How Providers Must Improve Value in Women's Health

written by Theresa Hush | May 16, 2019



Writing the Roji Health Intelligence® series on gender disparities and other women's health issues has been a revelation. As a woman who has worked in so many parts of the

health care industry, I was already aware of basic gender disparities, risk levels, incidence of disease, and economic issues that are predominant among women. Most women in health care have had their knowledge and judgment doubted as both patients and professionals. Women everywhere encounter the economic barriers associated with affordable health care, some much worse than others, and every woman who is a mother struggles with balancing the interests of children and income.

But here is what I was not prepared for: the cumulative weight and breadth of the problems—in disease after disease—that affect women and their search for good health. It is tragic that women die from heart attacks because the sex differences in cardiovascular disease are neither widely recognized nor understood, that women die after childbirth because risks are understated and urgent post-natal symptoms are ignored, and that women die from metastatic breast cancer because the money going to research focuses on prevention and early treatment. Devastating, as well, are the effects of pain and loss of functionality and independence experienced by women with progressive autoimmune diseases or who are simply old and alone.

The reasons that women struggle to get appropriate, quality health care may vary by disease, but there are common themes across all conditions. The most significant are these:

> Under-participation of women in clinical research, trials, and basic science.
> Until 1987, the National Institutes of Health (NIH) and Federal Drug Administration (FDA) did not require the participation of women in funded clinical research or

trials. While both revised policies, studies show that women's participation still lags. Furthermore, basic science research has no requirement about the inclusion of female subjects that would then carry forth in clinical trial participation. As a result, the scientific basis to diagnose and treat women is often also absent. Cardiovascular disease provides a stark example, where protocols are based on male symptoms, but tests that are definitive or sensitive enough to identify heart attacks in women are still under study, even as heart disease is the number one cause of death in women.

Slowness of medical science to "catch up" to known, sex-specific biology and diseases.

There are big gaps in provider awareness about how diseases affect women—even when these differences are proven. For example, there is a baffling lack of protocols to investigate heart attacks in women presenting with heartburn, jaw or back pain, and other symptoms common to women. As happens with auto-immune diseases, endometriosis, and other conditions, the non-existence of specific protocols to ensure that women's health issues are investigated leaves providers open to cultural biases. This leads to the dismissal of certain symptoms even when the relevance of those symptoms, such as fatigue and pain, is supported by scientific findings.

Lack of women physicians and researchers in leadership.

More women health care leaders are needed to direct priorities for research and patient care, educate providers, and be advocates for women professionals and patients.

Five Strategies for Successful Improvement of Women's Health in VBHC

1. Engage women as patients and partners in change.

This apparently trivial suggestion is nothing but—because women distrust health care providers and insurers. They also make the vast majority of health care decisions, not only for themselves but for their families. Alienating women either as patients or partners to others will lead them to seek out-of-network services for ACOs, health systems, and practices that will be participating in risk-based reimbursement. Perception of provider expertise is interwoven with willingness to respectfully communicate and discuss care so that women are taken seriously.

Providers need to invest in a proactive strategy of engagement: Educate women about symptoms associated with at-risk conditions, and teach them how to talk to physicians, including questions to ask when considering treatments. We must communicate to women that it is not only acceptable, but essential to question their physicians, seek evidence associated with options, and push back when they don't get answers.

2. Establish measures and improvement activities for women's health.

Women make up the bulk of visits for many providers, both in number of visits and charges. Providers should expect more women patients with high-cost illnesses because of incidence of disease, along with associated higher cost overruns compared to

financial targets.

Yet measures of women's overall health are virtually absent, especially in areas where care has been deficient. Providers will need to focus on cohorts of women as distinct high-risk groups and establish specialized communication channels and care designs. Further, women-reported outcomes will be essential for measuring trust, diagnostic delays, and patient clinical factors as well as social determinants of health.

3. Reconsider the delivery system of services for women.

Providers should address the concept of dedicated women's health services and whether they fragment rather than help women receive the best health care. The bottom line: ask them. Women should participate in the development of services and have a voice in their care.

4. Address cultural biases in services to women patients through physician awareness and education.

The existence of cultural biases toward women, especially relative to their symptoms, has been frequently studied and documented. The Roji Health Intelligence women's health series points to the most obvious examples. As is true regarding racial biases, only concerted efforts by providers will change these attitudes over time. This will require creating educational programs for physicians that help them adjust to the changing culture of physicians in Value-Based Health Care (VBHC).

Physicians in VBHC, in order to be effective partners in cost reduction and outcome improvement, will have a very different role in the future system. They will spend more time in patient consultation and shared decision-making, charged with presenting options for treatment supported by evidence and review of patient circumstances. The paternalistic physician, who directs medical services and expects compliance from patients, will become a rarity under VBHC. Why? Because changes in health care finance and the culture are driving patients to have a larger voice.

5. Support women physicians and researchers in their clinical practice and research.

Improvement of women's health will require equity for women physicians and researchers. Removal of discriminatory pay, mentoring women into leadership, and support for women in the workplace will all be essential to changing expectations for women patients, as well. Actively seeking research proposals that improve women's health issues should be an expected part of an academic health center's directed research process.

Viewing these efforts as "reverse discrimination" is wrong. Like efforts in VBHC to identify and address social determinants of health, gender is a major component of disease as well as its treatment.

As health care providers implement Value-Based Health Care, it will be easy to let gender disappear into the fabric of strategies to mitigate financial risk. Based on ample science that shows sex-differences in disease and treatment results, addressing women's health proactively would be the wiser action. It is also a moral imperative to deliver care to women

that is backed by science and good medicine, not based on sex.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image: Becca Tapert