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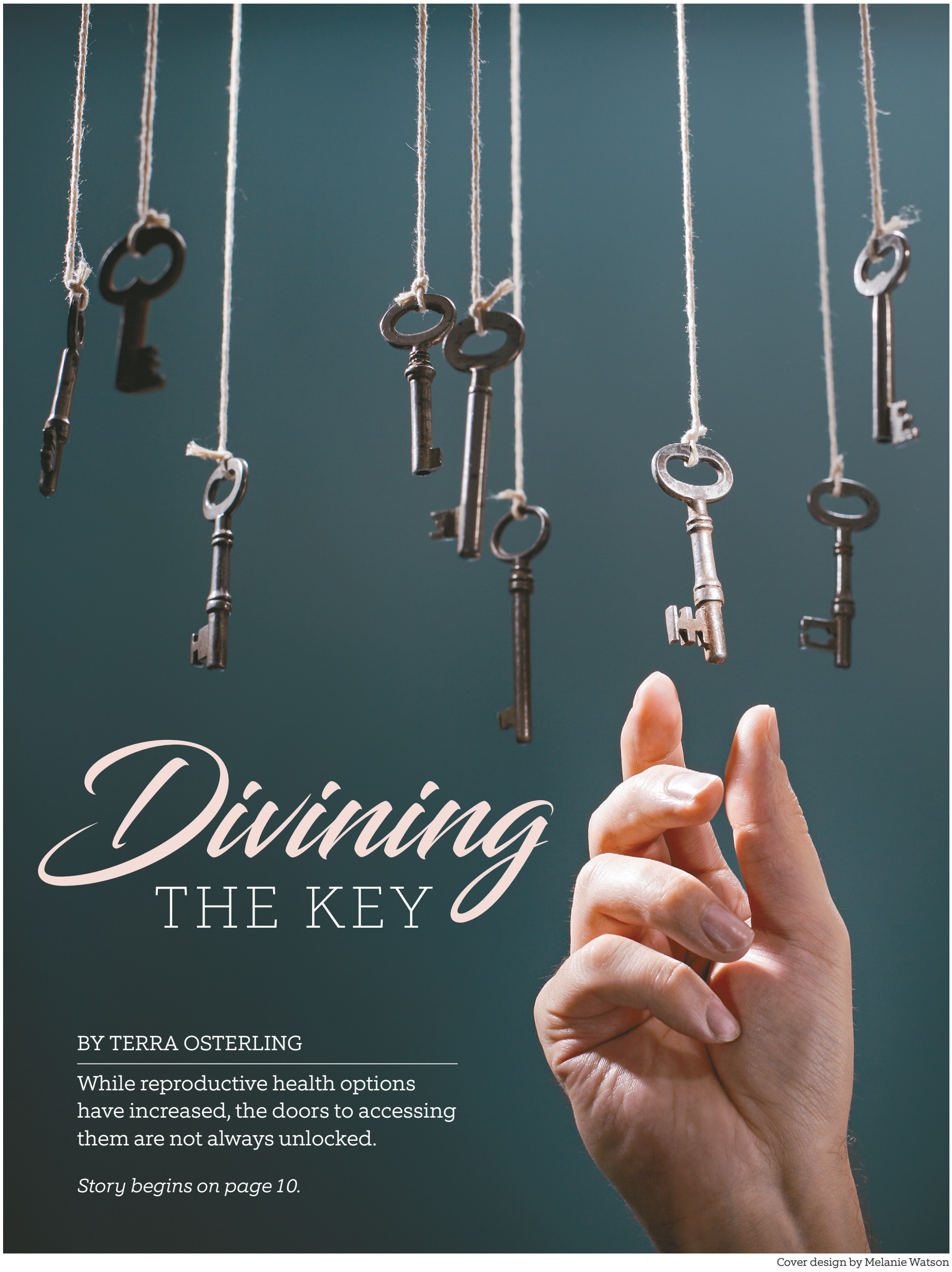
SPECIAL REPORT
Women's Health Care



Divining THE KEY

BY TERRA OSTERLING

While reproductive health options have increased, the doors to accessing them are not always unlocked.

