

BLEEDING GREEN: ON THE SOCIOECONOMIC POLITY OF WOMEN'S HEALTHCARE

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TC 660H

Plan II Honors Program

The University of Texas at Austin

May 2, 2018

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ABSTRACT

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In March of 2017, House Republicans shook the nation by proposing the American Health Care Act (AHCA) as a supposed alternative to President Obama's highly controversial Affordable Care Act (ACA). Citing Obamacare as a costly, restrictive program, House Republicans fought against the majority of its central aims, many of which had proven beneficial to American women. While Obamacare expanded women's coverage through Medicaid, Planned Parenthood, and "essential health mandates" the AHCA withdrew federal funding from such programs while eliminating the requirements that guaranteed women's access to basic primary, preventative, and reproductive care (including maternity and newborn care). Though the AHCA was ultimately pulled before being put to the vote, its implications still reverberate throughout the nation: women are scared for their rights and scared for a future in which their health care needs are ignored. The unfortunate reality, however, is that the AHCA is not novel in its marginalization of women and their needs. By examining history, we can see that modern events are merely an extension of underlying issues that persist within an inherently exploitive framework.

With modern issues in mind, this paper interests itself in three primary endeavors: discerning the factors that continuously undermine women's relationship with the system, examining the failure of efforts to address these factors, and suggesting ways to remedy these issues going forwards. By mapping women's healthcare over time and with both social and financial lenses, I will demonstrate that our nation needs to reform its ideological attitudes before undertaking procedural and structural reforms.

At 80 million, Millennials now represent the largest generation in the United States, surpassing Baby Boomers in number by a widening margin each year. By 2025, analysts speculate, Millennials will comprise nearly 75% of the nation's workforce—a number that's both astonishing and powerful in its implications (Schawbel). As the nation's largest and most socially divergent demographic, Millennials face heavy scrutiny from the generations that precede them. While Millennials frequently get criticized for their social habits, however, no one can dispute that they're shaking up the way things are done—from brunching to social policy. “Well-educated, entrepreneurial, tech savvy, and idealistic,” Millennials are more socially aware than prior generations, and more socially active as a result. As noted by Kshama Sawant, a Seattle city council representative and member of the socialist alternative party, “the younger generation of America [is] not going to be another docile generation waiting for their little piece of the American dream, partly because that little piece of the American dream [isn't] going to come to them because of the crisis that capitalism is in” (McGreal).

According to a recent poll, in fact, “a majority of American adults under the age of 30 now reject capitalism”: only 42% said they support capitalism, and only 19% identify themselves as capitalists (McGreal). Disillusioned with partisan politics and corporate corruption, a number of Millennials now seek “radical” alternatives such as democratic socialism. As the party's post-election growth demonstrates, Millennials are worried enough about the future to seek new options. Alarmed to see millions losing their healthcare and millions more forced to pay unsustainable premiums, many Americans now entertain the notion of universal healthcare, a hallmark of democratic socialism. Finally shedding the stigma of Communism, socialism now enjoys a resurgence of popularity amongst young Americans. As stated by Jeremy Corbyn, a

recent British Labour party candidate, socialism means “democratic control of the society that we live in” and a plan “for the many, not the few” (McGreal).

Still, it would be entirely inaccurate to say that Millennials have rejected capitalism outright.

While many consider capitalism an irredeemable and unsustainable model of care, others see it as the nation’s most expedient route to salvation. With considerable capital and powerful connections, some argue, businesses are well-positioned to evoke large-scale social change. As the nation’s most ideal-driven generation, “Millennials are driving a fundamental change in the way we think about corporate culture and what we see as the potential for impact in the social sector by both companies and employees” (Case). By scrutinizing the companies they engage with, Millennials have driven a substantial shift in the way that corporate America interacts with its social environment. Now more than ever before, companies are expected to invest in the industries and communities that surround and sustain them. Over the last two decades, this trend has become known as “corporate social responsibility,” one of the biggest business buzz-words of the 2000s.

So. What are we to make of the present climate in American healthcare? With both democratic socialism and corporate social responsibility on the rise, it’s apparent that change is afoot.

Though Americans have yet to discern the best course for reform, an increasing number recognize a need for substantial change. The question is—can we overcome historic challenges and reinvent the wheel of capitalistic care, or will we need to start afresh with a new, more closely controlled system? Given the success of recent “social entrepreneurship” and “social responsibility” initiatives, we are left with a confusing conundrum: businesses are both the

source and a potential solution to our system's present ills. Both well-financed and agile, businesses have the capacity to leverage innovation in a way that the government doesn't. The question is, will corporations step up to the challenge or will they continue to trend towards financially exploitative care? Furthermore, will the government step up to restructure care, or will it continue to make concessions to moneyed interests?

This paper doesn't offer concrete answers to either question, but it does start the conversation.

As a Millennial woman and as an American, I write with all the urgency of someone with a stake in the system. Though skyrocketing costs and decreasing coverage afflict nearly all in the system, women will be amongst the groups most affected by proposed changes. This marginalization, I will argue, is part of a continuous narrative in America's health care history. Paradoxically the most over-treated and undertreated demographic in the nation, women have consistently served as the target market of choice for medical capitalists. It is because of women's long history of medical exploitation that they will serve as an instructive example of the larger problems at play in modern healthcare. With change on the horizon, I want to consider not only the present but also our past. This essay is a reflection on the rise of women's healthcare—it's my hope that our greatest triumphs and most painful disappointments will illuminate the complexity of our current predicament and its potential solutions.

It's no secret that our nation currently faces a health care crisis: in 2015, the Centers for Medicare & Medicaid Services (CMS) reported that the U.S. spent an astonishing \$3.2 trillion (or \$9,990 per capita) on health care, marking a 5.8% increase from 2014. More problematic, however, is the fact that experts foresee expenses continuing to increase: according to the Center's calculations, expenses will continue to grow at a rate of approximately 5.6% from 2016-2025, outpacing the nation's GDP growth by an entire 1.2% (NHE Fact Sheet). Though population growth and treatment complexity contribute to this increase, studies show that neither factor fully explains the nation's swelling prices and sub-par outcomes. As illustrated by a recent report conducted by the Commonwealth Fund, the U.S. severely underperforms by comparison to similarly-resourced nations. Ranked last in nearly every metric measured, the U.S. proves that spending and quality are not directly linked. Despite spending the most on its system, the U.S. lags behind in access (affordability and timeliness), administrative efficiency, equity (difference between high and low-income individuals), and health care outcomes (mortality and disease specific outcomes) (Schneider).

With little to show for our spending, we've been forced to question: where is all of our money going, and how might we put it to better use? Though many have offered complex, multi-faceted answers to these questions, I will focus on the foundational systems and beliefs that have long problematized our system of care. Price inflation and inaccessibility, I will argue, are predictable symptoms of the profit-centered, exploitative system that we perpetuate. As Barbara Ehrenreich notes in the introduction of *Beyond Crisis: Confronting Health Care in the United States*:

There is something uniquely paradoxical about the American health care system: We spend more on it, per capita and as a percentage of GDP, than any other nation, [but] we get far from our money's worth in return [...] The system, in the conventional formulation, 'doesn't work.' This understanding is a huge advance [...]. But it also misses the point [...] the American health care system 'works' just fine—if you acknowledge that delivering health care is not its goal

Here critiquing the notion that health care is “broken,” Ehrenreich asserts that the system is actually highly successful at its primary aim— “[making] money for the private interests that dominate it” (McKenzie xv). Despite being written two decades ago, Ehrenreich’s commentary still rings true today: economic motives continue to shape health care, and social structures continue to evolve in support of status quo. By presenting our present crisis as part of a long-standing socio-economic issue, I will demonstrate our need to critically examine social *and* market-related beliefs before undertaking reform.

When feminist scholar Nancy McKenzie described the state of American health care in the 90s, she wrote that “the crisis of health care delivery [had become] so multiple as to be beyond crisis.” (McKenzie xx). Echoing sentiments similar to those expressed by Nixon in the 70s (the decade in which citizens first protested crisis-level expenses), McKenzie conveys a sense of urgency and despair that resonates today. Though rising costs and systemic inefficiencies almost unilaterally affect Americans in some form or fashion, women have historically been the most afflicted by the consequences of profit-driven care and cost-centered reform. Despite garnering an impressive \$36.5 billion dollars in revenue in 2016, women’s health care providers under-

delivered on key components of care: in addition to having the worst maternal mortality rate and the highest teen pregnancy rate of developed nations, the United States also struggles with rising female mortality (a result of both physical and mental ailments) and an extremely high cancer rate across female demographics. Though a number of these problems also appear in men's healthcare, the ginormous gap between spending and outcomes is far more apparent in women's healthcare, where the profit-centricity that Ehrenreich observes runs rampant. For centuries, women have fed the industry's appetite for profit, their bodies commercialized for the sake of others' gain. While middle-to-upper-class women have primarily experienced financial exploitation, impoverished women have often suffered neglect and marginalization. Because health providers have prioritized profit over holistic community welfare, they have seen little reason to accommodate those without financial resources (Ehrenreich). When examining the issue of women's healthcare, it is impossible to separate socio-political factors from financial ones because women's physical autonomy is her social autonomy-- and both have historically been compromised for the sake of power and financial gain.

Though women have risen to combat the cost and inaccessibility of care in the past, their efforts have largely been undermined by the nation's steadfast belief in capitalism, an economic system that has become deeply-engrained and associated with individual liberty over time. Both now and in the past, the nation's steadfast insistence on market capitalism has hindered its exploration of other, more viable models of care. Only consistent failure and intense public pressure have prompted medical authorities to re-examine the efficacy of capitalism in providing health care. In the course of this essay, I will investigate three questions linked to the idea of capitalism and care: 1) how has the nation's steadfast belief in capitalism affected its system of care? 2) how

have our system's shortcomings affected women in particular? and 3) how can our society learn from prior reform efforts to successfully shift the dynamic of women's health care away from exploitation and profit-centricity? By exploring these questions, I hope to demonstrate that only radical reform will instigate the sort of dramatic improvement that citizens wish to see. As indicated by the continuous reemergence of financially exploitative and socially stratified care, market capitalism has failed to produce the "competitive prices" and equity that politicians promised. To create effective, "woman-centered care," we will need to dismantle the myth of infallibility that protects capitalism from the scrutiny that it warrants.

