Women's Health Policy

Issue

Health care is a major issue for women. Their greater health needs, longer lifespans, lower incomes, roles in their family's health as mothers and caregivers, and reproductive health needs make their relationship with the health care system complex. Historically, reproductive health issues have dominated election campaigns' attention to women's health policy, with abortion taking center stage. However, women's health policy intersects with a far wider span of health policies, including private sector cost containment, expansions and reforms of public programs, family-friendly workplace policies, long-term care financing, access to safe and comprehensive reproductive health care services, and medical research priorities.

Background

Women interact in the health care system, as patients, mothers, caregivers, and health care providers. They have more frequent doctor visits, higher use of prescription medicines, and greater need for long-term care services than men. In addition to their own health needs, women also take on primary responsibility for managing health care for their children as well as caregiving for other chronically ill or elderly family members.

Despite great strides in the workplace and workforce participation, women still earn a fraction of men's salaries – median income levels are 45 percent lower for women than men.[1] As a result, nearly 41 million women are low-income.[2] As health care costs outpace inflation and the costs of health care are increasingly shouldered by individuals, women's lower incomes put them at a greater disadvantage. Many women in the workplace also face a tremendous challenge balancing their work and family responsibilities with their own health care needs. As the primary managers of their family's health care needs, workplace supports such as flex-time, family health coverage, and paid family leave can help assist women manage the different facets of their health care.

For many women, however, accessing health care is a challenge. One-quarter of women (27%) report that they have had to delay or forgo needed care, one in five (21%) could not afford to fill a prescription medicine, and 15 percent report that they could not obtain needed specialty care.[3] For the nearly 17 million women who are uninsured, access to high quality, comprehensive care is even more compromised.[4] There are also issues with regard to access to reproductive health services. There are broad differences from state to state in what services insurance plans must cover such as contraception, screenings, and preventive care, as well as limits on access to and coverage for abortion services. On the federal level, funding for family planning services under Title X has not kept up with inflation and international assistance for family planning has been severely curtailed.

Major Health Policy Issues of Importance to Women

Reproductive Health

Women's health policy has long been associated with reproductive health care. In previous campaign cycles, abortion has often dominated discourse about reproductive health and has emerged as a highly charged political issue. However, reproductive health policy extends far beyond abortion services, and includes other critical concerns such as family planning, coverage for pregnancy and maternity care, and sex education.

One area in which policy activity has flourished in recent years, primarily at the state level, is insurance coverage for contraceptives. It has been estimated that a typical woman who wants to have two children

will need to use contraception for at least 20 years.[5] However, insurance coverage for contraceptives lags behind coverage for many other basic benefits such as maternity care and other prescription drugs. As of September 2004, twenty-one states now require private health insurance plans to cover prescription contraceptives if they cover other prescription drugs[6]; however, the 54 percent of workers who are in self-funded plans are not affected by these laws.[7] Federal legislation has been proposed but not passed.

For low-income women, public financing of family planning services through the Title X and Medicaid programs provides both access to contraception and important primary care. However, Title X funding has not kept pace with inflation, potentially constraining access to family planning services for low-income women.

Sex education is another area affecting young women that has been squarely at the center of a highly polarized policy debate. The current Administration has shown strong support for abstinence-only programs that teach abstinence until marriage and prohibit programs that operate under federal funds from teaching about contraceptives and condoms. Federal funding for abstinence-only sex education has more than tripled since 2001.[8] Opponents of the abstinence-only policy argue for promoting comprehensive sex education, which teaches about abstinence as well as contraception and prevention of STDs. Supporters of abstinence-only programs argue that this sends mixed signals to students and that abstaining from sex is the only way young people can be protected from unplanned pregnancies and STDs.

Abortion remains the most highly regulated women's medical service. At the federal and state levels, strategies have been increasingly adopted to limit access to abortion. These include federal and state laws banning so-called "partial birth" abortions, parental consent and waiting laws, refusal clauses that exempt health care providers from performing abortions, and the appointment of judges who are opposed to abortion. Abortion rights proponents would seek to ease some of these barriers and facilitate access to abortion services as well as access to family planning services. Opponents of abortion rights would endorse policies that further limit access to abortion services.