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Cover design by Melanie Watson

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Women's autonomy affected by contraceptive access

But prohibitive upfront costs, insurance barriers shut out some women

By TERRA OSTERLING

In 2014, *Business Week* named the 1960 introduction of the birth control pill Enovid No. 9 one of the 85 most disruptive ideas in history, pointing to a Harvard study that found that the Pill has had "a singularly profound effect in advancing women's economic freedom."

In the 57 years since the introduction of the Pill, methods of contraception—also known as hormonal therapy—have come a long way. Education and access are still works in progress.

"Most people are uninformed about how hormonal therapy works, and myths do get perpetuated," says Amy Harrington M.D., associate professor at the University of Rochester School of Medicine and Dentistry and the associate residency program director for Obstetrics and Gynecology.

Educating medical students on the topic is as important to her as educating women.

"The Pill," says Harrington, who is also a physician in the Obstetrics and Gynecology department of University of Rochester Medical Center, "is hormonal therapy. It just happens to also prevent pregnancy."

According to the CDC, approximately 45 percent of all pregnancies that occur in the United States are unintended. A National Center for Health Statistics Report shows that 99 percent of women ages 15 to 44 surveyed between 2006 and 2010 used at least one contraceptive method at some point in their lifetime.

Contraceptive methods categorized as "highly effective" include tubal ligation and long acting reversible contraception, or LARC, such as IUD or rod implants. "Effective" methods include daily, weekly or monthly medications. "Less effective" methods include condoms, spermicide and diaphragms.

"I always discuss with patients options, side effects and all of the associated risks and tremendous health benefits of each method," says Harrington.

Amy Vallone of Webster was originally prescribed the Pill as a college freshman on a referral from her dermatologist to control acne. She stayed on the medication through most of her twenties, until she and her husband were ready to start a family.

"It turned out that the Pill also controls endometriosis for me, which came back with a vengeance when I went off it," says Vallone, who works for Monroe No. 1 BOCES on its Instruction and Technology Services staff. The condition caused her not only severe pain and a trip to the emergency room but also fertility issues.

After giving birth to twin daughters, Vallone immediately went back on hormonal therapy to treat her endometriosis and prevent pregnancy. She chose the progesterone-only Pill in part because a medication without estrogen is safer for women with a family history of breast cancer.

Photo by Kate Melton

Michelle Casey, president and CEO of Planned Parenthood of Central and Western New York, says that 60 percent of its patients consider Planned Parenthood to be their primary source for medical care.

Controlling endometriosis or irregular or heavy bleeding, which are both painful and debilitating for women, are common reasons women request hormonal therapies.

"Heavy bleeding is a frequent cause for emergency room visits and the most common cause for gynecological office visits," says Harrington. From child care concerns to work absences to taking personal or sick days for doctor visits, managing these types of conditions affects family economies and, by extension, employers.

The progesterone IUD, says Harrington, can be used to control these conditions, as well as to treat pre-cancer and actual cancer of the uterus for women who are not good candidates for surgery. There is also a link between contraceptive use and cancer prevention, says Harrington, who notes that using the Pill for one year reduces risks of ovarian and uterine cancer by 10 percent, while 10 to 12 years of use decreases these risks by 50 percent to 80 percent.

Contraception may also be indicated for patients whose medical conditions would make an unintended pregnancy a major health concern.

"Access to hormonal therapies and contraception is a big social, health and financial issue, apart from the family planning aspect," says Harrington.

Although it is the second most common method of contraception in the United States, there are significant barriers to women accessing tubal ligation when they want and need it most: post-partum. Harrington says that when women receive effective contraception before leaving the hospital it can in one to three years save $2 million to $5 million in unintended pregnancy costs to insurers.

