

WOMEN'S HEALTH

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WOMEN'S HEALTH

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

July 19, 1993

REMARKS BY THE FIRST LADY
AT THE IRIS CANTOR CENTER FOR BREAST IMAGING

University of California at Los Angeles
Los Angeles, California

MRS. CLINTON: Thank you so much for this extraordinary honor and for the opportunity to be with you today. I have looked forward to this occasion greatly, and it is a special privilege to have had a chance to participate in this extraordinary event.

The morning, for me, started out at the Charles Drew University for Medicine and Science, which, Chancellor Young has explained to me, is something that UCLA is also very proud of having been involved with, and there I saw firsthand many of the people who will be, in the future, providing health care to Americans.

I was very encouraged by the dedication and commitment that they demonstrated, because they share the goal that all of us share together, and that is, improving health care for Americans, but particularly for improving health care for American women.

This is a goal that Iris Cantor has been moving toward, and for which we are all grateful that she has. To have an award with her name attached to it is very special for me, because I know her as a champion of the arts and a champion of education and a champion of health, particularly breast cancer research and treatment.

She reminds all of us of what one can do when one puts one's mind and resources and dedication to the task of trying to make a difference, and a difference has truly been made here at the Iris Cantor Center. Just six years ago, as we saw from the video, this was a dream that arose out of Iris' own personal tragedy, with the death of her sister. Today, we can look around us and go far beyond just the short video that we were able to see, and we can know that today the center is in the process of giving evaluations and mammography screenings to 700 women each month.

We can applaud the pioneering work of physicians like Dr. Susan Love, whom you saw on that video, and whom I had the

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pleasure of meeting for the first time some months ago when I attended a gathering of breast cancer survivors and physicians and researchers to be brought up to date about what was happening in the area of breast cancer treatment and research, and learned for the first time of the work of Dr. Love.

We have heard from Dr. Bassett, and the accolades given to him are so well-deserved for the leadership that he has shown in an area that, very frankly, has been far too neglected until recently.

There are many others who serve with Dr. Love and Dr. Bassett, who have pioneered the use of core biopsies instead of surgical biopsies, and have done so much to move forward what we now know about breast cancer -- research into silicone implant leakage, the education of physicians through special one-year fellowships, and, particularly, the outreach programs we saw illustrated on the video for underserved women throughout Los Angeles.

Importantly to all of us, no matter whether we have come here -- as I have met some of you -- from New York or as far away as London and Australia, the standards that have been set for quality management of mammography here at this Center are really setting the curve.

Every woman in America and, indeed, in the world, owes this center a debt of gratitude because the mammography that she receives will be better because of what the Iris Cantor Center has been able to do. (Applause)

What I would like to do for a few minutes this afternoon is to put into context what this center has been doing, is doing, and will continue to do, and to talk about how it and the work it is doing on behalf of women will help to guide what we intend to achieve with respect to health care reform.

But let's start with some unpleasant reality. The health of American women should be better than it is. For too long, women have not had their health needs met with the same attention that the health needs of men have received. We have been on the medical and scientific sidelines. For too many years, when we watched our symptoms, our illnesses, our need for treatments increase, there has not been the corresponding response.

It is ironic that women historically have been relegated to the margins of the health care system. After all, we often are the primary care-givers for our children, for our aging parents, and yet we have not benefitted often from the kind of care and treatment we need most. Today, women are finally on the radar screen when it

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comes to research and treatment. We are speaking up. We are being heard. But we have to understand how far we have yet to travel in order to achieve the kinds of advances that the Iris Cantor Center are working toward every day.

It is truly up to us to create a new and healthier culture in our country, a culture in which we promote good health from the outset instead of spending lots of time, money, and energy to treat diseases that could be prevented. Women have a special responsibility, as we are now finding our voices in health care, to be the advocates for that kind of emphasis on primary and preventive care.

Those of you in this room who support this center are examples of the kind of concern and dedication I am talking about and that I hope we will continue to see more of in the future. Your generosity has already saved lives. You have already opened up new opportunities for poor and neglected women, and you have brought your energy and your resources to focus on breast cancer so that no longer can this disease be ignored.

Your support is crucial, because we need to work as hard as we know how and as hard as the scientists and doctors here at UCLA can to find a cure for breast cancer and for other diseases that primarily endanger women.

For too long, the conventional wisdom has been that women's health problems are no different from men's. After all, women usually live longer than men, so they must be healthier; right? Well, wrong. Women do have longer years, in terms of a biological advantage over men when it comes to life expectancy, but they do not have a medical advantage when it comes to funding, research, and treatment of the illnesses that burden them most.

Just last week, one of the most comprehensive surveys ever completed on women's health was released. It showed that last year one-third of all women did not receive basic preventive services such as Pap smears, clinical breast exams, or complete physicals. Among women over 50, only 44 percent received a mammogram, and, often, the reason cited for the failure to seek such primary or preventive care was the expense or lack of insurance. What this study confirmed is that women become more vulnerable and more exposed to serious illness as they get older, largely because their access to preventive care is limited and, until recently, because all too often the treatments that they received had not changed dramatically over a number of years.

So, too often, those bonus years that we perhaps can look forward to as a result of our gender are not really benefits at

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all. They become lonely days and nights, clouded by needless infirmity and inadequate care. Sadly, even today, women grow older with few clues about the health problems they face. Breast cancer is but one example. We don't know what causes it. We don't know how to prevent it. We don't know how to cure it. The truth is, we still know far too little about this disease and other diseases that primarily afflict women.

For example, do environmental factors, such as toxins or pollutants, diet, drugs contribute to the rise in breast cancer rates? We don't know. And the reason we don't know is because, until just a few years ago, we were not looking very hard for answers.

A few years ago, however, a group of energetic women's scientists and grass roots advocates alerted us to the inequities that existed in research and funding to try to determine what caused and how to prevent and cure women's diseases. Groups such as the Society for the Advancement of Women's Health Research showed us the appalling degree to which women were routinely excluded from major clinical trials of most illnesses.

Even when women are victims of the same diseases as men, such as coronary heart disease, hypertension, or strokes, research has focused on men. A major study on the relationship between cholesterol and heart disease involved 15,000 men and no women. In one of the most significant trials in the 1980s, which studies the preventive effects of aspirin on heart disease, there was not one woman included among the 22,000 patients screened, even though heart disease is the leading cause of death among women, followed by cancer and strokes.

For too long, the explanation has been that men were providing a more stable group for clinical trials, but the fact is that women are different from men, and the effects on women of interventions have to be tested on women for us to know what works and what does not.

Well, the national research agenda is finally recognizing that women have unique health problems, unique systems, and unique responses to treatment, so we are finally beginning to get attention to diseases such as breast cancer. But what about, also, cervical and ovarian cancer, osteoporosis, immunological illnesses such as lupus and MS, certain forms of mental illness, eating disorders, endometriosis -- all diseases which either exclusively affect women or disproportionately affect women?

Even one of the most universal female experiences, menopause, is barely understood today. Are hormone therapies helpful

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or harmful in coping with menopause? Do they increase, decrease, or have no effect on the possibility of contracting another disease, such as cancer? Nobody really knows, and the result is that women are often bombarded with confusing and conflicting messages about their own health at critical stages of their lives.

Now, I don't think I need to say to this group why we should be caring about these issues or why we should be focusing on women's health, but for those who might not think this is as obvious as we do, we need to make the case that focusing more attention on women's health is good for everyone. It will greatly benefit the 51 percent of our population who happen to be women and who will live longer and, we hope, healthier in those years, but also because their well-being often affects the well-being of their family members and because, in sheer economic terms, continued ignorance about women's health will cost our nation far more than any investment we can make to try to prevent and control the diseases that affect them.

If we have technology, as we do, sophisticated enough to direct missiles to targets thousands of miles away, then we ought to work to have technology sophisticated enough to detect every fatal lump in a women's breast, because every three minutes -- every three minutes, a woman in this country will be diagnosed with breast cancer, and every 12 minutes, a woman will die from it.

Just last week, a young woman whom I met at that meeting with Dr. Love in Williamsburg, Virginia, who had battled courageously against breast cancer, died. One of the last things she did was to bring her husband and her young son to the White House, because she wanted her son to meet the President.

As we were standing there in the Oval Office, with my friend, Sherry, confined to a wheelchair, after having exhausted every possible treatment that she could, with her son clinging to her leg, with her husband pushing the wheelchair, the last thing she said as she left the Oval Office, was to turn to the President and me and to say, "Don't ever let anyone forget what this disease does to those who are left behind."

I told her then that I would not. And, just as Iris Cantor felt that commitment to her sister, I intend to fulfill my commitment to Sherry. (Applause.)

Because, even though we can applaud what the center here is doing and what hard-working physicians and nurses and others are doing all over this country every day, the toll in human terms can never be completely over-looked until the disease is conquered, because every person who is a statistic, whether we talk about the numbers and the millions, the 2.6 millions who currently have it, or

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whether we talk about, on a very individual basis, someone like my mother-in-law, who is a breast cancer survivor, behind every one of those statistics there stands not just a single woman, but family members and medical personnel who are battling to save her life.

I hear from these women and their families all the time, and I know, as many of you do, what they are struggling against. I am grateful that, finally, we have, I hope and trust, put behind us the days of insensitivity, the days of the kind of treatment that was implied in the video, where women are made to feel somehow less than whole if they contract this disease, where women are treated as second-class citizens if they do get the courage to seek help. I trust those days are moving behind us, so that we can focus with sensitivity and caring on the women who need our help.

This effort has to be put into the larger context of what we are attempting to achieve with health care reform. I have been privileged for the last six months to travel around our country, to speak to all kinds of Americans, from the deans of prestigious medical schools to nurses on the front lines to business people, to patients in hospitals, and to listen to their stories. But there is one in particular that I keep coming back to and that I often tell, because it summed up for me what we are up against.

Several months ago, I was in New Orleans. I was visiting a small business that did not provide any contribution toward the health care insurance of employees, most of whom had worked for this small business for many years, but most of whom did not make very much money. I was sitting in a semicircle, talking to men and women who were telling me about the travails they were facing because of the extraordinary financial obstacles they faced in achieving health care.

I think, all too often, those of us who have health insurance, those of us who schedule our annual checkups, who do what we're supposed to do, think of those without as somehow not quite being responsible. You know, if they were responsible, they would take care of themselves, and we wouldn't have all these health problems.

Well, for many people, it's often a question between food and health care or between rent and health care. For many others, they try as hard as they know how to be responsible patients themselves, responsible parents, and there are so many obstacles that they face.

This one woman, who had worked for this company for 15 years, said she always tried to take good care of herself. She tried to do what we all should be doing -- you know, not smoking, not

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drinking to excess, not using drugs, taking care of your diet. She tried to do all of that, and, every year, she also dug into her own pocket and went for an annual physical exam. She told me that she had gone to her doctor and, during a manual breast exam, he had found what he thought of as a suspicious lump, and he referred her to a surgeon. She went to the surgeon. The surgeon examined her and told her that if she had insurance, he would biopsy the lump in her breast, but since she did not have insurance, he would just watch it.

I cannot tell you what it was like, but I think many of you can feel what I felt when I heard that woman say that. What I felt was that here was someone who was being responsible, was taking care of herself, was seeking out care in a very reasonable way, and was being told that she would be treated differently than someone who came holding that insurance card or someone who came who would be paid for tax dollars.

She fell in between the crack that exists between the privately insured and the government insured, and in that crack are about 40 million of our fellow citizens, the vast majority of whom get up every day and go to work and who are mostly women and children. She was being penalized in our health care system.

Now, it is traumatic enough for a woman to be told that she has breast cancer and to cope, as Dr. Love, said, with losing a breast or maybe even both. But can you imagine how it is like for that woman to get up every day and wonder whether she is living with cancer and not knowing it?

So, until we learn more about breast cancer, and until we pursue the work that is being done here, to try to prevent or cure breast cancer, we will all be in the same position as women are today with not knowing. But until we change our health care system, we will all share the unfair emotional burden that is afflicted on any of our fellow citizens because of the inequities in this system.

Now, fortunately, times are finally beginning to change. Women like Iris and many of you in this room -- cancer survivors, scientists, physicians, nurses, health care advocates, Members of Congress -- have all helped awaken our country to the challenge that breast cancer poses, and we have some progress to report.

In 1985, the federal government spent \$50 million on breast cancer research. In the current Appropriations Bill, \$449 million is earmarked for programs at several agencies. That's an improvement, and we hope that it will lead to the kinds of breakthroughs that we're all praying for.

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Scientists are also exploring promising drug therapies, such as taxol and tamoxifen, and they have uncovered potential uses of RU-486 in tumor treatments. And, at the National Institutes of Health, scientists may be on the verge of identifying a gene marker in high-risk women.

The President lifted the ban on RU-486 importation, and that will pave the way for more aggressive research. (Applause.) And he also lifted the ban on fetal tissue research, which may be useful in helping us find a cure. (Applause.) The President recently signed the National Institutes of Health bill, which includes the newly created Office of Research on Women's Health as part of the statute, so, for the first time, we will have an office in NIH that will focus in women's health issues as we begin to create a more balanced approach. (Applause.)

And, very importantly, the federal government is sponsoring a 14-year, \$625 million effort called the Women's Health Initiative, that will explore long-term patterns in heart disease, cancer, and osteoporosis, looking for some of the solutions that have eluded us thus far.

We are beginning to make the kind of commitment that is required, and the administration in Washington has targeted \$10.7 billion for research on prevention, treatment, and general health promotion, and there has been a significant increase, as I've said, in what effects women.

There has also been an increase targeted for the Public Health Service budget, so that we can begin to implement the standards for quality mammography that have been pioneered here at the Iris Cantor Center.

But, in order for any of this to work and to make a difference in our lives, we have to proceed with universal coverage for every American in a health care system that provides quality health care for men and women. (Applause.)

Let me just briefly describe to you what we hope that health care system will look like after this reform occurs. It will provide security for every American. Right now, those of us who are insured have no assurance that we will be insured next year.

Whoever you talk to today, in this changing economic climate, cannot tell you that if they are employed and their employer provides insurance, that the employer will continue to do so, or continue to do so at the level that was previously offered, or will be even in business in today's fast-changing global economy.

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So the first and foremost promise we have to make to the American people is this: No matter who you are, no matter who you work for, no matter whether you have ever been sick before -- and, therefore, have what is called a pre-existing condition -- you will have health insurance, no matter what. That has to be a solemn commitment that is made to everyone. (Applause.)

That health insurance has to provide a core of benefits in a package that emphasizes primary and preventive health care. We have done it backwards for too long. We have paid for the surgery, but not for the mammography. We have paid for the expensive drug treatment, but not for the screening. We need to emphasize primary and preventive health care that includes checkups, immunizations, Pap smears, mammographies, the kinds of early detection and prevention treatments that will save us money as well as save us lives. And, if we do that, we will need to be sure to have the kind of broad-based delivery of health care that will enable us to have the primary and preventive health care specialists, the physicians in family practice, and the internists and the pediatricians, the nurse practitioners and the nurse-midwives, the others who will be on the front line, delivering primary and preventive health care. If we do that, we will save money, and we will save lives.

That has to be the emphasis of the package of benefits that we give, because we have to change the mind set as to what health means. Health needs to be keeping people healthy, not just treating them when they are sick. The only way we can get there is by emphasizing primary and preventive health care, and we need to have incentives for people to take advantage of those kinds of interventions early.

If we provide security for everyone, and if we provide a good system of primary and preventive health care, we will begin to put our health care system on a much firmer footing, in terms of health outcomes and in terms of its financing.

We also need to assure that patients have the choice as to who they choose for their health care provider. We want to secure the individual's right to choose the physician, the hospital, the health plan that is best suited for that person.

In an area like Los Angeles, where you have so many providers and so many fine institutions, that will not be as big a problem, except in the currently underserved areas. It will do very little good to tell the people where I came from this morning that they now have health security and access, if they don't also have choice.

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But with their now having a reimbursement stream that will flow with them and the assurance that they will no longer be uncompensated care statistics, we think that the kind of delivery networks that need to exist even in underserved urban areas and rural areas will be created within a marketplace of new approaches to providing health care that will link fine institutions like UCLA with primary care providers in places like Watts --

(End of side one)

(Begin side two -- in progress) -- and the difficulties of providing health care in underserved areas, those areas have for too long gone without.

We think we can make a market there that will enable us to provide care to the citizens who live there, and we want the decisions about health care to be made by physicians, nurses, health care professionals, not government and insurance bureaucrats. We want to move back the centrality of the patient-physician relationship. (Applause.)

For those of you who have dealt with some forms of so-called "managed care" now, you know that, too often, you get on the phone, if you're a physician or you're a nurse or you're in the admission department of a hospital, trying to convince somebody a thousand miles away why you need to do the procedure that you want to do for this particular patient. Those decisions need to be made where the patient is.

Now, in order to do that, we need to simplify the reimbursement and the administrative side of health care. We have too many insurance companies, too many forms from both the private companies and the government. They need to be collapsed in, as close as possible, as a single form, so that physicians and nurses can get back to treating patients instead of pushing paper. It will make a big difference in the delivery of health care. (Applause.)

If we move on all of these fronts -- research, universal access, providing a core benefits package that emphasizes primary and preventive health care, making it possible for people to have choice, simplifying the system to save the money that we now spend on administrative and bureaucratic costs, we will have a system that better allocates the resources that are within it. And that is, in the end, what we are attempting to achieve.

We already spend more money than any nation on Earth, and we don't even cover most of our people. Many of our statistics cannot be matched against other nations whose standard of living is not as high as ours, because they do a better job in providing primary and preventive health care. We cannot afford to let this moment in history for this country go by.

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There will be a million reasons, as there always are when you're advocating change, why something should not be done, but we do not have a stable status quo. We have a status quo that continues to deteriorate. At one end, you have the very best of health care that you can find anywhere in the world, and yet, as you go down the line from the UCLAs and the Iris Cantor Centers of this world, down into where health care is not being delivered or being delivered inadequately because of the pressures of too few resources for too many people, we end up with results that no one in this country can be proud of.

We could, however, change that and do it in a way that will be financially beneficial for this country in terms of solving our continuing deficit problem and, more importantly, begin to treat all of our people with the respect and dignity they deserve to have.

But, in the end, even if we are successful, as we intend to be, in reforming the health care system of our country to be a more reasonable, cost-efficient quality deliverer of services, much of what we can achieve will depend upon each of us individually. We have to take responsibility for our own health, and we have to take responsibility for our own communities.

It is not always easy to take care of yourself when you've got so many things on your mind or when you're under the kind of financial pressure, as that woman I met in New Orleans is. But good health care starts with the individual, and good health care for this country starts with recognizing the connections among individuals.

We can improve our own health care. We can change our behavior. Hippocrates said it first, as I have found he often said things first, "The patient must combat the disease along with the physician."

What is at stake in this struggle and challenge we are confronting is not just changing the way we finance health care, it's not just eliminating administrative hassles or giving us more primary and preventive health care providers instead of specialists, or all of the individual, specific pieces of what will make up health care reform.

It is about once again asking individuals to be responsible for themselves, but also for those with whom they live and care about. It is, in the end, a vision about the kind of people we are and that we want to be. It is about creating an ethos of caring and it is about once again considering ourselves linked as part of a great community.

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In the end, that is what will make us healthier. It is being part of a community that is healthy. It is being part of a commitment to caring and individual responsibility. That is what the Iris Cantor Center is attempting to do.

For many of us, breast cancer is a very personal challenge. It is something that we want to have a part in seeing cured and prevented. But we want to do that, not just to combat a disease, but because we love someone, we have a friend we care about, we've been moved by somebody's story. Because, at bottom, it is that human connection that will make the difference.

So let us join our hearts and our hands together to support the changes that we need for ourselves as individuals, for our communities, and for our country.

Thank you all very much. (Applause.)

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A WOMAN'S GUIDE TO HEALTH CARE REFORM

HEALTH CARE THAT'S ALWAYS THERE

PRINCIPLES OF THE PRESIDENT'S HEALTH SECURITY PLAN

+ SECURITY

WOMEN WILL NEVER LOSE YOUR HEALTH CARE COVERAGE—EVEN IF YOU CHANGE JOBS, LOSE YOUR JOB, GET SICK, MOVE, OR START A SMALL BUSINESS.

+ SAVINGS

THE PRESIDENT'S PLAN WILL CONTROL THE SPIRALING COSTS THAT ARE CRIPPLING AMERICAN BUSINESSES, HURTING AMERICAN WOMEN AND THEIR FAMILIES, AND EXPLODING OUR DEFICIT.

+ SIMPLICITY

THE PLAN CLOSES LOOPHOLES CAUSED BY INSURANCE FINE PRINT, REDUCES THE PAPERWORK THAT CHOKES DOCTORS AND PATIENTS, CRACKS DOWN ON FRAUD AND ABUSE, AND REFORMS MEDICAL MALPRACTICE.

+ QUALITY

THE PLAN WILL IMPROVE THE QUALITY OF HEALTHCARE BY COVERING PREVENTIVE SERVICES THAT WOMEN NEED THAT KEEP YOU HEALTHY—BEFORE YOU GET SICK.

+ CHOICE

REFORM WILL PRESERVE A WOMAN'S CHOICE OF DOCTORS—AND INCREASE YOUR CHOICE OF HEALTH PLANS

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WOMEN BENEFIT

THE HEALTH PLAN AND YOU

The President's Health Security Plan is designed to provide you and all other Americans with available and affordable health care by *guaranteeing* access to high-quality health services regardless of your age, employment, income or health status.

The concept of providing security is a familiar one to women. Historically, women have played a central role in ensuring the physical, economic and personal health security of others by simultaneously taking on roles of worker, parent, teacher, caregiver, and spouse. Over half of all American women now work outside the home; at the same time, they assume all, or most of, the work in the home. They care and provide for children; they care and provide for aged parents.

Unfortunately, as central as women are to the health and well-being of others, their own health and well-being have been compromised in the past. Women have been relegated to second-class citizenship in medical care as a result of discriminatory practices in current business and health insurance policies and by inattention to gender differences in the conduct of biomedical research. All too many women today lack access to needed medical treatment because they do not have insurance. Unemployment, part-time employment, poverty and divorce limit or even deny access to health insurance and preventive and interventive medical care for women and, too often, the next generation of women and men—their children. This will all change with the new American Health Security Plan. From now on, you and your family will have access to all of the medical and preventive services needed to ensure good health throughout your lives.

RESOLVING THE WOMEN'S HEALTH CARE CRISIS

At the end of the 1980s, irrefutable national statistics pointed to a crisis in women's health. The numbers show that overall, women have worse health than men and that they experience a higher prevalence of certain health problems than men. Further, a number of medical problems are unique to women or affect them differently from men. Throughout their lives, the quality of life for women lags far behind that for men. Women experience more acute and chronic illnesses, resulting in a greater number of short and long-term disabilities. For example:

- ** Women's activities are limited by health problems approximately 25% more days each year than are men's activities.
- ** One-third of all men die within a year of a heart attack; the rate is greater among women. One half of all female heart attack victims die within a single year.
- ** Stroke accounts for a higher percentage of deaths among women than men in all stages of life.
- ** The rate of breast cancer is rising dramatically; today, 1 in 8 women will develop this disorder, in contrast to 1 in 20 in the 1960s.
- ** Osteoporosis affects over 24 million Americans, including 1/3 to 1/2 of all postmenopausal women.
- ** Women are the fastest growing population with AIDS.
- ** Depression affects twice as many women as men.

There are many misconceptions about women's health and illness, wrong beliefs held by health care practitioners and the public alike. For example, heart disease continues to be considered a "man's disease," but cardiovascular illness is the largest killer of women. Other disorders affect women differently than men. Thus, fully half of all women who have heart attacks die within a year, in contrast to less than a third of all men experiencing a heart attack. Unfortunately, health care today, all too often, does not recognize or respond to

these differences. The American Health Security Plan contains provisions for better health provider and patient education designed to correct these misconceptions and to achieve equity of health care for our Nation's women. Thus, each aspect of the Plan builds upon the next and links closely to other Federal initiatives in biomedical and behavioral research, in the way health care and prevention messages and services are delivered in our home communities, and in public and health professional education and training. As a result, for the first time in our Nation's history, women will have real security with access to the full range of health prevention and treatment services that they have been denied for so long.

THE AMERICAN HEALTH SECURITY PLAN

HOW THE PLAN WORKS: MEETING YOUR HEALTH CARE NEEDS

Women are guaranteed secure affordable health care under the American Health Security Plan without regard to where they live, where, or if they work, their level of income, or their health status. Health plans are offered through large employers and through regional health alliances that have the power of numbers behind them to purchase reasonably priced health insurance. Any woman, whether unemployed, self-employed, or employed part- or full-time is able to obtain coverage through an alliance.

A guaranteed basic package of preventive, diagnostic and treatment services will follow you and your family across jobs, across state lines, without regard to changing marital status or health, throughout your lifetime. This basic package is guaranteed, but each woman retains the freedom to choose, from among a range of options, the health plan that best meets her health care needs and personal finances. She can choose among a traditional fee-for-service plan, a network of doctors and hospitals, or a health maintenance organization (HMO). And, every year, she may change her mind and switch plans if needs or desires change over time.

