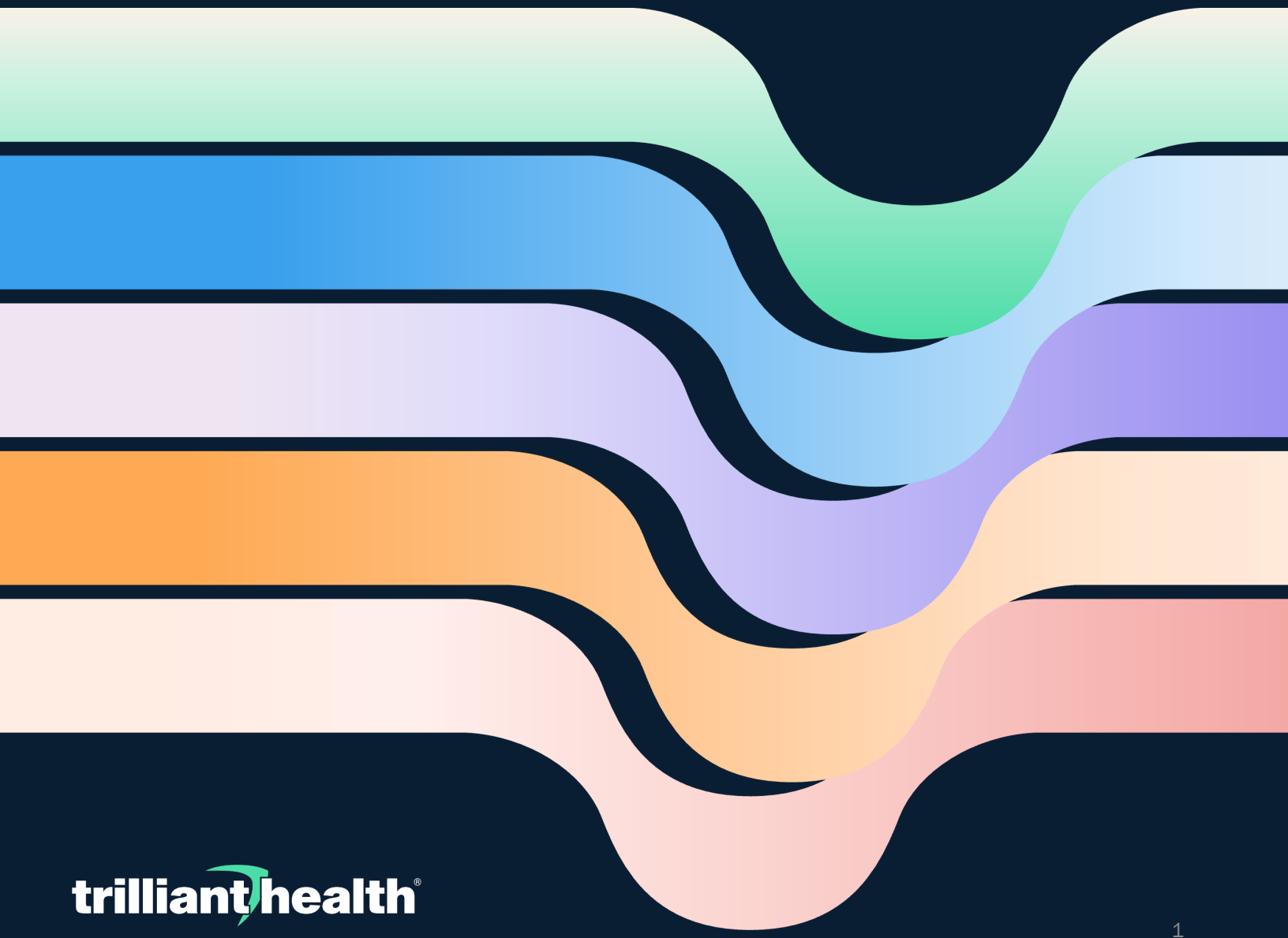
THROUGH LINES

How a *Limited Women's Health* Definition Inadequately Shapes Research, Investment and Care Delivery

MAY 2026



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Executive Summary

Despite decades of clinical investment and policy focus, women's health in the U.S. remains structurally underserved and strategically underprioritized. Moreover, growing demand and a recent increase in investment activity have not translated into better outcomes. Women are faced with fragmented benefit design, gaps in access to care and health outcomes that lag peer countries. These disparities are most evident in the ongoing maternal health crisis, characterized by a maternal mortality rate that has risen 131.9% since 1987 and is now more than 3x the average of other high-income OECD countries – despite the fact that an estimated 84% of pregnancy-related deaths in the U.S. are preventable.[1][2][3] Although women are the primary healthcare decision-makers within households, existing care models, reimbursement structures and clinical research do not appropriately prioritize their needs. The scope of women's health is often limited to sexual and reproductive care, which only accounts for 5% of women's total health burden even though an estimated 56% of that burden stems from conditions that disproportionately affect or manifest differently in women, including autoimmune diseases, cardiovascular disease and mental health disorders.[4] This misalignment between perception and reality manifests in suboptimal resource allocation – how research is funded, clinicians are trained and benefits are designed – that compounds over time. The historic misallocation of resources is amplified by emerging technologies, evolving reproductive patterns and widening access gaps, which compels a reevaluation of how, where and for whom women's healthcare is delivered.

This analysis examines seven critical trends that are reshaping women's health access, delivery and investment:

1. **The narrow definition of women's health deemphasizes underdiagnosed and undertreated conditions.**
2. **Female underrepresentation in clinical research contributes to adverse outcomes and limits clinical efficacy.**
3. **Fertility trends and rising use of assisted reproductive technology (ART) are reshaping reproductive demand for fertility care and reproductive autonomy.**
4. **Maternal mortality is increasing as access to obstetric care is decreasing – particularly among racial minorities.**
5. **Midlife and post-reproductive care remain underprioritized.**
6. **Declining physician supply and labor and delivery closures are narrowing the availability of women's healthcare.**
7. **Commercialization and consumerization of care are reshaping access and incentives through direct-to-consumer platforms and private equity deals.**

Together, these trends are disrupting where women seek care, which providers deliver it and how costs and utilization are distributed across the lifespan.

Women's healthcare spans every life stage, accounting for a disproportionate share of aggregate care utilization – making it a core driver of system performance, rather than a discrete service line. Stakeholders who continue to treat it as such risk misaligned capital investment, workforce planning, benefit design and care models required to manage this complex population effectively. Successful health system performance will depend in large part on how well it provides comprehensive care for women.

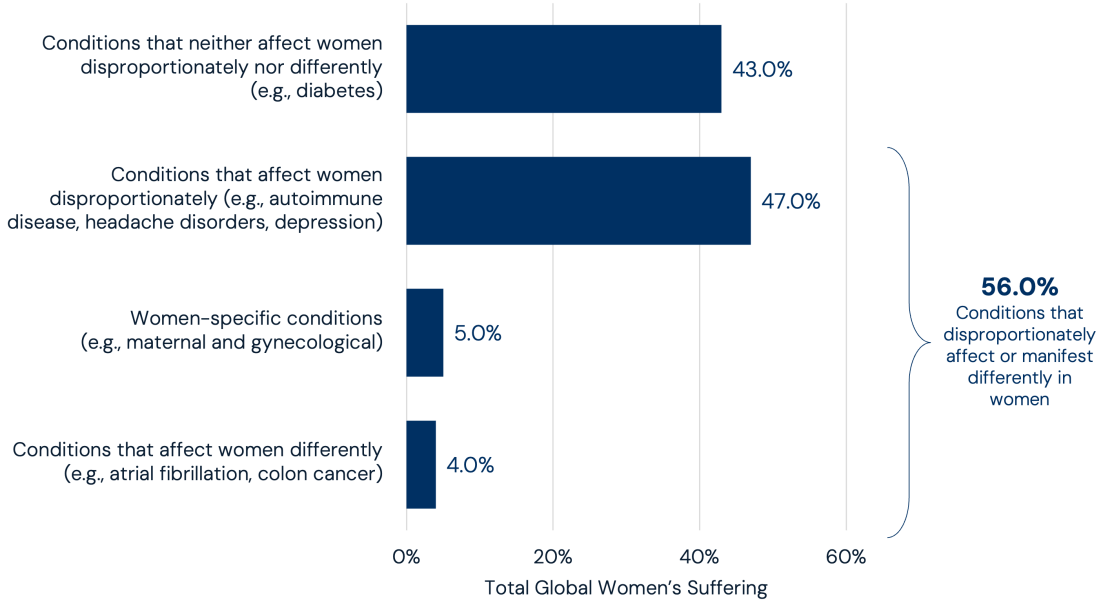
Table of Contents

The narrow definition of women's health deemphasizes underdiagnosed and undertreated conditions	4
Female underrepresentation in clinical research contributes to adverse outcomes and limits clinical efficacy	6
Fertility trends and rising use of assisted reproductive technology (ART) are reshaping reproductive demand for fertility care and reproductive autonomy	9
Maternal mortality is increasing as access to obstetric care is decreasing – particularly among racial minorities	15
Midlife and post-reproductive care remain underprioritized	19
Declining physician supply and labor and delivery closures are narrowing the availability of women's healthcare	22
Commercialization and consumerization of care are reshaping access and incentives through direct-to-consumer platforms and private equity deals	28
Conclusion	30

The narrow definition of women's health deemphasizes underdiagnosed and undertreated conditions

Women's health historically has been narrowly defined as sexual and reproductive health – a framing that understates the broader scope of conditions either exclusively or disproportionately impacting women. Sexual and reproductive health and maternal, newborn and child health account for just 5% of women's total health burden, while an estimated 56% stems from conditions that are more prevalent in women or manifest differently than in men (Figure 1).[5] This misalignment between perception and reality manifests in suboptimal resource allocation – how research is funded, clinicians are trained and benefits are designed – that compounds over time.

FIGURE 1. Total Global Women's Health Burden, by Condition Type



Note: Maternal conditions include maternal hemorrhage, maternal sepsis and other maternal infections, hypertensive disorders of pregnancy, obstructed labor and uterine rupture, abortion and miscarriage, ectopic pregnancy, indirect maternal deaths, late maternal deaths, maternal deaths aggravated by HIV/AIDS. Gynecological diseases include uterine fibroids, polycystic ovarian syndrome, women's infertility, endometriosis, genital prolapse, premenstrual syndrome and women's-specific cancers such as uterine cancer, ovarian cancer and cervical cancer.
Source: World Economic Forum.

The conditions driving the gap between the actual burden of women's health and the care delivered have substantial economic consequences. The top 10 conditions contributing to this burden (e.g., premenstrual syndrome (PMS), depressive symptoms and migraines) account for more than half of the estimated $1T in global economic gains projected from closing the women's health gap. Menopause and endometriosis account for an outsized share of this toll.[6] Approximately 80% of women affected by menopause report that it interferes with their daily lives, one-third experience depression and the condition is linked to premature departure from the workforce.[7] Endometriosis similarly drives absenteeism and productivity losses, compounding its clinical burden with lasting labor market consequences.[8]

The burden extends beyond conditions exclusive to women. Other conditions that disproportionately affect women – such as osteoporosis, cardiovascular disease and Alzheimer's disease – are similarly underdiagnosed and undertreated, often due to longstanding gaps in research, screening protocols and clinical trial inclusion.[9] For instance, healthcare training has historically centered on male physiology, leading to diagnostic blind spots for women and lower rates of treatment for conditions like heart disease.[10] Earlier diagnosis and more targeted interventions for these conditions represent an area of unmet clinical need, with implications for outcomes across diagnostics, digital tools and therapeutics.