Yet only half of women who request a post-partum tubal ligation will actually receive it.

Carrie McDermott, who lives in the Albany area, began using the Pill just out of college, used it again between pregnancies but wanted a more reliable method after her second child.

"I asked my gynecologist for a tubal ligation during my scheduled C-section for my youngest," says McDermott, who works for Albany Community Action Partnership as the program services manager of Family Engagement. Her doctor, a Catholic, declined to perform the procedure. McDermott was too close to her delivery date to switch doctors, so she went back on the Pill for a short time before asking about other options.

"I had returned to full-time work and had a toddler and an infant at home, so taking medication regularly was difficult," says McDermott. "The Mirena IUD was the perfect solution for me."

Again, citing his Catholic beliefs, her doctor declined to insert the IUD. He referred her to another doctor, but two months would pass before McDermott would have the procedure.

"I am overall proactive about my health care, but there were hurdles," she says. "And that was the fastest I could do it."

The IUD historically has required an up-front investment of $700 to $1,000, making accessing this method a challenge. Costs are a major factor but not the only barrier to contraception for most women.

"The idea of a woman having control over her reproductive health is the door that either opens or closes on the issues of education, jobs, career and ability to provide for a family," says Michelle Casey, president and CEO of Planned Parenthood of Central and Western New York.

PPCWNY serves an 18-county region with 10 health centers and provides a range of women's health services, including cancer and Pap screenings and breast exams.

Casey says that 60 percent of its patients consider Planned Parenthood to be their primary source for medical care, over 60 percent of their patients are on Medicaid-related insurance and 65 percent of family planning patients are at or below the federal poverty level. A little over 40 percent of patients served by PPCWNY are women of color.

A Pew Research Center analysis of data from the U.S. Census Bureau shows that in comparison to single mothers who are divorced, widowed or separated, never married mothers are significantly younger, disproportionally nonwhite, and have lower education and income—in 2011, this group's median family income was $17,400, the lowest among all families with children.

Rachael Phelps M.D., medical director of Planned Parenthood of Central & Western New York and a member of the Rochester Business Journal's 2009 Forty Under 40 class, says that prohibitive upfront costs and insurance barriers disproportionately affect young women, poor women, and women of color.

"These women have more unintended pregnancies because of an unjust system that discriminates against them," she says, further noting that in the United States, black women have unintended pregnancy rates more than twice as high as white women, and poor women have unintended pregnancy rates more than five times higher.

For how Planned Parenthood is responding to this racial disparity, she points to the Contraceptive Choice Project. The clinical study removed systemic barriers to offer disproportionately young, poor, minority women access to contraceptive options, first by presenting the full menu starting with the most effective LARC methods, then giving evidenced-based information, with all methods provided for free and made available on the same day.

Out of 10,000 women and teens in the study, when offered the method of their choice on the same day and when cost and other barriers to access were removed, 75 percent chose a LARC method. Within a year, women who chose the Pill were 20 times more likely to be pregnant than women who chose IUDs or implants.

"Racial disparity went away," says Phelps of what the Choice Project revealed. "This proves that unintended pregnancy is about access and education. A lot of the work we do at Planned Parenthood replicates the Choice Project."

Between 2008 and 2011, LARC use increased from 4 percent to 12 percent, correlating to drops in abortion rates and, for the first time in 30 years, in unintended pregnancy rates. Phelps further notes that the only way to decrease abortion rates is by preventing unintended pregnancy, and calls the Affordable Care Act a game changer by removing cost barriers to contraception methods.

Access to birth control is associated with women investing in their education, leading to higher employment rates and better careers, with those benefits extending to the next generation.

"By helping women to decide under what circumstances they become parents, Planned Parenthood empowers them to determine the course of their lives," says Phelps. "We are insuring that they can achieve their dreams for themselves and for their present or future children."