[PLEASE INSERT GENERAL OUTLINES

OF THE PLAN HERE.]

Q. I'm unemployed and uninsured. How can I participate in the plan? Can I afford it?

A. As long as you are either a U.S. citizen or a legal resident, you will receive a health security card entitling you to participate in a regional health alliance that acts as an insurance broker. You will be given the resources to purchase health care coverage through these alliances. The benefits in your plan will be no different from the benefits other Americans can purchase, without regard to their employment status.

Q. Both my husband and I work full-time. Can we have two insurance plans or are we required to elect a single plan through only one of us? How are our children insured?

A. First, it is important to distinguish between health care alliances and health care plans. Alliances are the purchasing agents for health care in a given region or for a given employer with over 5,000 employees. Families must elect a *single* alliance through which insurance will be purchased. Thus, if your spouse works for a firm that has its own corporate alliance and you work for a company that buys coverage through a regional alliance, you must choose one of the two alliances for insurance. Both your employer and your husband's employer would contribute 80% of the costs of coverage to the selected alliance. Within that chosen alliance, however, you could opt to purchase a single plan for the whole family or to purchase two different plans (one for you, one for your spouse). If you choose to purchase two plans, the costs would likely be higher. Your children are insured through the purchase of a family insurance plan through your chosen alliance. If you live in different states, you can be enrolled in different alliances. Different plans are available that meet needs based on marital and family status. **[NOTE: THE ANSWER TO THIS QUESTION MAY NOT REFLECT THE MOST RECENT DRAFT. PLEASE REVISE AS NECESSARY TO CONFORM TO THE CURRENT PROVISIONS OF THE PLAN IN THIS REGARD.]**

Q I work part-time. Is the health plan different for me?

A.: Once you join either a corporate plan or a regional health alliance, your employer is required to pay your health care premiums on a proportional basis depending on the number of hours you work each week. You and the government pay the balance, allowing you to buy coverage through the alliance at the same price as everyone else. The content and

coverage of the plan you purchase is the same as if you worked on a full-time basis.

Q. What happens if I change jobs or move to another state?

A. If you change jobs your insurance will follow you if it is purchased through a regional health alliance. Your new employer will simply begin paying when you join the company. There is no waiting period. If you move to employment in a large company with its own alliance, that alliance will become your insurance purchaser. The opposite is also true. If you move from a corporate alliance to a smaller organization that insures through a regional alliance, the regional alliance will be your insurer. If you move to another state, the alliance in your last place of residence may continue as your insurer for up to six months. After this period of time, you will be required to join an alliance in your new home state.

Q. I'm divorced and share custody of two young children with my former husband. How is their health care covered?

A. [NOTE: PLEASE ADD RESPONSE BASED ON THE CURRENT PLAN GUIDELINES.]

Q. I don't earn a lot on my job. I'm not sure I'll be able to afford the program's costs. What happens if someone in my family has a serious illness and I cannot afford the out-of-pocket health care costs in the plan?

A Let's answer the questions separately. Let's begin with whether you can afford to join the health program. Under the plan, all Americans are assured secure and affordable health care. If you work for a large company that chooses to form its own corporate health alliance and you earn less than \$15,000 a year, your employer must contribute insurance premiums of up to 95% of the lowest-cost plan it makes available to you and other employees. In any other case, if your employed income is below a certain set amount, you qualify for a subsidy to help pay for your share of the insurance premium on a sliding scale. Both of these provisions should help make coverage more affordable for you. Now for the second question: what if you can't afford the out-of-pocket copayments and deductibles. Again, if your income is less than a specified amount, you qualify for reduced costs based on a sliding scale. You never will have to forego needed medical care for you or your

family.

Q. I have a chronic health problem that requires treatment. I'm afraid to leave my current job for fear of not being able to get insurance that will cover the continued treatment of this condition. What does the health program do about people with ongoing health problems like me?

A. One of the most unforgivable inequities under our current system of health insurance is the so-called "pre-existing condition" clause that allows an insurance company to deny payment for the treatment of a medical problem that occurred before purchasing the health insurance. This can "freeze" a woman into a dead-end or low-paying job. It can eliminate just that element of choice that the American Health Security Plan will make possible. Under our program, *you cannot be denied insurance payment for the treatment of a pre-existing condition.* Thus, anyone with a history of prior illness that either continues or recurs will be able to be insured for treatment of that disorder. And that includes your children, too.

Q. I like the idea of physician choice, but what happens if my internist belongs to one plan and my gynecologist belongs to another?

A. The range of choices you have among practitioners is based solely on the type of health plan you choose. Different options will be available based on the kinds of cost sharing you find most financially comfortable for your personal situation. . For example, your costs may be lowest in a health maintenance organization, but you will not have the same freedom to choose among physicians that might be found in either a physician network or fee-for-service plan. Your choice of health plan, not your physicians' involvement in a particular plan, determines who you may select for treatment.

SAFEGUARDING WOMEN'S HEALTH

DISEASE PREVENTION AND HEALTH PROMOTION

One of the most encouraging aspects of women's health is that many conditions can be controlled or eliminated through healthier lifestyles and safer and healthier environments. Since a long, productive life depends, in part, on life-long health behaviors, efforts to promote health in later years must focus not only on older women, but on women of all ages. To that end, the American Health Security Plan is designed to foster health promotion and disease prevention throughout a woman's lifetime by providing ready, low-cost access to a wide range of preventive health services for medical problems, including a number that are of special concern to women.

For example, because cancer occurs in substantially lower numbers among women under the age of 45, cancer prevention and early disease diagnosis services rather than treatment strategies are urgently needed for younger women. The American Health Security Plan, therefore, encourages prevention and early intervention by including mammography, pap smears, smoking cessation and other cancer risk-reduction, prevention and early intervention services in its guaranteed national benefit package. These services are provided with *no copayment or deductible*. Similarly, high cholesterol levels, obesity and smoking are known risk factors for heart and coronary artery disease. The plan's inclusion of cholesterol checks, routine physical examinations and smoking-cessation programs act as risk-reduction methods for heart disease and stroke.

Moreover, the American Health Security Plan holds the promise for a healthier new generation of women by instituting preventive and early interventive services in infancy and beyond. Again, at no copayment or deductible, the plan provides regular routine immunizations, well-child check-ups, eye examinations and glasses, and laboratory testing for children from birth through age 19. A specialized program of lead-based paint testing is available to high-risk infants and youth, also at no copayment or deductible. Further,

through a major public health initiative that works in concert with the personal health care system, our next generation of American children increasingly will be protected against preventable communicable diseases, exposure to toxic environmental pollutants and poor quality health care.

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CLINICAL PREVENTIVE SERVICES

PROGRAM FEATURES

The Guaranteed National Benefit Package includes the following services:

- *Routine physical exams*
 - regular well-baby and child visits from birth through age 19
 - every 3 years between the ages of 20-39
 - every 2 years between the ages of 40-65
 - every 1 year after age 65
- *Pap smears (cervical cancer screening)/pelvic examinations*
 - every 3 years beginning at age 20 or onset of sexual activity through age 64
 - annual Pap smears and screening for women at risk for sexually transmitted diseases
- *Mammograms* every 2 years, beginning at age 50 or more frequently at any age for women at high risk
- **Clinical breast exams** with periodic health examinations beginning at age 20.
- *Cholesterol testing* every 5 years, beginning at age 20
- *Prenatal care* for women of any age
- *Immunizations* for tetanus and diphtheria every 10 years from age 20. After age 64, a one time vaccine against pneumonia and annual influenza vaccinations.
- *Routine eye examinations* every two years, beginning at age 18
- *Preventive dental services* for children under 18

THESE SERVICES DO NOT REQUIRE A COPAYMENT OR DEDUCTIBLE

Q: I see that mammography is a covered clinical preventive service for women age 50 or over. I'm only 34, but because my mother and grandmother died of breast cancer, I'm at high risk. My gynecologist has suggested that I begin regular mammography. Is this covered under the plan?

A. Absolutely. The key words are “at-risk” and “medically necessary.” If mammography is medically indicated for you because you are at high risk for breast cancer, such as a family history, you may have earlier and more frequent screening mammograms at no cost to you. Additionally, for diagnostic purposes and whenever medically indicated and appropriate, the plan covers mammography at any age, subject to the copayment and deductible features of the plan you have chosen. It is provided as part of the plan’s medical services rather than its preventive services. The same is true for testing for other disorders in specifically at-risk women, whether the disease is cancer, diabetes, AIDS, sexually transmitted disease, or many others.

Q My doctor has told me to lose weight and to quit smoking to reduce my risks of heart disease and lung cancer. I don't see anything in the prevention plan that could help me pay for this kind of service.

A: The American Health Security Plan requires health plans to make this type of service available to you if your physician recommends it. However, your plan may require you to pay a nominal fee for this type of service to encourage your continued participation.

Q As I get older, I become increasingly concerned about glaucoma and cataracts of the eye, both of which can lead to blindness.

A. We are concerned about the health of your eyes, too. Thus, the basic covered preventive services available to you at no copayment or deductible include routine eye examinations every two years. Obviously, if you are experiencing symptoms and seek treatment from an ophthalmologist, those services will be covered as physician services, and will be subject to your chosen plan’s copayments and deductibles.

REPRODUCTIVE AND PREGNANCY RELATED SERVICES

Some illnesses and health conditions are unique to women. Among these are conditions related to reproduction, including menstruation, pregnancy, childbirth and menopause. The years from young adulthood to menopause should be a woman's most productive years, not only as a member of society, but also in terms of her personal growth. Yet, because these also are the reproductive years, productivity and personal development, in large measure, depend on a woman's ability to live free from disease or difficulty in terms of sexual function, fertility regulation, pregnancy and delivery.

PRENATAL SERVICES: HEALTHY MOTHERS-HEALTHY BABIES

By providing extensive prenatal services, the American Health Security Plan is dedicated to ensuring that all mothers and their babies are healthy. Another bonus will be lowering the Nation's infant mortality rate. More than 6 million pregnancies occur every year in the United States. Unfortunately, pregnant women who receive either prenatal care in the last trimester alone or no prenatal care alone are three times more likely to die of pregnancy-related complications. Children born of mothers who have received little or no prenatal care, and who engage in risk-related activities, such as smoking, drinking, or taking drugs, run an exceptionally high risk of problems that jeopardize their lives. These include fetal alcohol syndrome (that often results in severe mental retardation), low-birth weight and difficulty breathing (that may delay the child's growth and development, or even compromise life itself), drug dependence (that causes an infant to experience drug withdrawal within days of delivery, and may result in a range of intellectual deficits), and AIDS (that, today, inevitably results in death).

Sexually transmitted diseases represent another severe threat to women's health, since infections often cause few symptoms and may go untreated. Studies have found that over 2.5 million women acquire chlamydia annually; over 100,000 infants die or suffer birth defects because of sexually transmitted diseases transmitted during pregnancy or at birth. Today, women are the fastest growing population with AIDS.

FAMILY PLANNING SERVICES

Preventive care and early interventions that emphasize healthy lifestyles and behavioral choices are the cornerstone upon which healthy families are based. Thus, the American Health Security Plan provides a variety of pregnancy and reproduction-related services that are targeted to respond to a woman's reproductive concerns and needs.

Access to safe and effective contraception is a critical women's health care need. The CDC

has found that from 1983 to 1988, 35% of births were unintended; of these 10% were unwanted. Of the approximately 1.1 million women ages 15-19 who become pregnant each year, 84% do not intend to do so. Infertility affects 1 in every 10 married couples who want to have children. As many as 45-50% of all women suffering from infertility have been found to suffer from endometriosis. As the result of recent breakthroughs in medical therapy, surgery and other techniques, approximately half the couples attempting to remedy infertility will achieve pregnancy. The choice to have a family today, fortunately, can be aided by medical science. Problems with conception may be remedied; the product may be a deeply hoped-for child.

Among the services available in the basic preventive health plan, offered at no copayment or deductible, are prenatal care and counseling for all pregnant women. Parenting programs, too, may be included. The plan's inclusion of little or no cost smoking-cessation, substance-abuse treatment, and programs designed to reduce the risk of sexually transmitted diseases, including AIDS is intended to foster both the increased health of women in general and the greater likelihood of healthy pregnancies, births, and infants. Infertility or concerns about genetic disorders are addressed by the plan. Our goal is to help ensure that every woman has available to her the full range of reproduction-related services that will foster her positive mental and physical health and the positive physical and mental health of her children.

REPRODUCTIVE/PREGNANCY RELATED SERVICES

	YES	NO
Birth control	X	
Pregnancy tests	X	
Infertility treatments (except <i>in vitro</i>)	X	
Prenatal care	X	
Childbirth classes	X	
Neonatal services	X	

Some of these services are at no copayment or deductible. Others are available as medical services, subject to the

chosen plan's copayment and deductible features

Q: How does the plan cover prenatal care?

A. Prenatal care for all women is covered as a basic preventive service. Prenatal services are covered with no deductible or copayment, consistent with the basic package of preventive services available under the plan. In fact, the plan covers pregnancy tests, if you believe you may be pregnant. Health plans also may offer parenting and childbirth classes, too. There may be a nominal fee for those classes.

Q. What kinds of family planning services are available under the plan?

A. The American Health Security Plan recognizes that responsible family planning is a decision that each woman has a right to determine. Birth control devices and prescription medicines are covered under the plan as medicines and medical devices. They require a physician's prescription and are subject to the same deductible found in the basic plan's coverage of medications.

Q. Because my brother and his wife had a child with a genetic disorder, my husband and I are worried that we are at-risk for conceiving children having the same disorder. Is amniocentesis or chorion villi sampling?

A. Certainly, with a family history of genetic anomalies or other at-risk status, such as the age of the mother, genetic testing may be indicated. The American Health Security Plan includes medically indicated amniocentesis and chorion villi sampling (two techniques to determine the presence of fetal genetic disorders) as covered medical services.

Q. We really want to have a child, but have not been able to conceive successfully. What provisions does the plan have for our infertility problem?

Under the medical services provisions of the American Health Security Plan, tests and procedures that your gynecologist or your partner's physician may perform to determine the reasons for infertility are covered, as are medications your doctor may prescribe to you or your partner to enhance fertility, and procedures to repair physical problems. The only

procedure not covered by the plan is in vitro fertilization. For the diagnosis and treatment of infertility, you will be responsible for the same copayments and deductibles found in the plan for all physicians' services, medications or hospitalizations. Your income will not be a barrier to receiving care. As in other aspects of the plan, a sliding scale exists to help you pay your share of the bill, should you not have sufficient income.

Q: I've just had a medically-indicated hysterectomy. My physician has suggested that I take estrogen replacement. I know that I'm expected to take this medication on a long-term basis. Will the plan help pay for this medication?

A. Of course. The American Health Security Plan assures that you never have to worry about the costs of medicines that are prescribed for you. Estrogen replacement therapy (ERT) is covered as are other prescribed medications, subject to your plan's deductible feature. We recognize that ERT not only helps avoid unpleasant side-effects of hysterectomy, but that it also can help safeguard against future medical problems you may experience as you grow older, such as heart disease and osteoporosis (bone thinning) that may lead to serious disability in later life. By providing coverage of ERT today, we are helping to practice preventive medicine for tomorrow.

Q. I don't want to have any more children. Will the plan pay for a tubal ligation for me? What about a vasectomy for my partner?

A. Family planning services including tubal ligation and vasectomy are covered under the plan.

MEDICAL SERVICES FOR CHILDREN
ENSURING A HEALTHY FUTURE FOR THE NEXT GENERATION

A mother's own sense of security often is dependent upon the level security she is able to provide for her children. Under the American Health Security Plan, no mother need worry about access to health care for her children. From prenatal care to birth and from the delivery room to a child's transition to adulthood, your child's health care needs are covered by the plan.

In addition to both prevention and physician services, the American Health Security Plan attempts to reach out to our Nation's children by supporting the development of innovative strategies to address priority health needs of community and national significance. Several of these proposed initiatives focus health education and outreach programs for children where they are found most frequently: in our schools. The Plan will foster further development of linkages between health and education in a new, comprehensive school health program. Moreover, efforts to help reduce adolescent and unwanted pregnancies will link existing social services programs to interventions targeted toward public education. Additionally, other aspects of the plan will include new programs of home visiting, case management for children with special needs, and child and spouse abuse interventive services.

COVERED CLINICAL SERVICES FOR CHILDREN

- All routine immunizations from birth, through age 19
- Doctor visits
 - 7 visits from age 0-2
 - 2 visits between ages 3-5
 - 5 visits between ages 6-19
 - Pap smear/pelvic exam at age 20 or after onset of sexual activity every three years
- Vision care for all children under age 18
 - routine eye examination annually
 - prescription glasses/contact lenses
- Preventive dental services for children under 18

Treatment for medical problems is covered under the physician care provisions of the plan, and is subject to the copayments and deductibles identified in your chosen health plan.

MEDICAL SERVICES FOR OLDER WOMEN

PROMOTING HEALTHY AGING

In recent years, the concept of aging has changed. Where once we believed that aging inevitably meant a physical and mental decline, today we know that, with an earlier commitment to a healthy lifestyle and life-choices, coupled with appropriate medical care over time, many older women and men can enjoy excellent mental and physical health for many decades.

On average, women live 8 years longer than men. But these bonus years have not necessarily been better years, since women experience more chronic disability than do men. However, many of the diseases and chronic conditions common to middle-aged and older women can be prevented or delayed through healthy behaviors and lifestyle choices in earlier years (such as heart disease, diabetes, obesity, and osteoporosis (bone thinning)). Coronary heart disease, affecting about 25% of older women, is the leading cause of death for women in this country. Diabetes, affecting about 7 million women, nearly half of whom are undiagnosed, causes shortened life from blindness, kidney disease and amputations. Obesity places as many as 27% of all women at risk of serious, disabling chronic conditions, such as heart disease, breast and colon cancer, and diabetes. Osteoporosis, affecting 20-25 million Americans and causing over 1.3 million bone fractures each year, causes painful disfiguring disability in one in four women over the age of 65. Moreover, osteoporosis is the single most important cause of hip-fractures in older women, a problem that often leads to premature death.

Other conditions are directly related to aging (arthritis and Alzheimer's disease). Women disproportionately suffer from arthritis, a degeneration of bone that leads to severe disability. As many as 10 million women have signs and symptoms of this disorder. Alzheimer's disease is responsible for 60-70% of all cases of dementia, a degenerative problem that begins with deterioration of memory and mental ability, and ends, most often in the need for total custodial care. This particular disorder affects not only the victim, but the family as well. Women, the primary informal caregivers, often assume the burden of caring for an elderly parent with Alzheimer's disease, doubling or tripling duty as a mother, worker and daughter, and, at the same time, doubling or tripling the stress associated with these multiple roles.

Through a range of covered services, the American Health Security Plan is designed to help ensure the greatest positive health of women in their later years. At the same time, it recognizes that, with age, the risk of severe disability and disease rises. The plan requires health alliances to ensure that each offered health act provides a range of services, coordinated with the existing Medicare program, designed to relieve the cost, fear and stress

associated with increasingly chronic disorders of later life.

Q. My mother, who lives with me, just suffered a mild stroke and is expected to make a slow recovery. Medicare now provides limited coverage for her current health care needs. How does the program link with Medicare? What provisions does the act contain for home-based services for my mother in the coming years? What about long-term care, should we be unable to continue to care for her in our home?

A The act's intent is to help your mother and other older Americans enjoy health security and to safeguard you and your family from undue economic and emotional hardship as caregivers. Let's take that answer in parts:

(A) Medicare recipients, such as your mother, continue in that program, but have the option of joining a regional alliance [States have the option of integrating your mother and other Medicare recipients into an alliance, but they cannot reduce her benefits as the result.

[PLEASE ADD ADDITIONAL MATERIAL REGARDING LINKAGE BETWEEN MEDICARE AND THE ACT FOR BOTH NONWORKING AND WORKING PERSONS OVER AGE 65]

(B) We recognize that home-based care often can extend the time a chronically ill person can continue to stay at home by providing services that otherwise could not be received at home. The plan will offer a range of home-based services including visiting nurses, home IV therapy, outpatient drugs and devices, homemaker and chore services, among others. For this reason, we provide home health care coverage when it is an alternative to institutionalization. After 60 days, that care is reevaluated and may continue if it continues to prevent institutionalization. **[PLEASE CLARIFY WHETHER THESE SERVICES ARE AVAILABLE TO OLDER PERSONS WITHOUT REGARD TO LIVING ARRANGEMENT.]**

(C) Extended care facilities, such as nursing homes and rehabilitation facilities are covered as alternatives to hospitals for patients with acute illnesses or disorders that require physical rehabilitation to achieve full recovery. Up to 100 days of care are provided in such instances. **[PLEASE CLARIFY HOW THIS COVERAGE FOR RECOVERY FROM ACUTE ILLNESS DIFFERS FROM COVERAGE FOR LONG-TERM CARE FOR**

OLDER PERSONS WITH CONDITIONS SUCH AS ALZHEIMER'S DISEASE. THE LATTER IS AN IMPORTANT UNDESCRIBED COMPONENT OF THE SYSTEM.]

Q. I've noticed that my vision and hearing are not as good as they once were. Are eye examinations covered? Glasses and hearing aids are expensive. Does the act cover these?

A. Eye examinations, once in each two-year period, are covered under the plan. Because the American Health Security Plan takes an incremental approach to coverage of all preventive and medical needs of all Americans, vision and hearing devices (glasses and hearing-aids) are not going to be covered immediately. However, within several years, hearing aids and eyeglasses for persons over the age of 18 will be part of the standard benefit package.

Q My mother has been diagnosed with end-stage cancer. She wants leave the hospital and come home to die. Is there an alternative to keeping her in the hospital?

A. The American Health Security Plan provides several alternatives. Should you choose to care for your mother at home, a variety of home health services are covered by the act. We even make provision for respite care in a specialized facility that will give you a chance to relieve your stress of caring for your mother for short periods of time without her having to be placed back in the hospital. In addition, if you are unable to care for your mother at home, the act provides for hospice care. A hospice is a specialized facility, often very home-like, that has been designed and staffed specifically for the care of terminally-ill patients who choose not to remain in a regular hospital.

MENTAL AND ADDICTIVE DISORDERS

SHATTERING THE STIGMA: PROVIDING EFFECTIVE TREATMENT

For the first time in the history of our country, a comprehensive package of benefits for the treatment of mental and addictive disorders will be available to every American. Today, mental and addictive disorders affect one in every five Americans. Some of these disorders occur more frequently in women.

Depressive disorders affect nearly 13 million of our citizens; depression affects women at twice the rate as it does men. This two-fold risk of depression begins after puberty and continues throughout a woman's lifetime. In elderly women, the prevalence of depression is more than three times that found in older men. Depressive illness exacts a heavy toll in terms of both lost social and economic functioning; it also is one of the greatest risk factors for suicide. Indeed suicide is the eighth leading cause of death in America; in the 15-24 year age group, suicide is the third leading cause of premature death. Depression affects sleep and daytime functioning alike. A woman experiencing medically-diagnosable depression may find herself unable to function at work, unable to cope with her home life, unable to sleep well. Until research is able to identify why depression strikes women in greater numbers and determine better means to prevent its occurrence, treatment is the first line of defense. As many as 80-90% of all depressions can be treated effectively.

Eating disorders affect 2-5% of American women, predominantly adolescents and young adults. The disorders—including anorexia nervosa and bulimia—places these younger women at significant risk of malnutrition and other medical problems, including osteoporosis. These disorders have among the highest death rates of all mental illnesses.

Substance abuse has become a serious health problem for American women. The rate at which women are smoking, drinking, and taking both legal and illegal drugs is rising to that found in the male population. The changing patterns of drug use among women are closely

linked to other social factors that structure their lives. Poor physical and mental health, coupled with social and environmental factors contribute to an increase in the epidemic of substance abuse among women. Indeed, substance abuse often co-exists alongside other physical and mental disorders affecting women. Further, we are concerned not only about the effect drugs and alcohol have upon women, but also their effect upon children. The human and economic costs of an AIDS baby, a crack baby, and a baby with fetal alcohol syndrome are untold. They are human costs we, as a Nation, cannot allow to continue.

Psychological and physical trauma exact a toll on a woman's mental health. Trauma results from a highly stressful event that is outside the range of expected experience. Examples include rape, life-threatening accidents, and natural disasters. Both physical and sexual abuse are important categories of trauma that can occur in the lives of women and that may undermine their mental and physical health. One of the possible results of this trauma is an illness called post traumatic stress disorder; yet another is substance abuse. Both of these outcomes compromise not only mental health, but physical functioning as well. They affect the ability to work, to relate to other people and to function altogether.

Mental problems also often occur for women as a result of physical illness. Depression and anxiety among hospitalized women patients is not uncommon. The benefit of treating that emotional problem is that the patient often recovers from the physical illness faster. Research has found this to be true for older patients with hip fractures, cancer patients, and countless women with both acute and chronic physical health problems.

The cornerstone of improved mental health for women and for all of our citizens is the early detection and treatment of mental and addictive disorders. The American Health Security Plan recognizes the urgent need for access to mental health and substance abuse treatments and is providing women with comprehensive benefits.

