WOMEN'S HEALTH

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1. **Develop an understanding of the pattern of disease and unique health issues specific to women in New York in comparison to women in the United Kingdom.**
2. **To develop an improved understanding of the conditions that are unique to women, using a holistic approach – Explore preventive medicine, nutrition & weight management, obstetrics, gynaecology, endocrine conditions, mammography and breast services, for instance.**

The Women's Health Center provides primary care for women, and its clinical staff consists of a primary care physician, a senior nurse practitioner and a doctor's assistant. Initially, the center also featured medical specialists in fields such as cardiovascular medicine, gastroenterology and orthopaedics. During my medical elective, I observed clinical practice, and conducted consultations with patients. Apart from working with the primary care physician and nurse practitioner, I also observed a cardiologist specialising in women's cardiovascular problems and an orthopaedic surgeon.

In recent times, there has been a shift in the delivery of women's healthcare from a focus on reproductive health to a more holistic lifestyle and wellbeing approach. In part, this is a result of society's realisation that differences between men and women extend beyond reproduction into physiology, life expectancy and response to illness and stress (Peterson-Sinclair 2004, Weil 2010). This shift may also have occurred as women have moved toward equality with men in other aspects of life, notably civil rights and employment (Timmermann 2009). Traditionally rooted in the medical specialties of reproductive medicine, obstetrics and gynaecology, provision of healthcare for women has become integrated into other specialties, including primary care, cardiology, rheumatology and endocrinology.

As a result of healthcare reform in the UK, numbers of general practitioners with specialist interests in particular fields of medicine (GPWSIs) have been expanded, with the aim of improving care for certain community groups and also improving cost efficiency (Gregory 2009). In the UK, general practitioners are commonly referring female patients to general practitioners with a specialist interest in women's health rather than to hospital specialists

(Gregory 2009). In the USA, concurrent with the spread of managed care, (in which primary care providers deliver most services and act as 'gatekeepers' to specialist services), women's health has evolved as an interdisciplinary field of medicine (Hoffman and Johnson 1995).

A key component of primary healthcare of women is health maintenance, which can be achieved through health promotion, screening and regular general health examinations (Hackley 2007). Health maintenance is important in reducing the risk of many conditions most likely to lead to death in women. Figure 1 lists the most common causes of death in women in the USA in the year 2000, while figure 2 lists the most common causes of death in women in England and Wales in the year 2003. Although the figures are not directly comparable, heart disease followed by malignant neoplasms are the most common causes of death in women in both countries.

All Races, Females	Percent*
1. Diseases of the heart (heart disease)	29.9
2. Malignant neoplasms (cancer)	21.8
3. Cerebrovascular diseases (stroke)	8.4
4. Chronic lower-respiratory diseases	5.1
5. Diabetes mellitus (diabetes)	3.1
6. Influenza and pneumonia	3.0
7. Alzheimer's disease	2.9
8. Accidents (unintentional injuries)	2.8
9. Nephritis, nephrotic syndrome, and nephrosis (kidney disease)	1.6
10. Septicemia	1.4

*Percent of total deaths due to the cause indicated.

Source: CDC Office of Women's Health. Available at: http://www.cdc.gov/od/spotlight/nwhw/1cod/00all.htm. Accessed April 22, 2004.

Figure 1. Leading causes of death in women in the United States, year 2000 (Hackley 2007).

