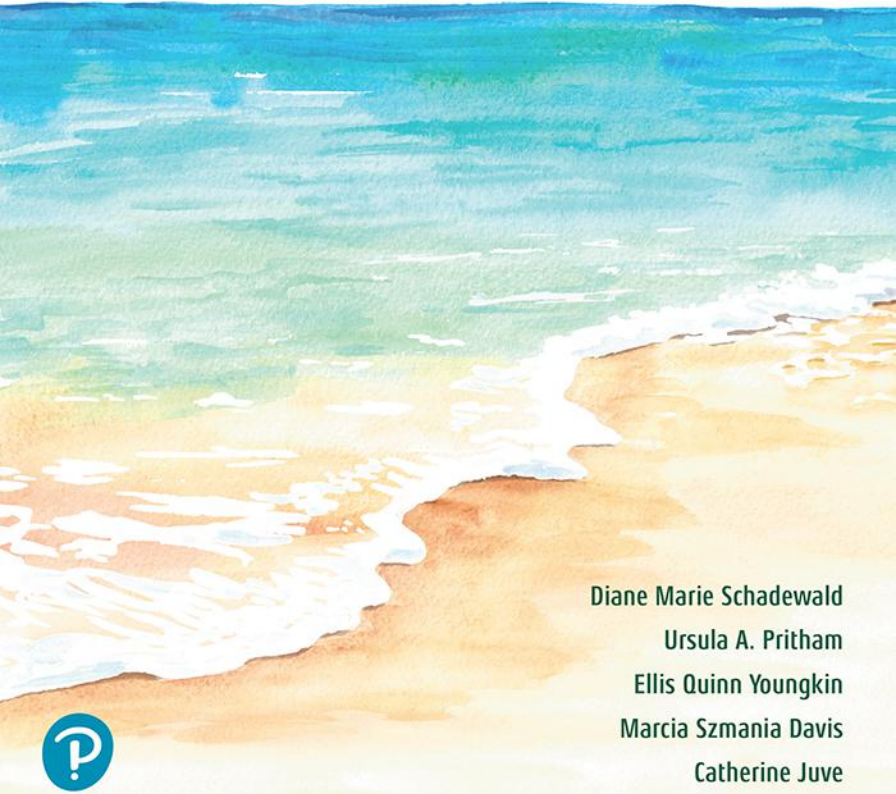
Women's Health

A Primary Care Clinical Guide

FIFTH EDITION



Diane Marie Schadewald
Ursula A. Pritham
Ellis Quinn Youngkin
Marcia Szmania Davis
Catherine Juve

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Diane Marie Schadewald, DNP, MSN, RN WHNP-BC, FNP-BC
Clinical Associate Professor
College of Nursing, University of Wisconsin-Milwaukee
Milwaukee, Wisconsin

Ursula A. Pritham, PhD, WHNP-BC, FNP-BC, SANE
Past Associate Professor and Graduate Program Director
School of Nursing, Georgia Southern University,
Statesboro, Georgia

Ellis Quinn Youngkin, PhD, WHNP, ARNP
Former Retired Professor and Associate Dean
Christine E. Lynn College of Nursing, Florida Atlantic University
Boca Raton, Florida
Faculty Emeritus
School of Nursing, Virginia Commonwealth University
Richmond, Virginia

Marcia Szmania Davis, MS, MS ED RNC, WHNP-BC, ANP-BC
Clinical Adjunct Faculty
John Tyler Community College
Richmond, VA

Catherine Juve, PhD, MSPH, WHNP
Clinical Associate Professor, retired
School of Nursing, University of Minnesota
Minneapolis, Minnesota

SVP, Product Management: Adam Jaworski
Director Product Management - Health Sciences: Katrin Beacom
Content Manager - Health Professions & Nursing: Kevin Wilson
Portfolio Management Assistant: Erin Sullivan
Associate Sponsoring Editor: Zoya Zaman
Product Marketing Manager: Christopher Barry
Field Marketing Manager: Brittany Hammond
Vice President, Digital Studio and Content Production: Paul DeLuca
Director, Digital Studio and Content Production: Brian Hyland
Managing Producer: Jennifer Sargunar
Content Producer (Team Lead): Faraz Sharique Ali
Content Producer: Neha Sharma
Project Manager, Global R&P: Anjali Singh
DGM, Global R&P: Tanvi Bhatia
Operations Specialist: Maura Zaldivar-Garcia
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Dedication

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Ellis Quinn Youngkin, PhD, RNC, WHNP, ARNP 1939–2018

We dedicate this text to Ellis Quinn Youngkin for her contributions to the development of nurse practitioners Ellis passed away in January of 2018. We remember her as a dear friend, mentor, and wonderful colleague. We like to think the painting on the previous page by Ellis depicts the path she saw for all of us.

I (Schadewald) met Ellis in 1992 when she was faculty at Virginia Commonwealth University (VCU). Ellis graciously offered to mentor me. Due to family needs and other life events I didn't reach out to Ellis again until late 2009 when I contacted her to inquire when a new edition of her and Marcia Davis's *Women's Health* textbook would be available. This contact restarted our relationship and Ellis served as a mentor to me in the development of the fourth edition of this textbook. Her wisdom and guidance were greatly appreciated and invaluable. Ursula and I asked Marcia Davis and Kathleen Sawin, both colleagues of Ellis's from her days at Virginia Commonwealth University, to write the following dedication to Ellis as they knew her longer than I or Ursula.