MENTAL HEALTH/SUBSTANCE ABUSE COVERAGE

- Inpatient services
 - up to 30 days per episode
 - up to 60 days per year
- Hospital alternatives: 120 days maximum
- Outpatient
 - unlimited visits for medical management
 - unlimited visits for substance abuse counselling and treatment
 - up to 30 visits per year for psychotherapy
 - diagnostic evaluation
 - crisis intervention services

[PLEASE CLARIFY IF THIS HAS CHANGED SINCE THE LAST ITERATION OF THE ACT.]

Q. My father has become increasingly depressed as he recovers at home from open-heart surgery. I want him to talk to someone, because he seems to be getting worse, and not better. Will the act cover these services?

A. Yes You father should receive a comprehensive evaluation, fully covered by the plan, to discover the causes of his mood changes following his surgery. If medication to relieve the depression is medically necessary, this treatment is fully covered. If he should require psychotherapy (talking with a trained mental health professional), he may receive up to 30 visits per year, subject to the specific plan's copayment and deductible features.

Q. My son recently has been diagnosed as suffering from a serious mental disorder, schizophrenia. I know this is a long-term disease. How does the health act cover my son's medical needs?

The plan provides comprehensive coverage for mental illness including crisis intervention, outpatient, and hospital services. Your son can visit a physician as frequently as medically indicated for the medical management of his illness. Additionally, the plan provides a

hospitalization benefit of up to 60 days annually. Whenever possible, the plan encourages outpatient alternatives to hospitalization including up to 120 days a year for day hospital and other community based treatments. Under the plan, your son will never be denied coverage for a pre existing condition and there will be no lifetime caps on the costs of his treatment.

Q. I've been depressed lately and friends have suggested that I see a psychiatrist. Do I have to see a psychiatrist to have the act help pay for my care? Could I see my family practitioner or a psychologist or social worker, instead?

Yes. Mental health services may be provided by a range of mental health professionals. What services you will need including the type of mental health professional will be determined by the results of a diagnostic assessment. However, medical management of mental and addictive disorders must be provided by a psychiatrist, psychopharmacologist, or other physician.

CANCER DIAGNOSIS AND TREATMENT

Cancer is the second leading cause of death among American women of all ages, accounting for a quarter of a million deaths each year. Lung cancer, that is due almost entirely to cigarette smoking, has surpassed breast cancer as number one cause of cancer death in women. This particular cancer can be prevented, almost in its entirety, if women simply stopped smoking.

Some cancers, such as that of the lung and breast affect both men and women. However, cervical, ovarian and uterine cancer are diseases that affect women exclusively. In this decade, approximately 2 million women will learn that they have breast cancer or cervical cancer; over one-half million may lose their lives from these two diseases. These deaths will occur despite the fact that proven tools exist for the early detection and control of these cancers.

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“If all women over age 50 had regular mammograms, the death rate from breast cancer in this country would drop by one-third.”

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Only 41% of women above the age of 40 follow recommended screening guidelines for breast cancer; over the age of 50 only 12% of women have regular mammograms. While the picture is somewhat better for cervical cancer screening and prevention, our goal is to reach all women.

Because prevention and early intervention is a cornerstone of the American Health Security Plan, we provide coverage for preventive screening procedures for both cervical and breast cancer. Pap smears for cervical cancer are specified every three years for women between the ages of menstruation and 50. Between ages 50-65, Pap smears are available every two years. Similarly mammograms are provided as preventive service every two years for women over the age of 50. Neither screening test is subject to copayment or deductible. Poor diet and smoking, both critical risk factors for some cancers, are the subject of programs offered by the plan to modify these health-damaging behaviors.

Remember, the tests described are preventive. Should you be at high risk for cervical or breast cancer, your physician would probably recommend that your screening be conducted on a shorter cycle or that screening for breast cancer begin earlier than age 50. The American Health Security Plan includes coverage for these services as part of the basic treatment package. Payment would be subject to the same copayments and deductibles found in your act for physician care and other laboratory services.

Q. I have just been diagnosed with breast cancer and am weighing my options about reconstructive surgery. How does the health act cover reconstruction after breast cancer surgery?

A. The plan covers reconstructive surgery following surgery for breast cancer.

Q. My oncologist—cancer physician—has told me about a new experimental drug that may help in the treatment of what I am afraid is severe ovarian cancer. Does the health act consider this type of treatment to be covered?

A. Yes, in part. Under the American Health Security Plan, all physician, facility and medically-indicated services associated with the treatment of cancer will be covered.

However, the cost of the investigational drug—one that has not yet been approved by the Food and Drug Administration—itself, is the only part of your treatment that would not be covered by your health plan.

Q. I am a recovering cancer patient with a need for support through the recovery process. Does the health act cover rehabilitation or support groups for cancer survivors like me?

A. Health plans may offer support groups as part of their benefit package.

IN SUM

Women will greatly benefit from the American Health Security Plan. For the first time in the history of our country, women will have complete access to the full range of quality health care services available in our country.

You will receive a health security card that guarantees you a comprehensive package of health benefits that can never be taken away, that will always be there. You and everyone else will have a choice of health plans. Your boss or insurance company won't decide how or where you can get your care—you will.

You will be able to sign up for a health plan where you work. If you're self-employed or unemployed, you will be able to sign up at the local health alliance, a place set up to bargain for and provide information to you, the consumer.

You'll get a brochure that gives you easy-to-understand information on each health plan option available to you. You'll know at a glance what doctors and hospitals are included, a statement about the quality of care, a consumer-satisfaction survey, the range of benefits, and the price. *You choose your plan based on your needs.* If you want to change plans later, you can do it.

It's simple. It provides security for you and your family with a comprehensive package of health benefits, with an emphasis on prevention and early detection. For women, this means access to critical health services that will promote good health across our lifetimes.

You and your family will enjoy improved quality of care and increased choices of health plans. There will be less paperwork and a simpler, more affordable health care system for us all. That's what the American Health Security Plan is all about. Health care that's always there. And that's why you as an American woman will benefit.

file

AMWA
Health Care Reform
Campaign Kit



American Medical Women's Association
801 North Fairfax Street, Suite 400
Alexandria, VA 22314
703/838-0500

Please note that resolutions to be voted on at the House of Delegates meeting may further clarify AMWA's positions on health care reform. Shortly after the Annual Meeting, Campaign participants will receive updated materials reflecting any such changes.

What is the "ASK ME ABOUT" Campaign?

The AMWA "Ask Me About" Campaign on health care reform is designed to bring the voice of women physicians to three important audiences: the press, elected officials and your own network of colleagues, patients and personal friends. Through them, AWMA's messages on health care reform will also reach the general public.

Why is your voice important?

You are an expert. Recent survey data indicates that the voice of medical professionals is key to convincing the American public about the importance of comprehensive coverage for women's health issues. You have both your training and your personal experiences to rely on in addressing these issues.

What will I be asked to do?

"Ask Me About" Campaign members will carry the message about women's health and health care reform to their own communities through letters to the editor and op-ed pieces, letters and visits with elected officials, talking with personal contacts and acting as a spokesperson for women physicians and women's health.

How much time will it take?

The campaign is designed so that you can participate at whatever level of activity is possible for you. This action packet provides materials to get started, including thorough descriptions about how to work with the press and elected officials and sample pieces which you can easily adapt.

The Campaign will keep members up to date on health care reform and AMWA activities on an ongoing basis. Please fill out the form enclosed in this kit and drop it in THE BOX at registration to sign up for the Campaign.

What if I've never done this before?

This is a great place to start--health care reform is the hottest topic around, and people will want to hear what you think about it.

ARENAS FOR ACTION

You don't have to do it all !!

The components of the campaign are identified below -- as you skim over them, think about which ones interest you. The rest of this packet will provide you with specific information designed to help you carry out these activities, even within the constraints of your very hectic schedule.

Press

Your work with the media in your state and community can strengthen public support for AMWA's positions on health care reform. You can convey your message in three different ways:

- ◆ OP-ED Pieces
- ◆ Letters to the editor
- ◆ Acting as a spokesperson with editorial boards, reporters and radio talk shows

Elected Officials

Elected officials, both at the federal and state level, are poised to be the key decision makers in re-shaping our health care system. It is important that your elected representatives are well informed about AMWA's positions on health care reform. You can convey your message through:

- ◆ Letters
- ◆ Phone calls
- ◆ Personal visits
- ◆ Testimony at public meetings and hearings with elected officials

Your Personal Network

Women physicians represent a powerful voice for the need to guarantee that women receive quality, comprehensive health care under a new plan. Each day you are in contact with a wide variety of people who care about your opinion:

WHO?

*Friends
Colleagues
Patients
Pharmaceutical and medical supply companies
Hospital administrators
Local health officials and staff*

WHAT?

Take advantage of any opportunity to:

*Talk about the issues, why you think they are important, and **correct myths and misinformation.***

*Encourage other people to become involved -- share the fact sheets, pass out buttons, and add people to the **"Ask Me About"** Campaign.*

Encourage others to work within their own organizations to publicly support comprehensive women's health care through resolutions, publications and public statements.

Become a Spokesperson

What you as a woman physician have to say about health care reform will be a welcome message to many groups. Accept offers and indicate your availability to speak at town meetings, organization meetings, debates, or other public forums held by schools, churches, colleges, professional organizations, women's organizations. If you can't do it, help to find a colleague who is available.

REMEMBER – This is a Team Effort

If you want additional help or have questions, call the **"Ask Me About"** Campaign at BASS and HOWES: **202/328-2200**

BACKGROUND INFORMATION

AMWA

WOMEN'S HEALTH

HEALTH CARE REFORM

This section provides background information and talking points to use as you begin to work on the *"ASK ME ABOUT"* Campaign.

The sheet labeled **AMWA ON HEALTH CARE REFORM** is specifically designed for you to copy and hand out to other people.

We have also included

A factsheet prepared by the Campaign for Women's Health, a broad based-coalition of over eighty national, state and grassroots organizations convened to ensure that health care reform addresses women's health needs. AMWA is an active member of the Campaign for Women's Health.

A factsheet describing data from a recent poll concerning abortion in a new health plan, conducted on behalf of the National Council of Negro Women and the National Women's Law Center.

Talking Points

AMWA

- The American Medical Women's Association (AMWA) is an organization of 13,000 women physicians and medical students dedicated to promoting equal opportunity for women physicians and promoting women's health.
- AMWA's House of Delegates will consider taking an official position regarding the configuration of a reformed health care system at its meeting on Friday, November 5th.
- AMWA has a unique role within the reform process to speak out for women patients to ensure their needs are met under a new plan.

AMWA and the Clinton Health Care Plan

- AMWA applauds the Clinton Administration's historic efforts to overhaul the U.S. health care system.
- Women physicians can be an important resource for encouraging the medical establishment to support key components of the Clinton plan, including support for coverage of a full range of reproductive health services, including abortion.
- While AMWA generally supports the concepts of the proposed Clinton plan, there are points of difference, particularly in the areas of reproductive care and the frequency of and access to early detection procedures.
- As the details of the plan become clear, AMWA will continue to comment on components which it supports, and those aspects about which AMWA has concerns.

Women and the Health Care System

- Women's health needs have been neglected and underserved in the current system. For many years, women were routinely excluded from clinical trials investigating conditions such as heart disease. Research on women's health concerns have been dramatically underfunded -- breast cancer is a tragic example.
- Twelve million women in the US do not have health coverage. For many millions more, their coverage is dependent on their husband's health insurance, and they are vulnerable to losing coverage because of divorce, unemployment or their husband's death.
- Women are the caregivers of our society. They care for children and family members who are ill or elderly. Ironically, they are the ones who have little support when they become ill or elderly.

AMWA on Health Care Reform

In April 1993 AMWA released a model benefits package which outlined the points which AMWA believes to be most significant in health care reform. Among its key provisions are:

- The process of health care reform should be comprehensive rather than piecemeal and result in a barrier free health care system for all Americans.
- Any new health care system must guarantee universal coverage to all Americans.
- A comprehensive health care system must cover a continuum of care, encompassing preventive, primary, acute and long term care.
- Women's health issues must be a major focus of any reform package. Women face multiple barriers to care and have many health care needs that differ from those of men.
- Prevention: It is essential to cover basic preventive services neglected in the current health care system such as patient and public education about STDs and osteoporosis and regular, basic, screening for breast and cervical cancer.
- Primary Care: Only one-third of U.S. physicians are in fields delivering primary care. AMWA supports incentives to encourage physicians to enter primary care, including loan forgiveness for medical students.
- Reproductive Health: Basic health coverage must include the full range of reproductive health services, from family planning to abortion, infertility and prenatal care. Abortion is not a political bargaining chip to be negotiated away, but an inseparable component of reproductive health care. It must be included for reasons of fairness, economics and public support, and above all, to ensure the provision of complete medical care.
- Mental Health: Women are disproportionately affected by mental health problems; they suffer twice the rate of clinical depression, three quarters of which is never treated. Coverage should include screening, treatment, and long term care when needed.
- Health Education: A reform plan should provide support for health education programs both for individuals and the community including prenatal, maternal and newborn care.
- Clinical Decision Making: The freedom of clinical decision making must be preserved in any reform plan.
- Location of Care: Care should be available in a variety of settings, including hospitals, physician offices, community health clinics, skilled nursing facilities and at home. Access should be enhanced through flexible hours of service, and the provision of transportation and child care.
- Provision of Care: For reasons of education and training, physicians are the appropriate professionals to oversee decision making about patient care. In addition, coverage must include a variety of licensed providers practicing under established guidelines.



HEALTH CARE REFORM IS A WOMAN'S ISSUE!

HEALTH CARE "FACTS OF LIFE" FOR WOMEN IN THE U.S.

- Twelve million women in the U.S. have no health insurance.
- Health insurance in the U.S. is tied almost exclusively to full-time employment, yet only thirty-seven percent of all women working full-time receive direct employer health care coverage, compared to fifty-six percent of working men. Further, women constitute two-thirds of part-time workers, who rarely receive health insurance through their jobs.
- Research has shown a direct correlation between poverty and ill health. Two out of three adults living in poverty in the U.S. are women. Nearly eighty percent of all the poor are women and children.
- On the average, women live seven years longer than men. This puts women at greater risk of chronic disease. It also puts women at greater risk for requiring long-term care, which is currently not covered as a benefit under most standard health plans.
- Women of color have shorter life expectancies, experience higher maternal and infant mortality, have higher incidences of chronic diseases such as diabetes, hypertension, cardiovascular disease, and certain types of cancer. Of all minority women, African American women and Native American women are most at risk.
- Nearly twenty-five percent of pregnant women do not receive adequate prenatal care, and this number is even higher for many minority women. Inadequate prenatal care is a major cause of low birth weight in infants, which in turn is the greatest single danger to infant health.
- It is estimated that one of every nine women in the U.S. will develop breast cancer. Approximately 46,000 women in the U.S. will die from breast cancer this year.
- The National Cancer Institute estimates that at least seven in ten deaths from cervical cancer could be prevented if more women had regular Pap smears. The incidence of cervical cancer among black women is twice that among white women.
- Heart disease is the leading killer of American women. American women have a one in two chance of developing a heart ailment. Yet, a 1988 study demonstrating that small doses of aspirin effectively prevented heart disease included 22,071 men and 0 women.
- Women constitute the fastest growing group of people with AIDS. In 1991, AIDS was one of the five leading causes of death in women ages fifteen to forty-four. HIV/AIDS poses an even greater risk to African American and Latina women, who represent 75% of the women with AIDS.

A Project of O.W.L.

666 Eleventh Street, NW, Suite 700, Washington, DC 20001 (202) 783-6686 FAX (202) 638-2356

Polling on Abortion and National Health Care

The National Women's Law Center and the National Council of Negro Women recently commissioned a national poll on the issue of abortion and national health care. These findings indicate that AMWA's position about abortion and health care reform finds great support among the American people.

People desperately want this issue to be returned to the medical arena.

They believe the government has no business in this issue--they want this to be a personal decision between a woman and her physician.

They are more comfortable with the abortion issue when it is discussed as part of the broader umbrella of reproductive health services or pregnancy related care.

They find the argument that abortion is a complex issue that is better left in the hands of a woman, her physician and her family to be very persuasive.

They also believe that prevention and policies that stress personal responsibility are key to reducing the number of abortions and to responding to the complexities raised by the abortion issue.

A recent CNN poll showed that sixty-two percent of physicians favor including abortion in the national health reform package.

WORKING WITH THE PRESS

The health care reform issue is front page news, and will continue to be for the foreseeable future.

The press is constantly looking for new, expert voices, particularly those who bring a slightly different "twist" to the story -- and that's what you bring!!

Once they know you as a good and reliable "source," the media will come back to you for reactions and opinions on a variety of women's health issues.

Your work with the media will strengthen public understanding and support for women's health.

Writing for the Press

Topics

There are obviously a wide range of topics on health care reform and women's health that you are qualified to write about and that would form the basis for letters to the editor or op-ed pieces.

Your submissions are more likely to be printed if there is a strong *hook*, such as recent coverage of the topic, statements by public officials, something that has happened in your community, or, in the case of op-ed pieces, if you are identifying something important that has been overlooked in the public debate or press coverage.

The best topics to use will change as the debate moves along, as specifics are presented, discussed, and revised. The **"Ask Me About"** Campaign will update members as various topics are focused on or ignored, and provide fact sheets, and sample letters and op-eds.

There are three topics which would be significant to address in this early stage of the debate:

The overall need: A general statement of the need for health care reform in order to address women's health care concerns.

Abortion and family planning: The plan must guarantee that all women will have coverage for the full range of reproductive health services, including family planning and abortion.

Prevention: It should be acknowledged that prevention is an important part of the Clinton health care plan, but in order to be meaningful for women, prevention must insure that screening services--Pap smears, pelvic exams and mammograms, for example--are covered in accordance with published medical guidelines.

Tips

- Write in your own voice and from your own experience. For women physicians, this means combining the weight of your credentials with personal stories about your own practice, your own patients, and how they have shaped what you believe is important.
- Identify yourself. Sign your letter, including your address and phone number, because they will want to check back with you to make sure you really wrote it. It won't hurt to establish credentials, by signing it with your title, such as M.D., D.O. or Professor of Medicine.
- Check with the intended newspaper or magazine to see if they have any specific guidelines for letters to the editor or op-ed pieces.
- It doesn't have to be to the *New York Times*. We sometimes think that the only way to influence opinion is to have letters published in prestigious national newspapers. In fact, you can have a very important effect on the media, elected officials and the general public in your area by working through your local media, where you are better known and established. Members of Congress read their local newspapers.

- Don't forget that the health sections and columns of the daily and weekly newspapers often invite letters and guest columnists.

Op-ed Pieces (Opinion/editorial)

*Op-ed pieces are short, clearly written essays which express an individual point of view. They are useful for **informing** readers about women's issues in health care reform, **convincing** readers about the need to make women's health a priority in health care reform, or focusing on a particular aspect of women's health and health care reform. They are an excellent opportunity to present AMWA and its goals. They are particularly good to use when there has been little news about women and health care reform and you want to keep the issue alive.*

Length should generally be between 500-1000 words, but be sure to check with the intended publication to find out their guidelines.

You have greater latitude in choosing a topic than with letters to the editor, because you can bring up a new, or unaddressed topic. Establish what makes the topic timely or important either in a cover letter or in the text itself (such as, "Last week, the National Cancer Institute released revised guidelines on mammograms," or "Since the introduction of the Clinton health plan, one of every two patients I have talked with has asked me about...").

An op-ed is an essay, and needs to have (as they taught us in English class) an introduction, a conclusion, and a middle where you clearly present your argument. If the editor is unable to follow your argument, he or she will assume that no one else can either.

Remember, this is an opinion piece -- say what your opinion is, and back it up with facts and personal experience.

Letters to the Editor

Letters to the editor are short articles generally written in response to something recently published with which you want to strongly agree or which you believe was slanted or inaccurate.

Keep it short. Letters should be no more than 200-500 words. If you are not concise, there is less chance your letter will get printed. Even worse, it may be printed with such substantial editing that you won't recognize your own letter.

Keep it relevant and timely. Newspapers generally print letters that address something that has recently been printed. The letter can point out an error or omission in an article or editorial, or laud the newspaper for making an important point. (You can write a letter to point out that an important topic is being ignored, but this is probably better raised in an op-ed piece.)

SAMPLE OP-ED

Health Care Reform (general)

I have observed that as the press has reported on the Clinton health care plan, women's health issues have been treated as yet one more "special interest." As a woman consumer of health care, and as a woman physician who treats women, I have a slightly different perspective. Women comprise a majority of health care consumers in this country, and I have learned to think of them as the real "gatekeepers" of our health care system. They choose their own and their children's physicians, they schedule and follow up on appointments for themselves, their children, elderly parents, and often, their spouses. They are the caretakers of children, and of elderly parents and spouses. Women nurses, aides and technicians have been the backbone of our health care delivery system from its inception.

This is not to say that women's health concerns have received the scrutiny or attention which their numbers would indicate. Women have historically been ignored in clinical trials, meaning that decisions about health care treatment for women were often made based on tests in which no women were involved. Research dollars have been abysmally low for "women's" diseases such as breast and cervical cancer.

Health care reform provides a significant opportunity to redress these shortcomings. In order to do so, it must speak clearly and specifically to those areas in which our health care system has historically worked against women's best interests. In order to do this, any health care reform package must focus on universal access, preventive, reproductive and long-term care. The result will be better use of our resources and better health care for women.

Universality -- More than 12 million women in the U.S. have no health insurance. Millions more are dependent on their husband's health insurance, which can end due to divorce, unemployment or spouse's death. Moreover, women often fill part time jobs which provide little or no health benefits. The concept of universal coverage, central to the Clinton plan, would remedy this problem, since health insurance coverage would be available to everyone, regardless of employment or marital status.

Prevention -- Historically, health insurance plans have refused to pay for preventive services, often known as "well care." While the Clinton plan proposes coverage of preventive care, and it is important that these procedures be available as often as published medical guidelines dictate. For women, it is critical that mammograms, pap smears and pelvic exams be available according to current medical practice. This is not the place to try to cut costs--good prevention programs are both cost effective and improve the quality of health care.

Reproductive Health Services -- If we are to adequately care for women and their families, a health care plan must cover the full range of options related to pregnancy: contraception, infertility treatments and pre- and post-natal care. It must provide education in preventing unintended pregnancy and sexually transmitted diseases such as AIDS. It is a legitimate goal of this plan to reduce the number of unintended pregnancies. But, I can assure you, no matter how much education and prevention we cover, we will still have unintended pregnancies. If our health insurance program is to comprehensively cover pregnancy related services, it must cover abortion for all women, regardless of their economic position.

For many years, abortion has been discussed primarily in the forum of public policy, separate from the world of medical care, where it belongs. Health care reform gives us the opportunity to place it firmly back in the health care arena.

Long-term Care -- Women take care of their elderly parents, women take care of invalid children. But when women become seriously ill who supports the caregivers? Thus, a long-term care component, which the Clinton health care plan proposes, is essential.

There is much to be applauded in the Clinton plan, particularly for the important progress it promises towards equity for women's health. But, women's health has always been first on the "chopping block". It is not hard to imagine that in discussions about financing and costs, some very real needs may be overlooked by our primarily male legislative bodies. Women, who have helped make the system work for others for so many years, must now ensure that the new system truly will work for all women.

SAMPLE OP-ED
Theme: Reproductive Rights

As a woman physician, I am very much in agreement with many of the principles of the Clinton health care plan. I also believe that there are some compromises that must not be made in order to achieve such a plan. For example, I believe there must be coverage, regardless of economic status, for a full range of reproductive health care services for women.

The new national health care plan as outlined will vastly improve how women's reproductive health needs are met. Coverage for family planning services, prevention and treatment of STDs, thorough and accessible pre- and post-natal care; early detection of ovarian and cervical cancers; therapies for menopausal and post-menopausal women all must be viewed as essential components of women's health care. But, as a woman who takes care of women, who knows about their lives, their diverse health needs and their families, it is clear to me that such health coverage will not be comprehensive unless abortions are included in the basic benefit package.

This question is likely to be one of the most politicized of the health care reform debate. For many years, I have been discouraged as I watched decisions about this issue being made in political forums so separate from the world of medical care, where these decisions belong. So, in some ways, I welcome the debate within the context of health care reform. If this gives us the opportunity to place abortion firmly back into the health care arena, then the debate will be worth having.

The President has stressed that his plan should reduce the number of unintended pregnancies, and therefore, the need for abortion. I am in agreement with the President and Surgeon General Joycelyn Elders, M.D. that our rate of abortion represents a failure in our system's ability to adequately address the health needs of women. The proposed health plan will vastly improve the availability of contraceptive and other reproductive health services for a substantial number of women. But, I can guarantee that, even with the best contraceptive programs, there will still be unintended pregnancies and the need for abortion. Every method of contraception fails sometimes--almost half of the women who unintentionally become pregnant are using contraceptives. And there will still be pregnancies as a result of rape and incest.

Studies have demonstrated that most women with private health insurance currently are covered for abortion services. Thus, to omit abortion from a basic benefits package would actually reduce benefits for those women. It is unthinkable that, as we seek to improve the comprehensiveness of health care coverage for all Americans, we would reduce coverage for reproductive care.