To properly frame my solution for the ills that plague women's health care, I will guide readers through a comprehensive analysis of the social and economic factors that have undermined reform efforts in the past. To clearly represent the interrelated nature of industry issues, I have separated my essay into five sections, each of which reflects a different component of my analysis. Chapter one will provide an overview of the socio-political events that first established profit-centered care: chapter two will examine the impact of profit-centricity on women's health care: chapter three will synopsize the successes and shortcomings of prior reform efforts: chapter four will argue against the presumed efficacy of laissez-faire health care: and chapter five will present a reform proposal that argues for the structural and attitudinal changes that accompany value-based care.

As readers will soon see, the issues at play in women's health care are not new. Though social change has forced medical institutions to make surface-level adjustments to their rhetoric, the system's fundamental structure has remained the same: patriarchal, hierarchical, and profit-

oriented. Playing to women's demands for increased recognition and bodily control, providers now frame their services as "choices" that enable women to exercise control over their health care. Though the breadth of women's medical options create the illusion of choice, however, they do little to actually promote women's agency in choosing how they engage with their providers (and their own bodies). By providing (and recommending) a range of options that operate within a traditional physician-patient, service-related framework, providers "support" women's agency in ways that fatten their pocketbooks. Though providers were once staunch opponents of women's empowerment (both medically and socially), they have now realigned themselves with the movement to better-position their services for consumption. As this example demonstrates, we can only overcome modern problems by understanding how they have grown over time. This insight will allow us to leverage new systems and ideas to overcome age-old issues that only expand as technology improves and society shifts.

Chapter 1: Historical context—how the mess was made

To give readers a comprehensive understanding of the universal issues at play, I will open my essay with an overview of the historical moments that have proven key to the development of modern health care. By examining the health-related socio-political movements of the 20th century, I will demonstrate that current problems in women's healthcare are merely a consequence of problems that have been left unaddressed for several decades. Despite its bold promises, the federal government has generally yielded to the socio-political pressures of each era and compromised the nature of its reform efforts. Often times, reforms have made concessions to moneyed players (first physicians and now insurers and Big pharma) and allowed them to strategically invest in shaping the public's perception of important issues. By allowing

those with financial stakes in the system to govern the shape of public dialogue, our government has contributed to the entrenchment of profit-centered care.

The long history of “modern” issues in health care can be traced back to the 1930s, a period of severe economic depression that prompted the government to assume an active role in health care. As the nation’s income gap widened and its middle class declined, more and more Americans were forced to live in sub-par conditions that contributed to illness. Recognizing that many Americans couldn’t afford basic treatment, the federal government positioned itself to intervene for the first time. After being elected in 1932, President Roosevelt commissioned the Committee on Economic Security to investigate potential areas for reform. Though the Committee initially endorsed national health insurance as part of its first proposal, it notably excluded the idea from its final report in 1935 (History of Health Reform). Fearful that health reform would polarize voters and attract powerful opposition from both the GOP and private medical lobbyists, Roosevelt excluded the issue from the Social Security Bill of 1935. To ensure that other essential reforms were passed, Roosevelt compromised his vision of health care and left many citizens without desperately needed aid. Like Roosevelt, many of the nation’s subsequent presidents would make concessions to capitalism in order to avoid political opposition from those with profit-based stakes in the system.

Health care didn’t substantially change until World War II (1939-1945), at which point labor shortages contributed to the birth of employer-sponsored health insurance (History of Health Reform). To attract greater numbers of workers, employers began to offer more extensive fringe benefits, including health care. Though only 20.6 million Americans carried private health

insurance in 1940, nearly 143 million carried private insurance by 1950 (Kelton). While this massive spike in coverage was beneficial to many, however, it came at the expense of the nation's long-term trajectory. As employers moved to offer more coverage, for example, they also worked to undercut labor unions, which were also offering health care benefits to members at the time. Furthermore, the development of an employer-centered system of care introduced employer-insurer relations, the dynamics of which remain problematic today. By introducing "negotiated fees," differential rates, and decentralization, private health insurers effectively normalized inefficiency within the healthcare system. To reduce the out-of-pocket costs that accompanied increased coverage, insurers began to negotiate discounted fees with in-network providers. However, because these negotiations were kept confidential, providers retained the ability to charge differential rates for the same services (Health Insurance Definitions). This system allowed providers and insurers to compete for profits, but not in an open enough manner to foster beneficial price competition. Unlike single-payer systems, which streamlined payments through a single source, America opted for a "decentralized" system that required complex payment coordination. This complexity has forced providers to spend an inordinate amount of money on administration, which consumes up to 12% of patient premiums and heavily contributes to the \$476-992 billion that gets wasted annually in healthcare (Moriates). Though private health insurance once accommodated a specific market need, its rapid, unorganized expansion created a system rife with inefficiency.

One of the first Presidents to push for radical healthcare reform was Harry Truman, who took office in 1949 just months after the close of WWII. Though Truman emphasized the importance of national health insurance in his "Fair Deal" domestic program, he met heavy resistance from

two influential opponents: southern Democrats and the American Medical Association (AMA), an advocacy group that represented American physicians (Kelton). Fearful that “a federal role in health care might require desegregation,” southern Democrats supported the AMA in its efforts to oppose federally-supervised health care (Markel). Perceiving national health insurance as a threat to the financial security of physicians, the AMA launched its National Education Campaign in 1948 to combat Truman’s proposals. Collecting an extra \$25 from each of its members, the AMA spent a collective \$1.5 million convincing Americans that national health care was “socialized medicine” and a disgrace to American liberty. (Kelton). By associating universal health care with Communism and inefficiency, the AMA successfully rallied the public behind its own interests. In fact, it wasn’t until the 1960s that an American president was able to gather support for affordable care and federal intervention. By appealing to citizens that were negatively impacted by risk-adjusted premiums, LBJ was able to gather sufficient support for Medicaid and Medicare (two tax-financed initiatives that began 1965) despite continued opposition from the AMA. While Medicare provided hospital, nursing, and physician care for the elderly, Medicaid provided coverage “for certain classes of the poor and disabled.”

As two of the nation’s most expensive healthcare reforms, both programs met public opposition in the 1970s, a period during which “general inflation and unchecked health care costs” became matters of central concern to the public (Health Care Reform). Responding to the ethos of the era, the federal government nearly halted reform efforts as it attempted to mitigate the damage of stagflation. Its “cost containment” strategies carried forward into the 80s, a period during which budgetary concerns took form as a series of aggressive, bottom-line cutbacks. Shortly after taking office, for example, President Ronald Reagan signed the Omnibus Reconciliation Act

(1981), a plan to dismantle public and preventative care programs while limiting federal oversight of health insurance. These cutbacks immediately crippled community health centers and widened the existing care gap between middle-to-upper class and impoverished Americans. For women beneath the poverty line, cutbacks meant the loss of basic primary care and essential services such as pre-natal care. Furthermore, as a result of these cutbacks, the nation's health care spending ironically *increased* 128 percent from 1980-1989, the period during which "cost-containment" measures were in full effect (Health Care Spending). This trend demonstrates an important (if largely ignored) truth about health care spending: short-term cutbacks often become long-term expenses. Since insufficient primary care creates a greater need for more expensive acute care, the government ends up paying exponentially more when it cuts back on basic treatment (Moriates)

After recognizing that reform efforts of the 80s had failed, Americans began to call for widespread reform again in the 90s. Responding to growing concern about health care security, President Clinton made national health reform an "urgent priority" in his Presidency and proposed a strategy of "managed competition" for reform (Clinton Offers a Managed Healthcare Plan). Under the guidelines of managed care, "insurers and health maintenance organizations [would] compete for consumer support over price and service, rather than over who can avoid enrolling higher-cost individuals." Furthermore, according to Clinton, the plan would "[strengthen] consumer bargaining power by pooling purchasing cooperatives and corporations" (Clinton Offers a Managed Healthcare Plan). To avoid the stigma of federal oversight and "over-managed" care, a legacy of the AMA, Clinton proposed a model that would fundamentally preserve the nation's capitalistic model of private, fee-for-service care. Though Clinton's

proposal never took off, it epitomized a common problem with health care reform: rather than challenging the norm and conceding that the nation's structure of care was flawed, reformers often followed the path of least resistance and attempted to patch the existing system.

The nation's first experience of radical reform thus came in 2010, the year that President Obama launched the Affordable Care Act. Quickly dubbed "Obamacare" by its detractors, the Act was harshly criticized for its supposedly "socialistic" and paternalistic nature. To combat this perception, Democrats co-opted the term "Obamacare" and re-associated it with the ideals that remain with us today—universal care provided by a government that cared about citizens' health. At its core, Obamacare was an attempt to expand health coverage by forcing insurers to offer consistent, affordable rates. Whereas insurers had previously maximized their profits through exclusion and differential coverage, Obamacare required insurers to provide all applicants with at least a basic level of coverage. Obamacare's "essential benefits" guaranteed that all citizens could access the following: outpatient services, prescription drugs, emergency care, mental health services, hospitalization, rehabilitative services, preventative and wellness services, laboratory services, pediatric care, and maternity/newborn care. Many of these services enormously impacted quality of care for women, who began to receive preventative and reproductive care in far greater numbers than ever before (How the Affordable Health Care Act Has Helped Women). However, "essential benefits" weren't free or easy to maintain. To keep plans affordable as coverage increased, the federal government invoked an "individual mandate" that required Americans to purchase insurance or pay a penalty. Households with incomes between 100-400% of the poverty line were eligible to receive federal subsidies, which made insurance affordable for most. Despite getting off to a rocky start, Obamacare ultimately

decreased the number of uninsured Americans by 20.5 million (Mangan). Though opponents of Obamacare have been quick to assault the program's expenses, the CBO predicts that repealing the ACA would increase our federal deficit by \$137 billion by 2025 (Ellis). Indeed, by substantially heightening the number of uninsured Americans, repeal of the ACA would result in an overwhelming need for acute care in hospitals, where the median cost of treatment is over a thousand dollars (Caldwell). With no insurance and no way to pay for highly inflated fees, patients would again turn to the government to pay for unsettled hospital expenses. By refusing to subsidize upfront care, the government would effectively commit itself to paying outrageous ER and chronic care expenses. Still, politicians continue to entertain aggressive cutback proposals that would further compromise the nation's health outcomes.