Delayed and missed diagnoses are typical in care journeys for conditions specific to or predominant in women. The "gender pain gap," defined as a clinical tendency in which women's reported pain is taken less seriously in clinical settings, contributes to different prescribing practices, higher rates of missed or incorrect diagnoses and delayed treatment.[11] Endometriosis is among the most commonly misdiagnosed conditions affecting women. Reported diagnosis times for endometriosis range from 0.3 to 12 years, reflecting a combination of symptom dismissal, social stigma and a historical reliance on a surgical requirement, leading to sustained periods of chronic pain prior to formal diagnosis.[12,13] Postpartum depression remains underdiagnosed and undertreated – despite affecting an estimated one in seven postpartum women – in part due to inconsistent screening practices and provider awareness.[14] Autoimmune diseases affect women at roughly 4x the rate of men.[15]

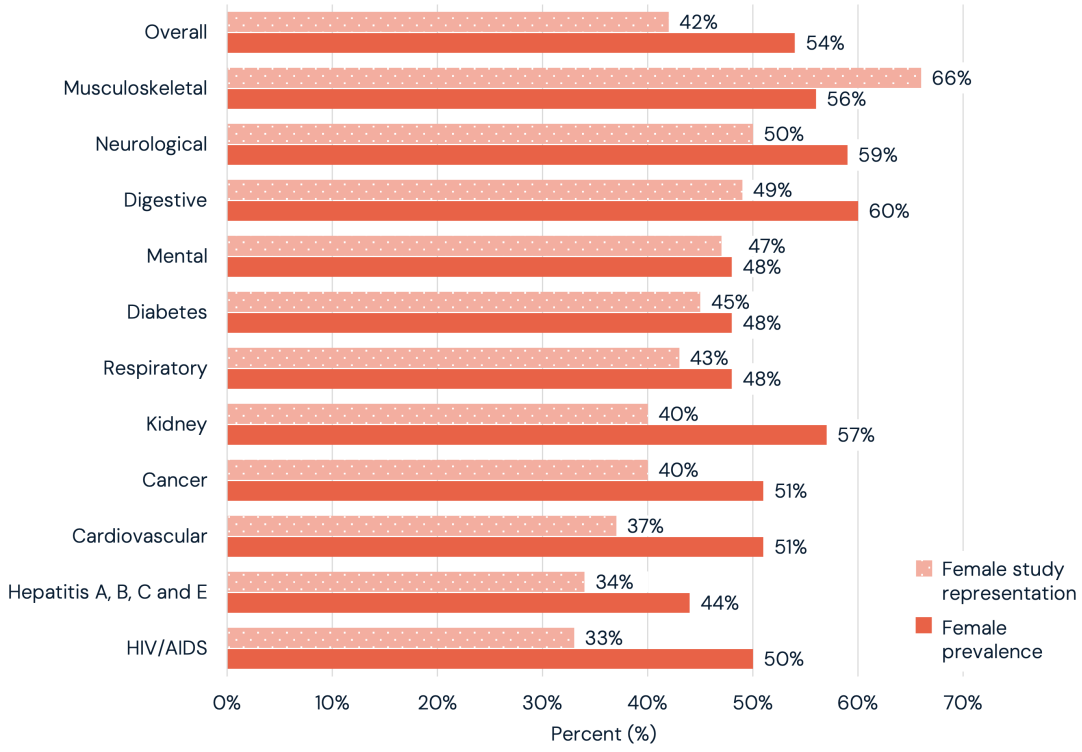
Other diagnostic gaps result from conditions that impact both men and women but manifest differently. For example, in cardiovascular care, women are seven times more likely than men to have a heart condition misdiagnosed or be discharged during a heart attack.[16] Where clinical training and diagnostic criteria are built on male-dominant research, sex-specific disease presentations can go unrecognized, producing delayed treatment or misdiagnoses for female patients across a range of conditions. Despite this, research has historically skewed toward male populations – only 11% of NIH research funding is allocated to women's health.[17]

Female underrepresentation in clinical research contributes to adverse outcomes and limits clinical efficacy

The utility of current and future clinical research in improving women's health outcomes is limited by the persistent underrepresentation of female cohorts in study design and conduct. For most of the 20th century, women were routinely excluded from clinical trials, with common cited reasons being possible future fetal risk and distrust of women to avoid pregnancy during the study period.[18,19] These exclusionary practices often persist in the present day. Although the NIH Revitalization Act of 1993 mandated the inclusion of women in federally funded clinical research, gaps in representation remain, particularly in conditions where women bear a disproportionate share of disease burden.

More than 40 years later, women account for only 42% of clinical trial participants despite representing more than 50% of the population.[20] More specifically, women account for 51% of the global disease burden of cardiovascular disease and 57% of chronic kidney disease but are included in only 37% of cardiovascular and 40% of kidney disease studies (Figure 2).

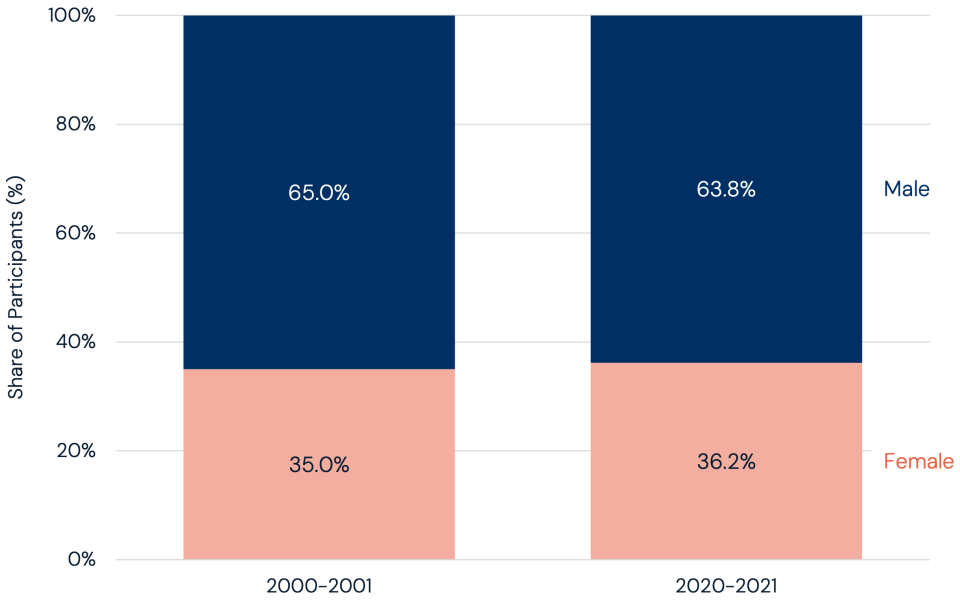
FIGURE 2. Global Disease Burden and Clinical Study Representation Among Women, by Disease State, 1999–2018



Source: Feldman et al., Quantifying Sex Bias in Clinical Studies at Scale With Automated Data Extraction, *JAMA Network Open*, 2019.

Women's representation in drug-specific clinical trials remained relatively unchanged over the past two decades, increasing marginally from 35.0% of participants in 2000-2001 to 36.2% in 2020-2021. (Figure 3). Underrepresentation in early-stage clinical trials that establish the safety thresholds and dosage protocols can lead to skewed and non-generalizable data that could be harmful to women. When dosage protocols are designed for male physiology (i.e., weight, metabolism, hormone levels), women may receive inappropriate dosages – increasing their exposure to adverse drug events or limiting therapeutic effectiveness at the standard prescribed amount.[21]

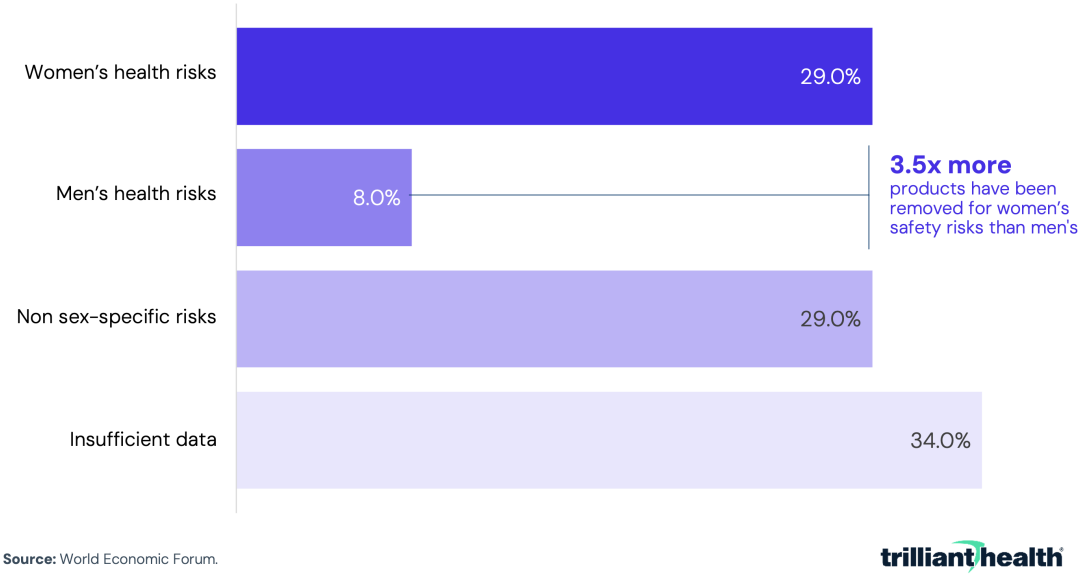
FIGURE 3. Share of Clinical Drug Trial Participants, by Sex, 2000-2001 and 2020-2021



Note: Data provided are global.
Source: Bøttern et al., Sex, Racial, And Ethnic Diversity in Clinical Trials, *Clinical and Translational Science*, 2023.

As a result, drug dosages and treatment protocols are frequently derived from male-dominant trial data. Because women differ from men in pharmacokinetics and hormone metabolism, this creates measurable exposure to elevated risks of overmedication and adverse drug events – and a disproportionate share of drug removals from the market for safety reasons are for female indications. Since 2000, women in the U.S. have reported adverse drug events 52% more frequently than men and serious or fatal events 36% more frequently.[22] In 2022, healthcare professionals reported 4.4M serious or fatal drug-related events for women, compared to 3.8M for men. Between 1980 and 2023, 29% of drugs removed from the market for safety reasons were attributed to women's health risks and 3.5x more products were removed for women's health risks compared to men's (Figure 4).

FIGURE 4. Share of Global Drug Withdrawals, by Type of Risk, 1980-2023



Source: World Economic Forum.

A core driver of these outcomes is the absence of sex-specific data across the most widely used clinical interventions. Of the 183 most widely used interventions across 64 health conditions – representing roughly 90% of women's health burden – only 50% report sex-specific data.[23] Among interventions with these data, 64% were found to disadvantage women through lower efficacy, reduced access or both, compared to 10% for men.[24] The absence of sex-specific clinical trial data means that differences in how conditions develop, progress and respond to treatment in women remain poorly understood – contributing to an estimated 40M to 45M disability-adjusted life years (DALYs) lost per year due to the women's health gap, with 60% of that burden attributed to sex-related biological differences.[25] Most women's health research focuses on conditions with high mortality (e.g., women-specific cancers like ovarian or cervical) and underrepresents conditions that lead to disability (e.g., endometriosis, menopause, PMS).