The President is correct to strongly endorse the concept of a single standard of health care regardless of economic status. If this is the goal, then abortion services must not be denied to poor women. I strongly reject any suggestion that such coverage would sanction or encourage abortion. Such arguments insult the ability of women to care for themselves and to judge what is best for their lives and the lives of their families. Universal coverage of abortion services simply assures that a compassionate society will accord every woman the same ability to make her own health decisions. If we are to recognize that abortion services are part of the definition of comprehensive reproductive health services, then this definition must be applied to all women.

I am also worried about opening a health care debate that would determine what services will be covered based on people's values. This slippery slope will soon, I fear, take us to discussions about care for AIDS patients, patients with lung cancer and other tobacco-related diseases, and others whose health conditions some attribute to "lifestyle choices."

Let us, as a country, once and for all look at reproductive issues in the context of comprehensive health care, and let us finally move this medical decision out of the statehouses, the courtrooms and the picket lines and back into the privacy of decision making between women, their families and their health care providers.

SAMPLE LETTER TO THE EDITOR

Theme: Prevention

To the Editor:

Your recent article, "Preventive Medicine, Boon or Boondoggle" fails to adequately state the case for preventive care.

Few health care professionals would argue with the increased emphasis on preventive medicine in the Clinton Health Care Reform plan -- it is good for patients and for the economics of health care.

Historically, health care plans have failed to cover the costs of preventive procedures and tests. Our system is built on a tradition of "sick care," while prevention focuses on the identification and avoidance of disease, or "well care." Anyone who has been denied payment for the costs of screening tests for breast or colon cancer is acquainted with this anomaly of our health care system.

So, as a physician, I welcome the plan's emphasis on prevention and education. But, I hope that the final plan will take into account the constantly changing science around such programs, and provide a way to ensure that preventive programs are covered according to the most current medical knowledge.

For example, the Clinton plan would cover mammograms for preventive purposes only every other year and only after age fifty. Twelve medical organizations, including the American Medical Women's Association, the American College of Obstetricians and Gynecologists, and the American Cancer Society recommend mammograms every one to two years for women between the ages of 40-49 and every year beginning at age 50. As we learn more about the efficacy of mammograms, these guidelines are reviewed and may be changed. This is all the more reason to provide a mechanism allowing for preventive procedures to be covered according to best current medical practice.

The Clinton plan should simply state that these preventive procedures will be covered in accord with published medical guidelines. Then, decisions about appropriate "well care" will be made where they belong--by patients and their doctors.

Sincerely,

Anne Smith, M.D.
Department of Obstetrics and Gynecology
Summit Hospital

CONTACTING YOUR ELECTED OFFICIALS

Members of Congress will soon be making the key decisions which will shape the way health care will be delivered in the United States.

State governments, acting on their own or to implement a national plan, will also have a great deal to say about the specifics of health care delivery in your state.

They need to hear from you!!

The personal is political. There's no need to deluge them with statistics -- they get plenty of those. You have a very unique point of view -- you are a physician, a woman consumer of health care, and you treat women patients. Bring your personal experiences to your letters and meetings with elected officials.

If you've never done this before -- tell them that. Then say why, what event, what issue, what patient motivated you to become involved in the health care reform issue.

Writing to Elected Officials

Individual letters to members of Congress, governors, state legislators and local elected officials do make a difference. A letter is a good way to call attention to an issue. Most Members of Congress and other elected officials respond to every constituent's correspondence. Just a few letters can have an impact.

Topics

There are several topics about health care reform which you can discuss in a letter. You can rely on the fact sheets for basic ideas, information and language.

★ A letter in which you stress the importance of women's health, express support for some of the basic principles in the Clinton plan, but point out your concerns on some of the specifics: such as coverage for mammograms or pap smears, or lack of clarity about abortion coverage.

★ A letter in which you explain in more detail your position and concerns on specific topics, including those mentioned above, mental health coverage, medical education or primary care.

★ A letter which responds, either in support of or to express concern about something you have seen or read that the elected official has said about health care reform.

Tips

Clearly state the purpose of the letter up front: Demonstrate that you understand the issues you are writing about.

Identify yourself: Establish your credentials. State that you are a physician from their home state/district and a member of AMWA (if you are representing AMWA's position on the issue about which you are writing).

Explain your position: Give one or more reasons why you urge the position that you do. Especially give pertinent facts out of your medical or other experience. Include specific information or examples, if possible, out of your expertise or practice.

Address the letter properly: The envelope should be addressed to The Honorable _____, at the addresses show below. Be sure to spell the Congressperson's name correctly. The letter should be typed or neatly written, preferably on your business or organizational letterhead. It should be in business style, with the legislator's name and address in the upper left hand side.

Request a response. Always end a letter by asking the legislator for a response. If you receive an interesting response, forward a copy to the AMWA office.

Keep your letter short and to the point -- one page, preferably. Be as brief as you can be and yet include all pertinent information.

Thank your legislator. If you legislator votes the way you want, remember to say thank you. Consider writing a letter to the editor of your local paper to publicly thank your legislator. Positive local media is always appreciated.

Where to Address Your letters

The Honorable _____
U.S. House of Representatives
Washington, D.C. 20515

The Honorable _____
United States Senate
Washington, D.C. 20510

Dear Representative _____

Dear Senator _____

letter to Congress

Theme: General

November 1993

The Honorable _____
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative _____:

I am writing both as a physician and as a woman consumer of health care in the United States. I congratulate President and Mrs. Clinton for their leadership in bringing the issue of health care reform to the forefront of our national political agenda. Like them, I believe that we must have health care reform, it must be comprehensive and it must guarantee universal coverage.

As someone who has cared for women patients for twenty years, I can assure you that the recent attention paid to the special health needs of women has been far too long in coming. I welcome the recent mandates for women to be involved in clinical trials and for additional research dollars for breast cancer.

But it is the reform of our health care system that has the real potential to remedy so many shortcomings about women's health care in the United States. For me, three aspects, universal coverage, preventive care, and reproductive health are particularly important.

Universal coverage will immediately help the twelve million women who currently are without health coverage. It will also provide security to the millions more who now depend on their spouse for coverage, which could be lost due to unemployment, divorce, or the death of the spouse.

Preventive Care: It has always been inconceivable to me that my patients were covered for tests once I believed something was wrong, but would not be reimbursed if I prescribed the same test in order to detect a disease at a pre-symptomatic stage. I am pleased that the Clinton health plan would mandate coverage for preventive screenings for Pap smears and mammograms, but I believe that specifying precise levels of coverage goes against best medical practice. It would be far preferable if coverage were consistent with current medical guidelines, which are revised as we learn more about disease and detection.

Reproductive Care: I hope that health care reform will once and for all take the issue of reproductive health out of the legislative arena and put it back into the medical arena. Health coverage for women will not be comprehensive unless it includes family planning, infertility, pre- and post-natal care and abortion. If we are to have a one-tiered health care system, all of these services must be available as part of the basic benefits package guaranteed to all women.

Thank you for your time and attention. I look forward to your response to my concerns.

Sincerely,

Anne Evans, MD
Family Practice Associates

Visits to Elected Officials

You can visit your Member of Congress either in Washington, D.C. or at local offices in your home state. A personal visit will enable your legislator to learn why you care about a particular aspect of the health care reform issue, and for you to hear his or her response. Cultivating a relationship with your elected representatives may facilitate your becoming an expert on whom she or he relies for accurate information on issues of importance to you.

Plan ahead. Call and arrange for an appointment ahead of time. For a visit in Washington, call the switchboard for Congress at 202/224-3121, and ask for your Representative or Senator by name. (Or call the AMWA National Office; the staff will be happy to make the appointment for you.) The telephone number for the state office is listed in the blue pages of your telephone book. The last days of a session, often July and October or November, are very busy and it may be difficult to get an appointment.

It is fine to meet with staff. If your elected official is unable to meet with you, make the appointment with the staff person responsible for the particular issue(s) about which you are concerned. Frequently one person is assigned to health issues. Staff are important -- they provide information and advice to the Member of Congress.

What to do when you get there. Be on time. Begin your conversation by explaining who you are, that you are a constituent, and that you are a physician, and specifically identify the aspects of the health care reform issue you want to discuss. State your position clearly. Give one or more reasons why you urge the position that you do, and offer pertinent facts out of your medical or other experience.

If possible, compliment her or him on a vote that you agreed with in the past. Even if you disagree with your legislator on the issue currently being discussed, you can still offer alternative views, and will in any event want to establish a working relationship for the future.

Leave materials. At the end of the meeting, thank the Member or staff person for meeting with you. Leave materials with them that are provided by the AMWA office. Be sure to leave your business card.

Thank them for taking the time to meet with you and for considering your viewpoint.

WORKING WITH YOUR PERSONAL NETWORK

You come into contact with dozens, sometimes hundreds of people each day -- and all of them will be affected by health care reform. It's the easiest topic in the country right now to start a conversation about -- and you have a very interesting and particular point of view about the issue.

Your Personal Network

Things you can do:

If you are in a conversation about health care reform, try to raise the issues of concern for women's health.

Although it may be awkward at first, try starting conversations on these issues. For example, you can begin by mentioning that this was a very important topic of discussion at the AMWA Annual Meeting.

If you write a letter to the editor or appear on a radio show, you may receive invitations to speak at church groups, civic groups, town meetings, etc. If you are unable to accept, try to find someone who can represent your views.

Let the organizations you are associated with know you are available to speak to them about women's health and health care reform.

Ask others who are interested to raise these issues within their own professional organizations. Show them samples of AMWA resolutions as examples of things their organizations can do. Offer to speak to these groups or to arrange a speaker.

Tips:

Remember, you are an expert both because of your training and because of the patients you treat. Help people personalize this issue by bringing your own experience to your conversations.

Rely on the fact sheets and talking points, as well as the op-ed pieces for background information and arguments.

If you have a question which you cannot answer, call the **"Ask Me About"** Campaign at the offices of BASS and HOWES 202/328- 2200.

Ask colleagues that are particularly interested to help by working with you on the **"Ask Me About"** Campaign. Hand out buttons and copies of the fact sheets. Tell them to call the Campaign at the offices of Bass and Howes (202)-328-2200 to request additional information and copies of the materials.

REMEMBER – YOU DON'T HAVE TO DO IT ALL – EVERY ACTIVITY HELPS!!!

JOIN THE "ASK ME ABOUT" CAMPAIGN

Campaign members will:

Put the voices and concerns of women physicians in the center of the health care debate.

Receive updates about the current status of health care reform and updates on AMWA activities.

Get support, encouragement and technical assistance from the **"ASK ME ABOUT"** Campaign.

000

Name _____

Affiliation _____

Address _____

City _____ State _____ Zip _____

Phone _____ (o) _____ (h)

FAX _____ Specialty _____

I plan to:

write letters to Members of Congress

 write letters and/or op-ed pieces to my newspaper

act as a spokesperson

_____ be interviewed by national media as requested by AMWA

_____ help organize a group of medical professionals in my community

_____ other _____

Please fill out this sheet and drop it in "THE BOX" at registration

AMWA
Health Care Reform
Campaign Kit



American Medical Women's Association
801 North Fairfax Street, Suite 400
Alexandria, VA 22314
703/838-0500

Please note that resolutions to be voted on at the House of Delegates meeting may further clarify AMWA's positions on health care reform. Shortly after the Annual Meeting, Campaign participants will receive updated materials reflecting any such changes.

What is the 'ASK ME ABOUT' Campaign?

The AMWA "Ask Me About" Campaign on health care reform is designed to bring the voice of women physicians to three important audiences: the press, elected officials and your own network of colleagues, patients and personal friends. Through them, AWMA's messages on health care reform will also reach the general public.

Why is your voice important?

You are an expert. Recent survey data indicates that the voice of medical professionals is key to convincing the American public about the importance of comprehensive coverage for women's health issues. You have both your training and your personal experiences to rely on in addressing these issues.

What will I be asked to do?

"Ask Me About" Campaign members will carry the message about women's health and health care reform to their own communities through letters to the editor and op-ed pieces, letters and visits with elected officials, talking with personal contacts and acting as a spokesperson for women physicians and women's health.

How much time will it take?

The campaign is designed so that you can participate at whatever level of activity is possible for you. This action packet provides materials to get started, including thorough descriptions about how to work with the press and elected officials and sample pieces which you can easily adapt.

The Campaign will keep members up to date on health care reform and AMWA activities on an ongoing basis. Please fill out the form enclosed in this kit and drop it in THE BOX at registration to sign up for the Campaign.

What if I've never done this before?

This is a great place to start--health care reform is the hottest topic around, and people will want to hear what you think about it.

ARENAS FOR ACTION

You don't have to do it all !!

The components of the campaign are identified below -- as you skim over them, think about which ones interest you. The rest of this packet will provide you with specific information designed to help you carry out these activities, even within the constraints of your very hectic schedule.

Press

Your work with the media in your state and community can strengthen public support for AMWA's positions on health care reform. You can convey your message in three different ways:

- ◆ OP-ED Pieces
- ◆ Letters to the editor
- ◆ Acting as a spokesperson with editorial boards, reporters and radio talk shows

Elected Officials

Elected officials, both at the federal and state level, are poised to be the key decision makers in re-shaping our health care system. It is important that your elected representatives are well informed about AMWA's positions on health care reform. You can convey your message through:

- ◆ Letters
- ◆ Phone calls
- ◆ Personal visits
- ◆ Testimony at public meetings and hearings with elected officials

Your Personal Network

Women physicians represent a powerful voice for the need to guarantee that women receive quality, comprehensive health care under a new plan. Each day you are in contact with a wide variety of people who care about your opinion:

WHO?

*Friends
Colleagues
Patients
Pharmaceutical and medical supply companies
Hospital administrators
Local health officials and staff*

WHAT?

Take advantage of any opportunity to:

Talk about the issues, why you think they are important, and correct myths and misinformation.

Encourage other people to become involved -- share the fact sheets, pass out buttons, and add people to the "Ask Me About" Campaign.

Encourage others to work within their own organizations to publicly support comprehensive women's health care through resolutions, publications and public statements.

Become a Spokesperson

What you as a woman physician have to say about health care reform will be a welcome message to many groups. Accept offers and indicate your availability to speak at town meetings, organization meetings, debates, or other public forums held by schools, churches, colleges, professional organizations, women's organizations. If you can't do it, help to find a colleague who is available.

REMEMBER – This is a Team Effort

If you want additional help or have questions, call the "Ask Me About" Campaign at BASS and HOWES: 202/328-2200

BACKGROUND INFORMATION

AMWA

WOMEN'S HEALTH

HEALTH CARE REFORM

This section provides background information and talking points to use as you begin to work on the *"ASK ME ABOUT"* Campaign.

The sheet labeled **AMWA ON HEALTH CARE REFORM** is specifically designed for you to copy and hand out to other people.

We have also included

A factsheet prepared by the Campaign for Women's Health, a broad based-coalition of over eighty national, state and grassroots organizations convened to ensure that health care reform addresses women's health needs. AMWA is an active member of the Campaign for Women's Health.

A factsheet describing data from a recent poll concerning abortion in a new health plan, conducted on behalf of the National Council of Negro Women and the National Women's Law Center.

Talking Points

AMWA

- The American Medical Women's Association (AMWA) is an organization of 13,000 women physicians and medical students dedicated to promoting equal opportunity for women physicians and promoting women's health.
- AMWA's House of Delegates will consider taking an official position regarding the configuration of a reformed health care system at its meeting on Friday, November 5th.
- AMWA has a unique role within the reform process to speak out for women patients to ensure their needs are met under a new plan.

AMWA and the Clinton Health Care Plan

- AMWA applauds the Clinton Administration's historic efforts to overhaul the U.S. health care system.
- Women physicians can be an important resource for encouraging the medical establishment to support key components of the Clinton plan, including support for coverage of a full range of reproductive health services, including abortion.
- While AMWA generally supports the concepts of the proposed Clinton plan, there are points of difference, particularly in the areas of reproductive care and the frequency of and access to early detection procedures.
- As the details of the plan become clear, AMWA will continue to comment on components which it supports, and those aspects about which AMWA has concerns.

Women and the Health Care System

- Women's health needs have been neglected and underserved in the current system. For many years, women were routinely excluded from clinical trials investigating conditions such as heart disease. Research on women's health concerns have been dramatically underfunded -- breast cancer is a tragic example.
- Twelve million women in the US do not have health coverage. For many millions more, their coverage is dependent on their husband's health insurance, and they are vulnerable to losing coverage because of divorce, unemployment or their husband's death.
- Women are the caregivers of our society. They care for children and family members who are ill or elderly. Ironically, they are the ones who have little support when they become ill or elderly.

AMWA on Health Care Reform

In April 1993 AMWA released a model benefits package which outlined the points which AMWA believes to be most significant in health care reform. Among its key provisions are:

- The process of health care reform should be comprehensive rather than piecemeal and result in a barrier free health care system for all Americans.
- Any new health care system must guarantee universal coverage to all Americans.
- A comprehensive health care system must cover a continuum of care, encompassing preventive, primary, acute and long term care.
- Women's health issues must be a major focus of any reform package. Women face multiple barriers to care and have many health care needs that differ from those of men.
- Prevention: It is essential to cover basic preventive services neglected in the current health care system such as patient and public education about STDs and osteoporosis and regular, basic, screening for breast and cervical cancer.
- Primary Care: Only one-third of U.S. physicians are in fields delivering primary care. AMWA supports incentives to encourage physicians to enter primary care, including loan forgiveness for medical students.
- Reproductive Health: Basic health coverage must include the full range of reproductive health services, from family planning to abortion, infertility and prenatal care. Abortion is not a political bargaining chip to be negotiated away, but an inseparable component of reproductive health care. It must be included for reasons of fairness, economics and public support, and above all, to ensure the provision of complete medical care.
- Mental Health: Women are disproportionately affected by mental health problems; they suffer twice the rate of clinical depression, three quarters of which is never treated. Coverage should include screening, treatment, and long term care when needed.
- Health Education: A reform plan should provide support for health education programs both for individuals and the community including prenatal, maternal and newborn care.
- Clinical Decision Making: The freedom of clinical decision making must be preserved in any reform plan.
- Location of Care: Care should be available in a variety of settings, including hospitals, physician offices, community health clinics, skilled nursing facilities and at home. Access should be enhanced through flexible hours of service, and the provision of transportation and child care.
- Provision of Care: For reasons of education and training, physicians are the appropriate professionals to oversee decision making about patient care. In addition, coverage must include a variety of licensed providers practicing under established guidelines.



HEALTH CARE REFORM IS A WOMAN'S ISSUE!

HEALTH CARE "FACTS OF LIFE" FOR WOMEN IN THE U.S.

- Twelve million women in the U.S. have no health insurance.
- Health insurance in the U.S. is tied almost exclusively to full-time employment, yet only thirty-seven percent of all women working full-time receive direct employer health care coverage, compared to fifty-six percent of working men. Further, women constitute two-thirds of part-time workers, who rarely receive health insurance through their jobs.
- Research has shown a direct correlation between poverty and ill health. Two out of three adults living in poverty in the U.S. are women. Nearly eighty percent of all the poor are women and children.
- On the average, women live seven years longer than men. This puts women at greater risk of chronic disease. It also puts women at greater risk for requiring long-term care, which is currently not covered as a benefit under most standard health plans.
- Women of color have shorter life expectancies, experience higher maternal and infant mortality, have higher incidences of chronic diseases such as diabetes, hypertension, cardiovascular disease, and certain types of cancer. Of all minority women, African American women and Native American women are most at risk.
- Nearly twenty-five percent of pregnant women do not receive adequate prenatal care, and this number is even higher for many minority women. Inadequate prenatal care is a major cause of low birth weight in infants, which in turn is the greatest single danger to infant health.
- It is estimated that one of every nine women in the U.S. will develop breast cancer. Approximately 46,000 women in the U.S. will die from breast cancer this year.
- The National Cancer Institute estimates that at least seven in ten deaths from cervical cancer could be prevented if more women had regular Pap smears. The incidence of cervical cancer among black women is twice that among white women.
- Heart disease is the leading killer of American women. American women have a one in two chance of developing a heart ailment. Yet, a 1988 study demonstrating that small doses of aspirin effectively prevented heart disease included 22,071 men and 0 women.
- Women constitute the fastest growing group of people with AIDS. In 1991, AIDS was one of the five leading causes of death in women ages fifteen to forty-four. HIV/AIDS poses an even greater risk to African American and Latina women, who represent 75% of the women with AIDS.

A Project of O.W.L.

666 Eleventh Street, NW, Suite 700, Washington, DC 20001 (202) 783-6686 FAX (202) 638-2356

Polling on Abortion and National Health Care

The National Women's Law Center and the National Council of Negro Women recently commissioned a national poll on the issue of abortion and national health care. These findings indicate that AMWA's position about abortion and health care reform finds great support among the American people.

People desperately want this issue to be returned to the medical arena.

They believe the government has no business in this issue--they want this to be a personal decision between a woman and her physician.

They are more comfortable with the abortion issue when it is discussed as part of the broader umbrella of reproductive health services or pregnancy related care.

They find the argument that abortion is a complex issue that is better left in the hands of a woman, her physician and her family to be very persuasive.

They also believe that prevention and policies that stress personal responsibility are key to reducing the number of abortions and to responding to the complexities raised by the abortion issue.

A recent CNN poll showed that sixty-two percent of physicians favor including abortion in the national health reform package.

WORKING WITH THE PRESS

The health care reform issue is front page news, and will continue to be for the foreseeable future.

The press is constantly looking for new, expert voices, particularly those who bring a slightly different "twist" to the story -- and that's what you bring!!

Once they know you as a good and reliable "source," the media will come back to you for reactions and opinions on a variety of women's health issues.

Your work with the media will strengthen public understanding and support for women's health.

Writing for the Press

Topics

There are obviously a wide range of topics on health care reform and women's health that you are qualified to write about and that would form the basis for letters to the editor or op-ed pieces.

Your submissions are more likely to be printed if there is a strong *hook*, such as recent coverage of the topic, statements by public officials, something that has happened in your community, or, in the case of op-ed pieces, if you are identifying something important that has been overlooked in the public debate or press coverage.

The best topics to use will change as the debate moves along, as specifics are presented, discussed, and revised. The **"Ask Me About"** Campaign will update members as various topics are focused on or ignored, and provide fact sheets, and sample letters and op-eds.

There are three topics which would be significant to address in this early stage of the debate:

The overall need: A general statement of the need for health care reform in order to address women's health care concerns.

Abortion and family planning: The plan must guarantee that all women will have coverage for the full range of reproductive health services, including family planning and abortion.

Prevention: It should be acknowledged that prevention is an important part of the Clinton health care plan, but in order to be meaningful for women, prevention must insure that screening services--Pap smears, pelvic exams and mammograms, for example--are covered in accordance with published medical guidelines.

Tips

- Write in your own voice and from your own experience. For women physicians, this means combining the weight of your credentials with personal stories about your own practice, your own patients, and how they have shaped what you believe is important.
- Identify yourself. Sign your letter, including your address and phone number, because they will want to check back with you to make sure you really wrote it. It won't hurt to establish credentials, by signing it with your title, such as M.D., D.O. or Professor of Medicine.
- Check with the intended newspaper or magazine to see if they have any specific guidelines for letters to the editor or op-ed pieces.
- It doesn't have to be to the *New York Times*. We sometimes think that the only way to influence opinion is to have letters published in prestigious national newspapers. In fact, you can have a very important effect on the media, elected officials and the general public in your area by working through your local media, where you are better known and established. Members of Congress read their local newspapers.

- Don't forget that the health sections and columns of the daily and weekly newspapers often invite letters and guest columnists.

Op-ed Pieces (Opinion/editorial)

*Op-ed pieces are short, clearly written essays which express an individual point of view. They are useful for **informing** readers about women's issues in health care reform, **convincing** readers about the need to make women's health a priority in health care reform, or **focusing** on a particular aspect of women's health and health care reform. They are an excellent opportunity to present AMWA and its goals. They are particularly good to use when there has been little news about women and health care reform and you want to keep the issue alive.*

Length should generally be between 500-1000 words, but be sure to check with the intended publication to find out their guidelines.

You have greater latitude in choosing a topic than with letters to the editor, because you can bring up a new, or unaddressed topic. Establish what makes the topic timely or important either in a cover letter or in the text itself (such as, "Last week, the National Cancer Institute released revised guidelines on mammograms," or "Since the introduction of the Clinton health plan, one of every two patients I have talked with has asked me about...").

An op-ed is an essay, and needs to have (as they taught us in English class) an introduction, a conclusion, and a middle where you clearly present your argument. If the editor is unable to follow your argument, he or she will assume that no one else can either.

Remember, this is an opinion piece -- say what your opinion is, and back it up with facts and personal experience.

Letters to the Editor

Letters to the editor are short articles generally written in response to something recently published with which you want to strongly agree or which you believe was slanted or inaccurate.

Keep it short. Letters should be no more than 200-500 words. If you are not concise, there is less chance your letter will get printed. Even worse, it may be printed with such substantial editing that you won't recognize your own letter.