Diane Marie Schadewald and Ursula A. Pritham

Born in 1939 in Durham, NC, Dr. Youngkin was a graduate of Duke University (BSN), the University of Maryland (MS), the Medical College of Virginia at VCU (Nurse Practitioner), and Old Dominion University (ODU) (PhD). A practitioner, educator, motivator, innovator, author, investigator, advocate, volunteer, administrator, artist, romance novel writer, friend, humorist, lover of adventures, and for most of her career a Women's Health Nurse Practitioner. But foremost, a wife, mother, daughter, grandmother, and lover of all family members and friends. That was Ellis Youngkin, the initial first author of this book, who left us all too soon. We knew Ellis through her many roles. She loved practicing as an Obstetrics and Gynecology (OBS-GYN) nurse practitioner for over 40 years. As an educator and co-director of several nurse practitioner programs both at VCU and ODU she had the highest standards for her students, but she was invested in creative ways to help them achieve those goals. Ellis was often heard to say that she was committed to serving women and wanted her students to give them the best care. She found joy in teaching and mentoring hundreds of Women's Health and Family Nurse Practitioners students, and they held her in the highest regard. She was an innovative educator, exemplified when she partnered with me (Sawin) to lead the development of the Weekend Family Nurse Practitioner Program at The School of Nursing, VCU. The program received federal funding to recruit nurses from rural communities in Virginia to travel to Richmond on weekends for classes, but stay in their communities for clinical rotations and practice upon graduation, thus enhancing the quality of health care in rural Virginia. An innovative author, she partnered with me (Davis) to develop the first edition of this text, integrating evidence needed to care for women of all ages, including women with a disability. She led the editing team of Drs. Kissinger, Sawin, and Israel in developing an innovative approach to pharmacotherapeutics for primary care in another text by organizing the content the way nurses and nurse practitioners "think," starting with the problem or diagnosis. In addition to these two groundbreaking texts, Dr. Youngkin authored numerous peer-reviewed articles in a wide variety of journals; sharing both her clinical knowledge and results from her work as a researcher. She had many honors including selection as a fellow to the prestigious American Academy of Nurse Practitioners and funding from the American Nurses Foundation. Ellis had a major impact on health care through her work with professional communities especially the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), for example serving on the editorial board of Lifelines (now Nursing for Women's Health), AWHONN's clinical practice journal. She also was ever-present in the community, whether practicing at student health, planned parenthood, a prenatal clinic, community clinic, or as a sexual assault nurse examiner. Ellis was equally effective presenting to national audiences or to high school students and had a special way of connecting to all audiences. She was an artist and even wrote, but never published, romance novels. She enjoyed showing her paintings at Arts in the Park in Richmond Virginia, and in the Villages in Florida where she lived. She was delighted that one of her most favorite paintings titled "Hope" hung in a nearby cancer center and was published in the *Journal of Arts and Aesthetics in Nursing and Healthcare* (2016, 3(2), 20–21). She saw friends as gifts in her life, dedication to friends permeated her being, and we were fortunate to have her in our lives. Ellis was a faculty member at VCU School of Nursing for 25 years, ODU for 5 years and and her last academic home, Florida Atlantic University (FAU), for 10 years. She was the Associate Dean at FAU School of Nursing at the time of her retirement in 2007. Ellis retired in 2007 to a life full of painting, writing, and prized time with her family. She was devoted to her family. She and her beloved husband Yunk, married for 58 years, were parents of two children and she was "Noni" to seven grandchildren. In retirement, Ellis painted prolifically—her paintings depict hope, joy, and journeys.

Kathleen J. Sawin and Marcia Szmania Davis

Contents

Preface

New to This Edition

1. Learning objectives for each chapter.
2. Chapter 26 *Substance Use Disorders in Women*.
3. Appendix B *Elective Termination of Pregnancy*.
4. Chapter 8 has information on care for transgender populations.
5. Chapter 10 has expanded information on complementary therapies.
6. Chapter 15 has information about HIV prevention with use of PrEP.

In addition each chapter has been updated to include current recommendations for diagnosing and providing care for women.

Editors' Notes

Many women, by choice or by necessity, will seek out the women's health care provider as their source of primary care. This fifth edition of *Women's Health: A Primary Care Clinical Guide* is designed to help meet the needs of providers who offer women more than basic reproductive health care. It covers the traditional reproductive and gynecologic content as well as selected common medical, psychosocial, developmental, and political problems, issues, and needs.

Part I, Women, Health, and the Health Care System, begins with a new chapter on the major historical and contemporary changes impacting women, focusing on the important societal, economic, and political factors that affect women's well-being. Chapter 2 discusses women's development into the 21st century with some basic information on the #MeToo movement included in the chapter, followed by Chapter 3, the epidemiology and diagnostic test and procedures chapter. Chapter 4 deals with adolescent health issues. Chapter 5 includes general guidelines for health care screening, and interventions for adult women. Chapter 6 is the chapter on older women's health.

Part II, Promotion of Wellness for Women, includes Chapter 7 on sexuality, Chapter 8 on the health needs of lesbians, bisexual, and transgender populations, Chapter 9 on health needs of women with disabilities, and Chapter 10 on complementary therapies in women's health.

Part III, Promotion of Gynecologic Health Care, delves into the more traditional health problems and needs of women related to the reproductive system. Chapters 11 through 18 cover menstrual concerns; fertility management; infertility; sexually transmitted infections (STIs) and vaginitis, including the 2015 STI treatment guidelines from the CDC; special needs of women with HIV; pelvic and abdominal diseases; breast concerns; and health concerns related to the menopausal transition.

Part IV, Promotion of Women's Health Care During Pregnancy, details uncomplicated and complicated pregnancy care, postpartum needs and problems, lactation issues, and fetal surveillance.

Part V, Primary Care Conditions Affecting Women's Health, addresses medical problems frequently encountered in primary care of women such as headaches, anemia, hypertension, asthma, and dermatologic conditions. Chapters 23 and 24 are dedicated to current information on common medical problems. Selected psychosocial problems, such as violence, depression, eating disorders, and their impacts on women, with insights into related health care needs and therapies, are discussed in Chapter 25. Chapter 26 is the new chapter on *Substance Use Disorders in Women.* The need for a separate chapter on this problem is imperative due to the opioid epidemic that arose since the publication of the fourth edition of this text.

The appendices address emergency childbirth and assessment of the newborn (Appendix A), the new elective termination of pregnancy appendix (Appendix B), selected screening tools and apps for women's health (Appendix C), billing and coding in women's health (Appendix D), laboratory values commonly referenced in women's health (Appendix E), and federal agencies in the United States that are concerned with women's health (Appendix F).

