The opinions shared in this speech are the personal opinions of Dr. Rebekah Gee.

On December 4th 1975 I was born to a 20-year-old woman and her 17-year-old boyfriend who decided they were not ready to be parents. Three days after my birth I was adopted by my Mom and Dad – Gordon and Elizabeth Gee. I attribute most of the good fortune in my life to the decision they made to adopt me, and I also recognize and appreciate the brave and unselfish decision my birth parents made to offer me a better future, one that they could not provide.

As a result of my adoption, I have been blessed to grow up as the only child of a seven-time University President, a man who despite there being no "nature" between us, provided an abundance of "nurture" that shaped me to be very much like him.

My mother, an ethicist who died of breast cancer when I was sixteen, wrote letters to me before her death that I opened each year until my 30th birthday. The woman I came to know intimately as a child and young adult, and then further through these letters, greatly influenced my decision to become a physician and an advocate for women's health.

I grew up Mormon and am the great-great-granddaughter of a Mormon prophet. Some of my Mormon relatives have been disappointed by my pro women views and non-traditional ways. However as mother to identical, twin girls and a step-mother to three more children who include another set of twins—I certainly meet and exceed the Mormon standard for large families.

My role as a parent of five has enriched my life in immeasurable ways. Children bring wonder, imagination and joy to our lives. Parenting is humbling—and parenting is the most challenging and rewarding job I have.

I also serve as Secretary of Health for the state of Louisiana.

In that role I lead the largest state agency for Governor John Bel Edwards. My job is to oversee a 14 billion dollar budget and the "health and health care" for a state of 4.6 million people.

My department has many responsibilities which include medical evacuations and medical response in preparation for and in the wake of hurricanes and floods, paying for 2/3 of nursing home care, inspecting all the restaurants and food service establishments in the state, hospital licensing, running the Medicaid program, maternal and child health, ensuring safe drinking water, and running the mental health, disability services and aging and adult services programs.

Under Governor Edwards's leadership, we have expanded access to healthcare through Medicaid for nearly 500,000 people. We cover 70% of pregnancy care and almost the same percentage of kids. Over the past two years we have taken what were previously patches of care throughout the state and woven them into a patchwork quilt of nearly complete coverage. Most of the folks who gained coverage are women of reproductive age.

We have made great progress. Some of the numbers I am most proud of deal with the care that people have received.

As a result of the Medicaid expansion more than 33,000 women, many for the first time in their adult lives, have received mammograms.

Over 300 have been diagnosed with breast cancer.

Some of these women have had their cancer caught early enough so their families don't have to go through what my dad and I endured … losing a wife/mother too young and too soon.

The work of expanding coverage makes my heart feel good.

I believe in this important work we do every day for the people of Louisiana and I strongly believe that health care is a human right.

As the richest nation on earth, we should not be putting women in a position to choose between mammograms and meals.

But my job also comes with frustrations. Right now at the top of that list is the toxic political discourse that is holding our country back —the name calling, the efforts that those at the highest levels of government are making to encourage the public to distrust facts, disdain science, and dislike the pillars of government.

We struggle to engage in civil political discourse - to listen to and engage with people with differing political perspectives. This lack of cooperation leads to stagnation and mediocre solutions for big policy problems.

One of biggest problems is that we invest in "sick care" not in "health care." Louisiana invests $14 billion dollars—nearly half the state budget—in health care services.

But all this spending is not making us healthy. We remain 50th or 49th in many of the most important indicators on health.

These poor outcomes are because of a number of factors. First and foremost, they are because 1/5 of the people in our state and born into and live their lives in chronic, crippling poverty.

Instead of enacting policy change that would lead to better health by ensuing universal quality early childhood education, equal pay, increased minimum wage, safe housing and safe neighborhoods – we spend most of our health capital on payments for "health care services." Services such as knee arthroscopies, $80,000 dollar medication regimens such as those that can cure Hepatitis C, specialist and emergency room visits—the clinical interventions.

We spend our "health dollars" on these things even though one of my mentors, Mike McGinnis, would remind us that health care services represent only about 10% of health. The rest of our health status is grounded in our environment, our behaviors, our economic realities, our zip code and our genetic code – the so called epigenetics of our lives.

Despite being the most expensive health care system by far in the world —the U.S. gets a poor return on our investment because we underspend and under prioritize these key determinants of health that make up the other 90% of health.

Women live their lives in poor physical and mental health and then we hope to be able to make them healthy in nine or fewer months of pregnancy

Quality affordable childcare is virtually non-existent.

We build cities without thinking about the public infrastructure that is needed to sustain a healthy environment and promote physical activity.

We lack meaningful resources for connection and support for individuals who age

It is the Louisiana way to build fields of dreams --- we build jails and prisons, nursing homes and hospitals. Proton beams and fancy 3d x-ray machines.

We do these things despite the fact that—they don't deal with the underlying problems.

The opioid crisis has a lot to do with loneliness, social isolation and depression. Our lives are shorter because we eat more and more, and exercise less and less, not because of lack of medical technology.

Our unhealthy behaviors and our poor mental health – are why for the first time in American history our kids will be sicker than we are.

I often think about how we can shift and blend our public spend to align better with improving the quality of our lives – what really matters.

In Louisiana we are shifting focus—

We are moving dollars into permanent supportive housing and community health workers who can visit a home to see if a baby is sleeping safely and provide social supports.

I am not arguing that it is the job of the health department to pay for all the things that make families strong—

What I believe is that when we spend our public dollars on health care services to the exclusion of these social supports—we are being penny wise, pound foolish.

Nowhere are these gaps more evident than in our field of obstetrics and gynecology.