Rank		No of deaths	% of all deaths
Males			
1	Ischaemic heart diseases	20,296	24.4
2	MN of trachea, bronchus and lung	8,549	10.3
3	Cerebrovascular diseases	5,082	6.1
4	Chronic lower respiratory diseases	4,635	5.6
5	MN of colon, sigmoid, rectum and anus	3,487	4.2
6	MN of prostate	2,609	3.1
7	MN of lymphoid, haematopoietic and related tissue	2,553	3.1
8	MN of oesophagus	2,089	2.5
9	Influenza and pneumonia	2,086	2.5
10	Cirrhosis and other diseases of liver	1,895	2.3
	All causes of death	83,339	100.0
Females			
1	Ischaemic heart diseases	8,106	14.2
2	MN of trachea, bronchus and lung	5,125	9.0
3	Cerebrovascular diseases	4,197	7.4
4	MN of breast	4,173	7.3
5	Chronic lower respiratory diseases	3,973	7.0
6	MN of colon, sigmoid, rectum and anus	2,093	3.7
7	MN of ovary	1,991	3.5
8	MN of lymphoid, haematopoietic and related tissue	1,686	3.0
9	Influenza and pneumonia	1,590	2.8
10	MN of pancreas	1,180	2.1
	All causes of death	56,980	100.0

Figure 2. Leading causes of death in women in the UK, year 2003 (Griffiths, Clare et al. 2005).

The majority of consultations I have observed during my elective in women's health have featured aspects of health promotion, screening for early signs of disease or counselling. Figure 3 lists common reasons for women's visits to primary care physicians. Although the data doesn't state whether the physicians visited specialised in women's health or not, a lot of the diagnoses listed are not specific women's problems, but generic conditions that could be treated by most primary care physicians, not specialising in women's health. However, following discussion with several patients I have encountered, many choose to consult with a primary care provider specialising in women's health because they feel like they are truly being listened to and in receipt of holistic care in an environment which enables them to discuss personal issues without fear of judgement or reprieve.

Primary Diagnosis	Percentage of All Visits
Essential hypertension	5.4
Normal pregnancy	3.3
Acute upper respiratory infection	3.1
Arthropathies, related disorders	2.8
General medical examination	2.5
Diabetes mellitus	2.3
Spinal disorders	2.3
Gynecologic examination	2.2
Rheumatism, other than back	1.9
Otitis media and Eustachian tube disorders	1.6
Chronic sinusitis	1.6
Allergic rhinitis	1.7
Malignant neoplasms	1.5
Asthma	1.5
Other heart disease	1.2
Acute pharyngitis	1.1
Lipid metabolism disorder	1.1
Ischemic heart disease	0.8

Source: Adapted from Cherry DK, Woodwell DA. National ambulatory medical care survey: 2002 survey. *Advance data from vital and health statistics*, No. 328. Hyattsville, MD: National Center for Health Statistics, June 5, 2002.

Figure 3. Common reasons for visits to ambulatory care offices by women, year 2002 (Hackley 2007).

Providing healthcare specifically aimed at women may have a wider impact in society, as women form the largest proportion of users of healthcare services, they are also often responsible for their family's health and act as decision-maker and instigator of access to healthcare services (Peterson-Sinclair 2004). Therefore, empowering women through education and greater access to healthcare resources may have wide-reaching beneficial implications for the health of society in general.

3. **Describe the pattern of health provision in hospitals and in the community in the United States of America and compare this to the pattern of health provision in the United Kingdom. Specifically, describe any patterns of health provision that are directly aimed at women.**

In the UK, the National Health Service (NHS) provides free care at the point of delivery, which therefore extends to primary care and general practice. As a consequence, virtually all UK residents (99%) are registered with a general practitioner (Colin-Thome 2007). Marshall and Wilson (2005) state that "general practice might be regarded by international observers as the jewel in the crown of the British health systems". The NHS is paid for through income tax deducted by the UK government and managed by the Department of Health through regional strategic health authorities, and primary care trusts. In England and Wales, the Secretary of State for health is a government minister who heads the Department of Health, which in turn oversees regional strategic health authorities (NHS Choices 2010). Although this setup varies slightly in Scotland and Ireland, the system allows regulations and guidelines to be passed down from national government to local government who then decide how to provide healthcare tailored to the local population's needs.

