

The movement to change the federal policy began in the early 1990s and has resulted in several important improvements. In the early 1990s, the federal government launched a series of initiatives designed to redress the problems generated by the long-term exclusion of women from research. Both the National Institute of Health (NIH) and the Food and Drug Administration (FDA) issued new guidelines providing for the inclusion of women, including members of racial and ethnic minority groups, in research. The most significant impact of these new guide-

130. Rothenberg, supra note 46, at 1206.
131. See Merton, supra note 124, at 400.
132. After a thorough analysis of the potential liability for researchers, Merton concludes, “In sum, the possibility of liability for prenatal or preconceptual harm to a subject’s offspring cannot be negated, but it is hardly inevitable or of colossal proportions.” Id. at 413. For a more general discussion of the potential liability as a barrier to women’s inclusion in biomedical research, see Michelle Oberman, Real and Perceived Legal Barriers to the Inclusion of Women in Clinical Trials, in Reframing Women’s Health, supra note 110, at 266.
133. See Merton, supra note 124, at 372 (detailing the creation of several women’s health initiatives and various women’s health research institutes).
134. See National Institutes of Health Revitalization Act of 1993, Pub. L. No. 103-43,
lines is that they circumscribe a set of conditions under which women’s exclusion from research will be permissible and thereby establish a norm of inclusion.\textsuperscript{135}

To date, women’s health experts have adopted a “wait and see” attitude regarding the success of these various initiatives at eradicating the problem of gender bias in clinical research. There is, however, great concern on the part of women’s health experts and advocates that the mere increased representation of women in clinical trials and the handful of federally-funded studies on health issues specific to women will not “cure” the problems emanating from a research structure that is accustomed to treating men as the norm and women as the exception.\textsuperscript{136} In part, this concern is due to the fact that the new federal guidelines are somewhat vague about the circumstances under which women may still be excluded from clinical trials.\textsuperscript{137} As Professor Merton notes, by permitting exclusion when inclusion would be “inappropriate,” NIH has guaranteed legal challenges: “‘Inappropriate’ is the kind of legislative language that keeps lawyers in fancy cars and fur coats.”\textsuperscript{138} Moreover, the regulation maintains the permissibility of excluding pregnant women from research.\textsuperscript{139} Because the fear of pregnancy is essentially the foundation for the exclusion from research of all women of reproductive age, this omission represents a fundamental failure to understand the source of this particular form of gender bias. Although the revised guidelines may hail a new standard of care, generating the possibility of negligence claims on behalf of women who have been excluded,\textsuperscript{140} until the issue of pregnancy has been re-


\textsuperscript{135} Rothenberg, supra note 46, at 1234-35, 1239-41 (summarizing new guidelines).

\textsuperscript{136} See Merton, supra note 124, at 394-95 (concluding that the new guidelines “amount[] to a ‘pretty please’ to the pharmaceutical houses, with a gratuitous abandonment of regulatory authority that is both unwarranted as a matter of law and not too smart as a matter of strategy” (footnote omitted)).

\textsuperscript{137} E.g., id. at 395.

\textsuperscript{138} Id. at 433.

\textsuperscript{139} See Rothenberg, supra note 46, at 1231. Rothenberg notes that before the NIH Revitalization Act was signed into law, “intramural researchers could exclude women where there was a ‘clear rationale’ for doing so, including where involvement of pregnant women ‘may [have] expose[d] the fetus to undue risks.’” Id. (footnote omitted). The FDA’s guidelines also essentially mandate the exclusion of pregnant women by providing that “[a]ppropriate precautions should be taken in clinical studies to guard against inadvertent exposure of fetuses to potentially toxic agents.” Guideline for the Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs, 58 Fed. Reg. at 39,411. Furthermore, the guidelines fail to require evidence of fetal toxicity from investigators seeking to exclude all women of childbearing potential. See id.

\textsuperscript{140} See Merton, supra note 124, at 416-28 (describing a series of potential causes of
solved, it is difficult to believe that the threat of such litigation will sufficiently outweigh researchers' incentives to exclude fertile women whenever possible.\textsuperscript{41}

Furthermore, managed care may have a dampening effect on the women's health research agenda. According to Dr. Lana Skirboll, NIH associate director for science policy, managed care organizations have told the NIH "flat out that they are not interested in basic research, transitional research, phase I and early phase II research."\textsuperscript{42} "[P]ressure[s] to balance the federal budget [certainly] leave no guarantees that the" generous NIH subsidies seen in the mid-1990s for women's health research "will continue."\textsuperscript{43} Academic health centers, long the principle forum for carrying out the national health care research agenda, have indicated that market competitiveness may hinder their capacity to conduct research.\textsuperscript{44} Managed care's industry-wide impact has forced academic medical centers to operate "more efficiently" by reducing costs and becoming more streamlined, which in turn limits their ability to support research projects that lack solid funding.\textsuperscript{45} As a result, women's health research will be increasingly dependant upon the private sector.