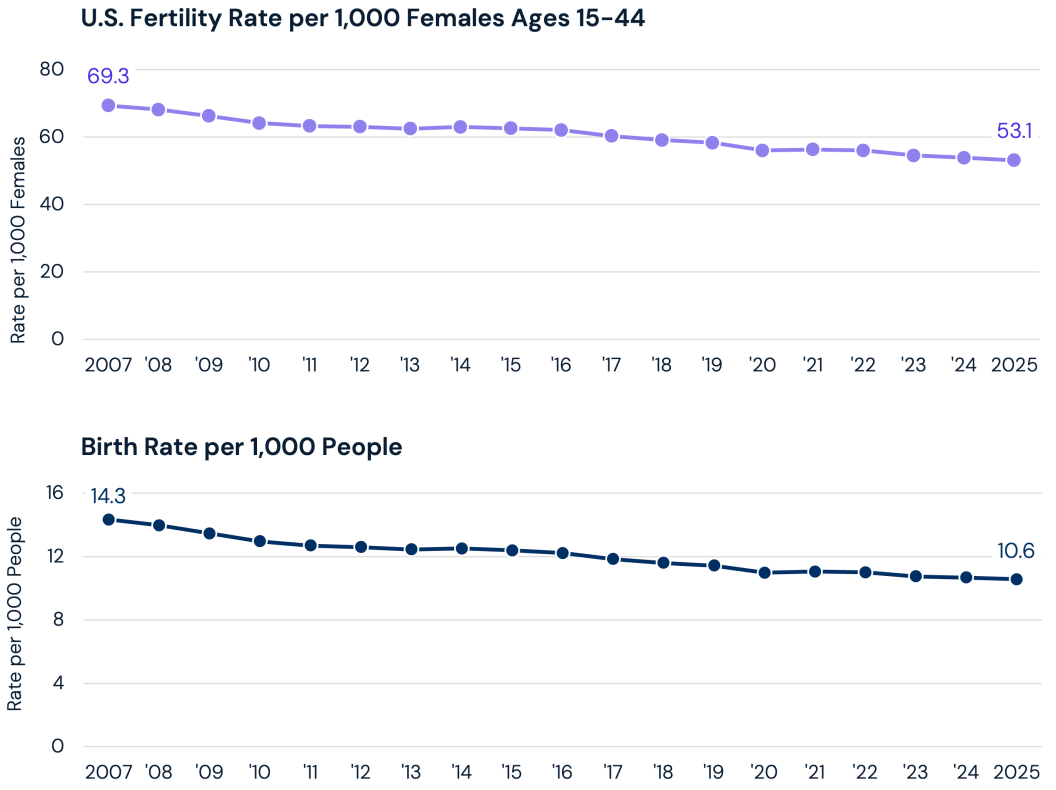
These gaps demonstrate a research design problem with systemic consequences. When sex-specific data is absent, differences in how diseases present, progress and respond to treatment in women go undetected – producing clinical guidance that is less accurate and less safe for female populations. Medical training exacerbates this – clinical education has historically centered on male physiology outside of reproduction, and more than half of residency graduates have reported their sex and gender-based medicine instruction as inadequate, with only 16.3% of program directors identifying it as a curriculum priority.[26] These gaps in provider training can translate into a care gap, leaving female patients susceptible to misdiagnosis or undertreatment.[27]

Fertility trends and rising use of assisted reproductive technology (ART) are reshaping reproductive demand for fertility care and reproductive autonomy

Fertility trends are influenced by a complex mix of personal, social and economic factors, which collectively shape reproductive and perinatal health trends in the U.S. Contributing factors include expanded access to contraception, higher educational attainment, growing labor force participation, delayed marriage and childbearing and economic pressures – notably the limited availability of affordable childcare and paid family leave policies relative to peer countries.

Birth and fertility rates in the U.S. have declined steadily over the past few decades. In 2025, the birth rate was 10.6 per 1,000 people – a 26.3% decline from 14.3 in 2007 (Figure 5).[28] At the same time, the general fertility rate – measuring births per 1,000 women of reproductive age – was 53.1 births per 1,000 women ages 15-44, a 23.4% decrease from 69.3 births per 1,000 women ages 15-44 in 2007. Underlying both trends is a fertility rate that has fallen below the replacement threshold of 2.1 births per woman, the level at which a generation can exactly replace itself, declining from 2.1 in 1990 to 1.6 in 2024.[29,30]

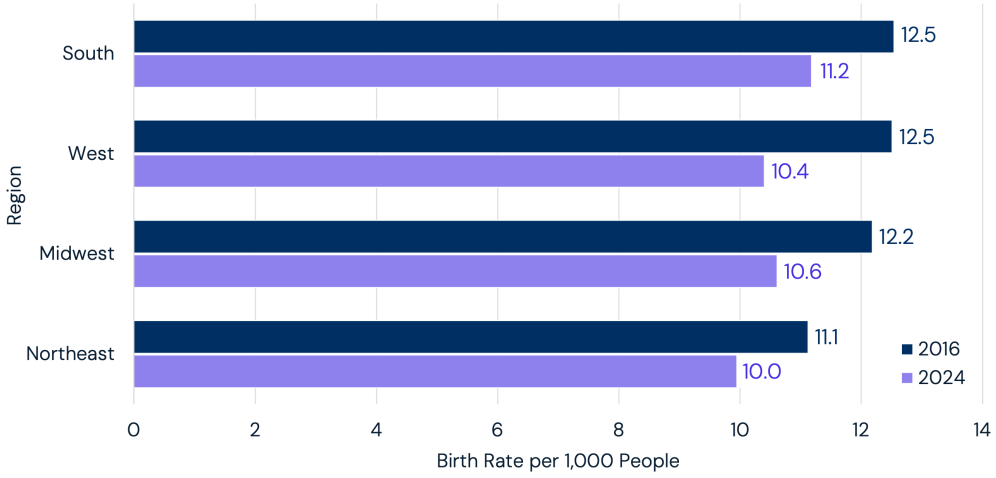
FIGURE 5. U.S. Fertility Rate and Number of Births, 2007-2025



Note: Fertility rate is births per 1,000 women ages 15-44. Birth rate is births per 1,000 people. 2025 data are provisional.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, 2026.

Birth rates and maternal age vary across demographics. The average maternal age increased from 21.4 in 1970 to 27.5 in 2005 and 29.8 in 2025, reflecting a consistent trend toward later childbearing in the past 50 years.[31] The Northeast has the highest average maternal age (31.0) and the lowest birth rate (10.0 per 1,000 people), while the South shows the inverse, if only slightly – a lower average maternal age (29.2) and the highest regional birth rate (11.2) (Figure 6).[32] Urbanization is generally associated with higher maternal age. Average maternal age is 30.6 in urban areas, compared to 27.9 in rural areas.[33] Maternal age is higher among married individuals (31.2) compared to single individuals (27.3).

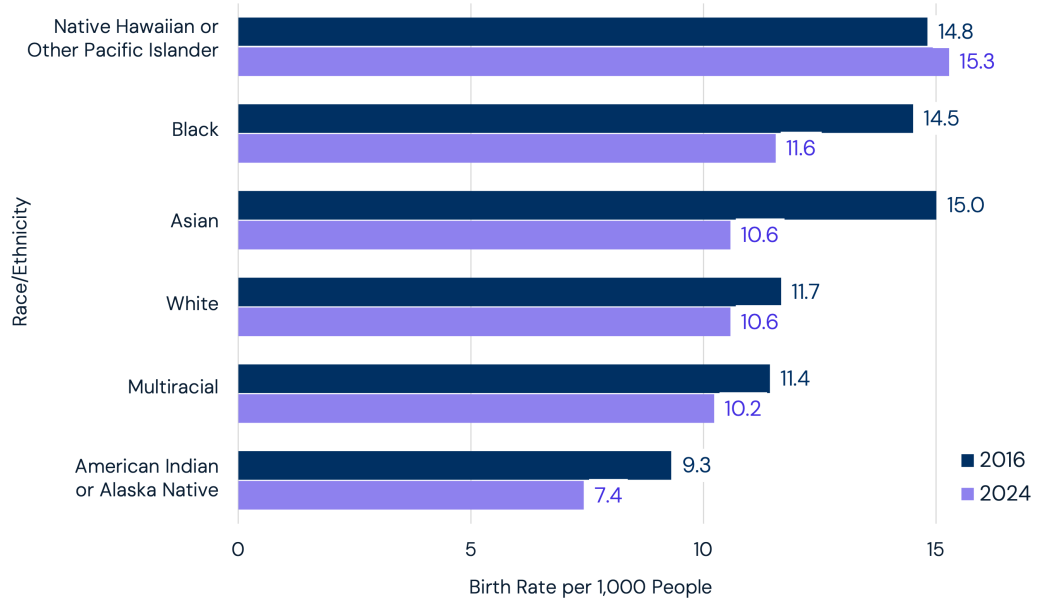
FIGURE 6. Birth Rate by Maternal Region of Residence, 2016 and 2024



Source: Centers for Disease Control and Prevention WONDER Database.

Birth rates also vary by race and ethnicity. In 2024, birth rates were highest among Native Hawaiian or Other Pacific Islander (14.8 per 1,000), Asian (15.0) and Black (14.5) mothers, and lowest among American Indian or Alaska Native mothers (9.3) (Figure 7). These differences reflect a mix of demographic composition, cultural factors and socioeconomic conditions, as well as access to reproductive healthcare that shape reproductive timing and fertility across populations.

FIGURE 7. Birth Rate by Maternal Race/Ethnicity, 2016 and 2024



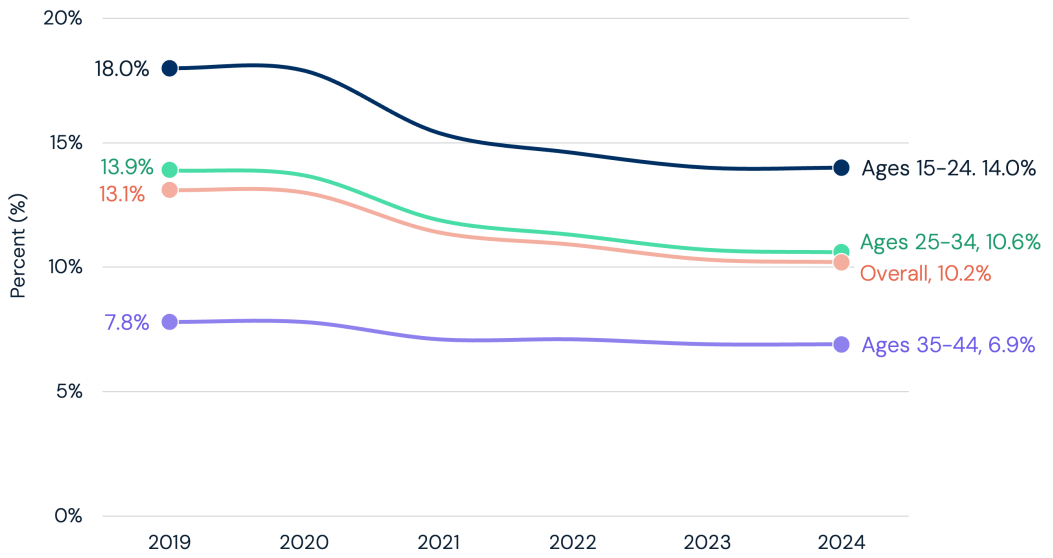
Source: Centers for Disease Control and Prevention WONDER Database.

Contraceptive use in the U.S. is shaped by access, policy, patient preference and social norms. The Affordable Care Act (ACA) increased the affordability of contraceptives by mandating coverage without cost sharing. While annual OB/GYN or primary care visits were once necessary to obtain contraceptives, 30 states and the District of Columbia permit pharmacists to prescribe, and direct-to-consumer (DTC) companies like Nurx and Hims & Hers have expanded contraceptive access.[34]

In 2023, the U.S. Food and Drug Administration (FDA) approved the first over-the-counter (OTC) oral contraceptive, which became available for purchase in early 2024.[35] However, misinformation on social media regarding contraceptives could influence some users to switch methods or discontinue use, underscoring an ongoing trend of growing trust in non-clinical sources of health information, which is particularly prevalent for women's health. Recent research also found a rise in permanent contraception procedures (i.e., tubal sterilization and vasectomy) among individuals ages 18 to 30 in 2022 and 2023.[36]

While access to both oral and implantable contraceptives has improved in recent decades, factors influencing demand continue to evolve in response to changing regulations, delivery channels and social perceptions. Between 2022 and 2023, 54.3% of women ages 15-49 were prescribed any form of contraception.[37] Between 2019 and 2024, the share of women ages 15 to 44 with oral contraceptive prescriptions decreased from 13.1% to 10.2%, with the highest utilization among women ages 15 to 24 (14.0% in 2024) and the lowest among those ages 35 to 44 (6.9%) (Figure 8). Between 2022 and 2023, other commonly used contraceptive methods included female sterilization (11.5%), long-acting reversible contraceptives (LARCs) (i.e., contraceptive implants and intrauterine devices) (10.5%) and male condoms (7.1%).[38]

FIGURE 8. Percent of Women Ages 15-44 with an Oral Contraceptive Prescription, By Age Group, 2019-2024