We particularly intend this book to be a resource that allows students and any primary health care provider to retrieve basic information easily. We see it as a reference with enough depth to be useful in a clinical setting, serving as a source of teaching advice for clients, including differential medical diagnoses, screening and early intervention measures, and guidelines for referral. Some of the chapters fit more easily into an outline format for diseases or other conditions, whereas many chapters conform to a more traditional text format or a combination format for presentation of issues.

We wish to remind the reader that the scope of advanced practice nursing varies from state to state, and the individual practitioner is responsible for knowing his or her legal limits of practice. Also, recognizing the rapidity with which new knowledge becomes available and standards change, the practitioner must stay ever alert.

Women's health care providers are continuously challenged to expand their knowledge and ability to help women fulfill a wide spectrum of needs, both physical and psychosocial. The provision of women's health has not been limited to reproductive organs for some time now. The broadening scope of women's health care is a critically important issue in this period of rapidly changing health care systems. The Patient Protection and Affordable Care Act of 2010 along with the Institute of Medicine's 2011 broad recommendations for essential services to be included for women hold the potential to greatly expand opportunities for women as well as providers of women's health care services. With these changes, hopefully, the struggle to attain holistic health care services for women will be relieved. That is, as long as the Patient Protection and Affordable Care Act is not drastically changed. If the act is repealed and/or replaced it is not clear what will happen with the recommended essential services for women identified in 2011 by the Institute of Medicine. Resources are burgeoning, empowering women to become more informed consumers in the health care arena. We, with the contributing authors, hope that you as students and primary care providers in a rapidly changing world of health care will find this book a useful and effective resource in your endeavors to provide women with the health care they need and deserve.

Our sincere thanks go to our excellent contributing authors. Their outstanding expertise and effort have made this book the useful clinical reference we envisioned. We also wish to thank the fine editors and staff at Pearson Education for their support and many hours of work on this project. Last, our deep appreciation goes to our families who encouraged us during the months of preparation and work. Special thanks to Robin, a practicing family medicine physician and educator and Ryan, a future physician. A note also goes to our inspiring young women, Megan, Lucia, Michelle, Debbie, Taylor, and Emmy Lou, who join the women of the 21st century in deserving the best health care of the new millennium.

We are deeply saddened by the passing of Ellis Quinn Youngkin on January 31, 2018 and give a special thanks to her family for allowing us to use a copy of her artwork for publication in this edition of the text. Please see the dedication to Ellis included in this front matter. Ellis and Marcia Davis had the original vision for this text and we hope this edition will honor their previous work. We would also like to thank the previous author/editor Catherine Juve for her work on the fourth edition of this well-known and widely used women's health text as well as her assistance in contacting some of the previous authors for this fifth edition. We hope that this new edition continues to contribute to excellence in women's health care and remains the go to text for educators and clinicians.

Diane Marie Schadewald

Ursula A. Pritham

Contributors

Kristine Alswager, MS, RNC, WHNP
Women's Health Care Nurse Practitioner
Women's Health Consultants
Minneapolis, Minnesota

Anne L. Bateman, EdD, APRN, BC
Assistant Professor, School of Nursing
University of Massachusetts Medical School
Worchester, Massachusetts

Mary Benbenek, PhD, RNC, FNP, PNP
Clinical Professor, School of Nursing
University of Minnesota
Minneapolis, Minnesota

Aimee Chism Holland, DNP, WHNP-BC, FNP-C, FAANP
DNP Program Director and Associate Professor, School of Nursing
University of Alabama at Birmingham
Birmingham, Alabama

Linda Christinsen-Rengel, MS, RNC, CNP
Nurse Practitioner
Regions Hospital Breast Health Center
St Paul, Minnesota

Michele R. Davidson, PhD, RN, CNM, CFN
Professor
Sentara College of Health Sciences
Chesapeake, Virginia

Mary Dierich, PhD, RN, C-GNP, MSPH
Adjunct Faculty, School of Nursing
University of Minnesota
Minneapolis, Minnesota

Christine Durler, MS, BSN, RN, CNP
Women's Health Care Nurse Practitioner
Women's Health Consultants
Minneapolis, Minnesota

Melissa A. Dahir, DNP, IF
Nurse Practitioner, Pelvic Pain, and Sexual Medicine Clinic
Omaha OB GYN Associates, P.C.
Omaha, Nebraska

Eva Fried, DNP, WHNP
Adjunct Instructor
Georgetown University
Washington, DC

Cheri Friedrich, DNP, MS, RN, CNP
Clinical Associate Professor, School of Nursing
University of Minnesota
Minneapolis, Minnesota

Melissa Frisvold, PhD, RN, CNM
Faculty, School of Nursing and Health Sciences
Georgetown University
Washington, DC

Karen Trister Grace, MSN, CNM
Adjunct Instructor
Georgetown University
Washington, DC

Debra J. Hain, PhD, ARNP, ANP-BC, GNP-BC, FAANP
Professor/Lead Faculty AGNP
Ronald and Elizabeth Blake Distinguished Professor
FNP Davie Campus Coordinator
Christine E Lynn College of Nursing
Florida Atlantic University
Boca Raton, Florida

Beth Kelsey, EdD, APRN, WHNP-BC, FAANP
Editor-in-Chief
Women's Healthcare: A Clinical Journal for NPs
NPWH Director of Publications
Assistant Professor
School of Nursing
Ball State University
Muncie, Indiana

Monica Moore, MSN, RNC
Nurse Practitioner, Lead Educator
Fertile Health, LLC
Ponte Vedra Beach, Florida

Coralie Pederson, MSN, RN, WHNP
Nurse Practitioner
Family Tree Clinic
St.Paul, Minnesota

Elizabeth Przybylski MSN, RN, WHNP, CNM
Midwife
Gundersen Health
La Crosse, WI

Melissa A. Saftner, PhD, CNM, RN, FACNM
Clinical Associate Professor, School of Nursing
University of Minnesota
Minneapolis, Minnesota

Susan D. Schaffer, PhD, FNP-BC
Retired
University of Florida College of Nursing
Gainesville, Florida