If readers take anything from this brief synopsis, it should be the following fact: although history demonstrates repetitive trends in health care reform, we have done next to nothing to break this cycle. Each time the economy dips, the federal government looks to make short-term budget cuts that will ultimately have a negative impact on long-term outcomes. Those who oppose these cuts are labeled financially impractical, and the term "socialized medicine" gets recycled as a method of silencing structural reform efforts. Despite its effective use in a number of capitalist societies such as the United Kingdom and Switzerland, national health care *still* gets branded as a socialist enterprise within the United States. Because citizens conflate private health care with consumer freedom (the ability to choose one's providers), they fail to realize that this freedom is limited in scope and contingent upon financial privilege. Since private insurers have little motivation to insure the sick and impoverished, the nation's most vulnerable end up uninsured or underinsured. Without access to sufficient primary care, Americans end up needing far greater amounts of

acute care, a far heavier burden on the nation's health care budget. To develop a cost-effective system of care, we will first need to overcome our preoccupation with short term expenses and prioritize the creation of long-term solutions.

Chapter 2: Capitalism within the microcosm of women's health care

In chapter 1, I gave readers a brief overview of the nation's health history in order to situate issues in women's healthcare within the framework of healthcare as a whole. Now, however, I will turn my attention to the impact that structural shortcomings have had on women in particular. In this chapter, I will step back in time to explain the social forces that have persistently disempowered women throughout history. I will argue that, by commodifying women's bodies, the American medical system has simultaneously exploited wealthy women while denying care to the needy and impoverished.

The nation's history of female-directed medical exploitation dates back to the 19th century, the point at which medicine was first "professionalized" by early doctors. In *For Her Own Good, Two Centuries of the Experts' Advice to Women*, Barbara Ehrenreich and Deidre English examine the evolution of medical care as a byproduct of the social events and influences of each era. Most importantly, the two scholars link our current conception of medical care to a transition that occurred in colonial times as a response to economic development and the introduction of profit-based incentives. In their second chapter, aptly titled, "Witches, Healers, and Gentleman Doctors," Ehrenreich and English observe that "the art of healing was linked to the tasks and spirit of motherhood." Because healing "combined wisdom and nurturance with "tenderness and skill," it was initially considered a "feminine" discipline that women of all social backgrounds

were expected to learn for household purposes. The most advanced however, traveled to spread their knowledge and give counsel to men and women throughout their region (For her own good).

This community-based model of medicine was directly challenged by “male medical professionals,” who presented the notion of “professional” medicine as “an advance over the unexamined tradition of female healing” (For Her Own Good 38). In a certain sense, they were right—“professional” medicine required training and a certain degree of accountability, both of which were previously absent from the discipline. Still, professional medicine was hardly the obvious advancement that early physicians proclaimed it to be. Characterized as much by its exclusivity as by its supposed rigor, professional medicine dramatically altered the dynamic of health care. Whereas female lay healers “operated within a network of information-sharing and mutual support, the male professional hoarded his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity.” This shift from female to male providers was less about gender than it was about changes to the nation’s outlook on care. “The triumph of the male medical profession,” Ehrenreich and English note, “involved the destruction of women’s networks of mutual help—leaving women in a position of isolation and dependency—and it established a model of expertism as the prerogative of a social elite” (For Her Own Good 38). In other words, male-initiated “professionalism” dramatically altered women’s health care by devaluing holistic, communal care and by instead placing a premium on structured, quantifiable services. Furthermore, it simultaneously stripped female healers of their authority, thus concentrating power within a male elite that looked to monopolize medical knowledge for the sake of profit.

Though many early American doctors were educated through apprenticeships, “elite” male physicians were educated in Great Britain, a country in which medicine was considered an “established and gentlemanly profession” (For her own good). Enamored with the prospect of status and wealth, American physicians attempted to establish similar systems of medical elitism in the United States. To this end, they worked to delegitimize competing providers and to extract a maximum amount of revenue from patients. To establish an exclusive relationship with female clients, early physicians avidly denounced female lay healers and introduced professional requirements that prevented competitors from entering the field. In the period between 1800 and 1820, “the organized forces of regular medicine were able to get seventeen states to pass licensing laws restricting the practice of medicine” (For Her Own Good 53). By making formal medical training a prerequisite of “professional practice,” early physicians were able to secure their control of the enterprise. Because women of the era were unable to receive advanced degrees, the legalization of “professional standards” effectively ended woman-to-woman care. This restriction destroyed holistic, community-based healing and replaced it with the hierarchical model that remains today.

Still, by the turn of the century, nearly “50% of babies born were still being delivered by midwives” (For Her Own Good 88). To eliminate their competition and solidify their hold over the industry, medical leaders slandered midwifery as “unscientific,” unclean, and a hindrance to the development of modern medicine (88). They called on women of all backgrounds to “make their contribution” to medical science by allowing medical students to deliver their children. Even after delegitimizing their competitors, however, male physicians experienced difficulty persuading the American public that healing was a commodity worth paying for. To convince the

public that their services were valuable, physicians first had to make healing discrete, tangible, and quantifiable -- three qualities that it inherently wasn't. Both multifaceted and inconsistent, healing implemented a holistic approach that fundamentally contradicted the central objectives of commercialism. Composed of many small kindnesses and immeasurable services, healing evaded the grasp of early profiteers.

Physicians, however, were not so easily discouraged. To increase the visibility of their services, doctors engaged in “heroic” medicine— medicine that “[competed] with the disease” to “produce the most visible symptoms” (Ehrenreich and English) To ensure that their services were quantifiable, medical professionals performed unnecessary, performative treatments that sometimes *compromised* patients’ welfare for the sake of profit. Though patients across the board fell victim to treatments of this sort, women suffered most as practitioners’ targets of choice. Biologically unique and socially restrained, women made prime targets for early physicians that were looking to make a profit off of illegitimate care. Indeed, as the profession grew increasingly crowded, doctors found that it was in their best interest “to cultivate the illnesses of their patients with frequent home visits and drawn-out treatments.” As Ehrenreich and English explain, “a few dozen well-heeled lady customers were all that a doctor needed for a successful urban practice [...] women whose husbands could pay the bills—became a natural ‘client caste’ to the developing medical profession” (59). As highly-prized (but intellectually belittled) objects of affection, wealthy women proved to be an excellent target for commercial care.

In their book, *Complaints and Disorders: The Sexual Politics of Sickness*, Ehrenreich and English further explore the integral role that women have played in the development of commercial care. Writing amidst a climate of social disillusionment in the 70s, Ehrenreich and English unreservedly critique the ideologies that physicians used to establish their authority and subordinate women's welfare to their own personal prerogatives. As the two scholars explain in their introduction, "our interest is primarily in medical ideas about women, particularly the ideas that struck a chord with us and seemed to explain our own condition" (*Complaints & Disorders* 37). Seeing their own experiences as part of ongoing narrative of medical sexism, Ehrenreich and English point to the late nineteenth and early twentieth centuries as pivotal points in the development of sexist ideology.

In the first chapter of *Complaints and Disorders*, the two scholars note: "women are not a 'class'; they are not uniformly oppressed; they do not all experience sexism in the same ways" (39). In fact, between 1865 and 1920, "class differences among American women [became] particularly sharp" and contributed to the construction of diametrically-opposed roles for women of different classes (39-40). Because women's lifestyles varied so greatly, medical professionals were unable to use a single ideology of sexism to justify their subordination of women (and their desires) both socially and medically. They thus developed two distinct models of sexism, each of which relied on wealth and class to define women's roles. While "affluent women were seen as inherently sick, too weak and delicate for anything but the mildest pastimes [...] working-class women were believed to be inherently healthy and robust" (5). Despite being far more susceptible to contagious illnesses and complications at childbirth because of their poor living/working conditions, working-class women received far less attention than their moneyed

counterparts. Viewed more as vectors of disease than as patients, working-class women were consistently disregarded by profit-hungry physicians, who preferred to treat “inherently sick” affluent women (45).

In what Ehrenreich calls a “reverse of causality,” doctors of the late 19th and early 20th centuries “found the soft, ‘civilized’ life of the upper classes more health-threatening and medically interesting than hard work and privation” (Complaints and Disorders 11). While wealthy women were treated as invalids and perpetually prescribed domestic confinement and bed rest, working-class women were expected to perform back-breaking work regardless of their illnesses. One example of this trend was the social popularity of traits considered to be characteristic of women’s “innate feminine weakness”-- pale skin, bright eyes, and a sickly disposition were attractive in an upper-class woman, and her husband’s ability to afford her idleness was a testament to the family’s social standing (81). By recognizing wealthy women’s unique position as socially-disempowered outlets of revenue, doctors were able to successfully position themselves for steady, long-term income. With the majority of their revenue coming from wealthy women, doctors had little incentive to see working-class women, whose subpar living and working conditions made them susceptible to a range of illnesses and side-effects that we now know side effects of stress and malnutrition.

Even after generations of campaigns for equal access to health care, this class divide still remains prominent. While middle to upper class women get targeted as “subjects of care,” poor women get dismissed as being less needing (or less deserving) of care that they cannot afford. Because health care gets treated as a commercial product, medical professionals ultimately tailor their

services to those who can afford to pay for extravagant, high-margin treatments. This phenomenon is best illustrated by medicine in the 19th century, at which point medical professionals used “female invalidism” to justify extraneous treatments. By relying on social conceptions of female inferiority, medical professionals were able to “identify all female functions as inherently sick” and prescribe severe and unnecessary treatments for regular occurrences such as pregnancy and menopause. According to a recent report by Statista, several of the top 20 medications prescribed to women include non-essential hormones that are intended to “treat” natural processes. Premarin and Estrace cream (designed to control menopausal symptoms), for example, bring in over 1300 million dollars in annual revenue alone, while various forms of birth control easily surpass this amount (Top 20 Health Products for Women). Though women should certainly have access to medications that they seek, we should be wary of the extent to which such medications are actively marketed by Big Pharma and prescribed by medical professionals. New medications and treatments are marketed in alignment with pro-empowerment rhetoric, but profit-directed motives still remain. By over-medicalizing women’s natural biological processes and emotions, Big Pharma has created a multi-billion dollar industry with heavy political weight.