We practice medicine in the profound, intimate spaces that most matter to people's lives. Depending on how we specialize as Ob/Gyns we are there when people are born—we are there for women when they die—and we are there when people make decisions about whether they want to parent or not.

We see the loneliness, the isolation, the impact of Adverse Childhood Experiences, unsafe housing, and risky behaviors on the health of the women and families we serve.

Arguably one the most sacred of these spaces is the role that we play in providing family planning services. As an adopted person, policy maker, mother and practicing physician I find myself thinking more and more about what our roles and responsibilities as obstetricians and gynecologists both should be and can be to support true "family" planning.

Not just pregnancy planning.

What are we doing to plan for the 90% issue? If 90% of health is not health care—why do we spend nearly 100% of our preconception and obstetrical encounters on only "medical" stuff?

I believe the questions that I was asked during pregnancy mirror the experiences of most pregnant women.

I was asked about diet, weight gain, and fetal movement. Never once was I asked if I knew how to safely place my babies to sleep, or whether I had a safe place for them to sleep. I was not asked if I was in a violent relationship or if my 160 year old home was free of lead.

No one asked me if I needed any help getting ready to be a parent.

No one asked me if I could "handle" it if I had twins or triplets—if I could afford them, if I had housing to support them and so on.

Yet these social determinants might matter just as much or more to the outcome of my pregnancy than my medical care.

Every question I was asked was focused on the physiology of pregnancy not the physiology of a family.

In fact, I believe that none of the truly important life questions were asked of me during that time.

And no questions were asked of my husband.

Assumptions about my race, age and socioeconomic status I'm sure played a role in not being asked certain questions, but I believe most women, including women much more vulnerable than I, are also not asked these questions.

Prenatal care focuses on our bodies, but not on our lives.

One of the primary reasons I became an obstetrician/ gynecologist is because I like the substrate of people's lives. And I like focusing on things that matter. Arguably nothing is more important in our lives than our families and the decisions we make around them.

However, rarely in the course of our conversations with women do we actually discuss their readiness to parent or their connection to people and resources necessary to care for themselves and their children.

The family planning movement should really be called "pregnancy planning" since the focus is on pregnancy rather parenthood and care for the whole person, whole family.

Just as similarly, the "pro-life" movement should be called "pro- birth" as the consistent viewpoint of folks who believe strongly in that movement focuses on the unborn child --- with great disagreement about the role of society in caring for the "born" ones.

The pro-life movement should instead be about "life" not just birth. Family planning should be about families- not just pregnancy. If both movements focused on the broader picture – there would be a lot more to talk about and a lot more to build on from a policy perspective.

As a practicing Obstetrician/Gynecologist my job is to take care of women- and because I feel my job is to support a women through whatever tough decisions she is making—like most Obstetrician/Gynecologists I am compelled to be "pro-choice."

But as a policy maker responsible for the health of a state of 4.6 million people I am "pro-family"

I believe that we need to get beyond the "pro-life, pro-choice" narrative of "to be born or not to be born… that is the question" and instead broaden our focus to better understand the lives of the individuals we care for and how best to support them in their decisions, which can mean playing a role in strengthening the family structures they are creating.

Broadening our role means that we will start to address the 90%-- the social determinants that actually make people healthy.

Beyond asking whether someone wants to be pregnant or not, we need to also be asking about readiness to be a parent and readiness to care for a baby in ways that empower women to be ready.

It means broadening our focus as clinicians to incorporate other aspects of a woman's life –

Create spaces for conversations about safety, economic stability, education, mental health, and neighborhood environment, while at the same time being respectful of ***her*** wishes.

Whole-person care doesn't mean we take on the work of providing for all the needs in women's lives, but we as clinicians along with our clinical teams can provide a significant level of social support during a critical moment in women's lives and in the development of their family supports and structure.

One of the reasons I think adoptions are so rare now is because we wait until the end of pregnancy to have these discussions, or we don't have these discussions at all. We assume once someone is coming to us for care that they want to parent, that they are ready to parent, when that absolutely may not be the case.

We need to ask ourselves, do we have the right team of people in our practices and partnerships to care for the whole person? What are we doing to truly be pro "Family?"

Should every woman have a social work visit prior to pregnancy?

Should every brand new parent be offered training or at least have a conversation focused on safe-sleep, breastfeeding and diapering?

Should every new mother have a home visit to help screen for violence, unsafe housing, environmental exposures, and food security?

Sometimes our profession assumes the pediatrician is taking care of these things. But sometimes the pediatrician is too late – babies die every day because parents have no idea how to care for them and **moms die too**—at increasing and alarming rates in our country, due to missed opportunities to identify risk.

How do we change our pregnancy checklists and clinical pathways to recognize the whole person?

When my birth mother was pregnant back in 1975, times were different. At that it was more the norm to give babies to other families who could take better care of them.

Being adopted by my parents was one of the greatest blessings of my life. When I grew up I was told that adopted babies are the most special of all—because they know they were really, really wanted – and really really loved. And that's how I felt.

I was lucky.

Both my birth parents and my mom and Dad were members of the Mormon Church. Both sets of my parents had access to advice on adoption and a social structure that supported adoption.

I now know that both my birth parents and my mom and dad were supported during the adoption process and my parents were screened to make sure they had all the tools they needed to parent. Some of these conversations happened long before I was born.

My parents waited over three years to get the call that a baby was waiting for them.

After my Dad got "the call" from the agency—he got in his car and drove to my mom's master's degree class at BYU to tell the class that "his wife just had a baby." They were giddy and they were nervous but they were ready.

What if all families were ready? That would be true Family Planning.