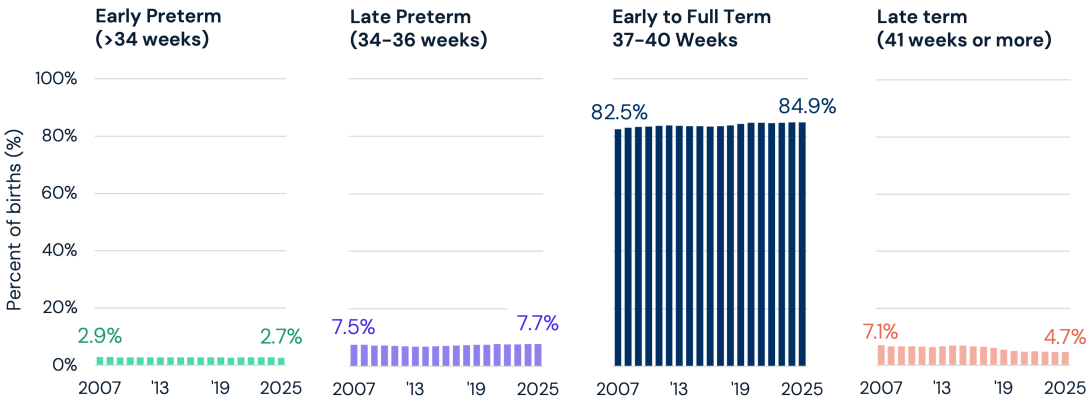
Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

Fertility trends, maternal health and birth outcomes are closely linked to the availability, timing and quality of prenatal and reproductive care, especially as average maternal age increases. Prenatal care is essential to ensuring optimal infant and maternal health status, providing regular opportunities to identify and manage complications. Recommended screenings aim to detect and address conditions such as gestational diabetes, hypertension, maternal obesity, mental health issues and preeclampsia. Beyond clinical monitoring, prenatal care may include nutritional counseling, physical activity guidance and mental health support.[39] Receiving no prenatal care is associated with a 3x higher likelihood of low-birthweight infants and a 5x higher likelihood of pregnancy-related infant death.[40]

Education, geographic access, cost and language differences contribute to disparities in prenatal care frequency. On average, prenatal visit frequency is highest among Asian (11.3) and White (11.2) populations and lowest among American Indian (9.9) and Alaska Native and Native Hawaiian or Other Pacific Islander (8.8) populations.[41] More specifically, Asian and White mothers are more likely to initiate prenatal care in the first trimester compared to Hispanic, Black, American Indian and Alaska Native and Native Hawaiian and Other Pacific Islanders.[42] Regionally, the South has the fewest average prenatal visits (10.7), compared to 11.3 in the Midwest, 11.2 in the West and 11.1 in the Northeast. Prenatal visit frequency is also higher among married individuals (11.3) than among single individuals (10.3). Higher educational attainment is also associated with prenatal care utilization. Those with a master's degree had more prenatal visits on average (11.8) than those with eighth grade education or less (8.9).

A full-term birth generally spans 40 weeks. Preterm (before 37 weeks) and early pre-term (32 weeks) births are associated with higher mortality and disability rates. Together, preterm birth and low birth weight accounted for 14.7% of infant deaths in 2024.[43,44] Nationally, the share of births reaching full term slightly increased from 82.5% in 2007 to 84.9% in 2025 (Figure 9). Over the same period, the share of preterm births remained at 10.4% in 2007 and 2025, while late-term births – births spanning 41 weeks or more – declined from 7.1% to 4.7%.[45]

FIGURE 9. Distribution of U.S. Births by Gestational Age, 2007-2025

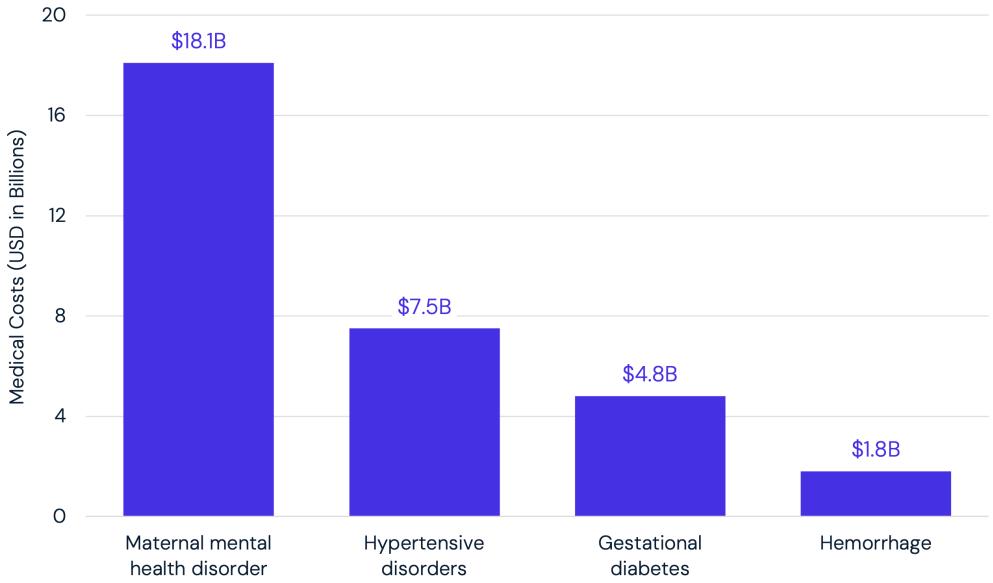


Note: 2025 data are provisional.
Source: Centers for Disease Control and Prevention WONDER Database.

As average maternal age has increased in the last 50 years, demand for procreative management and ART has increased as well. Patient volume for procreative management encounters grew 46.8% from 2019 to 2023.[46] Additionally, patient volume has increased for treatment of recurrent pregnancy loss, female infertility and menopausal or perimenopausal disorders, reflecting a shift toward more specialized fertility care.[47] In-vitro fertilization (IVF) remains the most common ART treatment – a process where eggs and sperm are combined in a laboratory before transferring embryos to the uterus. In 2024, there were 100,158 IVF births, accounting for 2.8% of U.S. births.[48] Oocyte banking, or egg freezing, has become more popular as an ART method – cryopreservation cycles increased 880% between 2010 and 2015.[49] Success rates decline with age, ranging from 88.9% among women younger than 35, 83.8% among women ages 35-37, 76.6% among women ages 38-40, 67.6% among women ages 41-42 and 50.7% among women older than 42.[50]

Pregnancy-related complications (e.g., hypertensive disorders, gestational diabetes, hemorrhage, cardiac arrest, sepsis) not only impact clinical outcomes but also drive significant healthcare costs. More specifically, maternal mental health disorders are the largest contributor of maternal morbidity medical and nonmedical costs (i.e., productivity losses, increased social service use), accounting for an estimated $18.1B in combined medical and nonmedical expenses.[51] Other leading cost drivers include hypertensive disorders ($7.5B), gestational diabetes ($4.8B) and hemorrhage ($1.8B) (Figure 10). These figures underscore the need for early detection and management of maternal health risks, particularly in high-risk populations.

FIGURE 10. Costs of Pregnancy and Delivery Complications in the U.S., 2019



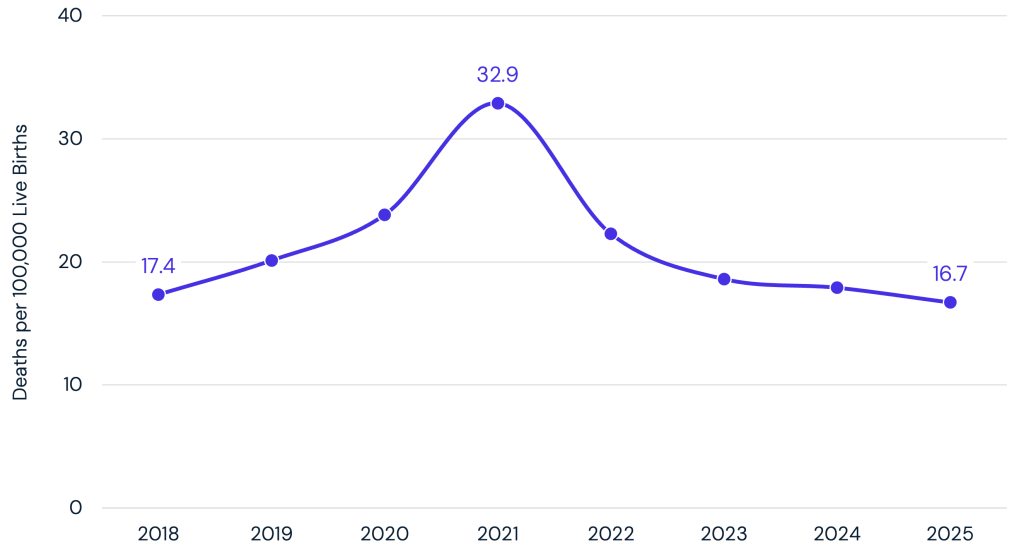
Source: The Commonwealth Fund.

Maternal mortality is increasing as access to obstetric care is decreasing – particularly among racial minorities

Pregnancy-related deaths in the U.S. have risen significantly over the past few decades – from 7.2 deaths per 100,000 live births in 1987 to 16.7 in 2025, a 131.9% increase. This trend was further intensified amid the COVID-19 pandemic, with mortality peaking at 32.9 deaths per 100,000 in 2021 (Figure 11). The leading causes of pregnancy-related death include hemorrhage, infection or sepsis and thrombotic events.

Mortality varies by race, age and geography. In 2025, Black women had the highest pregnancy-related mortality rate at 46.3, compared to 12.9 among White women, 9.9 among Asian women and 11.0 among Hispanic women. Maternal mortality rates also increase with age – from 10.0 deaths per 100,000 among women under age 25 ,16.7 for women ages 25-39 to 52.6 among those ages 40 and older.[52] In 2024, maternal mortality rates also show a clear gradient by urbanicity, with the highest rates in rural areas – 28.0 deaths per 100,000 live births – compared to 15.6 in more urban areas.[53] This pattern is seen across racial groups – between 2018 and 2024, Black women in rural areas had a maternal mortality rate 1.6x to 2.5x higher than Black women in urban areas and White women in rural areas had a mortality rate 1.4x to 1.7x higher than White women in urban areas.[54,55]

FIGURE 11. Maternal Mortality Rate in the U.S. per 100,000 Live Births, 2018-2025

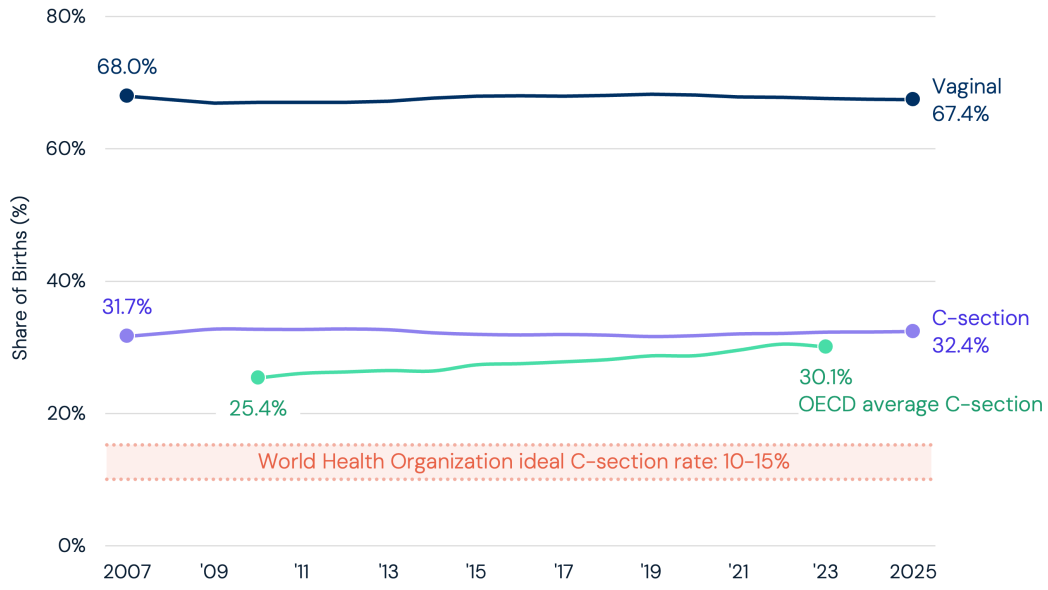


Note: 2025 data are provisional.
Source: Centers for Disease Control and Prevention WONDER Database and National Center for Health Statistics, 2026.