In the past, doctors reinforced the myth of “female invalidism” by producing “scientific evidence” that supposedly confirmed women’s innate biological inferiority. As Ehrenreich and English note, few restraints were placed on doctor’s imaginations, for human physiology and anatomy were not well understood at the time. Doctors, they observe, “had considerable intellectual license to devise whatever theories seemed socially appropriate” (Complaints & Disorders 63). In the 19th century, for instance, medical professionals perpetuated “the

psychology of the ovary”—the idea that a woman’s reproductive organs governed her entire being and made her susceptible to biological and psychological diseases. In both their papers and practices, “doctors found uterine and ovarian ‘disorders’ behind almost every female complaint, from headaches to sore throats and indigestion” (69). These beliefs, combined with a general lack of industry regulation, resulted in a period of aggressive physical procedures that were intended to alter female behavior. Among these treatments was “female castration” (ovary removal), a practice that quickly became common in spite of its physical and financial costs (78). Employed as a treatment for sexual appetite and other “socially undesirable” behaviors, ovariectomies were thought to make women more industrious and amenable. Though we now know that ovariectomies have no such effect on women’s personalities, doctors of the late 19th and early 20th centuries claimed that the procedure had an immediate, tangible effect on their patients. Whether or not doctors actually believed this to be the case is subject to question, but one thing is certain: ovariectomies perpetuated the “myth of female invalidism” at women’s physical and financial expense. It was no coincidence that middle-to-upper class women, whose husbands could afford to pay for medical treatment, were found to be in constant need of medical attention.

In fact, because the “myth of female invalidism” applied to *all* of women’s functions, medical professionals quickly asserted women’s need for psychological care as well. With the authority of “scientific evidence” at their backs, physicians legitimized speculative diagnoses that should have warranted public suspicion. In the mid-to-late nineteenth century, for instance, physicians recognized “female hysteria” as a legitimate (and supposedly prevalent) psychological disorder. As Ehrenreich and English note, “the nineteenth century epidemic of hysteria had a lasting significance because it ushered in a totally new ‘scientific approach’ to the medical management

of women” (Complaints and Disorders 20). Even after the pseudo-science of the late 19th century was disproved, science retained its privileged position within the field of medicine. By equating science with reason, doctors have been able to use scientific research to justify profit-driven, female-targeted care (Complaints and Disorders). Rather than treating women as holistic beings, doctors have isolated their symptoms and used their bodies as vehicles for treatment. Because our system rewards services and not holistic outcomes, doctors have naturally gravitated towards high-margin treatments that maximize their profits.

Yet as the disappearance of hysteria and “female castration” demonstrates, the precise nature of medical exploitation varies over time as it responds to social changes. In “Feminism and Profit in American Hospitals,” Jan Thomas and Mary Zimmerman track the “evolution and impact” of hospital-sponsored care by pooling information from various primary sources. Ultimately, Thomas and Zimmerman discern four primary models of hospital-sponsored care, each of which acts an extension of the prior: 1) programs 2) pavilions 3) health centers and 4) medi-spas. Though each model differed in structure, they all shared a common goal: to expand the breadth of female services within the scope of traditional medicine. At the very outset of their article, Thomas and Zimmerman highlight the lack of separation between hospital-sponsored and woman-centered care by observing that, in 2003, “almost one-half of U.S. hospitals [had] some type of women’s health center.” Though many have touted this statistic as evidence that the visibility of women’s health issues has increased, critics suggest that hospitals have “co-opted and diluted the changes [that were] proposed by earlier feminist activists” (360). By coopting feminists’ rhetoric of “empowerment,” they argue, hospitals have effectively feigned social progressivism while continuing to exploit women as “[objects] of treatment and revenue

production” (Thomas and Zimmerman 359). Though “woman-centered care” initially aligned with women’s social movements, it ultimately came to refer to “a particular package of services and programs offered by hospitals and their doctors” (Thomas and Zimmerman 360). Unlike feminist-run centers, which promoted self-help, education, and agency, hospital-run centers of the 80s looked to “capture the woman patient,” a middle-class woman with disposable income and good insurance. HWHCs accommodated women’s “wellness needs,” but in an exclusionary fashion that privileged women as consumers, not as informed decision-makers. While those with purchasing power were able to choose from a range of exploitative options, those without purchasing power had no option but emergency care.

First launched in the early 80s, hospital-sponsored women’s health centers (HWHCs) “developed primarily as marketing vehicle[s] to bring women’s health care dollars into the hospital system.” Unlike feminist-sponsored health centers, community-based providers that emphasized education, empowerment, accessibility, and advocacy (in a comfortable environment), HWHCs focused on finding ways to funnel female patients into existing forms of treatment. Thomas and Zimmerman explain, for example, that women’s health programs merely “repackaged” existing services “under a new name and logo” (365). Ultimately, women’s programs turned out to be nothing more than a series of promotional brochures, educational information, and hospital-directed referrals. Within the decade, however, a second, more involved model of woman-centered care emerged. Like early programs, health pavilions repackaged existing services, but they did so in a more elaborate and focused fashion. By adding health education to the mix of services offered, health pavilions encouraged greater use of in-patient services “such as reproductive care and cosmetic surgery” (367). Furthermore, recognizing that good ambience

would help make in-patient experiences more attractive to women, pavilions began to decorate and design their facilities in an aesthetically pleasing fashion. As this shift towards commercial care occurred, alternative health providers transitioned away from their former prioritization of education and more towards material amenities (368). Thomas and Zimmerman note that although many women enjoyed the luxurious treatments that they received, the pavilion model did little to empower women as individuals or medical consumers.

By the end of the century, yet another model of care had emerged to expand upon the ideas of the former two. As the “most comprehensive” of the decade’s hospital-sponsored initiatives, women’s health centers (HWHCs) performed a broad range of services that ranged from diagnostic care to multi-disciplinary treatment centers. The spirit of early HWHCs was best articulated by an early CEO of Redeemer Hospital, who explained that his center acted as “a one-stop-shop” for female patients. By “[integrating] physician services into women’s health services,” he explained, Redeemer was able to offer both primary care and reproductive care in the same location. Like feminist-run centers, HWHCs emphasized the importance of education, accessibility, and holistic care although they did so within the structure of traditional institutions. Though the model enjoyed early success, its success was short-lived. When HWHCs began to hire female physicians, they met resistance from existing male physicians, who feared that hospitals were “embarking on a project that would compete directly with them” (369). Speculating that female patients would obviously choose female physicians and luxury accommodations over standard services, male physicians treated women’s health programs as threats to their profession. Rather than contesting this stance, hospitals yielded to physicians’ demands and excluded female physicians from their model of care. This shift fundamentally

altered the trajectory of HWHCs by pointing them back towards a patriarchal, hierarchical model of care.

Though “many variations of the program, pavilion, and center model of women’s health services flourished in the 1980s,” continual competition and declining reimbursements led hospitals to restructure their priorities in the 90s. With governmental cutbacks chipping away at their margins, hospitals began to seek new ways of attracting female patients and generating service-related revenue (Thomas and Zimmerman 370). Placed under greater financial strain than ever before, hospitals began to prioritize high margin services over education and preventive care. For women in particular, priority realignments led to increasingly commodified care. Retail services and specialty boutiques became prominent parts of women’s health care, and some HWHCs went so far as to develop retail centers within their facilities. Other hospitals “[combined] medical services and alternative therapies in a spa-like environment [to create] a new niche, the medi-spa model HWHC.” This model “redefined beauty products as health products,” thereby creating “vast new sales possibilities for plastic and cosmetic surgery” (Thomas and Zimmerman 371). By conflating women’s health with their appearance and material comfort, hospitals ushered in a new era of profit-oriented luxury care that persists today. As in the 90s, boutique medicine remains a prominent part of high-dollar, “alternative” care. The services that providers offer continue to change over time with the newest technology and trends, but they still target the “sick” women of the upper class in a profit-centered fashion (Complaints & Disorders 6).

The ideological similarities between present and colonial models of care illustrate the deep-seated entrenchment of capitalism and sexism within our health system. Though the appearance

of women's health care has changed over time, its underlying structure and motives have remained the same. From the colonial era to present, physicians have treated "the female market" as source of stable revenue and exploited women's bodies for the sake of profit. As competition within the health marketplace has stiffened, hospitals have increasingly prioritized services with financial potential. Oftentimes, these services are not ones that maximize women's welfare, and they rarely (if ever) address the needs of women that lack financial resources. Operating under the guise of "woman-centered care," medical providers have hijacked the term "empowerment" and conflated it with the privilege of medical consumerism. At first, the term "empowerment" was used by feminists to refer to women's agency to do as they wished with their own bodies. By empowering women with the proper information, they believed, they could give women the ability to either care for themselves or engage with physicians in a more reciprocal, autonomous fashion. Providers co-opted this term by playing to its interest in choice: rather than offering women the choice to take health care into their own hands, however, they offered women a myriad of fee-for-service treatments. These treatments seemed to demonstrate a newfound focus on women and their needs while allowing providers to remain gatekeepers of women's healthcare. Though modern-day health care offers women a bounty of options, women remain disempowered because their options do not align with their fundamental needs. For women that can afford proper insurance, "woman-centered care" has come to mean customized, comfort-oriented services that are unessential to their wellbeing. For women without proper insurance, "woman-centered care" has become distant dream—a concern far less pressing than their need for basic primary and preventative care.

Though women's experiences with health care vary greatly depending on their social and financial backgrounds, their grievances paint a collective picture of our system's ills. Capitalism has consistently worked against women's physical and mental welfare by subordinating health outcomes to fiscal incentives. Our nation paradoxically increases spending on unessential women's services while cutting funds to programs that provide essential services for underserved women. Before our system improves, we will need to restructure our priorities and concede that market-capitalism has only advanced inequity over time.

Chapter 3: Attempts at Reform

In the prior section, I gave readers a brief overview of woman's long-term exploitation in order to highlight the broad, overarching issues that have problematized women's health care in the past. Even before the advent of modern feminism, these issues sparked grassroots resistance that echoes in the dialogue of modern reform. In this section, I will examine the impact of early reform efforts by investigating second-wave feminists' efforts to combat profit-driven care. Despite successfully rallying support for their cause, feminists failed to leave a lasting impact on the structure of women's healthcare. This failure, I argue, stemmed from the movement's financial limitations, which ultimately restricted its autonomy and flexibility. Because feminist centers were profit-blind, their financial vulnerability left them susceptible to institutional pressures.