Keep it relevant and timely. Newspapers generally print letters that address something that has recently been printed. The letter can point out an error or omission in an article or editorial, or laud the newspaper for making an important point. (You can write a letter to point out that an important topic is being ignored, but this is probably better raised in an op-ed piece.)

SAMPLE OP-ED
Health Care Reform (general)

I have observed that as the press has reported on the Clinton health care plan, women's health issues have been treated as yet one more "special interest." As a woman consumer of health care, and as a woman physician who treats women, I have a slightly different perspective. Women comprise a majority of health care consumers in this country, and I have learned to think of them as the real "gatekeepers" of our health care system. They choose their own and their children's physicians, they schedule and follow up on appointments for themselves, their children, elderly parents, and often, their spouses. They are the caretakers of children, and of elderly parents and spouses. Women nurses, aides and technicians have been the backbone of our health care delivery system from its inception.

This is not to say that women's health concerns have received the scrutiny or attention which their numbers would indicate. Women have historically been ignored in clinical trials, meaning that decisions about health care treatment for women were often made based on tests in which no women were involved. Research dollars have been abysmally low for "women's" diseases such as breast and cervical cancer.

Health care reform provides a significant opportunity to redress these shortcomings. In order to do so, it must speak clearly and specifically to those areas in which our health care system has historically worked against women's best interests. In order to do this, any health care reform package must focus on universal access, preventive, reproductive and long-term care. The result will be better use of our resources and better health care for women.

Universality -- More than 12 million women in the U.S. have no health insurance. Millions more are dependent on their husband's health insurance, which can end due to divorce, unemployment or spouse's death. Moreover, women often fill part time jobs which provide little or no health benefits. The concept of universal coverage, central to the Clinton plan, would remedy this problem, since health insurance coverage would be available to everyone, regardless of employment or marital status.

Prevention -- Historically, health insurance plans have refused to pay for preventive services, often known as "well care." While the Clinton plan proposes coverage of preventive care, and it is important that these procedures be available as often as published medical guidelines dictate. For women, it is critical that mammograms, pap smears and pelvic exams be available according to current medical practice. This is not the place to try to cut costs--good prevention programs are both cost effective and improve the quality of health care.

Reproductive Health Services -- If we are to adequately care for women and their families, a health care plan must cover the full range of options related to pregnancy: contraception, infertility treatments and pre- and post-natal care. It must provide education in preventing unintended pregnancy and sexually transmitted diseases such as AIDS. It is a legitimate goal of this plan to reduce the number of unintended pregnancies. But, I can assure you, no matter how much education and prevention we cover, we will still have unintended pregnancies. If our health insurance program is to comprehensively cover pregnancy related services, it must cover abortion for all women, regardless of their economic position.

For many years, abortion has been discussed primarily in the forum of public policy, separate from the world of medical care, where it belongs. Health care reform gives us the opportunity to place it firmly back in the health care arena.

Long-term Care -- Women take care of their elderly parents, women take care of invalid children. But when women become seriously ill who supports the caregivers? Thus, a long-term care component, which the Clinton health care plan proposes, is essential.

There is much to be applauded in the Clinton plan, particularly for the important progress it promises towards equity for women's health. But, women's health has always been first on the "chopping block". It is not hard to imagine that in discussions about financing and costs, some very real needs may be overlooked by our primarily male legislative bodies. Women, who have helped make the system work for others for so many years, must now ensure that the new system truly will work for all women.

SAMPLE OP-ED

Theme: Reproductive Rights

As a woman physician, I am very much in agreement with many of the principles of the Clinton health care plan. I also believe that there are some compromises that must not be made in order to achieve such a plan. For example, I believe there must be coverage, regardless of economic status, for a full range of reproductive health care services for women.

The new national health care plan as outlined will vastly improve how women's reproductive health needs are met. Coverage for family planning services, prevention and treatment of STDs, thorough and accessible pre- and post-natal care; early detection of ovarian and cervical cancers; therapies for menopausal and post-menopausal women all must be viewed as essential components of women's health care. But, as a woman who takes care of women, who knows about their lives, their diverse health needs and their families, it is clear to me that such health coverage will not be comprehensive unless abortions are included in the basic benefit package.

This question is likely to be one of the most politicized of the health care reform debate. For many years, I have been discouraged as I watched decisions about this issue being made in political forums so separate from the world of medical care, where these decisions belong. So, in some ways, I welcome the debate within the context of health care reform. If this gives us the opportunity to place abortion firmly back into the health care arena, then the debate will be worth having.

The President has stressed that his plan should reduce the number of unintended pregnancies, and therefore, the need for abortion. I am in agreement with the President and Surgeon General Joycelyn Elders, M.D. that our rate of abortion represents a failure in our system's ability to adequately address the health needs of women. The proposed health plan will vastly improve the availability of contraceptive and other reproductive health services for a substantial number of women. But, I can guarantee that, even with the best contraceptive programs, there will still be unintended pregnancies and the need for abortion. Every method of contraception fails sometimes--almost half of the women who unintentionally become pregnant are using contraceptives. And there will still be pregnancies as a result of rape and incest.

Studies have demonstrated that most women with private health insurance currently are covered for abortion services. Thus, to omit abortion from a basic benefits package would actually reduce benefits for those women. It is unthinkable that, as we seek to improve the comprehensiveness of health care coverage for all Americans, we would reduce coverage for reproductive care.

The President is correct to strongly endorse the concept of a single standard of health care regardless of economic status. If this is the goal, then abortion services must not be denied to poor women. I strongly reject any suggestion that such coverage would sanction or encourage abortion. Such arguments insult the ability of women to care for themselves and to judge what is best for their lives and the lives of their families. Universal coverage of abortion services simply assures that a compassionate society will accord every woman the same ability to make her own health decisions. If we are to recognize that abortion services are part of the definition of comprehensive reproductive health services, then this definition must be applied to all women.

I am also worried about opening a health care debate that would determine what services will be covered based on people's values. This slippery slope will soon, I fear, take us to discussions about care for AIDS patients, patients with lung cancer and other tobacco-related diseases, and others whose health conditions some attribute to "lifestyle choices."

Let us, as a country, once and for all look at reproductive issues in the context of comprehensive health care, and let us finally move this medical decision out of the statehouses, the courtrooms and the picket lines and back into the privacy of decision making between women, their families and their health care providers.

SAMPLE LETTER TO THE EDITOR

Theme: Prevention

To the Editor:

Your recent article, "Preventive Medicine, Boon or Boondoggle" fails to adequately state the case for preventive care.

Few health care professionals would argue with the increased emphasis on preventive medicine in the Clinton Health Care Reform plan -- it is good for patients and for the economics of health care.

Historically, health care plans have failed to cover the costs of preventive procedures and tests. Our system is built on a tradition of "sick care," while prevention focuses on the identification and avoidance of disease, or "well care." Anyone who has been denied payment for the costs of screening tests for breast or colon cancer is acquainted with this anomaly of our health care system.

So, as a physician, I welcome the plan's emphasis on prevention and education. But, I hope that the final plan will take into account the constantly changing science around such programs, and provide a way to ensure that preventive programs are covered according to the most current medical knowledge.

For example, the Clinton plan would cover mammograms for preventive purposes only every other year and only after age fifty. Twelve medical organizations, including the American Medical Women's Association, the American College of Obstetricians and Gynecologists, and the American Cancer Society recommend mammograms every one to two years for women between the ages of 40-49 and every year beginning at age 50. As we learn more about the efficacy of mammograms, these guidelines are reviewed and may be changed. This is all the more reason to provide a mechanism allowing for preventive procedures to be covered according to best current medical practice.

The Clinton plan should simply state that these preventive procedures will be covered in accord with published medical guidelines. Then, decisions about appropriate "well care" will be made where they belong--by patients and their doctors.

Sincerely,

Anne Smith, M.D.
Department of Obstetrics and Gynecology
Summit Hospital

CONTACTING YOUR ELECTED OFFICIALS

Members of Congress will soon be making the key decisions which will shape the way health care will be delivered in the United States.

State governments, acting on their own or to implement a national plan, will also have a great deal to say about the specifics of health care delivery in your state.

They need to hear from you!!

The personal is political. There's no need to deluge them with statistics -- they get plenty of those. You have a very unique point of view -- you are a physician, a woman consumer of health care, and you treat women patients. Bring your personal experiences to your letters and meetings with elected officials.

If you've never done this before -- tell them that. Then say why, what event, what issue, what patient motivated you to become involved in the health care reform issue.

Writing to Elected Officials

Individual letters to members of Congress, governors, state legislators and local elected officials do make a difference. A letter is a good way to call attention to an issue. Most Members of Congress and other elected officials respond to every constituent's correspondence. Just a few letters can have an impact.

Topics

There are several topics about health care reform which you can discuss in a letter. You can rely on the fact sheets for basic ideas, information and language.

- ★ A letter in which you stress the importance of women's health, express support for some of the basic principles in the Clinton plan, but point out your concerns on some of the specifics: such as coverage for mammograms or pap smears, or lack of clarity about abortion coverage.
- ★ A letter in which you explain in more detail your position and concerns on specific topics, including those mentioned above, mental health coverage, medical education or primary care.
- ★ A letter which responds, either in support of or to express concern about something you have seen or read that the elected official has said about health care reform.

Tips

Clearly state the purpose of the letter up front: Demonstrate that you understand the issues you are writing about.

Identify yourself: Establish your credentials. State that you are a physician from their home state/district and a member of AMWA (if you are representing AMWA's position on the issue about which you are writing).

Explain your position: Give one or more reasons why you urge the position that you do. Especially give pertinent facts out of your medical or other experience. Include specific information or examples, if possible, out of your expertise or practice.

Address the letter properly: The envelope should be addressed to The Honorable _____, at the addresses show below. Be sure to spell the Congressperson's name correctly. The letter should be typed or neatly written, preferably on your business or organizational letterhead. It should be in business style, with the legislator's name and address in the upper left hand side.

Request a response. Always end a letter by asking the legislator for a response. If you receive an interesting response, forward a copy to the AMWA office.

Keep your letter short and to the point -- one page, preferably. Be as brief as you can be and yet include all pertinent information.

Thank your legislator. If you legislator votes the way you want, remember to say thank you. Consider writing a letter to the editor of your local paper to publicly thank your legislator. Positive local media is always appreciated.

Where to Address Your letters

The Honorable _____
U.S. House of Representatives
Washington, D.C. 20515

The Honorable _____
United States Senate
Washington, D.C. 20510

Dear Representative _____

Dear Senator _____

letter to Congress

Theme: General

November 1993

The Honorable _____
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative _____:

I am writing both as a physician and as a woman consumer of health care in the United States. I congratulate President and Mrs. Clinton for their leadership in bringing the issue of health care reform to the forefront of our national political agenda. Like them, I believe that we must have health care reform, it must be comprehensive and it must guarantee universal coverage.

As someone who has cared for women patients for twenty years, I can assure you that the recent attention paid to the special health needs of women has been far too long in coming. I welcome the recent mandates for women to be involved in clinical trials and for additional research dollars for breast cancer.

But it is the reform of our health care system that has the real potential to remedy so many shortcomings about women's health care in the United States. For me, three aspects, universal coverage, preventive care, and reproductive health are particularly important.

Universal coverage will immediately help the twelve million women who currently are without health coverage. It will also provide security to the millions more who now depend on their spouse for coverage, which could be lost due to unemployment, divorce, or the death of the spouse.

Preventive Care: It has always been inconceivable to me that my patients were covered for tests once I believed something was wrong, but would not be reimbursed if I prescribed the same test in order to detect a disease at a pre-symptomatic stage. I am pleased that the Clinton health plan would mandate coverage for preventive screenings for Pap smears and mammograms, but I believe that specifying precise levels of coverage goes against best medical practice. It would be far preferable if coverage were consistent with current medical guidelines, which are revised as we learn more about disease and detection.

Reproductive Care: I hope that health care reform will once and for all take the issue of reproductive health out of the legislative arena and put it back into the medical arena. Health coverage for women will not be comprehensive unless it includes family planning, infertility, pre- and post-natal care and abortion. If we are to have a one-tiered health care system, all of these services must be available as part of the basic benefits package guaranteed to all women.

Thank you for your time and attention. I look forward to your response to my concerns.

Sincerely,

Anne Evans, MD
Family Practice Associates

Visits to Elected Officials

You can visit your Member of Congress either in Washington, D.C. or at local offices in your home state. A personal visit will enable your legislator to learn why you care about a particular aspect of the health care reform issue, and for you to hear his or her response. Cultivating a relationship with your elected representatives may facilitate your becoming an expert on whom she or he relies for accurate information on issues of importance to you.

Plan ahead. Call and arrange for an appointment ahead of time. For a visit in Washington, call the switchboard for Congress at 202/224-3121, and ask for your Representative or Senator by name. (Or call the AMWA National Office; the staff will be happy to make the appointment for you.) The telephone number for the state office is listed in the blue pages of your telephone book. The last days of a session, often July and October or November, are very busy and it may be difficult to get an appointment.

It is fine to meet with staff. If your elected official is unable to meet with you, make the appointment with the staff person responsible for the particular issue(s) about which you are concerned. Frequently one person is assigned to health issues. Staff are important -- they provide information and advice to the Member of Congress.

What to do when you get there. Be on time. Begin your conversation by explaining who you are, that you are a constituent, and that you are a physician, and specifically identify the aspects of the health care reform issue you want to discuss. State your position clearly. Give one or more reasons why you urge the position that you do, and offer pertinent facts out of your medical or other experience.

If possible, compliment her or him on a vote that you agreed with in the past. Even if you disagree with your legislator on the issue currently being discussed, you can still offer alternative views, and will in any event want to establish a working relationship for the future.

Leave materials. At the end of the meeting, thank the Member or staff person for meeting with you. Leave materials with them that are provided by the AMWA office. Be sure to leave your business card.

Thank them for taking the time to meet with you and for considering your viewpoint.

WORKING WITH YOUR PERSONAL NETWORK

You come into contact with dozens, sometimes hundreds of people each day -- and all of them will be affected by health care reform. It's the easiest topic in the country right now to start a conversation about -- and you have a very interesting and particular point of view about the issue.

Your Personal Network

Things you can do:

If you are in a conversation about health care reform, try to raise the issues of concern for women's health.

Although it may be awkward at first, try starting conversations on these issues. For example, you can begin by mentioning that this was a very important topic of discussion at the AMWA Annual Meeting.

If you write a letter to the editor or appear on a radio show, you may receive invitations to speak at church groups, civic groups, town meetings, etc. If you are unable to accept, try to find someone who can represent your views.

Let the organizations you are associated with know you are available to speak to them about women's health and health care reform.

Ask others who are interested to raise these issues within their own professional organizations. Show them samples of AMWA resolutions as examples of things their organizations can do. Offer to speak to these groups or to arrange a speaker.

Tips:

Remember, you are an expert both because of your training and because of the patients you treat. Help people personalize this issue by bringing your own experience to your conversations.

Rely on the fact sheets and talking points, as well as the op-ed pieces for background information and arguments.

If you have a question which you cannot answer, call the **"Ask Me About"** Campaign at the offices of BASS and HOWES 202/328- 2200.

Ask colleagues that are particularly interested to help by working with you on the **"Ask Me About"** Campaign. Hand out buttons and copies of the fact sheets. Tell them to call the Campaign at the offices of Bass and Howes (202)-328-2200 to request additional information and copies of the materials.

REMEMBER – YOU DON'T HAVE TO DO IT ALL – EVERY ACTIVITY HELPS!!!

JOIN THE "ASK ME ABOUT" CAMPAIGN

Campaign members will:

Put the voices and concerns of women physicians in the center of the health care debate.

Receive updates about the current status of health care reform and updates on AMWA activities.

Get support, encouragement and technical assistance from the **"ASK ME ABOUT" Campaign.**

[illegible]

Name _____

Affiliation _____

Address _____

City _____ State _____ Zip _____

Phone _____ (o) _____ (h)

FAX _____ Specialty _____

I plan to:

write letters to Members of Congress

write letters and/or op-ed pieces to my newspaper

act as a spokesperson

_____ be interviewed by national media as requested by AMWA

_____ help organize a group of medical professionals in my community

other _____

Please fill out this sheet and drop it in "THE BOX" at registration

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

July 19, 1993

REMARKS BY THE FIRST LADY
AT THE IRIS CANTOR CENTER FOR BREAST IMAGING

University of California at Los Angeles
Los Angeles, California

MRS. CLINTON: Thank you so much for this extraordinary honor and for the opportunity to be with you today. I have looked forward to this occasion greatly, and it is a special privilege to have had a chance to participate in this extraordinary event.

The morning, for me, started out at the Charles Drew University for Medicine and Science, which, Chancellor Young has explained to me, is something that UCLA is also very proud of having been involved with, and there I saw firsthand many of the people who will be, in the future, providing health care to Americans.

I was very encouraged by the dedication and commitment that they demonstrated, because they share the goal that all of us share together, and that is, improving health care for Americans, but particularly for improving health care for American women.

This is a goal that Iris Cantor has been moving toward, and for which we are all grateful that she has. To have an award with her name attached to it is very special for me, because I know her as a champion of the arts and a champion of education and a champion of health, particularly breast cancer research and treatment.

She reminds all of us of what one can do when one puts one's mind and resources and dedication to the task of trying to make a difference, and a difference has truly been made here at the Iris Cantor Center. Just six years ago, as we saw from the video, this was a dream that arose out of Iris' own personal tragedy, with the death of her sister. Today, we can look around us and go far beyond just the short video that we were able to see, and we can know that today the center is in the process of giving evaluations and mammography screenings to 700 women each month.

We can applaud the pioneering work of physicians like Dr. Susan Love, whom you saw on that video, and whom I had the

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pleasure of meeting for the first time some months ago when I attended a gathering of breast cancer survivors and physicians and researchers to be brought up to date about what was happening in the area of breast cancer treatment and research, and learned for the first time of the work of Dr. Love.

We have heard from Dr. Bassett, and the accolades given to him are so well-deserved for the leadership that he has shown in an area that, very frankly, has been far too neglected until recently.

There are many others who serve with Dr. Love and Dr. Bassett, who have pioneered the use of core biopsies instead of surgical biopsies, and have done so much to move forward what we now know about breast cancer -- research into silicone implant leakage, the education of physicians through special one-year fellowships, and, particularly, the outreach programs we saw illustrated on the video for underserved women throughout Los Angeles.

Importantly to all of us, no matter whether we have come here -- as I have met some of you -- from New York or as far away as London and Australia, the standards that have been set for quality management of mammography here at this Center are really setting the curve.

Every woman in America and, indeed, in the world, owes this center a debt of gratitude because the mammography that she receives will be better because of what the Iris Cantor Center has been able to do. (Applause)

What I would like to do for a few minutes this afternoon is to put into context what this center has been doing, is doing, and will continue to do, and to talk about how it and the work it is doing on behalf of women will help to guide what we intend to achieve with respect to health care reform.

But let's start with some unpleasant reality. The health of American women should be better than it is. For too long, women have not had their health needs met with the same attention that the health needs of men have received. We have been on the medical and scientific sidelines. For too many years, when we watched our symptoms, our illnesses, our need for treatments increase, there has not been the corresponding response.

It is ironic that women historically have been relegated to the margins of the health care system. After all, we often are the primary care-givers for our children, for our aging parents, and yet we have not benefitted often from the kind of care and treatment we need most. Today, women are finally on the radar screen when it

comes to research and treatment. We are speaking up. We are being heard. But we have to understand how far we have yet to travel in order to achieve the kinds of advances that the Iris Cantor Center are working toward every day.

It is truly up to us to create a new and healthier culture in our country, a culture in which we promote good health from the outset instead of spending lots of time, money, and energy to treat diseases that could be prevented. Women have a special responsibility, as we are now finding our voices in health care, to be the advocates for that kind of emphasis on primary and preventive care.

Those of you in this room who support this center are examples of the kind of concern and dedication I am talking about and that I hope we will continue to see more of in the future. Your generosity has already saved lives. You have already opened up new opportunities for poor and neglected women, and you have brought your energy and your resources to focus on breast cancer so that no longer can this disease be ignored.

Your support is crucial, because we need to work as hard as we know how and as hard as the scientists and doctors here at UCLA can to find a cure for breast cancer and for other diseases that primarily endanger women.

For too long, the conventional wisdom has been that women's health problems are no different from men's. After all, women usually live longer than men, so they must be healthier; right? Well, wrong. Women do have longer years, in terms of a biological advantage over men when it comes to life expectancy, but they do not have a medical advantage when it comes to funding, research, and treatment of the illnesses that burden them most.

Just last week, one of the most comprehensive surveys ever completed on women's health was released. It showed that last year one-third of all women did not receive basic preventive services such as Pap smears, clinical breast exams, or complete physicals. Among women over 50, only 44 percent received a mammogram, and, often, the reason cited for the failure to seek such primary or preventive care was the expense or lack of insurance. What this study confirmed is that women become more vulnerable and more exposed to serious illness as they get older, largely because their access to preventive care is limited and, until recently, because all too often the treatments that they received had not changed dramatically over a number of years.

So, too often, those bonus years that we perhaps can look forward to as a result of our gender are not really benefits at

all. They become lonely days and nights, clouded by needless infirmity and inadequate care. Sadly, even today, women grow older with few clues about the health problems they face. Breast cancer is but one example. We don't know what causes it. We don't know how to prevent it. We don't know how to cure it. The truth is, we still know far too little about this disease and other diseases that primarily afflict women.

For example, do environmental factors, such as toxins or pollutants, diet, drugs contribute to the rise in breast cancer rates? We don't know. And the reason we don't know is because, until just a few years ago, we were not looking very hard for answers.

A few years ago, however, a group of energetic women's scientists and grass roots advocates alerted us to the inequities that existed in research and funding to try to determine what caused and how to prevent and cure women's diseases. Groups such as the Society for the Advancement of Women's Health Research showed us the appalling degree to which women were routinely excluded from major clinical trials of most illnesses.

Even when women are victims of the same diseases as men, such as coronary heart disease, hypertension, or strokes, research has focused on men. A major study on the relationship between cholesterol and heart disease involved 15,000 men and no women. In one of the most significant trials in the 1980s, which studies the preventive effects of aspirin on heart disease, there was not one woman included among the 22,000 patients screened, even though heart disease is the leading cause of death among women, followed by cancer and strokes.

For too long, the explanation has been that men were providing a more stable group for clinical trials, but the fact is that women are different from men, and the effects on women of interventions have to be tested on women for us to know what works and what does not.

Well, the national research agenda is finally recognizing that women have unique health problems, unique systems, and unique responses to treatment, so we are finally beginning to get attention to diseases such as breast cancer. But what about, also, cervical and ovarian cancer, osteoporosis, immunological illnesses such as lupus and MS, certain forms of mental illness, eating disorders, endometriosis -- all diseases which either exclusively affect women or disproportionately affect women?

Even one of the most universal female experiences, menopause, is barely understood today. Are hormone therapies helpful

or harmful in coping with menopause? Do they increase, decrease, or have no effect on the possibility of contracting another disease, such as cancer? Nobody really knows, and the result is that women are often bombarded with confusing and conflicting messages about their own health at critical stages of their lives.

Now, I don't think I need to say to this group why we should be caring about these issues or why we should be focusing on women's health, but for those who might not think this is as obvious as we do, we need to make the case that focusing more attention on women's health is good for everyone. It will greatly benefit the 51 percent of our population who happen to be women and who will live longer and, we hope, healthier in those years, but also because their well-being often affects the well-being of their family members and because, in sheer economic terms, continued ignorance about women's health will cost our nation far more than any investment we can make to try to prevent and control the diseases that affect them.

If we have technology, as we do, sophisticated enough to direct missiles to targets thousands of miles away, then we ought to work to have technology sophisticated enough to detect every fatal lump in a women's breast, because every three minutes -- every three minutes, a woman in this country will be diagnosed with breast cancer, and every 12 minutes, a woman will die from it.

Just last week, a young woman whom I met at that meeting with Dr. Love in Williamsburg, Virginia, who had battled courageously against breast cancer, died. One of the last things she did was to bring her husband and her young son to the White House, because she wanted her son to meet the President.

As we were standing there in the Oval Office, with my friend, Sherry, confined to a wheelchair, after having exhausted every possible treatment that she could, with her son clinging to her leg, with her husband pushing the wheelchair, the last thing she said as she left the Oval Office, was to turn to the President and me and to say, "Don't ever let anyone forget what this disease does to those who are left behind."

I told her then that I would not. And, just as Iris Cantor felt that commitment to her sister, I intend to fulfill my commitment to Sherry. (Applause.)

Because, even though we can applaud what the center here is doing and what hard-working physicians and nurses and others are doing all over this country every day, the toll in human terms can never be completely over-looked until the disease is conquered, because every person who is a statistic, whether we talk about the numbers and the millions, the 2.6 millions who currently have it, or

whether we talk about, on a very individual basis, someone like my mother-in-law, who is a breast cancer survivor, behind every one of those statistics there stands not just a single woman, but family members and medical personnel who are battling to save her life.