Gwendolyn Short, APRN DNP, MSN, MPH, FNP-BC
Associate Professor, NP Program Director
Department of Nursing
St Catherine University
St Paul, Minnesota

Renee Sieving, PhD, RN, FAAN, FSAHM
Professor, School of Nursing & Department of Pediatrics
University of Minnesota
Minneapolis, Minnesota

Sarah Stoddard, PhD, RN, CNP
Assistant Professor, School of Nursing, Department of Systems, Populations, and Leadership
University of Michigan
Ann Arbor, Michigan

Jennifer M. Sullivan, MS, BSN, RN, CNP
Obstetrics and Gynecology
Fairview Health Services, Blaine Clinic
Blaine, Minnesota

Virginia "Gini" Weisz, PhD, WHNP-BC
Interim Associate Director of the Graduate Programs
Radford University School of Nursing
Waldron College of Health and Human Services
Radford, Virginia

Eugenia Hammett-Zelanko, PhD, RN, PMHCNS-BC
North Texas Veterans Administration Health Care System
Dallas, Texas

Contributors to the Fourth Edition

A special thank you and recognition go to those who contributed to the fourth edition of this book:

Jennifer Demma
Health Promotion and Assessment During Pregnancy

Jennifer R. Gardella
Infertility

Jane F. Houston
Vaginitis and Sexually Transmitted Diseases

Catherine Juve
Epidemiology, Diagnostic Methods, and Procedures for Women's Health
Assessing Adult Women's Health
The Menopausal Transition

Reena Lorntson
Common Gynecologic Pelvic Disorders

Debbie Ringdahl
Maternal Conditions Impacting Risk in Pregnancy

Jo Lynne W. Robins
Integrating Wellness: Complementary Therapies and Women's Health

Debera Jane Thomas
Health Needs of Lesbians and Other Sexual Minority Women

Donna Treloar
Women and HIV

Michelle J. Valentine
Infertility

Susan Wysocki
Nurse Practitioners in Women's Health: Where If the Future Heading?

Contributors to the Third Edition

A special thank you and recognition go to those who contributed to the third edition of this book:

Kathleen M. Akridge
Postpartum and Lactation

Lynette Galloway Branch
Breast Health

Joan Corder-Mabe, RNC, MS, WHCNP
Complications of Pregnancy

Valerie T. Cotter, MSN, CRNP
The Climacteric, Menopause, and the Process of Aging

Leslie Fehan, MS, CNM, WHNP
Integrating Wellness: Complementary Therapies and Women's Health

Elaine Ferrary, MS, RN, CFNP
Common Medical Problems: Cardiovascular Through Hematological Disorders
Common Medical Problems: Musculoskeletal Injuries Through Urinary Tract Disorders

Donna E. Forrest, RNC, MS, FNP, WHCNP
Common Gynecologic Pelvic Disorders

Marion Herndon Fuqua, MS, RNC, WHCNP
Assessing Fetal Well-Being

Jennifer R. Gardella, RNC, MSN
Infertility

Deborah Griswold, MSN, CFNP, ARNP
Menstruation and Related Problems and Concerns

Janet C. Horton, MS, RN, APRN-BC
Health Care Concerns for Women with Physical Disability and Chronic Illness

Rita A. Seeger Jablonski, PhD, RN, ANP-BC
Common Medical Problems: Cardiovascular Through Hematological Disorders
Common Medical Problems: Musculoskeletal Injuries Through Urinary Tract Disorders

Angela Carter Martin, MS, RN, CFNP, CS
Psychosocial Health Concerns

Deborah A. Raines, PhD, RNC, CNS
Assessing Adolescent Women's Health

Maryellen C. Remich, RNC, MS(N), OGNP
Promoting a Healthy Pregnancy

Kathleen J. Sawin, DNS, RN, CS, FAAN
Health Care Concerns for Women with Physical Disability and Chronic Illness

Barbara Peterson Sinclair, MN, OGNP, FAAN
Women and the Health Care System

Rachel Effolia Smith, MSN, FNP-CS
Women and HIV

Kelly L. Cokely Yeong, MS, WHNP
Assessing Health During Pregnancy

Contributors to the Second Edition

A special thank you and recognition go to those who contributed to the second edition of this book:

Brenda T. Brickhouse
Emergency Childbirth

Cynthia W. Bailey
Assessing Health During Pregnancy

Sharon Baker
Menstruation and Related Problems and Concerns

Judith B. Collins
Women and the Health Care System

Judy Parker-Falzoi
Common Medical Problems

Martha Edwards Hart
Immediate Assessment of the Newborn

Judith A. Lewis
Legal Issues in Primary Care of Women

Cathy James
Infertility

Mary Beth Bryant McGurin
Emergency Childbirth

Nancy Sharp
Women and the Health Care System

Reviewers

Adena Bargad, PhD, MSN, CNM
Assistant Professor of Nursing, CUMC
Director, Women's Health Subspecialty
School of Nursing
Columbia University
New York, New York

Diana Dowdy, DNP, CNM, RDMS
Instructor of Clinical Nursing, WHNP program
School of Nursing
Vanderbilt University
Nashville, Tennessee

Shellie O. Hawk, MSN, RN, CNM
Interim Concentration Coordinator WHNP
Kent State University
Kent, Ohio
Assistant Director Midwife Services
Cleveland Clinic
Cleveland, Ohio

Melinda McGaughy, DNP, APRN, FNP-BC
Assistant Professor of Clinical Practice
College of Nursing
The Ohio State University
Columbus, Ohio

Part I

Women, Health, and the Health Care System

Chapter 1

Access to Women's Health Care in the United States: Affordability, Equity, Rights

Beth Kelsey

Outline

Learning Objectives

1.1 Describe demographics of women in the United States.

1.2 Discuss funding for women's health care in the United States.

1.3 Explain concepts of health equity, health inequity, health disparity, and social determinants of health.

1.4 Discuss the history of and challenges to women's health rights.

Introduction

As clinicians, we should all strive to provide women's health care that is holistic, honors diversity and inclusion, and embraces engagement with clients as partners in decision making. To do so, we must be cognizant of the systems that influence health care and health care outcomes. This chapter focuses on the interconnection of the components that make up the United States (U.S.) health care system and that influence the quality and accessibility of health care for women. As well, it provides insight into the issues of equity and rights that are inextricably bound to quality and accessibility of health care for women in the United States.