Reproductive health is one of the areas where the policy positions differ most clearly. Some proposals (generally Democrats') emphasize broadening access to family planning by requiring insurers to cover contraceptives, increasing Title X funding, reversing current restrictions on international funding to family planning agencies and appointing judges committed to upholding Roe v. Wade. Others (generally Republicans) would focus on further increasing funding for abstinence-only education and upholding and promoting laws that require parent consent for minors and place limits on federal funding for abortion in the U.S. and abroad.

Improving Insurance Coverage and Affordability of Care

Like men, almost two-thirds of women receive their health insurance through employers.[9] With premiums rising at double-digit rates for the last four years, workers have increasingly had to make larger contributions toward escalating premiums yet without receiving comparable growth in salaries. Furthermore, the majority of workers with employer-based insurance face deductibles and/or copayments when they need health care services.[10] These are important concerns for women, because they are more likely to need health care services throughout their lives, yet have lower incomes and thus are less able to afford additional out-of-pocket expenses.

Some policymakers are looking to the individual insurance market as a possible avenue for expanding coverage to the uninsured. However, moving to greater dependence on this market also poses challenges for women. Although the premium costs for these plans vary and are sometimes quite low, the actual costs of these policies can be quite expensive including very high deductibles and large co-insurance charges. Individually purchased policies are also often limited by exclusions for prior health conditions or require special riders at additional costs for maternity care.

Medicaid, the nation's health and long-term care coverage program for the poor, today assists nearly one in ten women. Women make up nearly three-quarters of adult beneficiaries covered by the program. Historically, Medicaid has provided several benefits of particular importance to women, including covering

one-third of all births in the U.S., financing over half of nursing home care, and covering a broad range of preventive and screening services. Starting in the late 1980's, Medicaid was used as a vehicle to extend coverage to many low-income children, pregnant women, and working parents. More recently, these expansions have been curtailed and benefits reduced in response to the fiscal crisis facing most of the states. Choices about the future of the program – who will continue to be covered, what will be covered, as well as how care will be financed – have important consequences for the nation's 41 million low-income women and their families.

The future of Medicare is also a priority for women over age 65. Given their longer lifespans, women comprise the majority (57%) of Medicare beneficiaries, rising to 80 percent of the Medicare population over 85 years. Given their disproportionately lower-incomes (55% of women over 65 have incomes below 200% of the federal poverty level compared to 35% of men), the costs of Medicare premiums, deductibles and coinsurance as well as the affordability of medications are major concerns facing many women in their senior years.[11] The future of Medicare will continue to be a central issue for the nation's elderly women in the years to come.

With almost 17 million women uninsured, expanding health coverage to the nation's 45 million uninsured is a policy priority for women. Some proposals would use a mix of public and private sector approaches, expanding public coverage under Medicaid and SCHIP to more of the nation's low-income families and using various strategies to reduce costs so that more workers will be covered by their employers. Other major proposals aim to make individual health insurance plans more affordable to more people by subsidizing premium costs.

Balancing Work and Family Health Care Needs

Women take charge of nearly 90 percent of health care responsibilities for their children, including selecting their doctor, taking them to appointments, and choosing their health plans. However, for working mothers, this often presents challenges with their workplace responsibilities. Half of working mothers have to miss work when their child is sick, resulting in fears about job security and career advancement as well as tangible financial consequences. Half of working mothers do not get paid when they miss work to care for their sick children.[12]

Women are also the major providers of informal caregiving for family members with disabling conditions, such as aging parents or spouses. These women shoulder heavy health care responsibilities, on top of their own health, family, and workplace responsibilities. There is often little in the way of physical or psychological supports for these women.

Comprehensive workplace benefits and supports, such as paid family leave, are particularly important for women. In 2003, California became the first state to enact a paid family leave benefit, and while federal legislation was introduced earlier this year, it has not been a major issue in this year's election.