Multiple factors contribute to rising maternal mortality, including delayed childbirth, growing rates of chronic conditions and systemic inequities in healthcare. An estimated 84% of pregnancy-related deaths are preventable. Maternal mortality is especially high among Black women due in part to chronic stress – often described as "allostatic load" – that can accelerate biological aging.[56] The long-term health consequences of racism and structural disadvantage are compounded by both implicit and overt bias in clinical settings.[57] Mortality risk increases in parallel with maternal age, with a greater chance of complications such as preeclampsia, gestational diabetes, unplanned Cesarean sections (C-sections) and postpartum hemorrhage.[58]

C-sections in particular reflect broader patterns in consumer choice and delivery complexity. Nationally, 32.4% of births were C-sections in 2025, above the World Health Organization recommended rate of 10-15%.[59,60] The annual C-section rate has remained relatively steady, declining from 31.7% in 2007, but increasing moderately over the last five years (Figure 12). C-sections have higher clinical risks than vaginal delivery and cost 85% more on average – $28,998 compared to $15,712 in 2023.[61,62] These costs compound an already significant financial burden associated with pregnancy-related complications.

FIGURE 12. Share of Births by Delivery Type in the U.S., 2007-2025



Note: OECD denotes Organisation for Economic Co-Operation and Development. OECD Average excludes U.S. 2025 data are provisional.
Source: Centers for Disease Control and Prevention WONDER Database; Organisation for Economic Co-Operation and Development.

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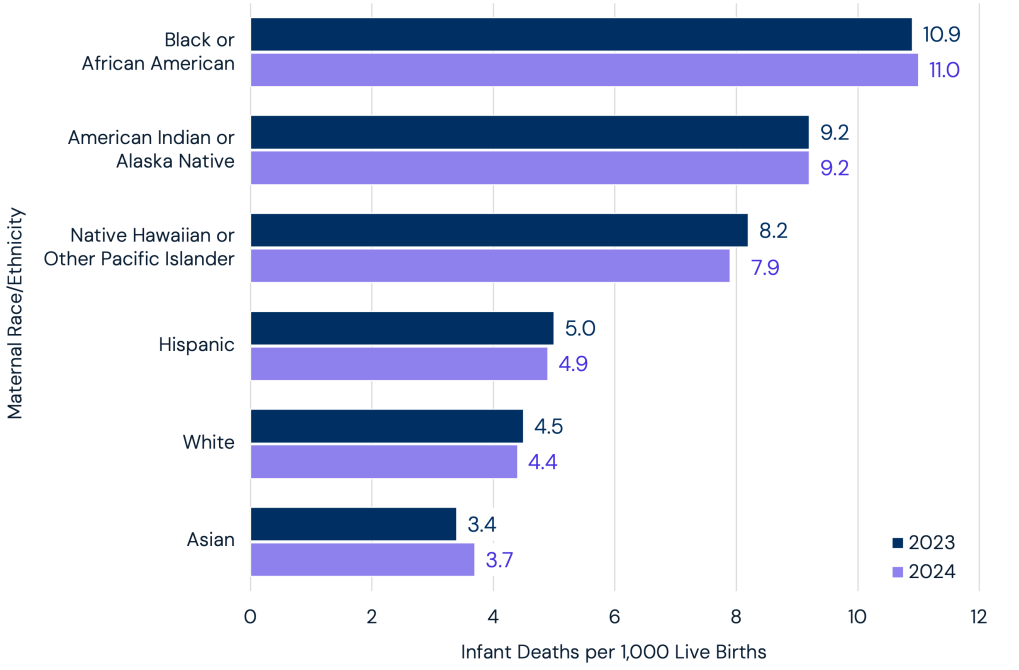
Demographic disparities extend to infant health outcomes, with infant mortality rates also showing wide variation by race, geography and age. Infant mortality is defined as the death of an infant within the first year of life. The five leading causes of infant mortality are birth defects, preterm birth and low birth weight, sudden infant death syndrome (SIDS), unintentional injuries and pregnancy complications.[63] Nationally, the infant mortality rate was 5.5 per 1,000 live births in 2024, a 16.7% decrease from 6.6 in 2007.[64,65] In 2024, Black infants had the highest infant mortality rate at 11.0 per 1,000 live births, compared to 4.9 for Hispanic infants, 4.4 for White infants and 3.7 for Asian infants (Figure 13). Geographically, the South and Midwest have the highest infant mortality rates. Mississippi (9.7), Arkansas (8.3) and South Carolina (7.5) had the highest infant mortality rates. In contrast, New Hampshire (3.0), New Jersey (3.4) and Massachusetts (3.5) had the lowest infant mortality rates.[66] Infant mortality is highest among mothers under 20 (10.6) and lowest among mothers ages 30–34 (4.6), declining through the early 30s before increasing again among older ages.[67]

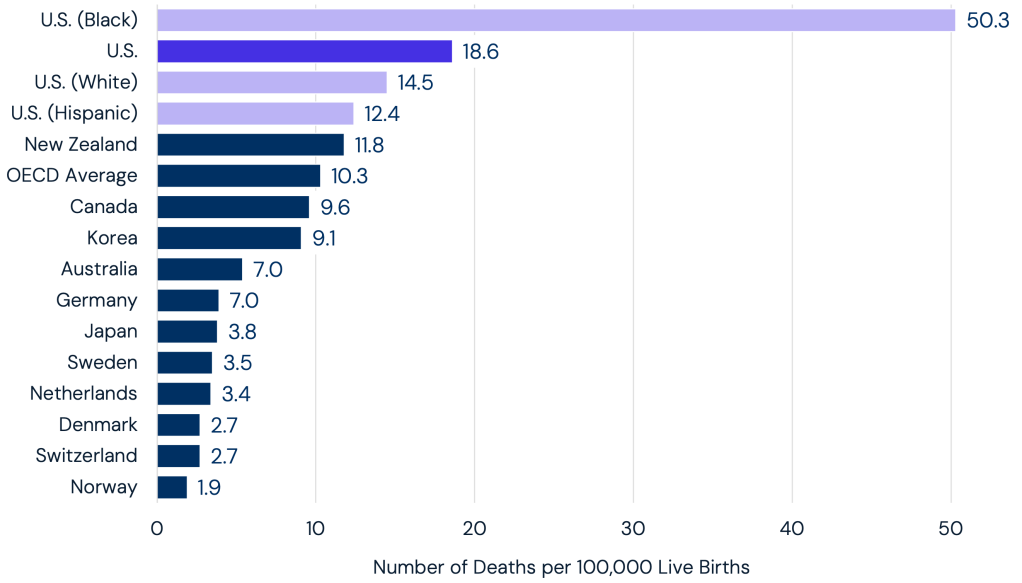
FIGURE 13. Infant Mortality in the U.S. per 1,000 Live Births, by Race and Ethnicity, 2023-2024



Source: Centers for Disease Control and Prevention National Vital Statistics System.

Compared to other high-income countries, the U.S. performs poorly across several maternal and infant health outcomes. In 2023, the U.S. maternal mortality rate was 23.8 deaths per 100,000 live births – ranging between more than 1.5x and 9.8x times the rate in other high-income OECD countries (Figure 14). The U.S. infant mortality rate was 5.6 deaths per 1,000 live births, compared to 4.0 deaths per 1,000 live births – the average rate among OECD countries.[68,69]

FIGURE 14. Maternal Mortality per 100,000 Live Births in Various High-Income Countries, 2021-2023



Note: Data for all countries except the U.S. are from OECD, provided as an average in the 3-year period 2021-2023. U.S. data are from 2023.
Source: *Health at a Glance 2025: OECD Indicators;* Donna L. Hoyert, Maternal Mortality Rates in the United States, 2023 (National Center for Health Statistics, Feb. 2025).

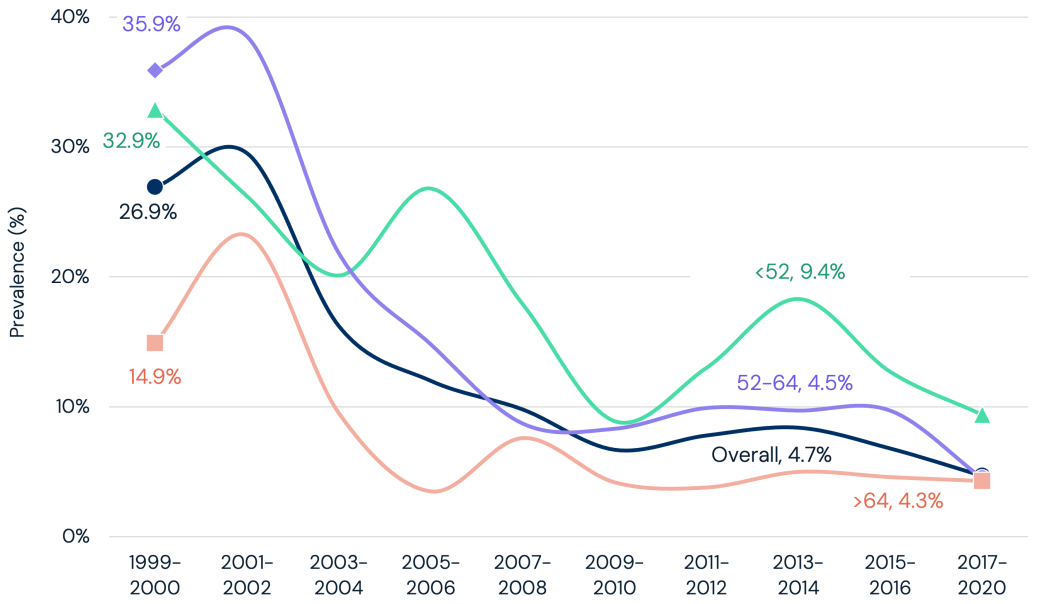
Strategies to bring the U.S. closer to its global peers include ensuring access to free or affordable primary care, comprehensive reproductive care before, during and after pregnancy, along with robust postpartum support (e.g., nutrition and exercise counseling, mental health care and breastfeeding guidance).[70] A maternal workforce that leverages midwives – and is consistently covered by insurance – may also help reduce risk.[71] Broader utilization of the midwifery workforce, however, is constrained by inconsistent scope-of-practice laws and licensure recognition – particularly for Certified Professional Midwives who are not licensed in all states – alongside physician supervision requirements, uneven reimbursement and limited patient awareness of non-physician birth attendant models.[72,73] Unlike most OECD countries, the U.S. lacks universal health coverage, leaving nearly 8M women of reproductive age uninsured.[74] In states that have not expanded Medicaid, hundreds of thousands of reproductive-age women – disproportionately Black women – remain in the coverage gap and are vulnerable to postpartum disenrollment, as some states continue to end coverage just 60 days after birth.[75] Across race, geography and age, maternal and infant mortality in the U.S. reflect well-documented patterns, persistent over decades and unfavorable relative to peer nations.

Midlife and post-reproductive care remain underdiagnosed and underutilized

In the U.S., the average age of menopause – the point in time twelve months after a woman's last period – is 52 years, with perimenopausal symptoms (e.g., hormonal changes, irregular menstruation, hot flashes) beginning two to eight years prior.[76] Every woman goes through menopause, yet it remains disproportionately undertreated, underfunded and under-researched. A November 2025 study found that 87% of symptomatic menopausal women do not seek treatment despite the discomfort of menopause symptoms.[77] Historically, women have attributed stigma, misinformation and the absence of consistent clinical protocols guiding providers on evidence-based care as barriers to accessing services to address menopause-related symptoms.

Hormone replacement therapy (HRT) – the use of estrogen, and in some cases, progesterone, to manage symptoms of menopause, including hot flashes, sleep disruption and mood changes – was widely prescribed throughout the 1990s. In 1999-2000, HRT prevalence among postmenopausal women was 26.9%, with the highest rate among postmenopausal women under 53 (Figure 15). In 2002, a widely publicized study reported associations between HRT and elevated risks of cardiovascular disease and breast cancer.[78] HRT utilization declined in the years that followed, decreasing to 4.7% in 2017-2020.

FIGURE 15. Prevalence of Hormone Replacement Therapy Among Women, by Age, 1999-2020



Note: 2020 data is pre-pandemic (only goes through March).
Source: Yang et al., Menopausal Hormone Therapy Use Among Postmenopausal Women, JAMA Health Forum, 2024.