Women in America—Who They Are

Women's biology, life circumstances, and experiences provide them with a unique set of health needs and health issues that vary throughout the lifespan. (See Chapter 3 for epidemiologic information on women's health.) Beyond gender and age, the intersection of determinants such as race and ethnicity, socioeconomic status, geographic location, sexual orientation, and gender identity influence women's health and health care.

Females make up 51 percent of the U.S. population. Reproductive-age females (aged 15 to 49) make up approximately 22.7 percent (76 million), females aged 50 to 64 make up a little over 9.9 percent (33 million) and females aged 65 and older make up almost 8.3 percent (28 million) of the total population (U.S. Census, 2016). Women who reached age 65 in 2016 can expect, on average, to live up to 85.6 years of age compared to 83 years of age for men. The number of women aged 65 and older is expected to double to over 44 million by 2035 (American Association of Retired Persons [AARP] Public Policy Institute, 2015).

As of 2016, approximately 23 percent of females were of a racial minority, and 8.6 percent were of Hispanic or Latina ethnicity. The racial and ethnic diversity of women in the United States is growing across all ages (U.S. Census Bureau, 2016). Projections indicate that people of color will represent the majority of the U.S. population by 2050 (American College of Obstetricians and Gynecologists [ACOG], 2015).

Nearly 16.3 million or one in every eight women lives in poverty. Poverty rates are exceptionally high for Black women (21.4%), Hispanic women (18.7%), and Native American women (22.8%). Families headed by single mothers are 5.4 times more likely than married-couple families to live in poverty. Overall, women make up nearly two-thirds of the elderly poor (National Women's Law Center, 2017).

U.S. Health Care System—Affordability of Health Care for Women

Health care systems are composed of resources, organization, financing, and management that culminate in the delivery of health services to a population. The World Health Organization (WHO) describes a good health care system as one that delivers quality services to all people, when and where they need them (WHO, n.d.). In the United States, this access to quality health care is dependent on the capacity to afford care, the availability of that care, and the ability to navigate effectively within a sometimes complicated and complex health care system. Driven by both governmental and nongovernmental funding, policies, and delivery mechanisms, the U.S. health care system has been described in both positive and negative terms. By some, it is considered to provide the best care in the world. By others, it is described as fragmented, inefficient, and more costly than care in any other country (Porche, 2019).

The capacity for individuals to afford health care in the United States is dependent on several mechanisms, including private insurance, the self-pay fee for service, and several government-funded programs. The largest funder of health care services in the United States is the federal government. Thus, the federal government establishes a considerable amount of policy that influences health care service delivery through financing and mobilization of funds (Porche, 2019). This government role in funding and setting policies regarding health care became highly significant in 1965 with the authorization of the Medicare and Medicaid programs through Title XVIII and Title XIX of the Social Security Act.

MEDICARE Medicare was created to fund health care, primarily hospital care, for people aged 65 years and older, regardless of income, medical history, or health status. In 1972, the program was expanded to cover people under age 65 with permanent disabilities. In the early 1990s, coverage for preventive services such as Pap tests and screening mammograms was added with a 20 percent co-pay requirement. In 2003, Medicare Part D was established, offering prescription drug coverage (Salganicoff, 2015).

Today, Medicare helps pay for many medical services, including hospitalizations, health care provider visits, prescription drugs, and preventive care, along with skilled nursing facility care, home health care, and hospice care. Medicare recipients include approximately 24 million women (Salganicoff, 2015). With the passage of the Affordable Care Act in 2010, Medicare preventive care service benefits have expanded.

MEDICAID Medicaid provides health care coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The program is funded jointly by individual states and the federal government. The federal government has established specific requirements all states must follow. For states to participate in Medicaid, they are required to cover specified groups of individuals. Beyond the mandatory eligibility classifications, states may choose to include other groups (Kaiser Family Foundation [KFF], 2017a).

Other than children, the majority (36%) of Medicaid recipients are women. Approximately two-thirds of adult women on Medicaid are in their reproductive years. In 2014, 19.1 million reproductive-age women were enrolled in the program (KFF, 2017a). Medicaid is the largest single payer of pregnancy-related services, financing 48 percent of all U.S. births in 2010 (Sonfield & Kost, 2015). All pregnant women who are uninsured and whose income is

at or below 133 percent of the federal poverty level (FPL) are eligible for Medicaid. Pregnant women with Medicaid are covered for all care related to pregnancy, delivery, and any complications that may occur during pregnancy and up to 60 days postpartum.

One in three nonelderly women with disabilities receives medical and supportive services through Medicaid. Additionally, women aged 65 and older may rely on Medicaid to cover nursing home stays and long-term care expenditures not covered by Medicare. Eligibility is based on income and assets as determined by individual states. Because women are more likely to live longer and experience higher rates of chronic illness and disability than men, they are more likely to require long-term care services in their lifetime. Approximately two-thirds of nursing home residents (66%) and people receiving home health care (62%) are women (KFF, 2017a).

AFFORDABLE CARE ACT In 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The ACA provided the single largest expansion in health insurance since the inception of Medicare and Medicaid. Over the first few years of the ACA, Medicaid was expanded, and tax credits were established so adults who lacked access to employer coverage could afford to purchase private insurance through a health insurance exchange program. Adults were mandated to obtain health insurance coverage or pay a fine for noncompliance (Porche, 2019). Under the ACA, all insurance plans must cover treatment for preexisting medical conditions. As well, adult children up to age 26 years can stay on their parent's insurance plan regardless of employment, student, or marital status. From the time of implementation of the ACA until 2017, the number of Americans with health insurance has significantly increased. For adult women under 65 years of age, this equaled a decline in the number of uninsured from 18 percent in 2013 to 12 percent in 2017 (Ranji, Rosenzweig, & Salganicoff, 2018a).

