Women’s health issues emerging as key public policy priorities in several states

by Laura A. Tomaka

Traditionally, women’s health issues have focused on those needs related to childbirth and reproductive health. Research, however, has revealed that disease affects men and women differently, and women are now regarded as a distinct patient group.

As a result, women’s health issues have come to encompass a broader range of concerns, including the effects and incidence levels of breast cancer, cervical and ovarian cancer, osteoporosis, depression, heart disease, stroke and domestic abuse.

And just as gender-based research has revealed the unique health needs of women, it also has revealed gender-based inequities in obtaining and paying for medical services.

Furthermore, research also has shown that the status of women’s health varies significantly by state.

Because health factors differ greatly from place to place, state policymakers are in a position to address the issues that most affect the female population living within their borders and to develop specific strategies for promoting women’s health. In doing so, states have adopted a number of approaches in an attempt to address the needs of women.

Recent state policy efforts include closing the gaps in health insurance coverage; helping women, especially low-income individuals, obtain early detection screening; mandating coverage of health services such as Pap tests, mammography and contraceptives; and educating women about the health conditions and behaviors that put them at risk.

The goal of these policies is not only to make health care services accessible and affordable, but also to educate and empower women by providing the knowledge and means to recognize and address the health issues that have the greatest impact on their well-being.
In 1991, Congress established the National Breast and Cervical Cancer Early Detection Program to provide low-income women with more access to cancer screening services. Nearly a decade later, President Bill Clinton signed the Breast and Cervical Treatment Act of 2000, which gives states the option of providing Medicaid to women with breast and cervical cancer. The new law is an important step in bridging the gap in existing benefits for low-income women and helping move those in need from mere diagnosis to treatment.

Across the nation, more than 20 states are debating measures to extend Medicaid benefits under the 2000 federal act. Several of these are in the Midwest. However, because state budgets in general, and Medicaid budgets in particular, are showing signs of being strapped, making money available to fund such measures may be the toughest barrier to implementation.

A bill proposed in the Nebraska Unicameral would provide payments for eligible women to receive breast and cervical cancer treatment. The program would reach women who lack other medical coverage, have not yet reached 65 years of age, and would not otherwise be eligible for Medicaid.

The House chambers in both Indiana and North Dakota have approved bills to provide assistance, through Medicaid coverage, to eligible women found to need treatment under the federal Breast and Cervical Cancer Prevention Treatment Act of 2000. Elsewhere in the Midwest, lawmakers have introduced bills relating to the federal law in Illinois, Kansas, Iowa and Minnesota.

In addition to expanding treatment services for breast and cervical cancer, some states have taken steps to bridge other gaps in medical coverage. Nebraska lawmakers voted last year to offer insurance coverage for women undergoing reconstructive breast surgery. Last month, North Dakota Gov. John Hoeven signed into law a bill that will provide similar coverage for women in his state.

During the last session, legislators in Michigan introduced several bills that would have required insurers to permit a minimum 48-hour hospital stay for women having undergone a mastectomy or lymph node dissection. None was successful. This session, another such bill is under consideration.

Some Kansas legislators are hoping to increase a woman’s control over choices made regarding her medical service. Currently, the House and Senate are reviewing bills that would require insurers to allow a woman to visit an obstetrician or gynecologist at least once a year without first receiving a referral from her primary care physician.

Access to treatment and to health care providers is not the only constraint women experience in making

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**QUICK FACTS**

The leading cause of death for American women over age 35 is heart disease. For women ages 25 to 44, the No. 1 cause of death is cancer.

One of every three women will die of heart disease or a heart attack. In 2000, nearly 200,000 women died from cardiovascular disease, about 50,000 more than men.

In the past 15 years, men’s death rates due to cardiovascular disease have declined; women’s cardiovascular disease death rates have not.

Female heart attack victims under the age of 50 are more likely to die than men of the same age.

One of every eight American women will develop breast cancer. In 1998, 41,737 women died from breast cancer.

Eighty percent of Americans afflicted with osteoporosis are women. Fifty percent of postmenopausal women with osteoporosis will suffer a bone fracture.