I hear from these women and their families all the time, and I know, as many of you do, what they are struggling against. I am grateful that, finally, we have, I hope and trust, put behind us the days of insensitivity, the days of the kind of treatment that was implied in the video, where women are made to feel somehow less than whole if they contract this disease, where women are treated as second-class citizens if they do get the courage to seek help. I trust those days are moving behind us, so that we can focus with sensitivity and caring on the women who need our help.

This effort has to be put into the larger context of what we are attempting to achieve with health care reform. I have been privileged for the last six months to travel around our country, to speak to all kinds of Americans, from the deans of prestigious medical schools to nurses on the front lines to business people, to patients in hospitals, and to listen to their stories. But there is one in particular that I keep coming back to and that I often tell, because it summed up for me what we are up against.

Several months ago, I was in New Orleans. I was visiting a small business that did not provide any contribution toward the health care insurance of employees, most of whom had worked for this small business for many years, but most of whom did not make very much money. I was sitting in a semicircle, talking to men and women who were telling me about the travails they were facing because of the extraordinary financial obstacles they faced in achieving health care.

I think, all too often, those of us who have health insurance, those of us who schedule our annual checkups, who do what we're supposed to do, think of those without as somehow not quite being responsible. You know, if they were responsible, they would take care of themselves, and we wouldn't have all these health problems.

Well, for many people, it's often a question between food and health care or between rent and health care. For many others, they try as hard as they know how to be responsible patients themselves, responsible parents, and there are so many obstacles that they face.

This one woman, who had worked for this company for 15 years, said she always tried to take good care of herself. She tried to do what we all should be doing -- you know, not smoking, not

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drinking to excess, not using drugs, taking care of your diet. She tried to do all of that, and, every year, she also dug into her own pocket and went for an annual physical exam. She told me that she had gone to her doctor and, during a manual breast exam, he had found what he thought of as a suspicious lump, and he referred her to a surgeon. She went to the surgeon. The surgeon examined her and told her that if she had insurance, he would biopsy the lump in her breast, but since she did not have insurance, he would just watch it.

I cannot tell you what it was like, but I think many of you can feel what I felt when I heard that woman say that. What I felt was that here was someone who was being responsible, was taking care of herself, was seeking out care in a very reasonable way, and was being told that she would be treated differently than someone who came holding that insurance card or someone who came who would be paid for tax dollars.

She fell in between the crack that exists between the privately insured and the government insured, and in that crack are about 40 million of our fellow citizens, the vast majority of whom get up every day and go to work and who are mostly women and children. She was being penalized in our health care system.

Now, it is traumatic enough for a woman to be told that she has breast cancer and to cope, as Dr. Love, said, with losing a breast or maybe even both. But can you imagine how it is like for that woman to get up every day and wonder whether she is living with cancer and not knowing it?

So, until we learn more about breast cancer, and until we pursue the work that is being done here, to try to prevent or cure breast cancer, we will all be in the same position as women are today with not knowing. But until we change our health care system, we will all share the unfair emotional burden that is afflicted on any of our fellow citizens because of the inequities in this system.

Now, fortunately, times are finally beginning to change. Women like Iris and many of you in this room -- cancer survivors, scientists, physicians, nurses, health care advocates, Members of Congress -- have all helped awaken our country to the challenge that breast cancer poses, and we have some progress to report.

In 1985, the federal government spent \$50 million on breast cancer research. In the current Appropriations Bill, \$449 million is earmarked for programs at several agencies. That's an improvement, and we hope that it will lead to the kinds of breakthroughs that we're all praying for.

Scientists are also exploring promising drug therapies, such as taxol and tamoxifen, and they have uncovered potential uses of RU-486 in tumor treatments. And, at the National Institutes of Health, scientists may be on the verge of identifying a gene marker in high-risk women.

The President lifted the ban on RU-486 importation, and that will pave the way for move aggressive research. (Applause.) And he also lifted the ban on fetal tissue research, which may be useful in helping us find a cure. (Applause.) The President recently signed the National Institutes of Health bill, which includes the newly created Office of Research on Women's Health as part of the statute, so, for the first time, we will have an office in NIH that will focus in women's health issues as we begin to create a more balanced approach. (Applause.)

And, very importantly, the federal government is sponsoring a 14-year, \$625 million effort called the Women's Health Initiative, that will explore long-term patterns in heart disease, cancer, and osteoporosis, looking for some of the solutions that have eluded us thus far.

We are beginning to make the kind of commitment that is required, and the administration in Washington has targeted \$10.7 billion for research on prevention, treatment, and general health promotion, and there has been a significant increase, as I've said, in what effects women.

There has also been an increase targeted for the Public Health Service budget, so that we can begin to implement the standards for quality mammography that have been pioneered here at the Iris Cantor Center.

But, in order for any of this to work and to make a difference in our lives, we have to proceed with universal coverage for every American in a health care system that provides quality health care for men and women. (Applause.)

Let me just briefly describe to you what we hope that health care system will look like after this reform occurs. It will provide security for every American. Right now, those of us who are insured have no assurance that we will be insured next year.

Whoever you talk to today, in this changing economic climate, cannot tell you that if they are employed and their employer provides insurance, that the employer will continue to do so, or continue to do so at the level that was previously offered, or will be even in business in today's fast-changing global economy.

So the first and foremost promise we have to make to the American people is this: No matter who you are, no matter who you work for, no matter whether you have ever been sick before -- and, therefore, have what is called a pre-existing condition -- you will have health insurance, no matter what. That has to be a solemn commitment that is made to everyone. (Applause.)

That health insurance has to provide a core of benefits in a package that emphasizes primary and preventive health care. We have done it backwards for too long. We have paid for the surgery, but not for the mammography. We have paid for the expensive drug treatment, but not for the screening. We need to emphasize primary and preventive health care that includes checkups, immunizations, Pap smears, mammographies, the kinds of early detection and prevention treatments that will save us money as well as save us lives. And, if we do that, we will need to be sure to have the kind of broad-based delivery of health care that will enable us to have the primary and preventive health care specialists, the physicians in family practice, and the internists and the pediatricians, the nurse practitioners and the nurse-midwives, the others who will be on the front line, delivering primary and preventive health care. If we do that, we will save money, and we will save lives.

That has to be the emphasis of the package of benefits that we give, because we have to change the mind set as to what health means. Health needs to be keeping people healthy, not just treating them when they are sick. The only way we can get there is by emphasizing primary and preventive health care, and we need to have incentives for people to take advantage of those kinds of interventions early.

If we provide security for everyone, and if we provide a good system of primary and preventive health care, we will begin to put our health care system on a much firmer footing, in terms of health outcomes and in terms of its financing.

We also need to assure that patients have the choice as to who they choose for their health care provider. We want to secure the individual's right to choose the physician, the hospital, the health plan that is best suited for that person.

In an area like Los Angeles, where you have so many providers and so many fine institutions, that will not be as big a problem, except in the currently underserved areas. It will do very little good to tell the people where I came from this morning that they now have health security and access, if they don't also have choice.

But with their now having a reimbursement stream that will flow with them and the assurance that they will no longer be uncompensated care statistics, we think that the kind of delivery networks that need to exist even in underserved urban areas and rural areas will be created within a marketplace of new approaches to providing health care that will link fine institutions like UCLA with primary care providers in places like Watts --

(End of side one)

(Begin side two -- in progress) -- and the difficulties of providing health care in underserved areas, those areas have for too long gone without.

We think we can make a market there that will enable us to provide care to the citizens who live there, and we want the decisions about health care to be made by physicians, nurses, health care professionals, not government and insurance bureaucrats. We want to move back the centrality of the patient-physician relationship. (Applause.)

For those of you who have dealt with some forms of so-called "managed care" now, you know that, too often, you get on the phone, if you're a physician or you're a nurse or you're in the admission department of a hospital, trying to convince somebody a thousand miles away why you need to do the procedure that you want to do for this particular patient. Those decisions need to be made where the patient is.

Now, in order to do that, we need to simplify the reimbursement and the administrative side of health care. We have too many insurance companies, too many forms from both the private companies and the government. They need to be collapsed in, as close as possible, as a single form, so that physicians and nurses can get back to treating patients instead of pushing paper. It will make a big difference in the delivery of health care. (Applause.)

If we move on all of these fronts -- research, universal access, providing a core benefits package that emphasizes primary and preventive health care, making it possible for people to have choice, simplifying the system to save the money that we now spend on administrative and bureaucratic costs, we will have a system that better allocates the resources that are within it. And that is, in the end, what we are attempting to achieve.

We already spend more money than any nation on Earth, and we don't even cover most of our people. Many of our statistics cannot be matched against other nations whose standard of living is not as high as ours, because they do a better job in providing primary and preventive health care. We cannot afford to let this moment in history for this country go by.

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There will be a million reasons, as there always are when you're advocating change, why something should not be done, but we do not have a stable status quo. We have a status quo that continues to deteriorate. At one end, you have the very best of health care that you can find anywhere in the world, and yet, as you go down the line from the UCLA's and the Iris Cantor Centers of this world, down into where health care is not being delivered or being delivered inadequately because of the pressures of too few resources for too many people, we end up with results that no one in this country can be proud of.

We could, however, change that and do it in a way that will be financially beneficial for this country in terms of solving our continuing deficit problem and, more importantly, begin to treat all of our people with the respect and dignity they deserve to have.

But, in the end, even if we are successful, as we intend to be, in reforming the health care system of our country to be a more reasonable, cost-efficient quality deliverer of services, much of what we can achieve will depend upon each of us individually. We have to take responsibility for our own health, and we have to take responsibility for our own communities.

It is not always easy to take care of yourself when you've got so many things on your mind or when you're under the kind of financial pressure, as that woman I met in New Orleans is. But good health care starts with the individual, and good health care for this country starts with recognizing the connections among individuals.

We can improve our own health care. We can change our behavior. Hippocrates said it first, as I have found he often said things first, "The patient must combat the disease along with the physician."

What is at stake in this struggle and challenge we are confronting is not just changing the way we finance health care, it's not just eliminating administrative hassles or giving us more primary and preventive health care providers instead of specialists, or all of the individual, specific pieces of what will make up health care reform.

It is about once again asking individuals to be responsible for themselves, but also for those with whom they live and care about. It is, in the end, a vision about the kind of people we are and that we want to be. It is about creating an ethos of caring and it is about once again considering ourselves linked as part of a great community.

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In the end, that is what will make us healthier. It is being part of a community that is healthy. It is being part of a commitment to caring and individual responsibility. That is what the Iris Cantor Center is attempting to do.

For many of us, breast cancer is a very personal challenge. It is something that we want to have a part in seeing cured and prevented. But we want to do that, not just to combat a disease, but because we love someone, we have a friend we care about, we've been moved by somebody's story. Because, at bottom, it is that human connection that will make the difference.

So let us join our hearts and our hands together to support the changes that we need for ourselves as individuals, for our communities, and for our country.

Thank you all very much. (Applause.)

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44.
From House Energy & Commerce
Committee testimony 9/28/93

Many employers believe that they could strike a good bargain for themselves. The problem is that, if you don't have a large number of employers and employees in the purchasing pools, then you begin to have the kind of risk adjustment that works to the disadvantage of the whole system. And we're very concerned about that. If we could build in adequate protections against that, we would be glad to -- you know, to look at options like what Washington has done.

But on a national level, we are afraid that you would not have the kind of protection against what they call in the insurance trade cherry-picking, and you'd have, you know, younger, healthier people being hired by employers and, therefore, the employers being able to negotiate a better deal because there wouldn't be any protection against doing that. And we think that might cause even worse kinds of outcomes for people than we currently have. So it's an area that we're open to discussing, but it's one that gives us a lot of concern.

REP. KREIDLER: Thank you, Mr. Clinton.

Thank you, Mr. Chairman.

REP. : Mrs. Clinton, Mr. Dingell is on his way back from the vote, and he would like to close the meeting. We'd promised you you'd be out at 3:00. Could you take a few more questions until he arrives?

MRS. CLINTON: I'd be glad to. I'd be glad to.

REP. : Thank you very much.

I recognize the gentlewoman from Pennsylvania.

REP. MARJORIE MARGOLIES-MEZVINSKY (D-PA): I would like to add my voice to those who appreciate and respect what you've done. And welcome.

My question has to do with Pap smears and mammograms. How do you reconcile the Pap smear and mammogram regimen in the basic benefits package that falls short of the recommendations from the American Cancer Society and other women's health groups? In particular, I'm concerned that women should receive annual or biannual Pap smears and annual or biannual mammograms after 40, not 50.

MRS. CLINTON: Well, I'm so glad you asked that, because there has been so much misinformation and misunderstanding about this feature. And I am happy to have the opportunity, Congresswoman, to clarify that.

As you know, there are many insurance policies now that do not cover diagnostic services like Pap smears and mammograms, which means that the woman bears the entire cost if she should obtain such a service. What we have done is to absolutely include them in the comprehensive benefits package. Mammograms and Pap smears are covered services. That means that you can never be denied insurance coverage for those particular diagnostic tests.

What we have further done, and what we have done in line with a recommendation from the United States Preventive Services Task Force, which was created under the previous administration under the previous head of the National Institutes of Health, is to adopt their recommendation. Their recommendation was that women over 50 should have a mammogram every other year. So, what we have done is to say all women are covered.

Every woman for whom any doctor believes it is medically necessary or appropriate can start at whatever age is the age that that doctor thinks is the one that she should begin. But for women over 50, the service will be completely free. Now, what that means is that if I have -- belong to a health plan that has no co-payment requirement, then I can start getting my mammograms and Pap smears before I am 50 on a medically necessary or appropriate basis without any cost. If I belong to one where I have a \$10 co-pay, that's all I will pay, but I can start anytime before 50 and do it as many times as my doctor thinks is necessary.

But every single American woman, when she reaches 50, which is the age that was recommended by this very extensive task force that looked at all of the evidence, no matter what plan she is in, she will have that service absolutely free. So, the co-payment will not be necessary. It will not count in any kind of deductible. It will be absolutely free.

We think that is the right balance to strike. If, in the coming weeks and months, the Congress believes that we should try to extend that free coverage below the age of 50, we will look at the cost of doing that.

But I want to assure every woman -- you know, my mother-in-law has had a struggle with breast cancer over the last several years. I, like most women, have tried to do what I should do with respect to mammograms, and I've paid the full cost because they were not a covered service in the past. And so, I take this very personally. They will be covered. No woman will be turned away. They will be part of the guaranteed benefits package. And then, for women most at risk over 50, as a further inducement for women to come in and do it, they will be absolutely free as part of the preventive services we provide.

REP. MARGOLIES-MEZVINSKY: So, if there is family history involved or something like that, according to the doctor's wishes, they will be covered.

MRS. CLINTON: If it is medically necessary or appropriate, and that is a standard that would certainly cover women with a family history or any kind of suspicious growth, it would not be in any way prevented or eliminated from coverage. If a woman believes it is appropriate, she will be entitled to have that service, and it will be covered as an insured service.

REP. MARGOLIES-MEZVINSKY: I suspect this next answer may have something to do with a report card, but will there be a compliance element involved here also? I feel that it isn't enough for an insurer of any sort to just have this service available.

REP. DINGELL: The chair advises the time of the gentlewoman has expired. The chair recognizes --

MRS. CLINTON: Mr. Chairman, I don't mind answering that. If you would like me to, I don't mind answering it.

REP. DINGELL: If that's your wish, then please, Mrs. Clinton.

MRS. CLINTON: Because I think the congresswoman has asked a very important question about insuring quality and making sure that information is accessible to real people and not just, you know, folks who read medical journals.

We're going to do everything we can, and that's why I applaud your state so much, because this kind of consumer guide is exactly the kind of information we are going to need. And that will be part of the report card process. But I also believe that there will be a great interest in making sure that consumers get good information.

I would imagine that all kinds of consumer groups and maybe even a whole new industry will grow up to provide information so that every year when you and I make our choice about what health plan to join we will be looking at all kinds of information that will help us make the best choice. And I will look first, as I know you will, at what is the quality. You know, what kind of treatment do they get and what kind of outcomes do they have and how good a job are they doing? That's what my bottom line is, and I think that's what most Americans feel as well.

REP. MARGOLIES-MEZVINSKY: Thank you very much.

REP. DINGELL: The time of the gentlewoman has expired.

The chair recognizes now the gentlewoman from Arkansas, Ms.

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MEDIA RELEASE
For immediate release
September 23, 1993

CONTACT: Vicki O'Reilly
(202) 783-6686

WOMEN'S GROUP SUPPORTS HEALTH CARE REFORM

WASHINGTON, DC -- President Clinton's health care reform proposal offers substantial benefits to midlife and older women, leaders of the Older Women's League, a national advocacy group based in Washington, D.C., said today. "In recognizing that universal access to health care is an essential right, the President has taken an important step forward for all Americans -- especially women," said OWL President Lou Glasse.

"We are pleased that the President's proposal authorizes states to adopt single payer systems," said Glasse. "OWL believes that a single payer system of health care financing is the best way to contain costs without sacrificing quality of care. In the meantime, we are pleased that the President has proposed a plan that will cover part-time workers, workers in small businesses and the unemployed."

"It is women who are most likely to hold low-paid and part-time jobs," Glasse stated. "For too long, many women have relied on a husband's insurance plan to meet their health care costs, leaving them without access to coverage if they were widowed or divorced."

-more-

Older Women's League

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Add One

"OWL applauds the President's emphasis on long-term care, within homes and in community settings," said OWL Executive Director Joan Kuriansky. "This is a vital concern for women who both provide the bulk of family caregiving and are most likely to require such care as they age. Long-term care services in a full range of settings -- at home, in community care facilities and, when necessary, in institutions -- must be available under a comprehensive plan."

"We must ensure that state governments have adequate funds to offer a full array of long term care services," Kuriansky said. "At the same time, we will work with the Administration and Congress to avoid possibly excessive Medicare cuts -- which could lower the quality of care and limit the number of health care providers willing to serve Medicare patients."

Additional provisions of the President's proposal which OWL praised are:

- The coverage of preventive as well as acute care services.
- The assurance that consumers may choose their own health care providers.
- Significantly expanded coverage of prescription drug costs.

"OWL's founders both died of breast cancer," Glasse stated. "It is long past the time when Pap smears, mammograms and appropriate cancer treatments are unavailable to many older women. We support cancer research and treatment schedules which provide to women adequate and appropriate care."

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Add Two

"OWL commends the President and Ms. Clinton for their leadership in bringing reform to this point," Kuriansky said. "We pledge to work with the Administration and Congress to successfully ensure that every person in America has access to comprehensive health care."

Founded in 1980, OWL -- the first national membership organization to focus exclusively on issues of concern to midlife and older women -- provides leadership on health care issues. OWL is represented on the three-member board of the Long-Term Care Campaign. It is the Convenor of the Campaign for Women's Health, a coalition of 80 women's, labor, and health care organizations representing over 8 million Americans who seek to ensure that women's voices are heard in health care reform.

CAMPAIGN FOR WOMEN'S HEALTH

PRESS RELEASE

For immediate release:
September 24, 1993

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**WOMEN'S HEALTH COALITION SUPPORTS HEALTH CARE REFORM:
PRAISES PRESIDENT'S PLAN, SEEKS CHANGES FOR WOMEN**

The Campaign for Women's Health, a coalition of eighty national, state and grassroots organizations, representing more than eight million individuals nationwide, applauds the introduction of President Clinton's health care reform plan. "The health care reform debate now underway is a chance to right the wrongs which daily compromise the health of American women," said Joan Kuriansky, Convenor of the Campaign for Women's Health and Executive Director of the Older Women's League.

"As the President releases his plan for health care reform, we urge him to remember the women: invisible in research, often partitioned by the medical establishment and treatment needs ignored," said Kuriansky. "The Campaign for Women's Health is seeking a health care system that does not treat women as second class citizens. We believe the President's plan offers us that opportunity."

More than twelve million women have no health insurance and millions more have insurance which does not meet their basic health needs. Women are 52% of the population and use more health services because they live longer and bear children. Women are the majority of health care workers and the unpaid caretakers of the

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family health. "Women's health is everyone's health," said Kuriansky.

"President Clinton has taken a major step forward by assuring that every American woman will have health care regardless of income, family status, employment, age, and health. For the first time we have a leader who makes it clear that health care for women is a right and not a privilege," said Julia Scott of the National Black Women's Health Project.

"The Clinton health care plan makes significant progress toward reorienting and restructuring the health care delivery system," said Virginia Trotter-Betts, President of the American Nurses Association. "It will ensure women access to health services by maximizing the delivery of primary and preventive health care in convenient community-based settings. In addition, the plan will remove restrictive regulatory and payment practices and other barriers that prevent women from choosing their health care services from a range of accessible, qualified providers."

The Campaign for Women's Health also praises the President's plan for including:

- a comprehensive benefits package guaranteed for all citizens, with a range of services from hospital care to health education;
- preventive health services, including periodic exams, Pap smears, and mammograms;
- subsidies for low-income women up to 150% of poverty, to

more

Add Two

cover premiums and copayments;

- community-based care, with incentives for providers and facilities to meet the needs of rural and urban women in nearby locations;

- choices from a range of providers, including a range of nurse and other non-physician providers;

- the first steps towards comprehensive long term care and mental health services.

Coalition members have called upon the President to make clear his support for including family planning and pregnancy-related services in the health care plan benefits package. "Reproductive health care is an inseparable and integral part of women's health and the plan must include the full range of reproductive health services for women," said Marcia Greenberger of the National Women's Law Center.

Campaign members are also concerned about low-income women under the plan. It is unclear how subsidies will adequately cover low-income women above 150% of poverty for whom the required financial contributions may pose a hardship. "It would be ironic to exchange the inequities of the current system for new ones and force women once again to choose between food on the table and paying for health care," said Kuriansky. "We are also concerned about how premiums and copays will be subsidized to women depending on their family and financial status," she said.

We salute the President for addressing the home and community-

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based needs of older citizens. "Long term care is a vital concern for women who both provide the bulk of family caregiving and are most likely to require such care as they age. Long term care services in a full range of settings -- at home, in community care facilities and, when necessary, in institutions -- must be available under a comprehensive plan," said Lou Glasse, president of the Older Women's League.

The Campaign for Women's Health will continue to assure that the interests of women and their health are met in health care reform. "We look forward to working with the president, Mrs. Clinton, and Congress in creating a health system that meets the needs of women and all Americans," Kuriansky said.



AGENDA

Campaign for Women's Health
News Conference
National Press Club
First Amendment Lounge
September 24, 1993 - 9:00 AM

Welcome and Introductory Remarks	Joan Kuriansky Campaign for Women's Health Chair Older Women's League Executive Director
Access for Women in Health Reform	Julia Scott National Black Women's Health Project Director, Public Education Office
Long Term Care Coverage	Lou Glasse Older Women's League President
Benefits Package	Cynthia Pearson National Women's Health Network Program Director
Reproductive Health Services	Marcia Greenberger National Women's Law Center Co-President
Provider & Service Delivery Issues	Gwendolyn Johnson American Nurses Association First Vice-President
The Campaign's Grassroots Project	Anne Bryant American Association of University Women Executive Director

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16 Pages

Health Care Reform:
A critical Issue for
Women. OWL Pamphlet.



HEALTH CARE

REFORM:

A CRITICAL ISSUE

For Women

CAMPAIGN FOR WOMEN'S HEALTH



HEALTH CARE REFORM IS A WOMAN'S ISSUE!

HEALTH CARE "FACTS OF LIFE" FOR WOMEN IN THE U.S.

- Twelve million women in the U.S. have no health insurance.
- Health insurance in the U.S. is tied almost exclusively to full-time employment, yet only thirty-seven percent of all women working full-time receive direct employer health care coverage, compared to fifty-six percent of working men. Further, women constitute two-thirds of part-time workers, who rarely receive health insurance through their jobs.
- Research has shown a direct correlation between poverty and ill health. Two out of three adults living in poverty in the U.S. are women. Nearly eighty percent of all the poor are women and children.
- On the average, women live seven years longer than men. This puts women at greater risk of chronic disease. It also puts women at greater risk for requiring long-term care.
- Women of color have shorter life expectancies, experience higher maternal and infant mortality, have higher incidences of chronic diseases such as diabetes, hypertension, cardiovascular disease, and certain types of cancer. Of all minority women, African American women and Native American women are most at risk.
- Nearly twenty-five percent of pregnant women do not receive adequate prenatal care, and this number is even higher for many minority women. Inadequate prenatal care is a major cause of low birth weight in infants, which in turn is the greatest single danger to infant health.
- It is estimated that one of every eight women in the U.S. will develop breast cancer. Approximately 46,000 women in the U.S. will die from breast cancer this year.
- The National Cancer Institute estimates that at least seven in ten deaths from cervical cancer could be prevented if more women had regular Pap smears. The incidence of cervical cancer among black women is twice that among white women.
- Heart disease is the leading killer of American women. American women have a one in two chance of developing a heart ailment. Yet, a 1988 study demonstrating that small doses of aspirin effectively prevented heart disease included 22,071 men and 0 women.
- Women constitute the fastest growing group of people with AIDS. In 1991, AIDS was one of the five leading causes of death in women ages fifteen to forty-four.