Within the ACA, there are a set of 10 categories of services (health benefit essentials) that health insurance plans must cover. These categories are ambulatory patient services; emergency services; hospitalization; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Because of the shift to a focus on preventive and wellness care, the ACA mandates health insurance, whether purchased through the health insurance exchange program or provided through the individual's employer, cover specific preventive services with no deductible or co-pay as long as the individual receives this care within the plan's network. Medicaid and Medicare must also cover specified preventive services with no out-of-pocket cost. An estimated 55.6 million women now have access to these no-cost preventive services (National Family Planning and Reproductive Health Association [NFPRHA], 2017a). See Table 1–1.

Table 1–1 ACA Women's Preventive Health Services Covered with No Cost Sharing

Preventive services	With U.S. Preventive Services Task Force (USPSTF) Grades "A" or "B" recommendations
Vaccinations	Recommended by CDC Advisory Committee on Immunization (ACIP)
Pregnancy-related care	Includes screening, counseling, and interventions
Additional women's preventive service*	Well-woman visits—at least one visit annually to obtain recommended preventive services, including pre/inter-conception care; primary purpose is delivery and coordination of recommended preventive services determined by age and risk factors Counseling for sexually transmitted infections—sexually active women Counseling and screening for HIV—sexually active women Human papilloma virus test as co-test with cervical cytology for women above 30 years of age; no more frequently than every 3 years Contraceptive methods and counseling—All Food and Drug Administration (FDA) approved methods, sterilization procedures, education and counseling for all women with reproductive capacity Screening and counseling for interpersonal and domestic violence Urinary incontinence screening Screening for diabetes in women with a history of gestational diabetes Screening for gestational diabetes between 24 and 28 weeks gestation and at first prenatal visit for women identified to be at high risk for diabetes Breastfeeding support, supplies, and counseling
Medicare covered preventive services at welcome and yearly wellness visits (CMS)**	Health history and risk assessment for personalized prevention plan Preventive services with USPSTF Grades "A" or "B" recommendations Vaccinations—recommended by CDC ACIP Advance care planning

*Recommended by Institute of Medicine (2011) and supported by Health Resources Services Administration (HRSA); most recently updated through the ACOG (2017) Women's Preventive Services Initiative. (2016).

** Center for Medicare and Medicaid Services (CMS) (2018).

The ACA also requires most plans provide no-cost coverage for FDA-approved prescription contraceptive services and supplies for women. In 2017, 75 percent of privately insured women who use prescription contraception reported their insurance fully covered the cost. This represents a substantial increase in no-cost contraceptive coverage since 2013 when it was 45 percent (Rosenzweig, Ranji, & Salganicoff, 2018). Under the ACA's preventive services provision, Medicaid must also cover contraception with no co-pay (Rosenzweig et al., 2018).

TITLE X FAMILY PLANNING PROGRAM The Title X family planning program was enacted during the Nixon administration in 1970 as a safety net to provide funding for a range of sexual and reproductive health care services at no cost to uninsured individuals at or below the poverty level and on a sliding fee scale to low- and moderate-income individuals. Services funded by Title X include pregnancy testing, contraception, cervical cancer screening, clinical breast exams for cancer screening, sexually transmitted infection screening and treatment, and HIV testing (NFPRHA, 2017b). The program is funded through the Health Resources Services Administration (HRSA) with an annual discretionary appropriations process by Congress. The program is administered by the Office of Population Affairs (OPA) within the Department of Health and Human Services (DHSS). Title X funds can be allocated to any clinic that provides family planning services to poor- and low-income clients. These clinics include Planned Parenthood centers, community health centers, health departments, school-based clinics, and some other private nonprofit entities (Ranji, Salganicoff, Sobel, Rosenzweig, & Gomez, 2017). In 2016, Title X-funded providers served more than 4 million clients with 64 percent having incomes at or below the FPL and 43 percent being uninsured (NFPRHA, 2017b).

The Title X program is specifically focused on family planning services and has never funded the provision of prenatal care or abortion care. In 1988, the Reagan administration promulgated restrictions prohibiting providers at Title X-funded sites from providing abortion information or referral to an abortion provider even if such information was requested by the client. Additionally, providers were mandated to provide all pregnant clients with information on prenatal care and social services, regardless of what options the client wanted to pursue. This ruling was referred to as the *domestic gag rule*. Over a period of 5 years, interpretations of the gag rule were disputed with the rule implemented in some states and not in others. In 1993, President Clinton issued a presidential memorandum directing DHHS to rescind the gag rule and promulgate new proposed regulations. The new regulations finalized in 2000 required providers to provide nondirective options counseling for clients with a positive pregnancy test. The regulations clarify that Title X funds could not be used to provide abortion care or to facilitate a client obtaining such care (i.e., making an appointment for her) (NFPRHA, 2018).

CHALLENGES TO AFFORDABLE HEALTH CARE While the number has decreased significantly with the ACA, approximately 12 percent of adult women under 65 years of age remained uninsured in 2017. Overall, close to one-half of these uninsured women (49%) reported that they had delayed or gone without care in the prior year due to costs (Ranji et al., 2018a, 2018b).

In states that did not expand their Medicaid programs, there are coverage gaps for adults with incomes below 100 percent of the FPL, and who are ineligible for Medicaid under the state's existing law. Approximately 5.3 million people fall into this category. As well, individuals who have an "affordable" offer of health insurance from an employer are not eligible for tax credits through the marketplace. Offers are considered affordable if the employee's contribution for single coverage is less than 9.5 percent of the family income. This criterion is based on the cost of single coverage and not inclusion of family coverage (RAND Corporation, 2015). Thus family coverage may not be affordable.

Immigrant women of reproductive age are approximately 70 percent more likely than the U.S.-born women in the same age group to lack health insurance (Center for Reproductive Rights, 2014). Noncitizens who are lawfully present in the United States must wait 5 years before they can enroll in Medicaid, and some states do not allow them to enroll even after completion of this waiting period. Undocumented immigrants are not eligible for Medicaid and are prohibited from purchasing private insurance through health insurance exchanges even with their own money (Center for Reproductive Rights, 2014).

