The Real Trend to Watch in 2019: #MeToo for Health Care

written by Theresa Hush | January 17, 2019

Health care pundits need to sharpen their game. Year-end trend predictions are mostly old news. Growth of Artificial Intelligence and other technologies, entry of non-traditional business in health care, and pressure on the bottom line from Value-Based Health Care—all have been well underway for several years. Further, these developments only reinforce health care providers' inward focus on managing internal machinery and health care financing, instead of real health care.

But consider this underreported trend that promises to reshape demand and shake up the supply of health care services: We are in the midst of a dramatic transformation of health care attitudes, services and organization by women acting as both health care consumers and professionals.

There's a lot to unpack here. Let's address women patient and consumer perspectives first, the motivating force that is generating momentum. In a future article, we'll evaluate the impact of women physicians and other professionals on the industry.

The #MeToo movement that gave voice to women who have experienced sexual harassment has empowered them to speak out about other forms of victimization, including sexual violence, unequal treatment in workplace opportunities and income, and more recently, discrimination in health care. Women have led the resistance to the ACA repeal and rallied against pre-existing conditions during recent mid-term elections.

Our prediction: These protests and political organizing will encompass the inequities women face by health care providers and payers, as well as directly challenge those institutions. Called the #MeToo movement in health care by one physician leader, the trend was recently highlighted by the American Public Health Association at its 2018 annual meeting. Providers should begin developing strategies now, because there is a lot to address.

Concern Over Inequality in Health Care Benefits Is Going Mainstream

As women learn more about health care gender inequities, frustration is growing. While differences between men and women's health care benefits were recognized on a limited basis (e.g. reporting on discrepancy that Viagra is covered by insurance but not certain contraceptives), there was no political forum until benefits and sources of care used by women came under attack by efforts to repeal the ACA. With the progressive dismantling of ACA provisions, women have had key protections curtailed. Limited benefit plans that exclude pregnancy coverage outside the ACA requirements, for example, is transforming frustration into anger.

Restrictions and de-funding of Planned Parenthood's broad range of women's health care services, narrowing of Medicaid, and proposals for coverage that re-instate pre-existing conditions (which used to include pregnancy) have all reduced affordable health care options for women or made their health care more expensive. Not only do women earn less than men on average, but their economic buying power is further restricted by limited benefit plans and other efforts to reduce benefits that disproportionally hurt women, particularly minorities. A recent poll illuminated the somber reality of women's ability to afford basic health supplies. Two-thirds of low-income women surveyed revealed that they could not afford to purchase tampons and menstrual products and had to resort to home-made alternatives, such as toilet paper and rags.

Providers Fail Women By Treating Them Unequally

Gender discrimination in cardiovascular disease (CVD) offers a compelling example of how women face dire consequences of health care inequities. Women with heart disease have

higher risks in terms of known differential risk factors and treatment efficacies, and poorer outcomes as a result. All of this has been known for the last decade. Although CVD is the leading cause of mortality among women, however, little has been done to address it. Women-specific research and physician education regarding effective and ineffective treatment modalities and protocols for women are woefully lacking, even after the data revealed that women experience cardiovascular disease very differently from men.

But heart disease is just one aspect of a much larger issue. Women are taken less seriously about pain symptoms, wait longer for pain medication in the emergency room and post coronary by-pass surgery, are seven times more likely to be misdiagnosed in the middle of having a heart attack than men, and are more frequently prescribed sedatives than appropriate pain treatment. Women also receive less effective medicine to relieve abdominal pain than men.

In daily life, women are not taken seriously when reporting severe menstrual pain, nor adequately diagnosed and treated, despite the risks of debilitating endometriosis.

Women are less likely to receive timely diagnoses for autoimmune and connective tissue diseases. When they present with eating disorders, underlying biological factors are less likely to be investigated and the disorder more likely to be associated only with behavioral problems (which are often under-covered or not covered at all). As with CVD, these and other diseases that are predominant among women lack research funding—some say because they do primarily affect women. Maya Dusenbery, in her recently released book *Doing Harm*, claims that medicine doesn't just ignore women, it harms them.

Without a unifying sense of maltreatment based on gender, each case can be dismissed—even by women—as someone else's problem. As more stories emerge, however, detailing discrimination against women's access to quality health care, the tide is turning. Coupled with #MeToo momentum and the politicization of health care benefit issues, the preponderance of evidence may well catalyze a #MeToo health care movement that demands change from health care providers and payers.

Catalyst to Activism: Women Devalued

#MeToo gained momentum because it focused on how powerful men abused their power, using sexual harassment or violence to gain advantage over women. How those power dynamics are defined has broadened to include related issues—domestic violence as well as, for many, reproductive rights.

It is no accident that *The Handmaid's Tale* captured the zeitgeist of this cultural transition. We see a growing volume of articles documenting various practices that are now understood as acts of violence. A recent article about the "husband stitch" practice during childbirth, to cite just one egregious example, has been trending on social media among women.

Trending also are accounts of women prosecuted because they miscarried babies as a result of car accidents or other events, referenced in this *New York Times* opinion piece. New reporting reveals how women who miscarry are denied effective drugs during this heartbreaking time, due to distrust about how they might use the drugs.

As women begin to understand these actions as a departure from the previous, pernicious disparity, and declare them to be hostile attacks, we are reaching a tipping point. With every story—U.S. maternal death rate is highest in the developed world, lack of urgency to address women's health issues such as metastatic breast cancer, and curtailment of women's health benefits like pregnancy care—it is only a matter of time before women, who demonstrated their political power in the 2018 midterms, will respond to this devaluation of women in health care as an abridgment of rights.

Providers Should Proactively Address Women

Young women are already steering clear of the traditional health system as much as possible, a trend that is beginning to impact revenue and delivery of health care. Older women with fewer options or more traditional habits regarding health care services will instead use pressure and politics to change the system.

For long term economic survival, let alone ethical principles, health care providers should begin to develop proactive strategies to minimize gender-based discrimination in all their clinical operations. Creating women-specific protocols for CVD diagnosis and intervention is essential, but similar actions should be taken to eliminate the biases in diagnostics and interventions for other illnesses, especially those that involve pain and any suspected behavioral components.

Education of physicians, residents and all medical personnel will be essential to both diminish disparate treatment of women and help create new communication mechanisms to ensure that women's symptoms are neither dismissed nor suppressed.

Beyond individual organizations, health care provider organizations should collectively lobby for legislative and policy positions as advocates for best women's health outcomes. In their research, they should propose and undertake studies that correctly take into account the separate biological makeup and response of women, and propose both research targeted to

women and separate gender evaluation of results for all research studies.

As this trend evolves into #MeToo for health care, providers will have no option to sit on the sidelines. Their choices are either to remain divisive through inaction and fail, or to become collaborative and succeed. Count on women to find or create systems that will treat them fairly and serve them well.

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