Long-Term Care

Long-term care is an under-recognized women's health policy issue. Two-thirds of people who receive home health services (67%) and three-quarters of nursing home residents (75%) are women.[13] A year of care in a nursing home can cost $50,000 or more. Hiring a home health aide at $12 an hour for four hours a day, five days a week would cost over $12,000 for a year. However, most employer-sponsored health insurance plans do not cover long-term care and neither does Medicare, a particularly large gap for many seniors. Stand-alone long-term care insurance is expensive and cost prohibitive for many seniors. This leaves Medicaid as the major payer for long-term care services, but only for those seniors who are very poor or who have impoverished themselves with large health expenses. As the population ages, the need for policy solutions that address the cost of long-term will become more acute.

Clinical Research

Research has shown that many diseases and conditions, including heart disease, smoking, and lung cancer, affect women and men very differently.[14] There are also several diseases, such as breast cancer

and osteoporosis, that primarily affect women, and another range of conditions, including pregnancy, menopause, and certain reproductive-related cancers that only affect women. Sex-based differences have been identified on several levels, including treatment efficacy, medication side effects, prevention strategies, and disease etiology.

Today, there are dedicated clinical trials investigating women's health, such as the NIH's Women's Health Initiative, and NIH policy requires that women be included in all federally funded clinical trials. Yet, there are still large gaps in knowledge about the effects of sex on many diseases and treatments. The amount of funding earmarked for women-specific research and for understanding the sex differences in the diseases that strike men and women have not been detailed by either candidate.

Assessing Candidate Positions

Health care has historically been an issue of particular significance to women. In a recent survey, women were more likely than men to report that health care will be one of the most important issues in determining their choice for president in the 2004 election.[15] However, it is important to understand that women's health is not defined by any single issue. Women have much at stake in a host of larger health care debates, and the importance they place on health care as a voting issue reflects the influence of larger health policy matters on their own and their families' health.

The following questions could be useful in understanding how the candidates propose to address some of the major areas of health policy affecting women.

- How can the government help improve women's access to health care?
- What policies should be in place with regard to access to women's reproductive health services?
- How should the federal government address the rise in health care costs? How can policies help ease the burden of shifting costs to consumers, such as higher premiums, deductibles, and co-pays?
- Should Congress pass federal legislation that requires health plans to cover contraceptives and other preventive services for women?
- What strategies can be used to ease some of the tensions women face in caring for their families while meeting their workplace responsibilities? Should the government enact legislation for paid family leave?
- What proposals would help improve health care access for low-income women and their families?
- What can be done to assist seniors and families with long-term care costs?
- What policies can be put in place to ensure that sufficient federal dollars are allocated to support health research of importance for women?

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[1] U.S. Census Bureau, March 2003 Current Population Survey.
[2] Low-income is defined as family incomes below 200% of poverty, which was equivalent to $30,520 for a family of three in 2003.
[3] Kaiser Family Foundation, *Kaiser Women's Health Survey, 2001*.
[4] Kaiser Family Foundation, analysis of Urban Institute estimates from March 2004 Current Population Survey.
[5] Alan Guttmacher Institute, *Contraceptive Use Factsheet*, www.guttmacher.org.
[6] Alan Guttmacher Institute, *State Policies in Brief: Insurance Coverage of Contraceptives*, September 1, 2004.
[7] Kaiser/HRET *Employer Health Benefits Survey*: 2004.
[8] Bush-Cheney campaign, *Agenda for America*, www.georgebush.com.
[9] Kaiser Family Foundation analysis of Urban Institute estimates from March 2004 Current Population Survey.
[10] Kaiser/HRET, *Employer Health Benefits Survey: 2004*.
[11] Kaiser Family Foundation analysis of Urban Institute estimates from March 2004 Current Population Survey.
[12] Kaiser Family Foundation, *Kaiser Women's Health Survey, 2001*.
[13] *Health, United States, 2000*. Nursing home data from the 1997 National Nursing Home Survey. Home health data from the 1996 National Home and Hospice Care Survey.
[14] Institute of Medicine, *Exploring the Biological Contributions to Human Health: Does Sex Matter?* 2001.
[15] Kaiser Family Foundation, *Health Poll*, June 2004.

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