The cost of prescription drugs remains one of the top health care concerns among Americans. One in three uninsured women reports either not filling a prescription, skipping doses, or cutting pills in half because of cost (Ranji et al., 2018a, 2018b). While most prescription drugs are covered under Medicaid plans, there is often a required co-pay. For drugs that may only be partially covered or not covered at all, there are some options available to receive a rebate for some or all of the cost of the prescription (KFF, 2017a). Still, 1 in 10 women on Medicaid report not filling a prescription because of the cost (KFF, 2017a). Medicare recipients must enroll in a supplemental insurance program with monthly premiums to cover outpatient prescriptions although there may still be out of pocket costs. One in 10 older women on Medicare do not have supplemental coverage (KFF, 2017b).

Limited Medicare coverage for long-term-care (LTC) services disproportionately burdens women. About two-thirds of all residents of nursing homes and residential

care communities are women (KFF, 2017a). Out-of-pocket costs can be prohibitive and many women must rely on supplemental Medicaid (KFF, 2017a). Gaps in LTC support services also have implications for the financial, physical, and emotional well-being of informal caregivers for older adults. The majority (66%) of these caregivers are women (Roth, Fredman & Haley, 2015).

Since its inception, the ACA overall and several specific provisions have been challenged on the grounds of being too costly, limiting states' rights, and being unconstitutional. Calls for a complete repeal have not been successful. However, bills have been proposed to make significant changes. Key among the proposed changes are the repeal of individual and employer mandates regarding health insurance coverage and ending the option for states to expand Medicaid going back to eligibility criteria from before 2014 for all new enrollees (RAND Corporation, 2017).

The Trump administration proposed revisions in Medicaid regulations to include work requirements, limiting how long an individual can be enrolled, locking out enrollees for a period if they do not follow specific rules, and mandatory drug testing (Solar & Sonfield, 2017). These considered revisions reflect a vision of Medicaid as a welfare program that people should rely on only briefly during their lives. Since its inception, Medicaid has experienced transformations initially centered on providing reproductive health care and finally culminated in the expansion of Medicaid as a long-term solution to health coverage for low-income individuals under the age of 65. Medicaid covers 20 percent of women of reproductive age, pays for close to half of U.S. births, and accounts for 75 percent of public dollars spent on family planning (Solar & Sonfield, 2017). Close to half (49%) of women on Medicaid work full- or part-time outside the home. Of those not working outside the home, 12 percent are ill or disabled, 6 percent are going to school, and 18 percent are taking care of their family or household (KFF, 2017a).

Access to sexual and reproductive health services is also challenged in other ways. The ACA policy requiring that private insurance plans, including employer-sponsored programs, cover the full cost of prescription contraceptives has been tested by the courts since it was put in place. Some employers with religious or moral objections to contraception claimed that the policy violated their religious rights and were granted limited exemption from providing coverage directly for contraceptives. In October 2017, the Trump administration broadened the exemption to the requirement for contraceptive coverage, although the broadened exemption has been blocked from implementation (Rosenzwieg et al., 2018). The Trump administration also proposed to remove the nondirective options counseling regulation so that a provider in a Title X-supported clinic could opt not to provide any information on abortion. Additionally, the Trump administration proposed to defund clinics (Title X and Medicaid) that provide abortion services, affecting primarily Planned Parenthood. (NFPRHA, 2018; Ranji et al., 2017).

IMPLICATIONS FOR PRACTICE Clinicians cannot provide the best care for women without an understanding of payment mechanisms, that is, what is covered and what is not included. Women of all ages should be encouraged to partake in all of the preventive health care services with mandated coverage. Clinicians should also consider cost as a factor in medication adherence when making drug choices and help clients utilize prescription medication assistance programs when needed.

Additionally, to advocate for quality, affordable and accessible reproductive and preventive health care for women, clinicians must be knowledgeable about proposed health care funding revisions and service restrictions. There are both governmental and nongovernmental resources available to stay up-to-date and to help clinicians analyze policy proposals to determine the effect they may have on the health of women. Please see the end of this chapter for a list of some nongovernmental resources and Appendix F for a list of some governmental resources.

Health Equity

Biological and genetic factors and individual health behaviors are traditionally the determinants used to explain why individuals are healthy or become sick. However, there is sound evidence that social determinants of health (SDH) affect health outcomes as much as biological and health behavior factors (Metzl & Hansen, 2014). SDH include nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of places where people live, work, learn, and play (Braveman, Arkin, Orleans, Proctor, & Plough, 2017; DHHS, 2018a). SDH have been shown to affect many conditions related to women's health, including but not limited to preterm birth, unintended pregnancy, infertility, cervical cancer, breast cancer, and maternal mortality (ACOG, 2018).

The terms *health inequity and health disparity* are not synonymous yet must be looked at in conjunction with each other. Health inequity exists when differences in health are avoidable, unfair, and unjust. Health equity exists when everyone has a fair and just opportunity to be as healthy as possible. Health equity is a guiding principle that motivates action to eliminate health disparities and can be a metric for assessing progress toward health equity (Braveman et al., 2017). Health disparities are differences in health primarily linked with SDH. Health disparities adversely affect groups of people who have systematically faced obstacles to health based on

characteristics historically linked to discrimination or exclusion. These characteristics include, but are not limited to, gender, race, age, ethnicity, socioeconomic status, sexual orientation, gender identity, and disability status (DHHS, 2018b).

A broad approach with attention to SDH at all levels—federal, state, community, and within each clinician's practice—is crucial to eliminate health disparities and to achieve health equity. Such an approach requires a greater focus on health within non-health sectors and recognizing and addressing health-related social needs through the health care system. Successful interventions will be multifactorial and require collaboration across sectors (Artiga & Hinton, 2018). Verbiest, Malin, Drummonds, and Kotelchuck (2016) propose that collaboration is essential in a reproductive and social justice movement to engage thought leaders and community advocates to create change.