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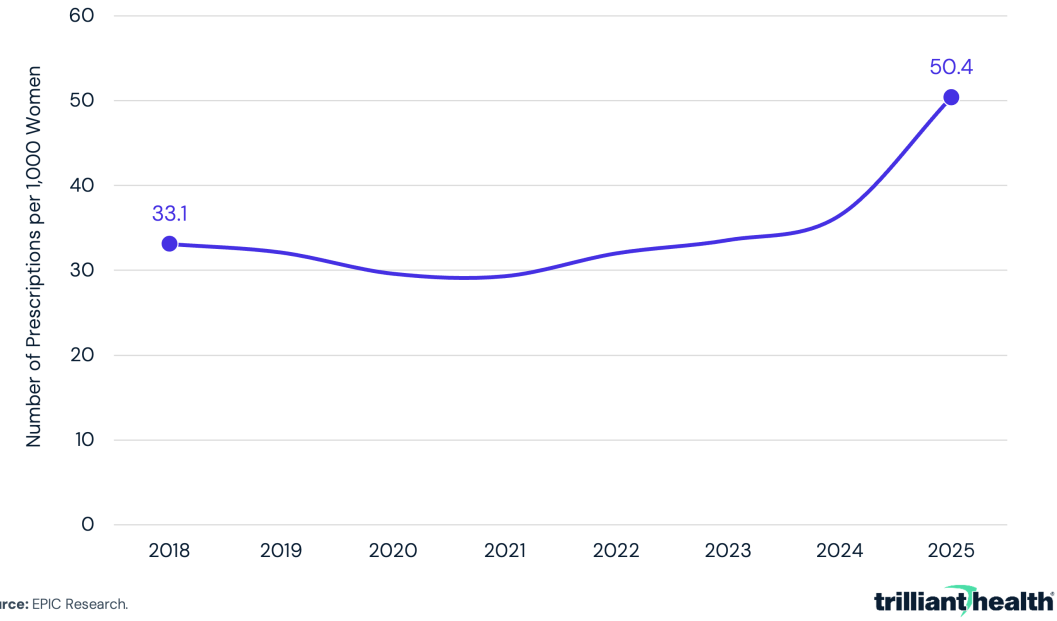
Subsequently, multiple studies published between 2004 and 2026 have challenged the methodology and generalizability of the 2002 findings, particularly the extrapolation of the results to younger postmenopausal women.[79,80,81,82,83] In November 2025, the FDA removed warning labels from estrogen patches – a formulation that carries distinct clinical advantages over alternatives, bypassing the liver and carrying a slightly lower risk of blood clots than oral estrogen and is less expensive than gels or sprays.[84,85] Following the label change, demand for estrogen patches increased substantially. By early 2026, estrogen patches were declared in shortage as uptake outpaced available inventory.[86]

HRT utilization among postmenopausal women ages 50 to 65 grew from 33.1 prescriptions per 1,000 women in 2018 to 50.4 in 2025, a 50.3% increase (Figure 16). However, utilization has not returned to pre-2002 levels. The persistent gap between current evidence and prescribing rates suggests that clinical practice has been slow to incorporate the methodological challenges of the 2002 findings.

FIGURE 16. Prescription Rate of Hormone Replacement Therapy Among Women Ages 50 to 65, 2018-2025



Source: EPIC Research.

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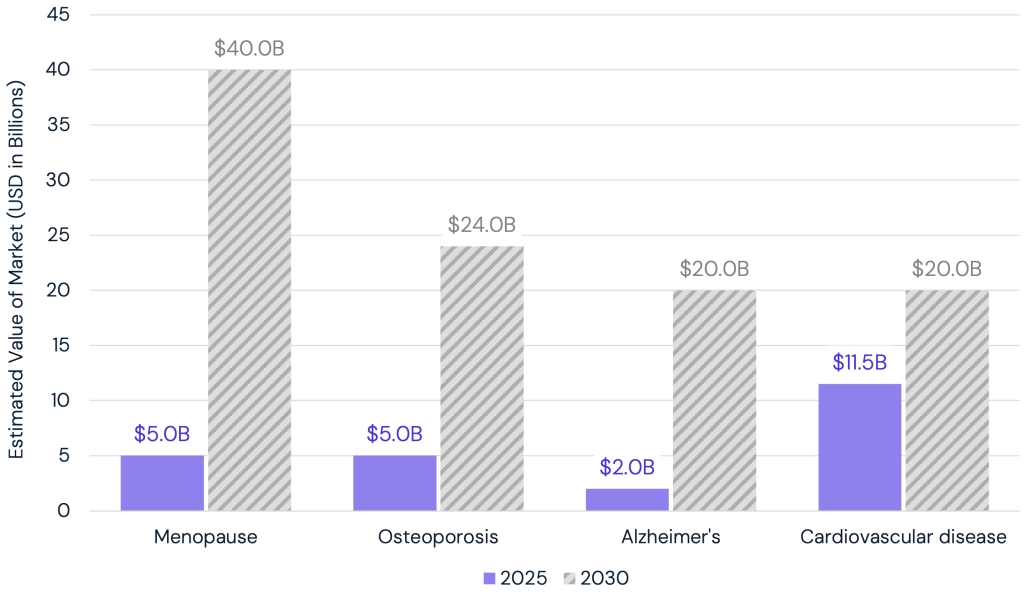
The scale of unmet need for menopause treatment remains significant. Roughly 80% of menopausal women report that it interferes with their daily lives, and one-third experience depression as part of the transition.[87,88] Menopause is also linked to premature departure from the workforce – a labor market consequence that extends the condition's impact well beyond the clinical setting.[89] Despite growing awareness and improving treatment options, the majority of symptomatic women still do not access care. Fewer than one in four women with menopause symptoms currently use any form of treatment.[90] The barriers – stigma, provider knowledge gaps and residual confusion around HRT safety – are well documented and largely addressable. The persistence of the treatment gap at this scale reflects not only scientific uncertainty but also the challenges systems face in translating existing evidence into timely action.

New care models are emerging to address this gap outside of traditional clinical settings. Companies like Oura, a smart ring manufacturer, and Midi Health, a virtual menopause clinic, have developed tech-driven platforms aimed at meeting the needs of women who are not accessing care through conventional providers.[91] These models reflect growing recognition that reaching symptomatic women will require delivery channels beyond the traditional office visit. The emergence of these companies reflects a broader market shift – as awareness of menopause as a treatable condition grows, investment in products and services targeting this population has expanded.

Analysts estimate that if all women with moderate to severe symptoms accessed appropriate care, the U.S. menopause market could grow 8x by 2030 – spanning pharmaceuticals, consumer products, telehealth and diagnostics (Figure 17).[92] Realizing this unmet demand relies on reimbursement policy, provider readiness and benefit design – not just commercial investment alone.

FIGURE 17. Projected Growth of Market Value Size of Products and Services for Common Women's Health Conditions, 2025-2030

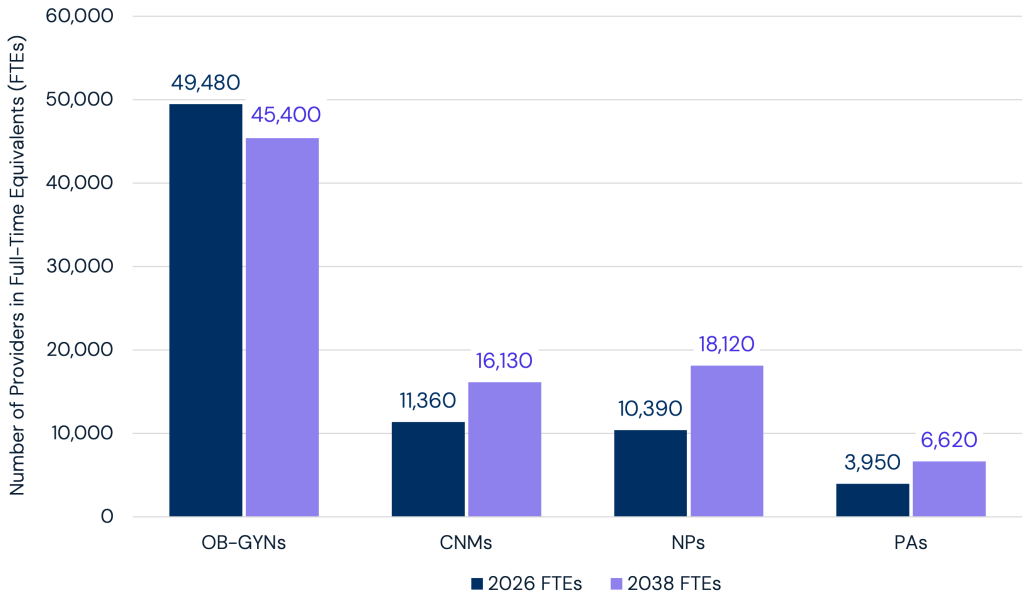


Source: Boston Consulting Group, 2025

Declining physician supply and labor and delivery closures are narrowing the availability of women's healthcare

As the U.S. is facing a maternal health crisis – characterized by rising mortality, racial disparities and outcomes well below peer nations – the supply of women's health providers and sites of care is shrinking. Women in rural areas and racial minorities are more likely to live in "maternity care deserts," counties without hospitals offering obstetric care and OB/GYN or certified nurse midwife (CNM) providers. Across the country, the supply of OB-GYNs is expected to decrease, and the National Center for Health Workforce Analysis (NCHWA) projects a shortage of 9,260 full-time equivalent (FTE) OB-GYNs by 2038 (Figure 18).[93]

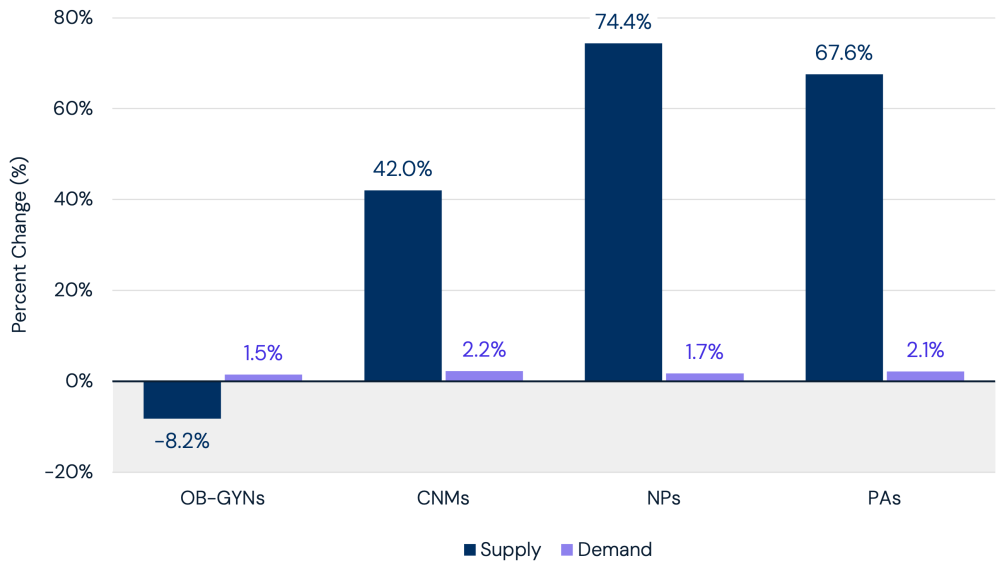
FIGURE 18. Current and Projected Number of Women's Health Providers, 2026 and 2038



Note: FTE denotes full-time equivalent and reflects the total number of hours worked by employees, CNM denotes certified nurse midwives, NP denotes nurse practitioner, PA denotes physician assistant. NPs and PAs are specific to women's health.
Source: U.S. Health Resources and Services Administration Workforce Projections.

Non-physician providers – including CNMs, nurse practitioners (NPs) and physician assistants (PAs) – are well-positioned to offset this shortage. Based on current utilization patterns and new entrants to the workforce, supply is projected to exceed demand by 2038 for these provider types. CNM supply is projected to grow by 42.0% by 2038, compared to 2.2% projected demand growth (Figure 19). Supply of women's health NPs is projected to grow by 74.4% and women's health PAs by 67.6%, while demand for each is projected to grow by only 1.7% and 2.1%, respectively.