Strengthened by the social movements of the 60s, healthcare reform gained momentum in the 70s, a period of organized resistance against the structure and hierarchy of "professionalized" medicine. The tone and spirit of 70s reform was best captured by *Our Bodies, Ourselves*, a book

that quickly gained status as the “bible of women’s health, selling more than 4 million copies” (Heather). The first edition was written by The Boston Women’s Collective, a small group of women that met in 1969 to “[share] their frustration with condescending, judgmental, and uninformative doctors” and later “create a list of ‘good’ doctors for women” (Heather). After “realizing that they lacked basic information on their bodies, health, and sexuality,” however, the women expanded their goal to encompass a much broader initiative—the objective of empowering women with medical knowledge. After working to collect both women’s stories and a bounty of medical information, the Collective ultimately published its work as an informational newsprint that later got republished as *Our Bodies, Ourselves*. At its core, *Our Bodies* served as a call to arms against medical paternalism and the restrictions of traditional care. Seeing healthcare as a socio-political issue for the first time, women worked to establish the legitimacy of self-care as an alternative to traditional care. Convinced of the transformative power of education, the Collective openly addressed topics that were socially uncomfortable yet essential to women’s welfare. For example, the book quickly became known for its “frank talk about sexuality and abortion (which was then illegal)” and for its examination of issues that mattered to all kinds of women (Heather). Whereas traditional providers focused on women’s *reproductive* health, the Collective addressed a variety of topics that ranged from preventative care to sexual wellbeing. By speaking directly to women of different backgrounds and needs, *Our Bodies* successfully advanced the public’s awareness (and advocacy) of informed self-care.

In her article, “Please Include this in Your Book: Readers Respond to *Our Bodies, Ourselves*,” Wendy Kline makes note of the following advice given by the Collective’s founders: “to get control of your own life and your own destiny is the first and most important task [...] but it

begins with getting control of your own body” (Kline). As long as women lacked bodily autonomy, they argued, men would continue to hold a certain degree of leverage over them. Echoing this message in *Our Bodies*, the Collective’s founders called upon women to “demand answers and explanations” and to become informed enough to “negotiate the system instead of allowing the system to negotiate [them].” With this goal in mind, second-wave feminists of the 70s brought renewed emphasis to education and self-help, two ideas that directly impacted women’s ability to push for “woman-centered” care. By promoting knowledge dispersion, feminists were able to demystify female medicine and dismantle the hierarchy that undermined their agency. Encouraged by the community support that they found, women grew increasingly engaged with their health care and the initiatives that kept them informed.

As the ripple-effect of *Our Bodies* demonstrates, individual empowerment is strongly linked to group empowerment. For example, after personally benefitting from the pamphlet’s knowledge, many women were motivated to support the cause and contribute feedback that further developed resources. As Kline notes in her essay, *Our Bodies* “offered a level of intimacy that encouraged readers to respond to its text [...] more than two hundred women wrote to the Collective in the 1970s and 1980s to share stories, seek advice, chastise, or praise. They commented on what was helpful, what was vague, what made sense, and what was missing” (Kline 89). Maura Ann Dowling, for example, wrote the following to The Collective to express her gratitude for *Our Bodies*: “I was a senior in college, had just ended a relationship with my boyfriend who had anger management challenges from some unresolved issues in his past. Then I found out I was pregnant. Fortunately I owned a copy of ‘Our Bodies, Ourselves’ [...] All through this OBOS was my midwife—always informative, always encouraging me to hear and

express my own voice” (Dowling). As Dowling articulates, OBOS served as an essential resource for women who had nowhere else to turn for basic knowledge. As another reader, Vanessa Fernando notes, “OBOS provided a community of sorts, a refuge, in which women discussed their own thoughts and fears and insecurities and shared information with one another in a way that alleviated fears and isolation” (Dowling).

However, because *Our Bodies* was so heavily relied upon, it also attracted pointed criticism. For those who looked to *Our Bodies* for critical information, any absence or shortcoming was excruciating. For example, after failing to find sufficient information on the potential consequences of conization (removing a cone of tissues from the cervix), one disgruntled reader wrote: “[I] got to the line that said conizations might lead to complications in pregnancy. You didn’t tell me what complication. The book didn’t tell me; it just added another layer of mystery and innuendo [...] I know enough to worry, but not enough to answer my own questions... Before you and your book there was nothing, but still...” (Kline). Here conveying her frustration directly to the Collective, this reader helped highlight one of the book’s many early shortcomings. By providing feedback on the materials they engaged with, women played a dynamic role in shaping the trajectory of the movement’s materials. Furthermore, as Kline observes, “women did not have to be actively involved in an organized group of feminists or even in a consciousness-raising group to participate in the movement” (Kline 89). By addressing issues that ranged from physiology to sexuality and pregnancy, *Our Bodies* created an inclusive feminist community that transcended geographical bounds and united women behind a common, representative vision. Furthermore, by increasing women’s awareness of paternalism, hierarchy,

and medical commercialism, *Our Bodies* has prompted greater demand for alternative care and freedom for autonomous, informed decision-making in traditional care.

Our Bodies greatly influenced the nation's first feminist-sponsored health centers, which arose as a direct response to women's increased demand for alternative care. In "The Dynamics of Cooption in a Feminist Health Clinic," Sandra Morgen explains the ideological basis of alternative care as "an organization run collectively by and in the interest of women in their community... the vision stressed equality in all phases of its operation: decision-making, division of labor, and access to knowledge, wages, and other rewards." These standards, Morgen explains, "embodied the premise that health care ought to be a right, rather than a commodity designed to generate profits." Rather than prioritizing profitable services (as hospitals did), women's health centers would prioritize education, accessibility, and self-help—the very same ideals that *Our Bodies* had instilled in its followers. Though women would later debate the best way to achieve these goals, they would remain central components of women's healthcare reform.

At first, many centers adhered these ideological ambitions by subordinating financial concerns to social ones. As time drew on, however, financial considerations prompted centers to reconsider their insular, profit-blind models. In her time as a participant-observer at Women's Health Center (WHC), a feminist clinic that emerged in the 70s, Morgen investigated the process by which "dominant ideologies and social relations" changed the structure of early feminist centers. She observed that, at its outset, the WHC embodied the very essence of feminist reform—unlike traditional hospitals, it fostered a sense of community and treated women as equals, not as

“subjects of care.” Instead of simply enacting treatment, the WHC worked to support women as they made *meaningful* choices about personal care. Unfortunately, as the Center expanded, its financial pressures pushed it to adopt an increasingly traditional structure of care. Though the Center began as an egalitarian, community-based structure, it quickly compromised its ideological integrity as economic pressures came into play. To accept funds from government entities, the Center elected president who was charged with overseeing the distribution of donated money. While the Center’s first president was only president in name alone, successive presidents were given large degrees of authority in the interest of promoting efficient decision-making. As the only individual with a handle on all of the Center’s activities, presidents quickly replaced the Center’s community consensus decision-making model. Also problematic was the fact that, as the Center’s services expanded, so too did its number of clients. This increase placed strain on the Center’s administrators, who found that expanding care resulted in longer waiting times, shorter appointment times, and rising fees—the same issues that inspired them to part from traditional systems of care.

To make its services more accessible to clients once again, the Center finally agreed to accept external funding from the State, which had offered financial support with “few strings attached.” As Morgen notes, however, “feminist health activists, including the WHC collective, did not enter lightly into decisions to seek State funds to operate their projects.” From the beginning, “movement participants were wary of allowing the ‘system’ a foothold in their organizations” (202). Still, the WHC decided to accept State aid for two reasons: 1) small-scale fundraising and minimal fees had become problematic and 2) relying on volunteer staff members had substantially limited its ability to provide beneficial services (202). Prior to accepting state aid,

the WHC raised the majority of its funds through fundraising, an activity that proved to be increasingly time-consuming and inefficient as the Center grew. Furthermore, because the WHC relied on volunteers to provide its services, its ability to act as a stand-in for traditional hospitals was fairly limited. Additionally, because volunteers went uncompensated, the Center tended to attract “white, young, middle class women who could afford to donate [their] time” (202). Since the majority of underserved patients were from minority demographics, the Center observed a visible difference between its volunteers and patients. Though this divide wasn’t problematic in and of itself, the WHC wished to create a more inclusive and representative environment as it progressed. Recognizing that its financial limitations would hinder its ability to “offer services and the opportunity of involvement” to working-class women, the Center agreed to use State funds or staff reimbursements in 1975.

Initially, State funds seemed relatively harmless, for the State merely asked that the Center name a director to manage its grants in the future. To comply with the State’s request while retaining its egalitarian structure, The Center elected a figurehead president while adhering to its original model of collective decision-making. Still, this “modest” compromise signaled the Center’s symbolic departure from non-hierarchical care and facilitated later modifications. For example, after recognizing that its wait times had become comparable to those at traditional hospitals, the WHC decided to hire a paid staff that could help it meet its growing demand for service-provision. Though wait times decreased, however, The Center’s implementation of full-time workers further undermined its egalitarian model by creating divides amongst workers.

The new jobs quickly sparked tension with the Center's existing volunteer staff, who began to push for compensation. Furthermore, because paid staff workers worked full-time, they quickly grew acquainted with the system's inner workings and became more adept at experience-based tasks such as administrative work. Over time, these inconsistencies contributed to distinct labor division at the Center: while volunteers often engaged with patients directly, full-time workers performed financial and administrative work that isolated them from patients. This task specialization created a cultural rift between workers and contributed to inefficiency and miscommunication at the Center. Whereas the Board had previously practiced collective decision-making, its shift towards specialization prompted segmented, departmental decision-making. Specialization of this sort hastened decision-making, but it overlooked the importance of consensus and over-privileged the director, whose opinion came to act as stand-in for interdepartmental oversight. The Center's collectivism was further compromised by its growing volume of administrative work, which required individual rather than collective decision-making for the sake of time and practicality. As the Center's volume of grants and contracts grew, it simply became impossible for staff members to remain informed about every initiative undertaken. Over time, the WHC's decision to accept state funds resulted in restructuring that ultimately undermined its ideological initiatives. Though the Center never consciously sacrificed its ideals, it yielded to bureaucratic demands and processes that eventually yielded the same result.