The leading cause of injury to women ages 15 to 44 is domestic violence, with more victims than car crashes, muggings and rape combined.

Twenty-five percent of American women experience clinical depression, while only 20 percent of them receive treatment.

_Sources: Society for Women’s Health Research, Center for Disease Control’s National Center for Health Statistics and National Women’s Health Information Center_
veto, however, has hampered funding of the project. In 1999, the Indiana Legislature passed a bill giving the state’s Office of Women’s Health statutory permanence. Last year, the office announced the availability of $350,000 in grant money to assist community efforts on women’s health education and awareness.

The Michigan Department of Community Health is leading a statewide effort to promote women’s health through a campaign targeting concerns such as breast cancer, osteoporosis and the risks associated with smoking.

Wisconsin lawmakers are currently considering a resolution to support a statewide women’s health platform with the goal of eliminating “inequities in health prevention and treatment of women,” including the extension of insurance coverage for women and access to screening and treatment programs.

In February, North Dakota House members passed a resolution directing the state’s Legislative Council to conduct an interim study on the “feasibility and desirability of creating” a Division of Women’s Health within the Department of Health, as well as a state Advisory Committee on Women’s Health. If approved by the Senate, the study’s findings will be reported for the 2003 legislative session, along with any legislation required to implement recommendations.

Laura A. Tomaka is a program manager for CSG Midwest.
### Key causes of death for women (per 100,000)
(Number in parentheses indicate national rank)

<table>
<thead>
<tr>
<th>State</th>
<th>Heart disease</th>
<th>Stroke</th>
<th>Lung cancer</th>
<th>Breast cancer</th>
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<tr>
<td>Illinois</td>
<td>103.9 (33)</td>
<td>25.0 (30)</td>
<td>27.7 (29)</td>
<td>22.1 (46)</td>
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<tr>
<td>Indiana</td>
<td>104.4 (34)</td>
<td>27.6 (40)</td>
<td>30.1 (42)</td>
<td>20.5 (35)</td>
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<td>Iowa</td>
<td>86.0 (19)</td>
<td>22.7 (16)</td>
<td>24.4 (12)</td>
<td>18.6 (13)</td>
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<td>Kansas</td>
<td>84.5 (17)</td>
<td>23.8 (24)</td>
<td>25.2 (16)</td>
<td>18.4 (9)</td>
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<td>Michigan</td>
<td>106.9 (38)</td>
<td>25.2 (32)</td>
<td>28.3 (31)</td>
<td>20.7 (37)</td>
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<tr>
<td>Minnesota</td>
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<td>23.0 (19)</td>
<td>23.5 (10)</td>
<td>19.3 (19)</td>
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<tr>
<td>Nebraska</td>
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<td>22.1 (10)</td>
<td>22.1 (8)</td>
<td>18.8 (16)</td>
</tr>
<tr>
<td>North Dakota</td>
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<td>22.6 (14)</td>
<td>21.6 (7)</td>
<td>17.9 (8)</td>
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<tr>
<td>Ohio</td>
<td>107.9 (39)</td>
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<td>21.2 (42)</td>
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<tr>
<td>South Dakota</td>
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<td>19.5 (4)</td>
<td>16.9 (4)</td>
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<tr>
<td>Wisconsin</td>
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<td>24.6 (28)</td>
<td>23.5 (10)</td>
<td>18.4 (9)</td>
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<tr>
<td>United States</td>
<td>98.0</td>
<td>24.5</td>
<td>26.9</td>
<td>20.2</td>
</tr>
</tbody>
</table>

Source: “Making the Grade on Women’s Health,” National Women’s Law Center

### Source Guide

For more information on women’s health issues and related legislation:

- Center for Women Policy Studies
  www.centerwomenpolicy.org
- Jacob’s Institute of Women’s Health
  www.jiwh.org
- National Association for Women’s Health
  www.nawh.org
- National Women’s Law Center
  www.nwlc.org
- Office on Women’s Health, U.S. Department of Health and Human Services
  www.4woman.gov
- Women’s Health Project
  www.whealth.org
- Women’s Policy Inc.
  www.womenspolicy.org