Clinicians can advocate for federal and state policies and public health initiatives, but can also implement changes within their clinical practices and communities to reduce health disparities. ACOG (2018) suggests specific actions that include screening for SDH in the health history, establishing social service liaisons within the community that can provide assistance with essential resources (e.g., food pantries, utility bill payment), developing medical-legal partnerships to enable clients to receive help with legal matters that directly affect their health (e.g., access to safe housing, legal aid for immigration challenges), and having professional interpreters available.

Clinicians must be humble about recognizing the limits of their knowledge about a client's situation. This entails avoiding generalizing assumptions, being aware of biases, using client-centered communication, and being respectful when asking open-ended questions to better understand the client's circumstances and values (ACOG, 2018). Recognizing the importance of SDH can help clinicians better understand clients, effectively communicate about health-related conditions and behavior, and improve health outcomes.

Women's Health Rights

Some of the most critical decisions protecting women's rights to control their bodies and destinies have come with landmark U.S. Supreme Court rulings in the past 50 years. These decisions have all favored the side of the right to privacy. The U.S. Constitution does not explicitly protect the right to privacy. Decisions regarding this right typically have been based on interpretation of amendments within the Bill of Rights (Linder, 2018). The Court may be called upon to resolve conflicts between levels of government (state and federal) or between laws enacted by the legislature and the interests of specific groups. Judicial interpretation occurs in three ways. The Court may interpret the meaning of laws that are written broadly or with some vagueness, may interpret how some laws are applied, and may declare that a law made by Congress or the states is unconstitutional, thereby nullifying the statute entirely (Milstead, 2016).

One of the first landmark U.S. Supreme Court decisions protecting the right to privacy was *Griswold v. Connecticut* (1965). This case stemmed from a statute passed in 1879, whereby the state of Connecticut prohibited the use of any drug, medicinal article, or instrument to prevent conception. When Planned Parenthood opened a clinic in New Haven, Connecticut, in 1961 to provide contraception to married women, the medical director, Dr. Buxton, and the executive director, Estelle Griswold, were arrested and charged with a misdemeanor related to their clinic work. They appealed their convictions and challenged the validity of the law with the case making it to the U.S. Supreme Court. In 1965, the Court found in favor of Griswold that married couples had the right to use contraception while engaging in private acts. The fundamental right to privacy established through this ruling has extended to other Supreme Court decisions related to rights regarding reproductive choices and sexual freedoms. In 1972, the U.S. Supreme Court held that under the equal protection clause of the U.S. Constitution, unmarried couples had the same right to contraception as married couples (*Eisenstadt v. Baird*) (Linder, 2018).

Based on the right to privacy, in the 1973 case of *Roe v. Wade*, the U.S. Supreme Court struck down a law prohibiting abortion. The Court decision regarding *Roe v. Wade* made abortion legal in all 50 states (Linder, 2018). Since that time, federal and state governments have sought to institute regulations that erode a woman's ability to obtain safe, legal abortion. The 1976 Hyde Amendment blocked the use of federal funds to pay for abortion with exceptions only for pregnancies that endanger a woman's life or that result from rape or incest. The Trump administration is considering further restrictions to disqualify all individual insurance plans that offer abortion coverage from receiving federal assistance for cost-sharing reduction payments and other mechanisms to stabilize premiums. Mainly, this would serve as a major financial disincentive for plans to offer abortion coverage for policyholders (Sobel, Rosenzweig, & Salganicoff, 2018).

Additionally, individual states have implemented laws and restrictions that significantly limit a woman's access to abortion. Such limits include 24-hour waiting periods, added qualifications for abortion clinics and abortion providers, parental notification, and gestation limits. Because of these restrictions in many areas of the country, women must travel hundreds of miles to find qualified abortion providers. Thus, access to abortion is not ensured by the right to have an abortion.

In the 2013 *United States v. Windsor* case, the U.S. Supreme Court struck down Section 3 of the 1996 Defense of Marriage Act (DOMA) which denied federal recognition to same-sex marriages. In 2015, the Court in *Obergefell v. Hodges* overruled a prior decision and held in a 5–4 decision that the Fourteenth Amendment requires all states to grant same-sex marriages and recognize same-sex marriages granted in other states. This ruling came 12 years after *Lawrence v. Texas* in which the Court struck down laws that had remained in 13 states prohibiting couples from engaging in same-sex sexual relationships (Linder, 2018).

Ross and Solinger (2017), long-time reproductive justice activists and scholars, describe three primary principles for reproductive justice: (1) the right not to have a child, (2) the right to have a child, and (3) the right to parent children in safe and healthy environments. Additionally, they note that sexual autonomy and gender freedom for all individuals are imperative to reproductive justice.

During the 20th century, the U.S. Supreme Court supported laws to ensure the right to obtain contraception and abortion services. As we moved into the 21st century, we saw the ACA expand the availability of health insurance coverage for more individuals, with preventive health care services that included contraception. In this 21st century, the Supreme Court has supported at least some laws that promote sexual autonomy and gender freedom. Today. we face uncertainty regarding protection of these accomplishments. Being able to move forward in our quest for true health equity and reproductive justice requires that clinicians provide the best health care for women, and be knowledgeable advocates for health care systems, policies, and legislation that support social and reproductive justice as well as accessibility and affordability of quality health care for all.

NONGOVERNMENTAL ORGANIZATION RESOURCES: WOMEN'S HEALTH POLICY, EQUITY, AND RIGHTS

American College of Nurse Midwives (ACNM) www.midwife.org

American College of Obstetricians and Gynecologists (ACOG) www.acog.org

Association of Reproductive Health Professionals (ARHP) www.arhp.org

Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN) www.awhonn.org

Center for Reproductive Rights www.reproductiverights.org

Guttmacher Institute www.guttmacher.org

Kaiser Family Foundation www.kff.org

National Abortion Federation (NAF) www.prochoice.org

National Association of Nurse Practitioners in Women's Health (NPWH) www.npwh.org

National Family Planning and Reproductive Health Association (NFPHRA) www.nationalfamilyplanning.org

National Women's Law Center (NWLC) www.nwlc.org

North American Menopause Society (NAMS) www.menopause.org

Planned Parenthood Federation of America (PPFA) www.plannedparenthood.org

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