Still, it's difficult to fault the WHC for the entirety of its downfall. Though the Center's Board played a conscious role in its transition away from collective care, the State played a far greater role in influencing its structural development. After getting its foot in the door, the State used its

financial leverage to influence the Center's trajectory. Its most obvious method of influence was "selective funding," a process by which state funds were allocated to programs that either matched or reinforced State initiatives. Morgen observes that "because of the enormous asymmetry between the resources and power of the State and small grassroots organizations such as the WHC, the state could use economic leverage to shape WHC activities and structures" (Morgen 203). Rather than explicitly stating its opposition of feminist reforms, the State used its money to implicitly discourage reform initiatives. For example, in the years that Morgen observed the WHC, the State selectively funded "direct services" while withholding aid from "community education, community organizing, health advocacy, and other social activist projects" (Morgen 203). To preserve the existing order (and the support of its moneyed supporters), The State chose to finance only profitable, measurable services that directly contributed to hospital income. Though preventative services and educational projects were tremendously effective, the government deemed them "too expensive" to warrant financial support.

In addition to using strategic funding, the State leveraged its financial position to make feminist providers wary of engaging in social activism. The Center first became reliant on external funding in 1976, the year that it hired its second director, a professional who dedicated herself to increasing the reach of the Center's services. Recognizing that large-scale expansion would require external funding, the Center's director denounced "politically motivated opposition" as "abrasive behavior" that detracted from the WHC's ultimate mission: "provide necessary services for women" (Morgen 206). Myopically focused on expanding treatment capacity, the WHC's new director willingly sacrificed the Center's socio-political autonomy. The State

consciously exploited the Center's financial needs by insisting upon "contract billing," a system by which reimbursements were paid at period ends, not as services were rendered. Because the State ran notoriously late on its reimbursement payments, the WHC frequently ran late on its own bills, including payroll (Morgen 205). By 1978, the Center "was owed thousands of dollars (for 6 months of contracted services) by one of its state funding sources" (Morgen 205). Such large-scale debt made the Center unstable, and day-to-day functions came to depend on state funding, which could be easily revoked.

As the WHC grew in size, its financial dependence on the State continued to worsen. After beginning to provide complex services, "the staff felt accountable to the community to continue to provide those services." Knowing that cutbacks could substantially impact many women, the Center experienced difficulty limiting its financial expenses. For example, as the Center continued to add paid positions, volunteers "gave up other jobs and became more vulnerable" to financial threats against the Center. Perpetually fearful that the State would withdraw its funds, the WHC began to advise staff members to avoid controversial activism. By making itself the gatekeeper of much-needed funds, the State inadvertently exerted its influence over progressive providers while remaining politically indifferent. Rather than making women's healthcare a social battle, the State made it a financial one—one that it could easily win. As the WHC's downfall demonstrates, ideological ambition isn't enough—financial flexibility also plays an important role in upholding the integrity of social reform. Though second-wave feminists were driven and well-intentioned, their failure to plan for financial pressure hindered their ability to create lasting change. Without governmental support, feminist centers were often forced to

abandon the preventative and educational programs that separated them from hospital-sponsored centers.

The strong connection between fiscal and ideological autonomy is best demonstrated by *Our Bodies*, an initiative that remained true to its intentions through decades of operation. In her article, “Transforming Doctor-Patient Relationships,” Sheryl Ruzek traces the evolution of *Our Bodies* through the decades and observes that, although its content and delivery have changed, *Our Bodies* remains both profit-blind and “woman-oriented.” Keeping its goal of empowerment-oriented education in mind, *Our Bodies* has opened itself to a range of inputs and taken a dynamic, proactive approach to content reform. Though “keeping the book affordable was always at odds with expanding coverage,” the Collective resisted the temptation of external funding on more than one occasion. To preserve the trust of its readers and the integrity of its mission, the Boston Collective continued to fund its own publications, selling them for \$2.98 in 1973 with “substantial discounts for clinics and women’s groups” (181). Though demand for the book could have easily supported a far higher price, the Collective shunned profit as an impediment to its ability to rapidly spread knowledge. Since the 70s, the Boston Women’s Collective has substantially changed. Now an incorporated entity with a board and unionized staff, the organization is far from its humble beginnings as a discussion circle. Despite increasing in size and formality, however, the Collective has never wavered in its “commitment to validating women’s personal experience and organizing for change” (182). By refusing to entertain moneyed interests, the Collective has successfully maintained its ideological purity while expanding the reach of its message. Though the precise nature of the Collective’s work has changed over time, its prioritization of trust and integrity have remained constant. As the

Collective's present, bureaucratic structure demonstrates, expansion and formalization can prove beneficial to reform when properly leveraged.

Unfortunately, however, complex care is far more expensive than educational reform, the primary focus of *Our Bodies*. As a result, it will be difficult for alternative providers to remain financially independent in the same manner. Because health care expenses have risen so much in recent decades, it's far most realistic to concede that the government will need to play a substantial role in funding future reforms. Given the entrenchment of profit-driven, service-based care, it's essential that the federal government lend its weight to grassroots reform efforts. The first step to evoking meaningful change will be to acquire *genuine* support for efforts that challenge status quo.

Chapter 4: Capitalism in American Health Care

In chapter 3, I gave readers a brief account of second-wave clinics in order to highlight the strengths and weaknesses of prior reform efforts. Ultimately, I conclude that in order for our system to change, the federal government will need to financially endorse plans that challenge status quo. In this section, I will work to explain why Americans have remained resistant to infrastructural change despite recognizing the system's blatant shortcomings. Social and legislative factors, I will argue, have overlapped to contribute to the economic entrenchment of commercialized care. Because citizens have unquestioningly accepted the applicability of laissez-faire capitalism to healthcare, America remains married to the idea of private health care in spite of its failures. As I will demonstrate, however, the principles of capitalism fundamentally contradict the nature of health care.

In his article, “Economism and the Commercialization of Health Care,” Howard Brody works to explain the nation’s fixation on capitalistic care. Describing America as a fundamentally “economistic” society, Brody claims that its citizens view the world through an economic lens and apply economic principles to all of their social functions. Though Brody concedes the benefits of having a “market economy” (defined as managing a “certain portion” of social activity through market exchanges), he argues that having a myopic focus on economic principles can damage the nation’s social infrastructure (503). When the economy “is the society,” Brody explains, it “is not expected to cohere with important social values.” Rather, “the market defines and dictates those values [...] has no bounds, and is assumed to be flawlessly self-regulating” (503). In the past, this concept manifested as Adam Smith’s “famous metaphor of the ‘invisible hand’,” which proposed that markets “self-regulate” to produce social equilibrium and a balance of interests. As Brody notes, however, even Smith understood that this ideology only functioned within “appointed bounds” and a proper social framework (503). Without the sort of self-restrictive social guidelines that Smith envisioned, American capitalism has overextended its influence and overtaken social structures that defy its governing principles.

As Marianne Fahs point out in her article, “The Economic Consequences of Inaction,” “current federal inaction is based on the economic theory of competition, which embodies the principle of laissez-faire—literally, let the private market alone to do its work” (Fahs 127). As indicated by our nation’s history of reform, the federal government often argues that provider-insurer competition ultimately drives down the cost of care for average Americans. As demonstrated by rising costs, however, healthcare has defied the principles of market capitalism. For “the ideals

of competition to be approached,” certain factors such as free entry, perfect knowledge, and consumer sovereignty must be present within the system. Unfortunately, as a non-commodity product, healthcare evades these standards. For example, though market capitalism mandates that “consumers have time to search the market to exercise their sovereignty,” “medical care requirements are often urgent, leaving no time to shop for the best price” (Fahs 127).

Furthermore, though fair market competition calls for free market entry, the AMA and state licenser boards restrict the entry of new providers. Finally, though capitalistic competition presumes that consumers have perfect knowledge about products, medical consumers are often unable to obtain sufficient information on treatments and services prior to receiving them. Given these shortcomings, “competition” in health care has yielded only rising costs, profit-concentration, and systematic inefficiency.

Still, because market capitalism is taken as a “common sense” approach in America, it escapes public scrutiny. As Brody argues: “My main critique of economism is that it is not proposed; it is assumed to be self-evidently true as a matter of common sense [...] So long as one of our society’s central ideologies is thus protected from reasoned scrutiny, health care ethics cannot address the most critical issues raised by commercialization” (506). Indeed, though many presidents have undertaken health care reform, most have attempted to institute their reforms while making concessions to private interests. Rather than challenging private insurers, for example, President Bill Clinton advocated a system of “managed competition” that would “artfully combine competition and regulation” (The Bush-Clinton Health Reform). Convinced that buyer leverage would temper soaring costs, Clinton failed to question the nation’s underlying belief that market competition would produce a beneficial outcome. Despite

recognizing the system's ills and hearing the nation's call for radical reform, Clinton attempted to advance a broken, poorly-structured system. Ultimately, it's not that our nation hasn't recognized the inadequacy of its system-- it's that it hasn't conceded a need for drastic change. Thus far, reform efforts have fallen short of infrastructural change, the only way to sufficiently alter status quo. After decades of failed reform, it's high time that we re-examine our model. Rather than fitting healthcare to the mold of market capitalism, we should fit the system's structure to human-centered objectives and treat it as the long-investment that it is.

Feminists undertook the task of enacting holistic care in the 70s and 80s, but their movement lacked the public support, financial backing, and practical tools necessary for long-term success. Now, however, the conditions are ripe for substantive reform. With costs on the rise and outcomes on the decline, even medical providers concede that the system needs to undergo reform (Bernstein). Though doctors once disputed reform as a threat to their professional freedom, they now support it as a way to usurp private insurers and improve patient outcomes. As The Institute of Medicine (IOM) notes in "Crossing the Quality Chasm," one of its recent reports, "even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions" (Moriates). To improve health outcomes on a national scale, we will need to design a system that supports "wellness" in both financial and ideological terms.

Chapter 5: Reforming Women's Health Care

In Chapter 4, I asked readers to re-examine their faith in market capitalism, an economic structure that has become emblematic of the nation's freedom and prosperity. I argue that although capitalism has served the country well in a number of regards, it has no place in healthcare, a field far-removed from traditional market factors. Having thus demonstrated the nation's need for structural reform, I will now argue that, at present, our nation finally has the technological capacity to revamp its system of care. By combining telehealth with the ideals of value-based care, our nation can finally realize feminists' initial vision: community-based care that promotes holistic welfare, not exploitative services. The well-woman model may have failed its first time around, but accessible, quality care for the masses is now closer than ever before. By maximizing cost-efficiency, telehealth and other structural reforms can financially *and* socially benefit our system of care. To understand the potential implications of technology and "value-based" for women, it is first necessary to understand their influence within the industry as a whole.