In order to register with a general practitioner, UK and European Union nationals need to present proof of identification and address and their NHS number, which is allocated at birth or at the point of approved immigration. The choice of practice is most often determined by the area people live in, but this may also be determined by proximity to their place of work or a choice to remain with a long-term general practitioner after relocating (NHS Choices 2010, Roberts 2010). The greatest proportion of healthcare funding in the UK is derived from the public purse, but private health plans are also available, whereby patients pay premiums to private health insurance companies in return for quicker and more personal access to specialist care in private hospitals.

Visiting nationals from countries without a reciprocal health arrangement with the UK may temporarily register with a general practitioner, but they must pay an upfront cost for their care (NHS Choices 2010). Thus, the system of provision of primary care in the UK appears to come close to the ideal of providing universal and accessible care for all (Gambrill 1980). However, the system differs greatly in the USA, where the greatest proportion of healthcare funding is derived from private contributions rather than government funding (Neubauer and

Driessle 2009). This means that there is greater potential for inequity of access to healthcare. The private system is subsided for the consumer and the government provides an alternative source of healthcare funding for disadvantaged groups – poor, disabled, low income families, veterans or elderly people, either Medicaid or Medicare (KFF 2011, Neubauer and Driessle 2009). Although a subsidised health funding system exists for disadvantaged groups in the USA, such patients are often subject to limitations in choice of care provider and access to best possible care for their particular needs (Neubauer and Driessle 2009). Advantages of the largely privatised system of healthcare in the USA include increased competition, greater investment and development of new technologies to improve patient care (Neubauer and Driessle 2009).

One problem with the NHS is that because its budget is controlled by the government, it is subject to an element of political bureaucracy; recurrent spending reviews, tightening of the budget and several costly 'independent' organisations being setup to monitor NHS spending and quality outcomes (Gregory 2009, Neubauer and Driessle 2009).
Similarly to NHS funding, Medicaid and Medicare programs are also subject to political bureaucracy - budget cuts and consequent loss of services for patients, such as dental treatment and prescription medications, which the patient has to pay for out-of-pocket (Neubauer and Driessle 2009).

Provision and optimisation of primary care is not only dependent on funding and political climate, but also on universal disparities such as gender, ethnicity, socioeconomic status, culture, education and quality of care (Hackley 2007, Peterson-Sinclair 2004). These problems are akin to both the USA and UK, requiring health care providers to develop a degree of cultural competence to enable them to understand the whole individual and provide best possible care.

4. **To gain increased exposure to the specialty of women's health, with the aim of determining whether this could be a career option for me. To gain an insight into what it means to be a doctor living & working in the United States of America.**

Primary care aims to provide holistic care for patients, taking responsibility for all aspects of patients' lives; social, cultural and psychological, providing continuity of care, equity and

universal access. These aims are achieved in different ways in the UK and the USA, with both systems featuring advantages and disadvantages. Political influence, funding, and disparities such as gender, ethnicity and social class have created two-tiered systems, with unequal access to best healthcare in both the UK and the USA. The dominance of the private system in the USA has led to competition, and rapid development and implementation of advanced technologies for the improvement of health. The availability of free healthcare at the point of delivery in the UK has led to an impressive rate of 99% of patients being registered with a general practitioner.

With the expansion of numbers of general practitioners specialising in women's health in both countries, certain infections and chronic diseases are being managed better, allowing for improved focus on health promotion and disease prevention. Primary care is best provided when the clinician can treat patients holistically, across the divides of race, education, culture, and financial status, working to understand the individual and community network to provided care that works for the woman.

Personally, I thoroughly enjoyed my medical placement, the staff and patients were very welcoming and I gained invaluable clinical experience. In particular, I was fascinated by the extent of the influence of health insurance provider on the quality of care that patients receive. For instance, when the primary care physician wished to request investigations or refer patients to specialists, the decision about which service or which specialist to choose was determined by the patient's health insurance. This differs greatly from the UK, where patients can be referred to a specialist of their choice. Another major difference I noted was that patients are able to contact their primary care provider directly, by telephone or email for medical advice at all times. Overall, my elective has reinforced my enjoyment of practising medicine and has contributed to my interest in general practice/family medicine as a career.

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