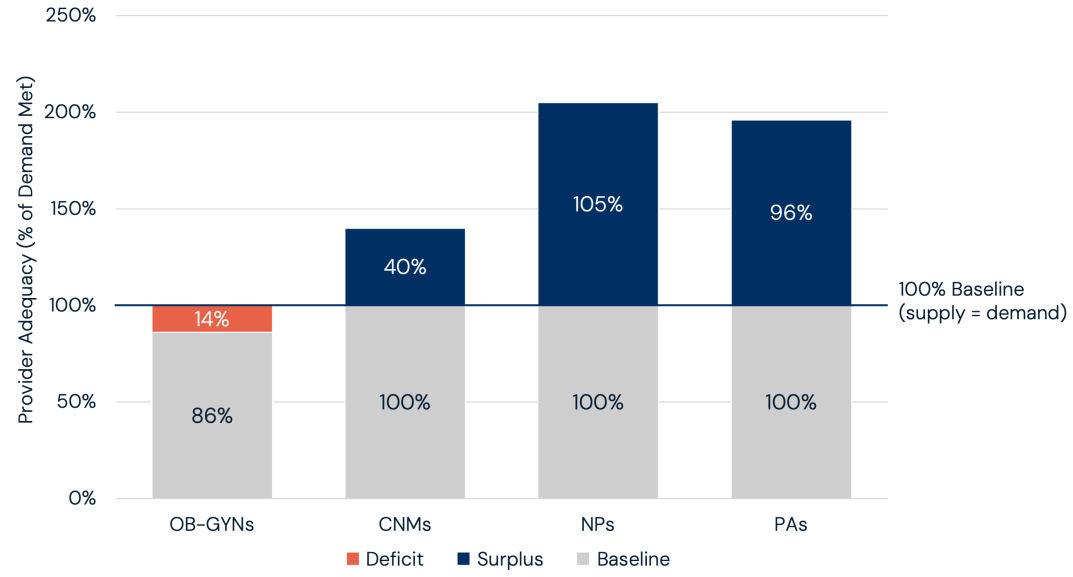
FIGURE 19. Percent Change in Projected Supply vs. Demand of Women's Health Providers, 2026 to 2038



Note: CNM denotes certified nurse midwives, NP denotes nurse practitioner, PA denotes physician assistant. NPs and PAs are specific to women's health.
Source: U.S. Health Resources and Services Administration Workforce Projections.

Based on these projections, non-physician women's health providers will significantly exceed demand, with NPs at 205% projected supply adequacy, PAs at 196% and CNMs at 140% by 2038 (Figure 20). However, regulatory barriers such as scope-of-practice laws may influence the presence of non-physician providers.[94,95]

FIGURE 20. Projected Supply Adequacy of Women's Health Providers, 2038

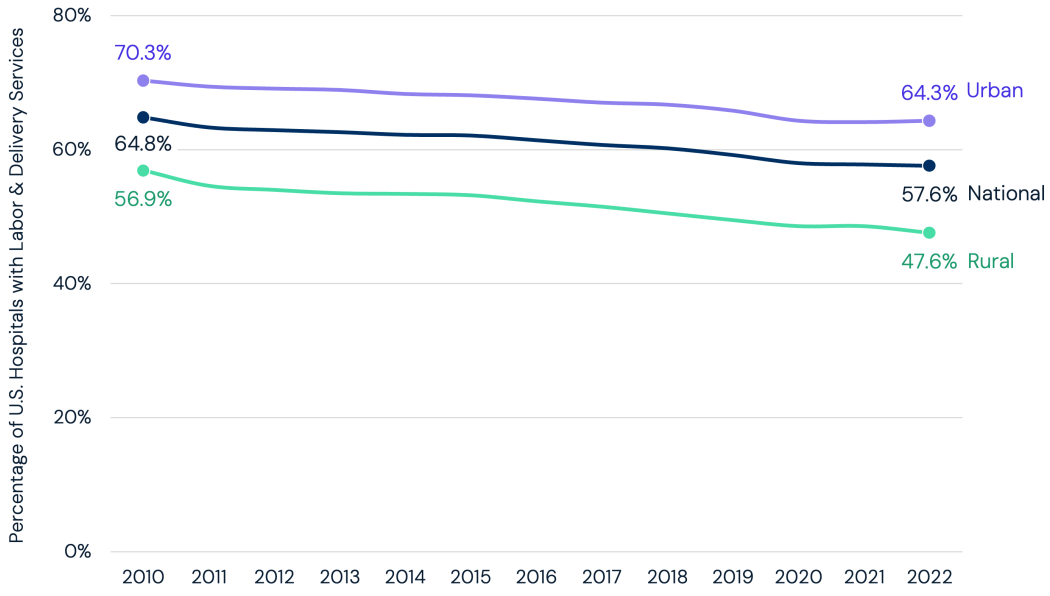


Note: CNM denotes certified nurse midwives, NP denotes nurse practitioner, PA denotes physician assistant. NPs and PAs are specific to women's health.
Source: U.S. Health Resources and Services Administration Workforce Projections.

Notably, provider supply adequacy varies widely by geography. The Northeast is projected to maintain an adequate number of OB-GYNs, while the West, Midwest and South are projected to face shortfalls.[96] Provider shortages are particularly acute in rural areas, where a 46% shortage is projected.[97] By 2038, states with the lowest projected adequacy of OB-GYNs include Utah (57.7%), Idaho (59.4%), Arizona (61.1%), Oklahoma (68.9%) and Iowa (68.9%), while Washington D.C. (200.0%), Vermont (137.5%), Hawaii (131.6%), Alaska (122.2%) and Rhode Island (122.2%) rank highest.[98]

Access to labor and delivery (L&D) services is worsening, particularly in rural areas. Between 2010 and 2022, the share of hospitals offering L&D services has declined in both urban and rural areas, by 6.0 and 9.3 percentage points, respectively. As of 2026, a majority (59%) of rural U.S. hospitals no longer provide L&D services.[99]

FIGURE 21. Percentage of U.S. Hospitals With Labor & Delivery Services, 2010-2022

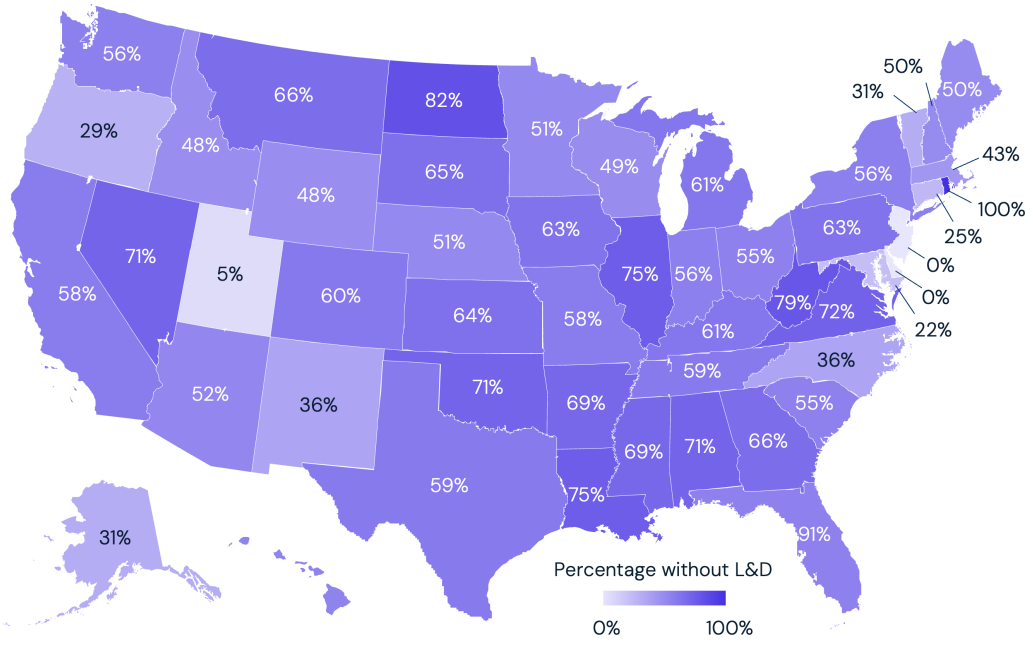


Source: Kozhimannil, et al, Obstetric Care Access at Rural and Urban Hospitals in the United States, JAMA Network Open, 2024.

Rural hospitals without L&D services are prevalent across several states, including 91% in Florida, 82% in North Dakota, and 79% in West Virginia. (Figure 22). At the same time, all rural hospitals in New Jersey and Delaware offer L&D services.

FIGURE 22. Percentage of Rural Hospitals Without Labor and Delivery Services, 2026

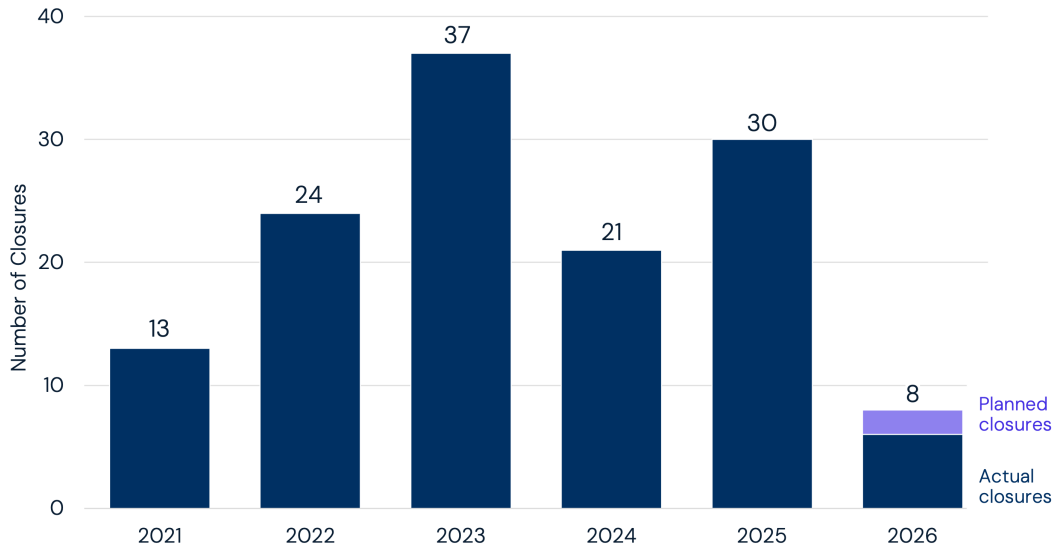
National: 59%



Note: Rhode Island has no rural hospitals.
Source: Stopping the Loss of Rural Maternity Care, Center for Healthcare Quality & Payment Reform, 2026.