As noted in the introduction of this essay, America spends far more on healthcare than other developed nations despite falling short on a number of essential outcomes. Rather than making cutbacks however, our nation should look to better invest its resources. By revamping our system's priorities, I argue, we can enhance the quality of women's healthcare while reducing long-term costs. As Christopher Moriates and Vineet Arora explain in *Understanding Value-Based Healthcare*, "healthcare is fraught with complexity, fragmentation, inefficiency, unexplained variation, and waste. In order to navigate this complexity "in [a way that makes] care more affordable, safe, and convenient," they argue, patients and providers will need to

“understand how to deliver and receive high-value care” (Chapter 1). High-value care, they assert, will involve the creation of a system that maximizes patient outcomes while minimizing expenses. Straightforward as this definition is, it allows for a fairly flexible definition of “value” that makes space for a range of approaches to “high-value care.” As Harvard cardiologist and journalist Dr. Lisa Rosenbaum suggests, “value in healthcare depends on who is looking, where they look, and what they expect to see” (Moriates Chapter 4).

Regardless its interpretations, however, “value” often prompts one of two initiatives: waste reduction or strategic investment. As Moriates and Arora point out, the U.S. suffers from *inefficiency*, not from lack of wealth or medical expertise. Despite spending 82% more on health care than Canada, its nearest northern neighbor, the U.S. ranked 7 spots below its competitor in an evaluation conducted by the World Health Organization in 2011 (Chapter 1). Wasting nearly 30 cents of every dollar spent on healthcare, the U.S. squanders a large percentage of taxpayers’ funds. Unlike other developed countries, which attempt to minimize transactional inefficiencies, the U.S. accepts such expenses as part of its central model. Rather than using a single-payer system to streamline payments, the U.S. *de-centralizes* its system at the expense of \$190 billion in annual administration (Moriates Chapter 1). Though policy-makers continue to defend private insurance as a hallmark of American choice, they fail to mention that only privileged citizens enjoy the freedom of provider choice. Since many Americans rely on either the government or their employers for insurance, few have the ability to exercise their purchasing power in a way that upholds competitive market conditions. Because private insurance is both financially inefficient and socially detrimental, it makes sense to eliminate it from the American system.

If the U.S. were to adopt a universal, single-payer system, it could reinvest saved administrative resources in the production of long-term, patient-focused outcomes. Rather than struggling to cover administrative overhead, providers could take a more *strategic* approach to investing in quality care. As Moriates and Arora observe, the U.S. currently invests in expensive care for the elite minority, not affordable care for the majority. Enamored with the prestige of “cutting-edge medicine,” many providers have come to conflate technological progress with quality improvement. Technology, however, is far from the cure-all that many imagine it to be: despite its many indisputable benefits, technology (and other forms of innovation) also plays a key role in driving cost growth. Going forward, it will be important for our nation to stringently evaluate the cost-efficiency of technological investments in order to remain widely effective.

Take, for example, the growing role of technology in maternity care. Though certain inventions have substantially improved hospitals’ ability to treat low-birthweight infants, they have done little to improve the cost or quality of care for most pregnant women. As Moriates and Arora point out, fetal telemetry has become standard practice despite doctors’ lack of evidence that newborn babies are better off. Scholars have observed, in fact, that “the only thing fetal telemetry appeared to do reliably was markedly increase the national C-section rate from just 5% of births in the early 1970s to 32% of births in 2014” (Chapter 8). This increase has “[significantly contributed] to the \$5 billion price tag of avoidable C-sections” and boosted the industry’s profitability by a significant sum. As the example of telemetry demonstrates, our nation needs to exercise greater discretion in its use of technological innovation. Though technology has the capacity to improve care outcomes, its use should be limited to circumstances in which its “net benefit” is apparent. By regulating technology in this manner, providers can navigate the fine

line between “moderating the growth of medical expenditures and maintaining a world-class capacity to innovate in medicine” (Chapter 8). In general, however, providers must be willing to recognize that technology doesn’t always produce the greatest “net benefit” for patients. Rather than myopically focusing on individual outcomes (generally those of wealthy patients), providers should prioritize systems that benefit entire communities.

To “maximize patient outcomes while minimizing expenses,” health providers should focus on developing primary care, a system that emphasizes the following four pillars: first-contact care, continuity of care over time, comprehensiveness (holistic, well-rounded care), and coordination of care with other parts of the healthcare system. Unlike most wealthy nations, which prioritize primary care as a foundational component of high-value care, the U.S. continues to treat “primary care as an afterthought despite its proven benefits” (Chapter 9). Though a large number of acute medical cases are entirely preventable, the U.S. fails to prevent such ailments with early diagnoses, education, and proper home management. By failing to “provide timely access to care,” the U.S. “counteracts much of the value that primary care offers: catching disease processes early and preventing costly visits and hospitalization” (Arora and Moriates). To make primary care more cost-effective, we will need to follow the motto: “an ounce of prevention is worth a pound of cure.”

Unfortunately, however, our present system is ill-equipped to provide sufficient primary and preventative care. As the American population ages and develops “increasingly complex healthcare needs,” our nation’s demand for primary care heightens. Between 2005 and 2025, physicians’ workload is expected to increase a startling 29%. According to data from the Health

Resources and Service Administration, this increase will result in a shortage of 20,000-50,000 primary care physicians over the course of the next decade (Chapter 9). In order to provide holistic, high-quality care for women, we will first need to remedy the drastic supply/demand mismatch that leaves poor populations underserved. To accomplish this goal, we will first need to target medical school graduates, who increasingly shun careers in primary care as time passes. At present, less than 20% of medical school graduates matriculate into primary care, a figure that represents a 25% decrease from the 80s. This decrease, Moriates and Arora observe, is a direct result of several factors such as “primary care bad mouthing” at medical schools, dissatisfaction with primary care resident experiences, and a “hidden curriculum” in medical schools that “glorifies specialty careers and hospital-based health services.” This glorification ultimately contributes to unequal compensation, which further pushes medical students to pursue careers in specialty care. Faced with hundreds of thousands of dollars in academic debt, students are far more likely to opt for specialization, which pays an average of 267% more than primary care.

In order to create the sort of preventative, educational system that second-wave feminists imagined, we will need to “reignite the primary care pipeline” that sustains efficient, wellness-focused care (Moriates Chapter 9). We can begin this process by restructuring incentives, which will help renew students’ interest in the practice of general medicine. According to the Council on Graduate Medical Education, “primary care salaries will need to be at least 70% that of specialists in order to entice graduating medical students to pursue careers in primary care” (Moriates Chapter 9). Such increases, (perhaps combined with loan forgiveness), could make primary care far more appealing to financially-pressured students. Still, financial alterations alone will not be enough to catalyze sufficient change. In order to prompt dramatic job growth,

our nation will need to change the way that medical professionals are educated. Only by teaching holistic care can we hope to eventually create patient-focused doctors. For example, rather than teaching doctors to look for obscure illnesses, “a number of residency programs are supplementing clinical competencies with communication, quality improvement, and the practice-based learning skills integral to team-based care.” By academically emphasizing the virtues of patient-focused medicine, medical schools can reinforce the importance of general care and enhance doctors’ ability to prevent severe illness. Ultimately, effective general care can help patients minimize their need for specialty care. As basic care becomes more and more accessible, individuals will be able to take on increasingly proactive roles in their own welfare management. As this occurs, the nation’s healthcare expenses will naturally decrease as greater engagement and preemptive care lessen Americans’ need for expensive acute care. Still, such adjustments will take time, and their impact will almost certainly benefit those of financial privilege to a greater degree. Even as the number of primary practitioners increases, it’s unlikely that they will go on to serve privileged and underprivileged communities in equal proportion. Given practitioners’ historic preference for middle-to-upper-class neighborhoods, it’s essential that we develop realistic ways of delivering primary care to the underserved.

Telehealth, I will argue, is the key to developing expansive care that serves the impoverished as well as the financially well-provisioned. Broadly speaking, telehealth “encompasses a variety of technologies and tactics” that are used “to deliver virtual medical, health, and education services.” (What is telehealth?). First developed to extend expert treatment to the underserved, telehealth acts as a modern extension of the “well-woman” model that second-wave feminists once advanced. By placing an emphasis on knowledge and community, telehealth programs

expand quality care to women that are generally marginalized by our present system. As Doug Desjardins notes in his article, “Prenatal telehealth programs reach out to at-risk women,” telehealth programs have helped rural and impoverished women obtain the type of routine care that middle-class, urban women receive. For example, prior to telehealth initiatives in the early 2000s, rural women often experienced difficulty reaching obstetricians. Thus, when they experienced complicated pregnancies, they had to drive hundreds of miles to receive the sort of specialty care that they required. Recently, however, telehealth pioneers have stepped in to help rural women connect with specialists in a faster and more affordable fashion. In Georgia, for example, the Women’s TeleHealth Program distributes portable ultrasound machines that connect underserved clinics with remote specialists. By viewing live scans and utilizing videoconferencing technology, these specialists are able to give patients the immediate personal attention that they require (Desjardins).

Though telehealth encompasses a range of applications, videoconferencing has come to play a central role in many telehealth initiatives. The Tele-Lactation Pilot Project (TLPP) in Indiana, for example, has “explored the feasibility of using videoconferencing technology to provide breastfeeding education and support to low-income women” (Friesen). After discovering that 60% of mothers failed to meet their breastfeeding goals because of improper lactation support, health reformers began to look for ways to “integrate technology-facilitated education and consultations into women’s routine primary care” (Friesen). By providing women with prenatal and postnatal support sessions, TLPP professionals were able to supply the sort of “positive reinforcement, encouragement, and informational support” that breastfeeding mothers needed to be successful in their breastfeeding experiences.