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A MODEL BENEFITS PACKAGE FOR WOMEN IN HEALTH CARE REFORM

SUMMARY

The Campaign for Women's Health believes that health care reform must address the health needs of women. As 52% of the population, women are the major consumers of health services. Women are also the majority of health caregivers and the traditional caretakers of family health. Women's health is everyone's health.

A comprehensive benefits package is fundamental to women's interests in health care reform. All services which are necessary or appropriate for the maintenance and promotion of women's health should be included in a benefits package.

Health care is far more than the treatment of illness, disease, accident or disability. In addition to hospital care and physicians services, women require a range of primary and preventive services from physicians and non-physician providers in a variety of settings. The following represent a comprehensive set of services, settings and providers -- beyond treatment of illness or disease -- for inclusion in a benefits package which will address women's health needs:

Primary and Preventive Care:

periodic history and physical exam,
including blood pressure check,
urinalysis, total blood cholesterol
osteoporosis screen
mental health screen
domestic violence screen
dental check
vision check
speech and hearing checks

prescription drugs and devices
laboratory tests and immunizations as needed
HIV counseling and anonymous
testing
evaluations for nutrition, exercise, mental health,
tobacco use, drug and substance use,
harassment/violence prevention,
sexuality education and counseling

Primary and Preventive Reproductive Health Care:

periodic gynecological history and exam,
including pelvic exam, Pap smear, clinical
breast exam
mammogram
contraceptive drugs and devices
maternity care
prenatal
labor and delivery
complications of pregnancy and childbirth
postnatal

counseling and services for:
family planning
abortion
sterilization
infertility
sexually transmitted diseases
gynecological infections
menstrual disorders
pregnancy
menopause

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Long Term Care:

chronic illness and disability care
speech, physical and occupational
therapy
mental health care
nutritional services
home care services, equipment and
supplies
social support services

community support services
prescription drugs and devices
counseling for diet, exercise,
injury prevention, tobacco use,
drug and substance use, dental,
violence, vision, speech and
hearing care

Settings:

hospitals
physicians' offices
allied health practitioners' offices
community and rural health centers
specialized centers
public health clinics
school-based or -linked clinics

family planning clinics
birthing centers
skilled nursing centers
long-term care facilities
hospices
home care
respite care

Health Care Providers:

physicians
physician assistants
nurse practitioners
clinical nurse specialists
certified nurse midwives
lay midwives
licensed clinical social workers
licensed allied health practitioners

optometrists
podiatrists
psychologists
pharmacists
physical, occupational, and language
therapists
home care workers and home health
aides

A MODEL BENEFITS PACKAGE FOR WOMEN IN HEALTH CARE REFORM

Introduction

Health care reform offers an opportunity to redefine the dimensions of health and health care. While the public has understood for some time that health care is not the provision of medical services, the system has not. Currently our health system is quick to pay expensive bills for CAT scans, while it ignores the essentials of primary care, the cost-effectiveness of preventive care and the importance of long term care.

Creating an appropriate standard under which a core benefits package is established is key to the success of the entire system. Carefully reviewing current and proposed qualifying language, the Campaign established the following standard: **All services which are necessary or appropriate for the maintenance and promotion of women's health should be included in a benefits package.**

We do not recommend the application of a medically necessary standard because we believe it is inconsistent with the promotion of good health. Although the term medically necessary is not yet defined in pending legislation, many earlier proposals applied the medically necessary standard embodied in Medicare. As defined by law, Medicare covers services necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body part.

Defining a benefits package solely on the basis of medically necessary services could contradict the goal of comprehensive health care reform and in some instances be contradictory to provision of preventive services, a full range of reproductive services including abortion, and long term care.

Primary and Preventive Care

The shift towards a cost-conscious health care system which prevents illness, disease and disability invites a strong emphasis on primary and preventive care for women. The majority of primary and preventive care services are low-cost, low-tech services which can be provided by a range of health practitioners in one-stop, out-patient settings. Most primary care services do not require a physician, other than for consultation and referral. The provision of the primary and preventive care services for women listed in this summary would address the majority of common health problems seen daily by primary care providers. Equally important, these same services also screen for cardiovascular and infectious diseases, cancers, injuries and the other major causes of death and disability in women.

Periodic History and Physical Exam, Including Blood Pressure Check, Urinalysis and Cholesterol Screen. Personal health history and family history are reviewed to predict which patients are at risk for disease. Screens for common diseases such as diabetes and hypertension prolong life and are cost-effective. A full physical exam also includes an eye exam, thyroid evaluation and urinalysis. Blood pressure and weight checks as well as cholesterol screening evaluate the patient for cardiovascular disease, the leading cause of death for American women. Evaluations for nutrition, tobacco use, exercise, drug and substance use and violence, as well as mental health status, are completed. **Regular, periodic primary care visits provide the most important assessment of health status.**

Osteoporosis. Osteoporosis is a major cause of death and disability in women. It is a preventable, progressive disease which afflicts 50% of women over the age of 45 and 90% of women over 75. This bone-thinning disease results in 1.3 million fractures each year and over 50,000 deaths, costing an estimated \$7-10 billion annually. Yet, **the disease is largely preventable by alerting younger women to the importance of dietary changes, weight-bearing exercise and calcium.** In women over age 35 bone loss may be arrested with a combination of diet, exercise, calcium supplements and, in high risk women, with estrogen replacement therapy and other treatments.

Mental Health Screen. Women suffer twice the rate of clinical depression as men. However, three-quarters of American women who experience clinical symptoms of depression never receive treatment. Some forms of anxiety disorder are also more common in women. An overwhelming percentage (90%) of eating disorders occur in women. And, in general, women's experience of mental illness differs from that of men, requiring appropriate screening and treatment. Over 20% of primary health care visits are mental health related. The American Psychological Association states that parity of mental health benefits with medical/surgical benefits is cost effective. ***Routine mental health screening for women would ensure improved detection of mental illness in its earliest stages.***

Domestic Violence. Every 15 seconds an American woman is beaten in her own home. Women are twice as likely to be injured by violence as to be diagnosed with cancer. Battering is the single major cause of emergency room visits by women. The health consequences of violence against women result not only in bruises, broken bones, infection and disease but, in long-term mental health problems as well. The costs can be high -- medical expenses are 2.5 times higher and physician visits twice as high for victimized women versus non-victimized women. ***Emergency room protocols to identify victims have been initiated in some hospitals but, should be made available nationwide.*** Police arrest programs have demonstrated that ***early intervention may be effective in breaking the cycle of violence.*** However, ***routine domestic violence screening by health professionals -- recently endorsed by the AMA -- is still uncommon.***

Dental Check. Women are 20 times more likely than men to experience temporomandibular joint dysfunction (TMJ). Pregnant women show a significant increase in gingivitis and tooth decay. Post-menopausal women are 90% of individuals with Sjogren's syndrome, an oral cavity disorder. ***Failure to treat preventable tooth decay results in more than \$16 billion in annual costs.*** Dental screening would identify dental problems in women at early, preventable stages.

Vision Check. Diabetic retinopathy is a serious complication of diabetes, leading to blindness if left unchecked. African-American women have twice the risk for diabetes as white women. Other populations, including Native American, Cuban, Mexican-American and Puerto Rican women also have a high prevalence of diabetes. Women are a larger segment of the elderly, a population also at risk for vision problems. The National Eye Institute reports that ***over half the cases of blindness due to diabetic retinopathy could have been prevented if detected early.***

Speech and Hearing Checks. Hearing loss is the most common health problem for older women where hearing loss is associated with aging rather than physiologic dysfunction. Older women often inaccurately view hearing loss as an uncorrectable consequence of aging. ***Good preventive care includes a periodic assessment for speech-language and hearing function.*** Limitations in independent living and functional status due to hearing loss can be reduced if detected early.

Prescription Drugs and Devices. Prescription drugs and devices are an essential component of some forms of diagnosis, prevention and treatment for women. They must be included as a covered benefit for women so that primary and preventive care can be effective in slowing or halting the progression to more serious conditions women may face. ***Appropriately prescribed drugs and devices can improve health status and lower overall health cost.***

Laboratory Tests and Immunizations. Specific laboratory tests and immunizations are important diagnostic tools and serve to prevent illness and disease. For example, a fasting glucose test for a woman with a prior history of gestational diabetes may alert her and her provider to the onset of diabetes. Certain immunizations are known to be efficacious, such as DTP (diphtheria-tetanus-pertussis) and hepatitis B vaccine. ***Infectious diseases such as polio were once widespread -- there were more than 18,000 cases in 1954 -- and have now all but disappeared because of basic and low-cost immunizations within primary care.***

HIV Counseling and Anonymous Testing. Women are the fastest growing population with HIV. An estimated 80,000 women aged 15 to 44 are currently infected. HIV seropositivity is now nearly equal among men and women in several tested populations. By 1995, the Centers for Disease Control (CDC) estimates that 75,000 women will have AIDS, compared to 26,000 today. ***Universal anonymous testing with pre- and***

Infertility. Infertility affects 2.3 million couples or 1 in 12 couples in the U.S. *The National Center for Health Statistics reported that 1.3 million women had one or more visits for infertility treatment in 1988.* Diagnosis of infertility in women includes determining when and if ovulation occurs, the post-coital test, endometrial biopsy and laparoscopy. *The majority of infertile couples require conventional treatments, with fewer than 2% of couples using assisted reproductive technologies.* Infertility exacts an emotional toll on women, compounding the health consequences of this condition. The American Psychological Association has reported that infertility is a major risk factor for depression in women.

Sexually Transmitted Diseases. The major sexually transmitted diseases (STDs) include gonorrhea, syphilis, genital herpes, chlamydia, human papillomavirus and AIDS. *Many of the sexually transmitted diseases have no clear symptoms to alert women to seek treatment -- screening is vital.* Untreated STDs can lead to pelvic inflammatory disease (PID), a serious condition which can result in ectopic pregnancy and infertility. The Centers for Disease Control (CDC) report that at least 7 forms of malignancy have been associated with STDs. Untreated STDs can cause fetal and infant morbidity and death. *One study in California estimated that \$6 million in treatment costs could be saved in one year if patients in family planning clinics with asymptomatic chlamydial infections were screened.* A CDC pilot chlamydia screening program led to a 51% decrease in the chlamydia rate among family planning clients between 1988 and 1991.

Menopause. A majority of American women spend up to one-third of their lives post-menopausally. While menopause is a natural physiologic process, and not a medical condition, little is known about it. Some of the health difficulties associated with menopause include hot flashes, vaginal and urinary tract changes, thinning of bone and changes in mental health. *Health providers and educators can aid the majority of women to experience menopause without medical interventions.*

Long Term Care

Long term care integrates a continuum of home, community and institutional services. These services include medical services, health care, mental health services, personal care, nutrition services and social services. These services are delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity.

Long term care is a woman's issue and a family issue. Long term care is an intergenerational issue:

- 62% of women over age 85 either reside in nursing homes or need assistance to live at home
- 40% of all Americans who need long term care services are under age 65
- a majority of Americans have experienced a long term care crisis or expect to within five years
- almost 80% of long term care is provided by unpaid caregivers, usually women family members

Surveys show that Americans are willing to provide long term care for family members but, they lack support services to help them sustain their caregiving responsibilities. *Many long term care support services can be provided in the community and in the home, including:*

- for mental health care the older population needs to be better served by community mental health centers, private practitioners and nursing homes than currently
- nutritional services, including meals, counseling and education, can be provided in congregate settings and through home-delivered meals programs
- home care services, equipment and supplies, including home health aid, hospice benefit, mental health care, speech, physical and occupational therapy can be offered in the home
- social support services, including respite care, social worker, homemaker, help with heavy chores, caregiver support and training programs enable families to provide long term care
- community support services, including transportation, escort, adult day care, senior centers and information and referral services
- for prescription drugs and devices older Americans make up 12% of the population but, purchase 25% of all prescriptions written annually, paying 64% of their prescription drug costs out of pocket
- counseling services, including counseling for diet, exercise, injury prevention, tobacco use, drug and substance use, dental care, violence prevention, vision, speech and hearing care

post-test counseling will ensure that women will choose to be tested. Anonymous testing should be made accessible to women, in public health clinics, family planning clinics and other settings where they seek primary care services. Studies by the CDC have shown that persons who are tested at anonymous test sites are more likely to seek additional care.

Primary and Preventive Reproductive Health Care

Reproductive health services are an inseparable part of primary and preventive services for women. The full complement of reproductive services are linked to one another and are an integral part of women's health and well being. Reproductive health services must be treated as a total package of services for women. Reproductive health is part of the continuum of services over the life course because women's reproductive health needs precede, include and follow the childbearing years.

Periodic Gynecological History and Exam, Including Pelvic Exam, Pap Smear and Clinical Breast Exam. The gynecological history and exam includes a survey of the woman's reproductive history, current sexual activity and contraceptive use. The pelvic exam includes a check for abnormalities of the uterus, ovaries, rectum and abdominal organs. Screening for and counseling about sexually transmitted diseases is included. The Pap smear detects cancer in early stages -- cancerous cells can be detected up to 10 years before invasive cervical cancer develops. ***The survival rate of women with cervical cancer detected by Pap smear approaches 100%.*** The clinical breast exam is performed to screen for breast cancer, the second most common cause of cancer in women. The exam is also an opportunity for the practitioner to teach breast self-exam (BSE) and to make a referral for mammography. ***Regular, periodic gynecological history and exam is essential primary care for women.***

Mammogram. More than 180,000 women were diagnosed with breast cancer in 1992 and 46,000 women died from the disease. Reducing the mortality from breast cancer depends, in part, upon early detection. ***Mammograms are a proven screening tool for detecting breast cancer in women. Research indicates that universal access to screening mammography would reduce breast cancer mortality by 30 percent.*** However, many sub-populations of women including older, African-American, Hispanic and poor women do not get screening mammograms. Physicians failing to recommend mammograms for their patients and the lack of both public and private insurance coverage contribute to the underutilization of mammograms.

Maternity Care. The full range of maternity care services, including prenatal, intrapartum and postnatal care, are known to produce better outcomes for both mother and child. Women who lack access to prenatal care are twice as likely to give birth to low-birth-weight or premature babies. ***An Institute of Medicine study reported that for every dollar spent on prenatal care to low income women, savings of \$3.38 in medical care for their low-birth-weight infants could be achieved.*** Forty percent of women experience no complications during the prenatal or intrapartum period. However, the remaining 60% experience complications, about half being major complications. Maternal mortality and morbidity including infection, hemorrhage, toxemia and surgical interventions are reduced with appropriate and timely maternity care.

Family Planning. Family planning services reduce the incidence of unplanned pregnancies -- half of all pregnancies each year -- by increasing access to contraceptive services. Family planning also improves pregnancy outcomes for both mother and child by increasing the spacing between births. The National Commission on Infant Mortality estimates that 10 percent of all infant deaths would be prevented if all pregnancies were planned. ***Every public dollar spent to provide contraceptive services saves an average of \$4.40 that would otherwise be spent providing medical care, welfare and social services to pregnant women.***

Abortion. Maternal mortality in New York State fell by 26% after abortion was legalized in the state in 1970. ***The availability of safe abortion services is associated with declines in maternal mortality, low-birth-weight infants and neonatal mortality.*** According to the Alan Guttmacher Institute, the availability of legal abortion was the single most important factor in the decrease in neonatal mortality between 1964 and 1977.

Health Care Delivered in a Variety of Settings

Although most Americans think of health settings as the doctor's office and the hospital, a wide variety of settings already exist for the delivery of health care. Community health, rural health and migrant health centers, public health and family planning clinics, school-based or -linked clinics and allied health practitioners offices are existing settings where a range of health services are provided. Health care reform offers an opportunity to increase and support the cost-effective delivery of affordable services in these many settings.

Health care reform also offers an opportunity to restructure consumer access to health services. Primary, preventive and long term health care can be delivered in convenient, community-based and affordable settings such as the workplace, schools, day care centers and in the home. In a restructured health care setting the hospital would no longer expend costly resources to provide primary or chronic care but, would provide only acute care services. Community-based care means primary, preventive and long term care would be more accessible and less costly than it is today.

An example of a community-based setting is a family health center, located near or at a public school and meeting the health needs of families, including women's health care needs. Community-centered care emphasizes family and individual health, convenient access and utilization of existing community resources such as schools or worksites.

Health Care Delivered by a Range of Providers

With health care reform, women should have the option of care from the health care provider of their choice, including the choice of women providers. Providers should include not only physicians, but nurse practitioners, clinical nurse specialists, certified nurse midwives, lay midwives, licensed clinical social workers, optometrists, podiatrists, psychologists and other allied health practitioners.

In our current system many barriers prevent many non-physician providers from being full participants in the health care system. The major obstacle to their participation is the practitioner limits set by Medicare, Medicaid and other federal and state laws. *With a restructuring of the health care system we can enable a range of providers to provide health services in an efficient, affordable and coordinated manner.*

Midwives are an example of accessible, appropriate and cost-effective providers of primary and preventive care for women. Midwives work in a range of settings in the community -- hospitals, free-standing clinics, physicians offices, birthing centers and the home. Midwives offer maternity care services with a minimum of costly interventions. Yet, studies of midwifery care demonstrate that mortality rates are equivalent to those of physicians, certain types of morbidity are much lower, surgical procedures are fewer and breastfeeding rates are higher.

Conclusion

Health care reform is an opportunity to simultaneously provide health care to the 37 million uninsured and to create a system which offers accessible, appropriate and affordable health care for all our citizens. It is *a unique opportunity to redress many of the inequities women have faced securing health care for themselves and their families.*

This model benefits package for women demonstrates that the majority of health care for women does not demand complex technology or sophisticated medical settings -- both at a high cost. Rather, *the majority of health care for women is basic care which can be provided in low-cost settings by a range of efficient providers.*

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The Alan Guttmacher Institute	National Abortion Federation
Amalgamated Clothing and Textile Workers Union	National Abortion Rights Action League (NARAL)
American Association of University Women (AAUW)	National Action Forum for Midlife & Older Women
American Civil Liberties Union (ACLU)*	National Association of Commissions for Women
American Dietetic Association	National Association of Nurse Practitioners in Reproductive Health
American Fertility Society	National Black Women's Health Project
American Federation of State, County and Municipal Employees (AFSCME)	National Council of Jewish Women
American Medical Women's Association (AMWA)	National Council of Negro Women
American Nurses Association (ANA)	National Displaced Homemakers Network
Arizona Business Women for Health	Nat'l. Family Planning and Reproductive Health Assoc.
Association of Junior Leagues International	National Federation of Business & Professional Women
Association of Reproductive Health Professionals	National Foundation for Women Business Owners
AWHONN: Association of Women's Health, Obstetric & Neonatal Nurses (formerly NAACOG)	National Institute for Women of Color
Bass & Howes	National Organization for Women (NOW)
Black Women's Agenda	NOW Legal Defense and Education Fund
B'nai B'rith Women	National Women's Conference Committee
Boston Women's Health Book Collective	National Women's Health Network (NWHN)
Catholics for a Free Choice	National Women's Health Resource Center
Center for Policy Alternatives	National Women's Law Center
Center for Population Options	National Women's Party
Center for Women Policy Studies	National Women's Political Caucus
Clearinghouse on Women's Issues	Older Women's League (OWL)
Coalition of Labor Union Women (CLUW)	Organization of Pan-Asian Women
Communications Workers of America (CWA)	Pennsylvania Coalition Against Domestic Violence
Delta Research & Educational Foundation	Planned Parenthood Federation of America
Endometriosis Association	Public Citizen Health Research Group
Families USA	Public Voice for Food & Health Policy
Farmworker Justice Fund	Religious Coalition for Abortion Rights (RCAR)
Federally Employed Women	Service Employees International Union (SEIU)
Federation of Nurses and Health Professionals	Soc. for the Advancement of Women's Health Research
General Federation of Women's Clubs	United Food and Commercial Workers Internat'l. Union
Institute for Research on Women's Health	Wider Opportunities for Women (WOW)
Institute for Women's Policy Research	Women for Racial and Economic Equality
Interstitial Cystitis Association, Maryland	Women in Communications, Inc.
Jacobs Institute of Women's Health	Women's Action Alliance
Kentucky Commission on Women	Women's Bar Association of D.C.
The Mautner Project for Lesbians with Cancer	Women's Int'l. League for Peace and Freedom
Members of Sigma Gamma Rho Sorority, Inc.	Women's International Public Health Network
Mennonite Central Committee	Women's Legal Defense Fund (WLDF)
Na'Amat USA	Women's Research and Education Institute (WREI)
	YWCA of the USA

* The ACLU endorses and participates exclusively in the civil liberties related activities of the Campaign for Women's Health.

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News Release

FOR IMMEDIATE RELEASE
SEPTEMBER 24, 1993

CONTACT: SHARON FISCHMAN
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**STATEMENT OF MARCIA GREENBERGER,
CO-PRESIDENT OF THE NATIONAL WOMEN'S LAW CENTER,
ON REPRODUCTIVE HEALTH CARE AND THE HEALTH REFORM PLAN**

For decades, the health needs of women in the United States have been underfunded, overlooked and cut out of key health programs. Correcting these inequities is long overdue. President Clinton's health reform plan can provide comprehensive health care for all American women, but its promise must be turned into reality.

President Clinton's health care plan contains critical improvements in health care for women. It stands for the principle that all women, regardless of age, economic or health status, will have access to health insurance. Whether a woman is employed, where she is employed, or the size of her employer will not dictate her eligibility for insurance. And changing jobs will no longer put women at risk of losing their insurance. Access is key, and for us -- to borrow a now popular phrase -- non-negotiable.

But access is not the only question. Also key is whether a woman's basic health care needs will be covered. And no area is more central to women's well being than reproductive health. For many women, gynecological exams are the only regular health care they receive. President Clinton's plan guarantees coverage of preventive health services that run the gamut from routine checkups for pregnant women to diagnostic and screening services such as mammography and pap smears. Although these are progressive and important additions, if they are to be truly preventive and if the plan is to live up to its promise, they must be provided more frequently than currently indicated in the plan. Short-sighted cost cutting measures that put women's lives in jeopardy are unacceptable. Pap smear and mammogram schedules need to follow accepted medical standards.

Family planning services, including access to contraceptive care, are essential to the health of women and their families. The Center is pleased that the health reform plan covers "family planning services," but we will work with Congress to ensure that "family planning services" clearly cover education, counseling, infertility services, screening and treatment for sexually transmitted diseases, and voluntary sterilization. The plan should also explicitly state that contraceptive drugs and devices are included as a basic benefit.

And, it is of critical importance to women nationwide that the Administration ensure that "pregnancy-related services" is defined as including prenatal care, labor and delivery, post-natal care, and termination of pregnancy. The range of providers covered by the plan will ensure that women can receive the diverse styles of care available currently. The inclusion of a range of providers is both essential to women's primary care and cost effective.

(more)

NATIONAL WOMEN'S LAW CENTER

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Women need to fight not only to retain the sorely-needed improvements to their health care that are already in this plan, but also to expand the plan to improve upon it. Women have too much at stake here to allow politics to invade the doctor's office.

And we know politicians have been relentless in trying to dictate to a woman and her doctor what health care she should have -- particularly for abortion. We will not allow politicians in Washington or state capitals, bureaucrats administering a plan, or a woman's employer to tell her and her doctor when she can or cannot have an abortion. The National Women's Law Center will fight to make comprehensive health care a reality for all women by supporting President Clinton's plan and by building on its key principles -- but also by making sure that loopholes, vague language, and back room deals don't shortchange women.

#30

The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families including employment, education, reproductive rights and health, family support and income security, with special attention given to the concerns of low-income women.



NATIONAL BLACK WOMEN'S HEALTH PROJECT

Public Education / Policy Office

Julia R. Scott, Director

PRESS RELEASE
SEPTEMBER 24, 1993

CONTACT: JULIA R. SCOTT
202-835-0117

NATIONAL BLACK WOMEN'S HEALTH PROJECT PRAISES CLINTON'S HEALTH CARE REFORM PLAN; BUT SEEKS INCREASED ACCESS TO SERVICES AND ANTI-DISCRIMINATION PROVISIONS

"The National Black Women's Health Project (NBWHP) applauds the President's commitment to reforming our health care system and improving the health of our population," said Julia R. Scott, Director of the NBWHP's Public Education and Policy office. "We are particularly pleased that the reform plan emphasizes preventive health care and covers the full range of reproductive health services, including abortion, which is a critical element of 'pregnancy-related care.'"

Scott said, "However, we are concerned about access to services for poor women---many of whom are African American and other women of color---and the absence of strong anti-discrimination provisions. Currently, care for pregnant and postpartum women whose family income is as high as 200% of poverty are covered, at no cost to them. Under the Plan, however, subsidies will be only be available to families whose incomes fall under 150% of poverty. This means that many low-income pregnant and postpartum women will have to pay for health care that is currently provided by the governments. Health care reform should not force women to make a choice between feeding their family and paying for health care. Discriminatory attitudes and practices especially against the poor, women of color, the elderly, and people suffering from diseases that carry a social stigma must be eliminated."

"In addition, Medicaid currently pays for supplemental services such as transportation for Medicaid recipients. The Plan will continue providing such services for AFDC/SSI cash recipients only," said Scott. "This represents a major loss for non-cash recipients, many of whom are pregnant and postpartum. These services are critical for this vulnerable population."