There have been more than 100 L&D department closures between 2021 and 2026 (Figure 23). These closures have measurable impacts on access, and in turn, maternal health outcomes. In rural communities, average travel time to the nearest hospital providing L&D services is often 30-50 minutes or longer, compared to under 20 minutes in urban areas.[100] A 2020 study found that women living in maternity care deserts faced a significantly higher risk of pregnancy-associated mortality compared to those with better geographic access. However, the same study found that racial disparities in maternal mortality outweighed the risks from geography alone.[101] A lack of appropriate obstetric care increases maternal and fetal risk – and threatens to worsen the existing maternal mortality crisis.[102]

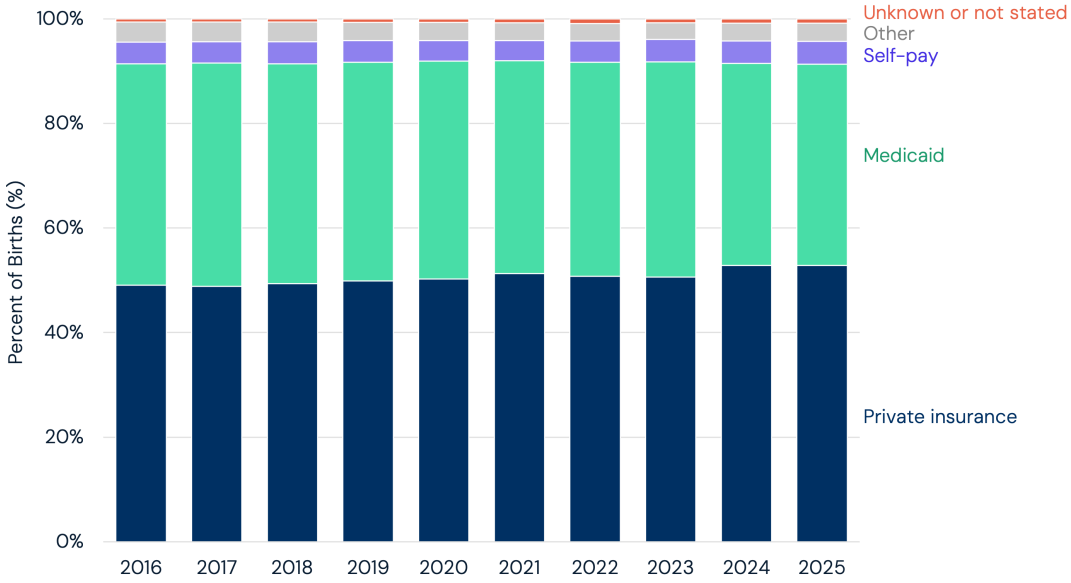
FIGURE 23. Closures of Labor and Delivery Units at Rural Hospitals, 2021-2026



Source: Stopping the Loss of Rural Maternity Care, Center for Healthcare Quality & Payment Reform, 2026

The high cost of maintaining L&D services, which require 24/7 coverage from physicians, nurses and anesthesiologists, is a major contributor to the increasing rate of unit closures.[103] Reimbursement consistently does not offset these costs regardless of payer, particularly for complex deliveries. Nationally, Medicaid covers approximately 40% of U.S. births, but inadequate private insurance payments also threaten maternity care viability – particularly in rural settings, where private health plans cover 40% of births (Figure 24).[104]

FIGURE 24. Distribution of Births, by Principal Source of Payment for Delivery in the U.S., 2016–2025



Note: 2025 data are provisional.
Source: Centers for Disease Control and Prevention WONDER Database.

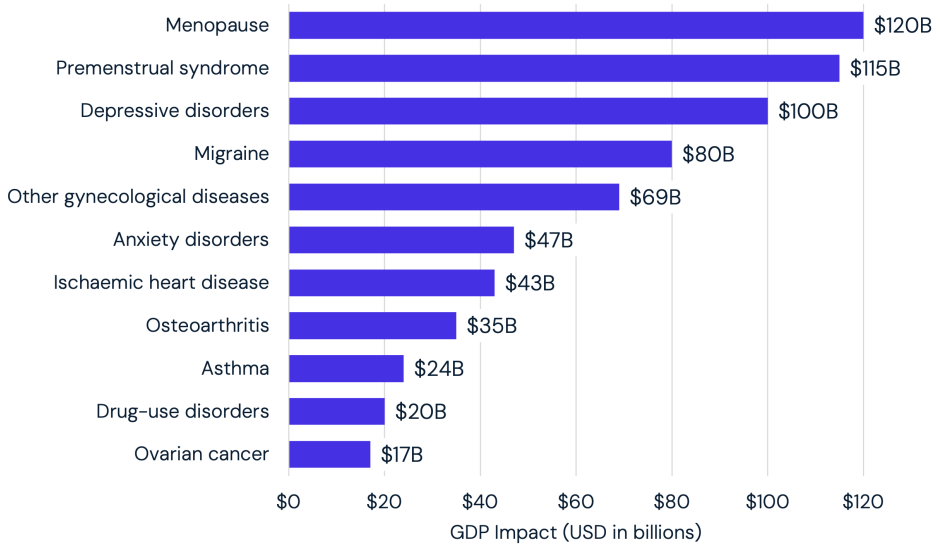
The financial pressure is most acute in rural settings, where rural hospitals already operate on thin margins, if any, and cannot offset maternity care losses through other service lines (i.e., emergency and surgical care). Rural hospitals often struggle to recruit enough qualified clinicians and staff – not only because of geographic challenges, but due to inadequate reimbursement. In the past two years, more than 130 rural hospitals offering L&D services have operated at a loss.[105] Without sufficient revenue to support safe and sustainable maternity care, many of these hospitals may be forced to close their L&D units entirely.

Commercialization and consumerization of care are reshaping access an incentives through direct-to-consumer platforms and private equity deals

A growing convergence of consumer demand, technological innovation and investor interest is reshaping the women's health market. Long viewed as a niche market, women's health is now is associated with substantial opportunities for commercialization – driven in part by the rising purchasing power of women, who make 80% of consumer decisions in the U.S. healthcare industry.[106] Private equity (PE) firms have taken particular interest, consolidating OB/GYN practices through a "buy-and-build" model that emphasizes regional scale and operational streamlining.[107] Between 2020 and 2023, there were at least 44 PE transactions in women's health, with deal activity dominated by a few major firms such as Atlas Partners, Shore Capital and BC Partners.[108]

The economic case for closing the women's health gap explains increasing PE investment. A 2024 analysis from the World Economic Forum found that improving women's health could generate approximately $400B in global GDP impact through reductions in disease burden alone – equivalent to avoiding 24M years lived with disability.[109] Globally, effectively addressing the top 10 conditions experienced by women, such as menopause and PMS, would represent more than 50% of the economic impact (Figure 25). Expanded workforce participation and increased productivity contribute an additional 20% of the total projected $400B in global GDP impact from closing the women's health gap, reflecting a well-established link between women's health outcomes and their economic participation.[110] Poor health drives both absenteeism and presenteeism – reducing productivity even when women remain employed.

FIGURE 25. Global GDP Impact of Closing the Women's Health Gap, by Condition



Note: Based on estimates, number of women aged 45–55 (excluding peri- and postmenopausal women), multiplied by the share of symptomatic cases (92%).
Source: World Economic Forum.

Employers have emerged as a key stakeholder in benefit design for women's health, particularly through fertility and menopause benefits – areas where benefit design has historically lagged clinical need and employee demand. In 2024, 37% of employers with 200 or more employees provided coverage for fertility medications.[111] Menopause benefits lag further behind – only 6% of employers of the same size offer menopause support benefits.[112]

The influx of investment has raised questions about quality of care, transparency and clinical outcomes. Critics argue that PE-backed providers may steer patients toward unnecessary services or prioritize care for more lucrative demographics.[113] PE-acquired OB/GYN offices in urban areas retained patients with household incomes 24% higher than the national average in 2017, raising questions about whether commercialized care models reach the populations with the greatest clinical need.[114] Two studies found that consolidation may also reduce provider availability if acquisitions lead to closures or service cuts – potentially shifting the balance of care in already underserved communities.[115,116]

Consumer-facing innovation has expanded access to care in areas historically underserved by traditional delivery models. DTC platforms, wearables and telehealth services have grown rapidly in women's health, particularly around menopause and fertility. Venture capital investment in "femtech" reached over $1B in 2022, yet investment has since declined – North American funding fell by nearly two-thirds between 2021 and 2023.[117] This contraction reflects broader challenges in translating clinical demand into sustainable business models, as seen in workforce reductions at high-profile platforms such as Maven Clinic and Tia.[118,119]

Conclusion

The seven trends documented in this analysis underscore how women's health research, financing, delivery and regulation are fundamentally misaligned with the scope and clinical need encompassing women's healthcare. Across nearly every metric (e.g., maternal mortality, menopause treatment, access to prenatal care, representation in clinical research), women are disproportionately underserved or are experiencing unfavorable outcomes, often more so for racial minorities. This misalignment creates pressure on demand – as average maternal age continues to increase, more women are utilizing fertility services, managing menopause-related symptoms and engaging with digital platforms that bypass traditional providers – signaling that existing care models may not be sufficient.

The maternal health crisis is one of the clearest indicators of this structural mismatch between supply and demand. Although births are declining, maternal mortality remains high and demand is growing for specialized obstetric care and fertility management. At the same time, access to obstetric care is shrinking, both in terms of individual providers and sites of care. More than half of rural hospitals no longer offer labor and delivery services, largely because reimbursement fails to cover the cost. Non-physician providers – CNMs, NPs and PAs – have the potential to extend capacity but remain underutilized due to regulatory barriers, such as scope-of-practice laws.

The narrow definition of women's health, however, compounds these gaps by systemically excluding large portions of women's health needs from research, investment and care delivery – making the resolution of these gaps difficult so long as the definition remains inadequate. Sexual and reproductive health account for just 5% of women's total health burden – yet this framing continues to determine how the system allocates research funding, clinical training and benefit design. This overemphasis, in turn, results in an underemphasis on and underdiagnosis of conditions that disproportionately affect women, including endometriosis, autoimmune disease and cardiovascular disease. This underdiagnosis is attributable in part to the gender pain gap that shapes how symptoms are perceived and triaged in clinical settings.

Underlying all of this is a research infrastructure that has deprioritized female biology. Female underrepresentation in clinical trials – where women account for only 42% of participants – the absence of sex-specific data in half of widely used interventions and a product safety record that has removed drugs for women's health risks at 3.5x the rate of men's are not coincidental outcomes – they reflect an assumption that male data is generalizable to female populations.[120,121] The consequences are exemplified by the estimated 40M to 45M disability-adjusted life years lost annually, and adverse drug events reported by women at rates 52% higher than men since 2000.[122] Addressing these gaps will require sex-specific data, paired with medical education reform, to prepare providers to recognize sex-specific disease presentations across the lifespan.

The HRT timeline encapsulates much of what ails women's health, characterized by two decades of clinical inaction resulting from inaccurate research, leaving tens of millions of symptomatic women without effective care. The recent FDA warning label removal and rising prescription uptake represent a correction, but the pace of that correction – spanning more than 20 years – reflects how slowly the system can often respond despite new evidence.[123]

For health systems, a service-line approach to women's health leaves significant gaps unaddressed. Women's health needs extend well into midlife and beyond – into menopause management, cardiovascular risk, autoimmune disease and mental health – yet most care models and capital investments are structured around expectant mothers. Longitudinal engagement that spans the continuum of women's health needs would reduce quality gaps and capture demand that is currently being absorbed by DTC platforms and consumer health products, whose very existence reflects an inadequate response from the traditional system.

For policymakers, nearly 8M women of reproductive age are uninsured, and several states continue to end Medicaid postpartum coverage at 60 days.[124,125] Targeted Medicaid expansion and extended postpartum coverage are the most direct levers available to improve women's health. Investments in workforce development for CNMs, women's health NPs and PAs – where supply is projected to exceed demand by 2038 nationally but remain critically short in rural and Southern markets – should be paired with scope-of-practice modernization and payment parity to direct that supply where it is needed most.[126]

For payers and employers, obvious changes to benefit design could improve women's health, some of which have equally obvious return on investment in terms of reduced absenteeism and presenteeism. Currently, only 37% of large employers cover fertility medications, 6% offer menopause support benefits.[127,128] Updating actuarial assumptions and benefit designs to reflect these gaps – and the productivity and workforce participation costs of leaving them unaddressed – is of clinical and financial importance.

Recent legislative proposals, such as the Supporting Healthy Moms and Babies Act, aim to strengthen maternity care access by requiring private insurers to cover prenatal, delivery and postpartum services without cost-sharing. Other developed countries have already introduced similar family-friendly policies. For example, Italy offers parental leave until a child turns 12, while Japan extended public insurance coverage for maternity expenses.[129] This reflects growing momentum to treat maternal health as essential infrastructure rather than an ancillary benefit.[130] At the same time, the defunding of women's health programs under the Trump administration – including the suspension of Title X funds and rollback of reproductive health data collection – highlights how policies can restrict access, destabilize safety-net services and weaken the evidence base needed for effective care.[131]

Women's health cannot be separated from broader healthcare system performance. The projected $400B in global GDP impact from closing the women's health gap is a measurable outcome – driven by more healthy women, fewer conditions requiring treatment, greater workforce participation and higher productivity.[132] Stakeholders who treat women's health as core infrastructure – investing in women-centered research, collecting sex- and ethnicity-specific data and building care models that span all of a woman's life stages – will be better positioned to meet future demand and improve population-level outcomes.