The result of this seems likely to be a narrowing of the scope and the focus of the women's health agenda. Because managed care organizations are driven by cost consciousness, scientific research is interesting and worthy of funding primarily insofar as it elucidates cost-related information. For example, one for-profit managed care organization that claims to be actively engaged in women's health research describes a breast cancer project in which it surveyed women plan participants in order to ascertain barriers to mammography.\textsuperscript{46} Women who fail to obtain mammograms often miss the early detection of breast cancer and therefore court higher risks in terms of morbidity and mortality.\textsuperscript{47} They also are far more expensive to treat.\textsuperscript{48} This study found that women simply forgot to

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\textsuperscript{41} As Professor Merton concludes, "[B]ecause I believe that every issue about the exclusion of women from research eventually collapses back into the question of pregnant women, I believe also that until and unless that question is resolved, the seemingly larger issue will remain open." Merton, supra note 124, at 388.

\textsuperscript{42} Stephanie Stapleton, Can Research Survive Managed Care?, AM. MED. NEWS, July 28, 1997, at 3.

\textsuperscript{43} Id.

\textsuperscript{44} Eric G. Campbell et al., Relationship Between Market Competition and the Activities and Attitudes of Medical School Faculty, 278 JAMA 222, 222 (1997).

\textsuperscript{45} Id.

\textsuperscript{46} Telephone Interview with Debra Oberman, Manager of Policy and Legislative Affairs, United HealthCare Corporation, Minneapolis, Minn. (Sept. 1997).

\textsuperscript{47} Id.

\textsuperscript{48} Id.
schedule mammograms and that by providing doctors with postcards to send out as reminders, a significantly higher number of women obtained the annual examination. 149

In a sense, one might hope that the private sector would be sufficiently motivated to fund women's health research because the findings would enable them to compete more effectively in the health care marketplace. Moreover, in an ideal market, managed care organizations that skimped on women's health needs in the short-run would be stuck in the long-run with sicker patients and higher costs. However, this result is not necessarily certain in today's market because studies indicate that the average patient will not stay in any given managed care organization's system long enough to cost the organization more as a result of its prior limited care. This is particularly true for the Medicaid population, which is comprised mostly of women who cycle in and out of Medicaid. 150

In light of this, it is not surprising that managed care entities tend to ignore the gender-specific data that does exist in favor of the short-term cost savings that come from limiting services and providing one brand of care—the same for all people. 151 The implications of this economic calculus on the women's health research agenda are ominous. Coupled with the anticipated federal cut-backs in clinical research, these gender-neutral policies threaten to undermine efforts to identify the health needs of women and the ways in which health and disease manifest differently in women and men.

VI. CONCLUSION: RAMIFICATIONS OF MANAGED CARE ON WOMEN'S HEALTH AGENDA

If we are to advance an agenda of improving women's health status and enhancing the quality of women's encounters within the health care system, women's health advocates must become careful observers of the managed care industry. It is no longer sound to articulate an agenda premised upon practices developed under indemnity-based insurance. Instead, the entire spectrum of women's health issues must be reality-checked against the managed care backdrop, which may relieve the problem, may worsen it, and/or may create an entirely new set of problems.

Managed care has not proven to be the demon many women's health experts predicted it would be. On the contrary, it has helped to make clear what the women's health movement has long known—"women's health" is an umbrella term, covering subpopulations of women with widely varying

149. Id.
150. See THE COMMONWEALTH FUND, supra note 8, at 5.
151. See, e.g., supra notes 36-37 and accompanying text (describing the tendency of managed care entities to prefer drug therapy when offering mental health services in spite of significant data supporting psychotherapy as a more effective long-term treatment).
health care needs that are being met with different degrees of success by managed care organizations.

At another level, and more importantly, managed care's explicit bottom-line focus should alert women to the need to gain power within the health care establishment. The great promise of managed care to provide basic health maintenance at a reasonable price can be realized for women only if those who understand and operate these health care systems also understand the diverse and complex health care needs of all subpopulations of women. Therefore, those who have spent decades working to understand the forces that collaborate to undermine women's health must now become those who understand the structure and function of managed care organizations. Until women are seated at the table with those who dictate how much and which health care services will be provided at what cost, no system of health care will meet their needs.