With knowledge-dispersion and connectivity as parts of its central agenda, telehealth offers a sustainable model for community empowerment. An illustrative example of the model's potential is Project ECHO (Extension for Community Healthcare Outcomes), one of the nation's first telehealth projects to expand on a large scale. First created in 2003 as a way to expand treatment of hepatitis C in New Mexico, Project ECHO has since broadened its efforts to encompass other ailments and localities. Now operating 130 hubs for over 65 diseases, Project ECHO stands testament to the powerful potential of telehealth as a tool for information sharing. As the project's website explains, the initiative "[puts] local clinicians together with specialist teams at academic medical centers" in order to "share knowledge and expand treatment capacity." By encouraging members to participate in weekly virtual clinics and seminars, Project ECHO disseminates valuable knowledge and empowers disadvantaged providers to improve their communities' health. In fact, because the quality of instruction and communication at ECHO is so high, local clinicians are able to produce expert-quality outcomes: as the New England Journal of Medicine reported in 2011, "the quality of hepatitis C care provided by Project-ECHO trained clinicians was equal to that of care by university-based specialists" (About ECHO). By "breaking down the walls between specialty and primary care," ECHO has empowered local clinicians to effectively (and cost-efficiently) attend to their own communities' needs.

In the past, providers have aimed to monopolize knowledge as a source of profit and market dominance. This system has disadvantaged patients, who experience limited access and premium prices as a result of medical territorialism. In order to universally improve patient outcomes, we

will need to oppose status quo and promote an open culture amongst providers and patients. Rather than acting as gatekeepers of knowledge, providers should work cooperatively to connect people with the information that they need. By reprioritizing patient welfare, we can enhance health outcomes while saving both patients and providers a great deal of money on care. As DM Cosgrove notes in his article, “Ten Strategies to Lower Costs, Improve Quality, and Engage Patients: The View from leading Health System CEOs,” “patient-centered care isn’t just socially responsible—it’s quickly become a financial necessity for health care organizations.” According to Cosgrove, patient-engagement “is quickly becoming the norm amid growing evidence that patient-engaged care is associated with better health outcomes, better care experience for patients, and lower health care costs.” In primary care settings, he explains, patient-centered communication can lead to “faster recovery, improved clinical outcomes, a better care experience, and fewer diagnostic tests and referrals.” Since “well-informed patients are less likely to choose more aggressive and costly courses of treatment,” they often undergo fewer expensive, unnecessary tests. Contrary to the “Web MD” stereotype, properly- informed patients can play meaningful, constructive roles in their diagnoses.

By facilitating “meaningful engagement,” telehealth can help patients increase both the quality and efficacy of their doctors’ diagnoses. In “The Impact of Patient-Centered Care on Outcomes,” in fact, Moira Stewart found that patient-centered communication increased patient-engagement and patient-physician agreement while simultaneously lessening patients’ demand for diagnostic tests and referrals. By cultivating strong relationships and an open dialogue with patients, physicians were able to gain useful information on the issues that they were attempting to treat. For example, by working to understand patients’ expectations, personal boundaries, and lifestyle

limitations, doctors were able to prescribe treatments that were *realistically* actionable. Furthermore, because patients felt that they had actively contributed to the suggested solution, they were more invested in adhering to its guidelines. From a financial standpoint, then, patient-centered care improves “efficiency” by lessening misdiagnoses and increasing patient adherence.

Telehealth holds the potential to greatly augment patient-centered communication because it strengthens the line of communication between providers and patients. By freeing dialogue from physical limitations, technology has made patient-provider communication nearly limitless. The Lynn Community Health Center in Massachusetts, for example, has recently teamed up with the Center for Connected Health to set up a text-based educational program for pregnant teens. The pilot program involved a test group of women aged 13 to 25 who were texted one to four times a week with messages such as “Have you rescheduled your ultrasound?” or “It’s baby picture time!” Simple as these reminders were, they ultimately produced positive feedback and irrefutable results: data demonstrated that women who received texts were 9% more likely to receive recommended levels of care than women who did not receive them. By using telehealth technology, Lynn practitioners were able to reach out to teen patients in a new way and improve the sense of support that they felt. As one nurse from the center notes, the program helped a number of teen moms realize that help “was only a phone call away.”

In spite of its promise, however, telehealth has been somewhat slow to spread in many states. As Julia Adler-Milstein asserts in her article, “Telehealth Among US Hospitals: Several Factors Including State Reimbursement and Licensure Policies, Influence Adoption,” it’s essential to understand “why some hospitals adopt telehealth while other do not.” Though data from the

Information Technology Supplement to the American Hospital Association's 2011 annual survey shows that 42% of US hospitals have telehealth capabilities, a far smaller percentage actually implements telehealth programs. According to Adler-Milstein, "rates of telehealth adoption by state vary substantially" and are often linked to differences in state policy. For example, while policies that promote private reimbursement generally encourage adoption, policies that require special licenses reduce hospital participation. For women to universally benefit from the cohesion and support of telehealth initiatives, we will first need to standardize its acceptance and use in medical communities throughout the nation.

The first barrier to overcome will be formal legislation, which explicitly prohibits the practice of telehealth in certain states/localities. In many states, current laws "dictate that physicians must be licensed in the state that they are practicing" (Castro). Since telehealth professionals often see patients outside of their practice areas, state license laws have become a substantial impediment to the practice of remote medicine. In order to standardize such laws, it's likely that the federal government will need to intervene and officially approve the practice of interstate medicine. Another substantial barrier to telemedicine has been reimbursement, which also differs from state to state. While certain providers support telemedicine as a cost-effective form of treatment, others remain unconvinced of its merits. Without high quality, definitive evidence, private insurers remain wary of supporting telehealth initiatives. In order to expedite the process of telehealth adoption, the federal government should sponsor the sort of rigorous, large-scale research that would help policymakers ascertain the positive effects of telehealth initiatives. As Anne Ekeland and Allison Bowes observe in their article, "Effectiveness of telemedicine: a systematic review of reviews," it's highly problematic that we continue to evaluate telemedicine

by outdated, limited studies of varying rigor and quality. To prevent healthcare providers from using such studies to evade telehealth funding, the federal government will need to step in to expand evidence of its effective modern applications.

However, telemedicine doesn't just incur external opposition; it also incurs internal resistance.

As Johanna Taylor observes in her article, "Examining the use of telehealth in community nursing: identifying the factors affecting frontline staff acceptance and telehealth adoption," staff attitudes can range "from resistance to enthusiasm, with varied opinions about the motives for investing in telehealth and the potential impact on nursing roles." In order to normalize telehealth in mainstream medicine, Taylor asserts, providers will first need to reinforce "clinical buy-in." For telehealth initiatives to succeed, staff members must be fully convinced of their efficacy and net-benefit. If telehealth programs are treated ambiguously, insufficiently covered in training protocols, or regarded as medical "fads" by employees, they are likely to fall short of performance targets. To increase the efficacy of telehealth initiatives, providers will need to emphasize the role that telehealth plays in the creation of sustainable, effective programs for the average woman.

Conclusion

Despite acting as a leader in medical innovation, the U.S. lags behind in its provision of basic health services (Detsky). By treating health care as an enterprise, our nation has commodified its citizens' well-being and stripped health care of its association with holistic wellness. As noted in the prior chapter, the 2000s have demonstrated that we now possess the technological capacity to bring wellness-focused reforms to scale. Still, as demonstrated by the mixed success and slow

implementation of telehealth solutions, attitude and legislation are more important to the process of reform than technology. In the prior section, I suggested a number of measures that the federal government *should* take to encourage the adoption of telehealth, and, on a larger scale, to restructure the goals of American health care. Given the present administration's short-term approach to health budgeting, however, it seems unlikely that the federal government will initiate such reforms in the near future.

Since the New Deal Era, Americans have increasingly looked to the government for support when their basic needs aren't met. Where government programs fail, non-profits and religious organizations step in to try and evoke change where they can. Still, their efforts are frequently limited by their limited resources, for change requires money as much as good intent.

Historically, however, money and social change have been treated as mutually exclusive entities, for money was seen as a "corruptive force" in social efforts. Though the current state of our healthcare system stands testament to the validity of this concern, businesses and moneyed individuals are equally poised to evoke the greatest degree of positive change. As demonstrated by the positive impact of corporate social responsibility efforts, businesses definitely have the ability to instigate meaningful social change.

In late January of this year, Amazon solidified its plans to enter the health-care industry, a field that founder and CEO Jeff Bezos had been eyeing for some time. What analysts didn't expect, however, was that Bezos would be bringing Warren Buffet and Jamie Dimon into the industry with him. Though the partners have yet to declare a definitive trajectory, they have announced that Amazon, Berkshire Hathaway, and J.P. Morgan Chase & Co. intend to combine forces and

“change how health care is provided.” In their press release, the three companies said that they plan to set up “a new independent company that is free from profit-making incentives and constraints” in the near future. The company will initially focus on its founder’s staffs, but with the long-term goal of disrupting the entire health care industry.

According to Bezos, the company’s first focus will be on “technology solutions that will provide U.S. employees and their families with simplified, high-quality and transparent health care at reasonable costs” (Nosta). Only time will tell how Amazon plans to realize this vision, but Bezos’s vision itself is worth noting: “hard as it might be,” he observes, “reducing health care’s burden on the economy while improving outcomes for employees and their families would be worth the effort” (Nosta). By investing in more efficient and effective care in the short-run, we can lessen costs and improve our nation’s economic capacity in the long-run. Bezos’s vision demonstrates that our nation’s “social” and “economic” spheres are more closely intertwined than ever before. With as much capital and influence as the government (but without the interests of lobbyists in mind), American businesses have the capacity to catalyze substantive change in the healthcare system. Though federal legislation will continue to play a central role in the development our nation’s health system, it is no longer the only force large enough to evoke large-scale change. In this pivotal era, the dynamic between business and social systems has yet to be defined. Still, one thing’s certain—with the technological support, social backing, and financial capacity for change, the nation’s long-standing status quo is more threatened now than ever before.

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BIOGRAPHY

Kaela Lemond was technically born in Raleigh, North Carolina on October 10, 1996, but moved back to Austin with her parents (both UT alumni) at the age of 2 and therefore considers herself an Austinite by birth. After graduating from a local private school, Kaela enrolled at the University of Texas at Austin in 2014 as dual major in Finance and Plan II Honors. Throughout the course of her studies, Kaela realized that finance wasn't fun and switched to become a Management major. She now plans to continue degree-collecting in her post-graduate life and recently enrolled at ESADE Business school in Barcelona to pursue her Masters in Business Analytics. Before doing so, however, she plans to take a gap year interning at Spanish startups and becoming DELE certified. She's excited for what the future will hold.