Scott said, "If these issues are not resolved, they will translate into critical barriers to care for the poor."

FOR IMMEDIATE RELEASE
September 24, 1993

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**STATEMENT OF EXECUTIVE DIRECTOR ANNE BRYANT OF THE
AMERICAN ASSOCIATION OF UNIVERSITY WOMEN**

AAUW'S 135,000 MEMBERS POISED TO TAKE ACTION

On behalf of the American Association of University Women and its 135,000 active members, I applaud the President's and Congress' commitment to securing the basic right of health care reform for all Americans. AAUW strongly supports health care reform that provides comprehensive reproductive health services, including abortion and emphasizes primary and preventive care in a variety of community settings.

As a leader in the Campaign for Women's Health, we are prepared to join the other eighty organizations representing eight million local activists in launching a nationwide grassroots mobilization campaign to educate women across the country about what is at stake for them in health care reform. Our strategy will add millions of women's voices to the call for equitable health care, and together our needs will be addressed in the public debate.

Women's and girls' health needs have been long-ignored by the male-dominated medical and political communities. Not only are women the major consumers of health care services, but they constitute the majority of health caregivers as well. Health care reform must cover all our health needs to be meaningful and effective. Singling out a condition for discriminatory treatment is wrong and inadequate and we will not stand for it.

(more)

HEALTH CARE 2-2-2

For too long, women's health care has been parceled out a la carte. Women and girls need a full service menu for health care. That means such health care services as contraception, screening and treatment for sexually transmitted and reproductive tract diseases, maternal care, and abortion. It also means primary and preventive services such as pap smears and mammograms must be covered. For a woman, an annual pap smear and mammogram is just as important as a physical exam is to a fifty year old man.

For many women, particularly the uninsured or the underinsured, reproductive health care has been their only point of entry into the existing health care system. AAUW will oppose any effort to allow states or regional health care alliances to opt out on reproductive health benefits, including abortion coverage. To do so is to perpetuate an unfair distribution of benefits. We intend to stand firm in defending all women's rights to these services.

We are encouraged by President Clinton's focus on the health of women and children. We urge Congress to follow his lead because primary and preventive health care services for women and children are the best guarantees to a healthy citizenry and a more productive workforce.

Women will not be silent in the health care reform debate. It's time that women be treated and respected as whole persons capable of making their own moral choices regarding reproductive health care. Congress has been handed the opportunity to right the wrongs that have caused women to suffer serious and often fatal consequences of inequitable health care. AAUW and the Campaign for Women's Health will do everything in our power to ensure that Congress doesn't blow it.



CAMPAIGN FOR WOMEN'S HEALTH

WHO MAKES UP THE CAMPAIGN...

The Campaign for Women's Health is a broad coalition of over eighty national, state, and grassroots organizations representing more than eight million individuals nationwide. Member organizations include women's groups, labor unions, health care organizations, and others concerned about women and their health.

CAMPAIGN GOALS AND PRINCIPLES...

The Campaign is working to ensure that health care reform meets our principles and goals, including:

- ▶ **UNIVERSAL ACCESS.** Everyone must have access to quality health care. Employment and marital status, ability to pay, age, enrollment in public assistance programs, and pre-existing conditions must not be barriers to care.
- ▶ **COMPREHENSIVE BENEFITS.** Our health care system should offer a broad package of health services to all, including primary care, preventive care, screening, diagnostic, and treatment services, a full range of reproductive health services, including family planning and abortion, and long term care.
- ▶ **PROVIDERS AND SETTINGS.** Health services should be available from a choice of providers, including physicians, nurse practitioners, physician assistants, and other allied health practitioners. Services must be available in a variety of settings, ranging from the home, to large medical centers, to small rural clinics.
- ▶ **ACCOUNTABILITY.** The health system must be accountable to women and their health concerns. Women who represent the broad spectrum of women's health interests must be included on any health boards, commissions, or other advisory and regulatory boards.
- ▶ **RESEARCH.** A reformed health system must include a national research agenda with increased attention to the health needs of women. New studies on the health of women must be initiated and ongoing research project must include women.

The Campaign for Women's Health has been an active player in the health care reform debate:

- The Congressional Quarterly reported that the Campaign for Women's Health is the organization "most likely to succeed in winning Hillary Clinton's favor."

- The Campaign's Model Benefits Package for Women in Health Care Reform has been a key document in the current debates. Linda Bergthold, Co-Chair of the Benefits Working Group of the White House Task Force on Health Care Reform described the model benefits package as "the most thorough and specific package I've seen."

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CAMPAIGN FOR WOMEN'S HEALTH

**Statement
by
Joan Kuriansky
September 24, 1993**

Good Morning. My name is Joan Kuriansky and I am Executive Director of the Older Women's League and Convener of the Campaign for Women's Health. Founded in 1990, the Campaign seeks to ensure that women's health concerns are addressed in the debate on health reform. Today the Campaign is a broad coalition of over eighty national, state, and grassroots organizations representing more than eight million individuals nationwide. The Campaign is a project of the Older Women's League.

"As the President releases his plan for health care reform, we urge him to remember the women: invisible in research, often patronized by the medical establishment and treatment needs ignored. The Campaign for Women's Health is seeking a health care system that does not treat women as second class citizens. We believe the President's plan offers us that opportunity.

Currently, twelve million women in the United States have no health insurance. Many others are poor enough to only qualify for health coverage under Medicaid. Yet others are dependent on their husband's health insurance. A change in marital status due to widowhood or divorce can precipitously plunge a woman into poverty and without health insurance.

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Today, many health services essential to women are unavailable or available only on a limited basis, even to women who have some form of insurance. Many diseases and conditions unique to women, more prevalent in women or which affect women differently require better care than women are receiving today.

Recognizing the current inequities in the health care system, Campaign members developed a set of principles by which we measure health reform proposals. In 1992, the Congressional Caucus on Women's Issues largely adopted these principles as a basis for their work on health reform. We also developed a model benefits package that we want to see incorporated into a national health plan. It is from this perspective that the members of the Campaign have reviewed the President's initial plan.

We salute the President for proposing a bold plan which begins to address the Campaign's major goals. We commend the plans' intent to cover a majority of people residing in the country and not tying one's access to health care to one's employment or marital status. We support the integration of Medicaid into the standard health plan. We support the thrust of the mandated guaranteed benefits package including an emphasis on preventive and primary care. We applaud the inclusion of home and community based long term care in the national plan as well as the provision of prescription drugs.

Importantly, there are outstanding areas of concern that we will work with the President, Hillary Clinton and the Congress to address. We will only support a plan that fully addresses women's treatment needs including a full range of reproductive health

services, a plan to protect low income persons above the subsidy level and an accountability system that includes the expertise of women's health advocates. With me today are several members of the Campaign who will highlight some of the areas of interest and concern to us. We are very honored that members of Congress have joined us.

The ability of passing legislation that responds to women's health needs require the joint efforts of the White House, Congress and citizens concerned about health care. To that end, the Campaign is launching a large scale grassroots effort to reach out to our members across the country to be sure that women's voices will be heard throughout the course of this revolutionary debate.



STATEMENT OF LOU GLASSE
President, Older Women's League
September 24, 1993

Good morning. I am Lou Glasse, President of OWL -- the Older Women's League.

We welcome President Clinton's health care reform proposal which offers substantial benefits to midlife and older women.

OWL applauds the President's inclusion of long-term care as an essential part of a universal health care plan. This is a vital concern for women who both provide the majority of family caregiving and are most likely to require such care as they age.

As the President noted in his address, older persons are an increasing portion of our population. This rate of growth will soar in coming years. Women outlive men by an average of seven years, and are the majority of the older population. Sixty percent of those age 65 and over are women. Sixty-eight percent of persons 80 years of age and older are women. Women are more likely to suffer from chronic illness, while being least able to pay for health care.

In addition, three out of every four caregivers to the elderly are women. The average caregiver is a 45 year-old married woman. Thirty-five percent of caregivers to the elderly are over age 65. Many women assume eldercare responsibilities at a time of crisis and may continue to provide the quality care they feel their loved one deserves for years -- with no outside support.

Our nation's health care system can, and must, permit older persons to receive the supportive services they want to enable them to remain in their homes and to age with dignity. At the same time, responsibility for this care for long periods can not be placed solely on the shoulders of family members. In-home and community services are needed that promote quality care and that protect the caregiver's own health.

OWL welcomes the President's inclusion of these services in home and community settings in his proposal. This is an important first step toward developing a full continuum of long-term care. We urge the President and Congress to expand coverage to include institutional care, beyond that currently provided to those who are impoverished.

To make this proposal work, we must ensure that state governments have adequate funds to offer a full array of long-term care services.

In addition, OWL will work to avoid possibly excessive Medicare cuts, which could lower the quality of acute care and limit the number of health care providers willing to serve Medicare patients.

OWL commends the President and Hillary Rodham Clinton for their leadership in bringing reform to this point. We pledge to work with the Administration and Congress to successfully ensure that long-term health care needs are met and that every person in America has access to comprehensive health care. Thank you.

NATIONAL WOMEN'S HEALTH NETWORK

CAMPAIGN FOR WOMEN'S HEALTH

CLINTON HEALTH CARE REFORM PLAN BENEFITS PACKAGE

statement by
Cynthia Pearson
National Women's Health Network Program Director

The Clinton plan, announced this week, takes important steps forward for women's health. Traditional health insurance protects people against the unpredictable expense of illness and accidents. However, the majority of women's health care expenses, at least until old age, are for well-woman care. Routine exams and screening tests, which can help prevent disease, are performed on well women. It is well women who need family planning, pre-natal and childbirth services. Traditional insurance coverage leaves out these women.

We are delighted that the President's health care reform plan guarantees a national benefit package which includes preventive and routine care. Without these services, health care reform will not meet women's needs.

Today, many women cannot get routine women's health care such as pelvic exams and Pap smears because they have no insurance, or they have an insurance plan that does not cover it. All too often, cancer prevention is available only to those women who can afford to pay for it themselves.

This inequity is reflected in cancer statistics. Currently, African American women are less likely than white women to develop breast cancer, but they are more likely to die of it. African American women die of breast cancer at least partly because they are less likely to have regular mammograms.

Founders • Barbara Seaman • Phyllis Chesler, Ph.D. • Belita Cowan • Alice Wolfson • Mary Howell, M.D.

Nearly five thousand women die each year of cervical cancer. Almost all of those deaths could be prevented. Early detection of cervical cancer using the Pap smear screening tests allows physicians to cure women. Low income women, and Spanish-speaking women are much more likely to die of cervical cancer because they are not screened with regular Pap smears.

President Clinton has taken another important step in meeting women's health needs by requiring that preventive health services be offered for free. In contrast to other services, no co-payment will be required.

In summary, the benefits package proposed by President Clinton is good news for all, but especially good news for women.

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NATIONAL WOMEN'S HEALTH NETWORK

CAMPAIGN FOR WOMEN'S HEALTH

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NEWS RELEASE

FOR IMMEDIATE RELEASE
September 24, 1993

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**STATEMENT OF GWENDYLON JOHNSON, MA, RN, C
BOARD OF DIRECTORS, AMERICAN NURSES ASSOCIATION**

**ON WOMEN'S HEALTH PROVISIONS
IN THE CLINTON HEALTH CARE REFORM**

The nurses of this country enthusiastically support President Clinton's Health Care Plan. We firmly believe that it will benefit women by significantly reorienting and restructuring the health care delivery system. Women consumers will finally have the security of knowing they have access to comprehensive, affordable, quality health care services.

Preventive and primary health care must be available in convenient community-based settings -- at the workplace, in the schools, in day care centers and in the home. This is crucial because women need not only access to insurance, but access to health care services. Women frequently are forced to cancel their own appointments with a health care provider when child care is not available, when transportation becomes unaccessible, or when the woman feels that she must attend to the needs of her



children and family over her own health care needs. If receiving health care means traveling across town or over many miles in a rural area, many women opt to stay home. Community based health care with the availability of the necessary support services such as transportation and/or assistance with child care services as opposed to care that is available only in a hospital or medical center setting would increase the likelihood that women would seek early appropriate care for themselves.

Under the Clinton plan, the health care setting could be restructured so that the hospital would serve as the place where acute health care needs are met, but other health care sites would be more appropriate as well as less expensive for the provision of preventive and primary care. The Clinton plan includes funding for school-based clinics, community clinics, as well as enhanced funds to encourage nurses and other health care professionals to practice in underserved areas.

In a restructured health care system, women should have the option of receiving care from the health care provider of their choice. Providers should include not only physicians, but nurses (including advanced practice nurses) and other allied health professionals. Research demonstrates that women of reproductive age are most likely to use their reproductive health provider as their primary health care provider; older women are most likely to use internists; and poor women are most likely to use emergency departments. These type of care arrangements do not utilize either the most cost-efficient or the most appropriate provider. By allowing health plans to

balance a woman's health needs with enhanced self-care capabilities and more accessible provider services, health care can be delivered in a more efficient as well as a more coordinated manner.

An expanded role for primary care providers across the delivery system will provide long-term cost savings as women and men maintain health, prevent disease and require less expensive care. To be effective, however, barriers that restrict the utilization of the most cost-effective quality health care provider must be removed. Limits set by Medicare, Medicaid and other federal and state laws represent the most significant obstacles.

Today, most women can not choose from a range of qualified providers. President Clinton's plan would change this. The American Health Security Act removes artificial barriers to practice that hinder nurses and other non-physicians from delivering health care services. In addition, President Clinton's plan includes new funding for the education of health professionals as primary care providers.

Women consumers will benefit from having the obstacles to nurse providers removed. Here in Washington, a nurse practitioner runs a health services program in an inner city homeless shelter for women. She is their only health care provider. She diagnoses and treats health problems and helps prevent many more serious health problems from occurring.

Certified nurse midwives (CNMs) provide effective maternity care. A recent study found that nurse-midwives use more natural and less invasive labor and delivery procedures resulting in less physical trauma to the mother, a shorter hospital stay, fewer premature deliveries, and babies which are as healthy as those delivered by physicians.

America's nurses believe that access to appropriate, quality, affordable health care is a right, not a privilege. This means access for all people, including women of all ages, incomes, and races. The reforms proposed by the Clinton Administration demonstrate a commitment to fix a system that is broken. Nurses are pleased that President Clinton has recognized that primary and preventive health care across the lifespan is central to restructuring of the health care system. This proposal acknowledges that a health care plan that continues to focus on illness and cure, without an appropriate balance of prevention and care, will not work. To be more effective, a health care system must do more than provide equipment, supplies, facilities, and people power. It must also guarantee universal access to an assured standard of care. It must use health resources effectively and efficiently - balancing efforts to promote health with the capacity to cure disease. It must provide care in convenient familiar locations and it must make full use of the range of qualified health professionals and diverse settings for care. These factors are constant and imperative to guarantee access to health care services for all women.

In short, the American Nurses Association is proud to support President Clinton's health care plan because we think it represents a critical opportunity to fix America's health care system and improve health care for all Americans, including women. In the next several months as the health care debate moves to the United States Congress, ANA will work in conjunction with the Campaign For Women's Health to ensure that women's health issues are addressed in our reformed health care system.

###

The American Nurses Association is the only full-service professional organization representing the nation's 2.2 million Registered Nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.



CAMPAIGN FOR WOMEN'S HEALTH

MEDIA CONTACT LIST

Representatives of the Campaign for Women's Health are available for one-on-one interviews to comment on the Clinton health care plan. Campaign contacts deal with a variety of issues of concern to women in health care reform, including:

General Women's Health Issues:

Joan Kuriansky, Campaign for Women's Health & OWL
Anne Kasper, Campaign for Women's Health
(202)783-6686

Access Issues:

Julia Scott, National Black Women's Health Project
(202)835-0117

Benefits:

Cynthia Pearson, National Women's Health Network
(202)347-1140

Provider/Service Delivery Issues:

Christine deVries, American Nurses Association
(202)554-4444 (ext.449)

Reproductive Health Services:

Ann Kolker, National Women's Law Center
(202)328-5160
Julia Scott, National Black Women's Health Project
(202)835-0117

Long Term Care:

Lou Glasse, Older Women's League
Joan Kuriansky, Older Women's League
(202)783-6686

Breast Cancer Services/Treatment:

Joanne Howes, National Breast Cancer Coalition
(202)328-2200

A Project of O.W.L.

666 Eleventh Street, NW, Suite 700, Washington, DC 20001 (202) 783-6686 FAX (202) 638-2356



WOMEN'S HEALTH

Women are increasingly the victims of life-threatening illness, yet still are at the bottom of our medical research agenda. Funding for research into breast and ovarian cancers, osteoporosis and other diseases remains inadequate. Although women are more likely to use health care than men, they are less likely to have insurance:

- *Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs--jobs which usually don't offer health insurance to employees.*
- *Women tend to live longer and require more long-term and home health services that are often not available or affordable.*
- *Many women must rely on their spouses for health insurance, and risk of being dropped if they divorce or if they are widowed.*
- *From the beginning of the health reform process, women's health and preventive care concerns were at the core of the program. The Health Security plan will emphasize the kinds of care and research that protect women's health and guarantee comprehensive care.*

Comprehensive Benefits

- Under the Health Security plan, all women will be guaranteed coverage regardless of health status, marital status, employment status, or ability to pay.
- Women will be guaranteed a comprehensive package of benefits that will include unprecedented free coverage of a wide range of preventive services, including mammograms, Pap smears, diagnostic services, and prenatal care.
- The plan includes coverage for health services that help prevent unwanted pregnancies.

Preventive Health

- The Health Security plan will cover a schedule of preventive screenings, tests, and checkups covered in only a few of today's health insurance policies. These include regular mammograms for women

with a close family history of breast cancer and will be covered under the regular cost sharing provisions, like other medical procedures.

- The nationally guaranteed comprehensive benefits package will also include free coverage for mammograms every two years for women over age 50 free-of-charge--no matter which plan someone chooses, as an extra incentive for those most at risk.
- Preventive services included in the comprehensive benefits package are provided at ages specified by the report of the U.S. Preventative Services Task Force. These recommendations can be modified by the National Health Board as new information becomes available.

Supports Women's Health Research

- New research initiatives will concentrate on child health (including birth defects, prenatal care, and adolescent health), and illnesses that primarily strike women -- including breast cancer, ovarian cancer, and osteoporosis.
- Medical research initiatives will be expanded to include efforts to isolate and cure diseases such as breast cancer and cervical cancer.

Expansion of Home and Community-Based Long-Term Care Services

- The addition of a new home and community-based long-term care program and the expansion of nursing home coverage will help reduce the undue burden born by many women caregivers.

October 8, 1993

SECURE, COMPREHENSIVE CARE:

BREAST CANCER COVERAGE UNDER THE HEALTH SECURITY PLAN

Women are increasingly the victims of life-threatening illness, yet still are at the bottom of our medical research agenda. Funding for research into breast and ovarian cancers, osteoporosis and other diseases remains inadequate. Of all the health problems American women face, however, breast cancer is the deadliest.

The Facts on Breast Cancer in America:

*Stress hinders
biopsy - low rate*

- One in nine women in the U.S. will develop breast cancer in her lifetime. (National Breast Cancer Coalition)
- 2.6 million women in the U.S. have breast cancer today, and this year another 182,000 American women will be diagnosed with the disease, approximately one woman every three minutes. (National Breast Cancer Coalition)
- 46,000 women will die from breast cancer this year in the U.S., approximately one woman every 12 minutes. (National Breast Cancer Coalition)
- There is no known cause or cure for breast cancer.

The Health Security Act addresses women's health care seriously and comprehensively, guaranteeing coverage to all women, regardless of health status, marital status, employment status, or ability to pay. Specifically, the Health Security Plan will cover a schedule of preventive screenings, tests and checkups at no cost, protection available in only a few of today's insurance policies.

BREAST CANCER EARLY DETECTION AND CARE COVERAGE UNDER THE HEALTH SECURITY PLAN

Medically necessary or appropriate care: Women of any age can receive clinical services, including clinical breast exams, and mammograms at any time when they are medically necessary or appropriate with cost sharing as specified by their plan.

Care for women at risk: Women of any age who are defined to be at risk of breast cancer by the National Health Board will receive additional visits, including clinical breast exams, and mammograms at a schedule appropriate to their risk status *with no cost sharing.*

Care for all women: All women receive regular clinician visits, including clinical breast exams, every three years from age 20 - 39 and every two years from age 40 - 64 *with no cost-sharing.* All women will also receive routine screening mammograms every two years, beginning at age 50, *with no cost sharing.*

In addition, the following services are covered for pap smears:

Pap/pelvic exams are covered annually for women who have reached childbearing age and are at risk of cervical cancer as part of clinical preventative services *with no cost-sharing*. Once three negative smears are obtained, pap smears are covered every three years for women age 20 - 39 and every two years for women 40 and above. If the patient is at risk for fertility-related infectious illnesses, pap smears may be covered more frequently.

Additional pap smears: Additional, or more frequent pap smears may be done at any time they are medically necessary or appropriate. In these cases, the services are covered *with cost-sharing* as is any other medical procedure.

SUPPORTING WOMEN'S HEALTH RESEARCH UNDER THE HEALTH SECURITY PLAN

The clinical preventive services package will be supported by significant increases in investments in breast cancer research.

- This year the National Institute of Health's breast cancer research budget increased by 44 percent, from \$208 million to almost \$300 million.

Additional increased funding for early detection and preventive services is available through the following agencies, which have increased investment in their own breast cancer research programs:

- | | |
|------------------------------------|---|
| • Centers for Disease Control | From \$71 million to \$78 million |
| • The Food and Drug Administration | From \$3 million to \$13 million |
| • The Department of Defense | This year earmarked \$210 million for breast cancer research. |

Under reform, new research initiatives will concentrate in prevention of many illnesses affecting large numbers of women, including mental health, reproductive health and osteoporosis.

#

The National Breast Cancer Coalition • a grassroots advocacy effort

- **Breast cancer is the most common form of cancer in American women.** It rarely occurs in men. An estimated 2.6 million women in the U.S. are living with breast cancer: 1.6 million who have been diagnosed and an estimated 1 million who do not yet know they have the disease.
- **One out of nine women in the United States will develop breast cancer in her lifetime — a risk that was one out of 14, in 1960.** This year, a new case of breast cancer will be diagnosed every three minutes, and a woman will die from breast cancer every 12 minutes.
- **In 1993, approximately 182,000 new cases of breast cancer will be diagnosed and 46,000 will die from the disease.**
- **We do not know what causes breast cancer or how to cure it.** Women with breast cancer are dying at the same rate today as they did in the 1930s, and the same basic methods of treatment are being used: surgery, chemotherapy and radiation.
- **Since 1960, more than 950,000 U.S. women have died of breast cancer.** This is more than two times the number of all Americans who have died in World Wars I and II, the Korean, Vietnam and Persian Gulf Wars. Forty-eight percent of these deaths occurred in the last ten years.
- **Thirty eight percent of African American women with breast cancer will not live more than five years, and 25% of white American women with breast cancer will not live more than five years.** Forty percent of all women with breast cancer are dead within ten years.
- **Every woman is at risk for breast cancer.** The risk of developing breast cancer increases as a woman ages, if she has a family history of breast cancer, has never had children or had her first child after age 30. Most breast cancer (over 70%), however, occurs in women who have no identifiable risk factors.

- Breast cancer is the leading cause of death for women 40-44 and the leading cause of cancer deaths in women 15-54. Incidence of breast cancer increases with age, rising sharply after age forty. Two-thirds of all breast cancers occur in women over 50.
- Mammography does not prevent or cure breast cancer, it can only detect it "early". In this context, "early" means that the tumor can be there for six to ten years before it is detected by mammography.
- Most breast irregularities are found by women themselves, yet many women do not know how to perform breast self-examination and few do so regularly.

**CONTACT:
THE NATIONAL BREAST
CANCER COALITION
FOR INFORMATION ON HOW TO
HELP FIGHT TO END THIS EPIDEMIC**

**P.O. Box 66373
Washington, D.C. 20035**

THE WHITE HOUSE
WASHINGTON

September 28, 199

Example of
Nurses letter
that went out.

Ms. Alice Pekarek, RN
29662 Spruce Road
Evergreen, Colorado 80439

Dear Ms. Pekarek:

Thank you for contacting the First Lady. She apologizes for the delay in responding to your letter, but there has been an overwhelming amount of mail coming into this office, especially on the topic of health care reform. Mrs. Clinton appreciates hearing your thoughts, and is pleased to have the opportunity to respond to your concerns.

Mrs. Clinton has always believed that nurses and nurse practitioners are critical to successful health care reform. She is very aware that nurses make daily differences in the lives of individuals and communities. The Administration recognizes that the critical component to making health care reform work lies with those on the front lines -- the health care providers -- nurses.

Nurses help keep families healthy and can help save money in health care costs down the road. Whether by using the "teaching moment" during a routine clinic visit to ask about a child's immunization status or by asking other important questions, the nurse's expertise as a primary provider is essential.

Health care reform will reduce the professional barriers for nurses and cut the paperwork that forces them to spend as much time at a desk as a bedside. Additionally, the President's health care reform will:

- ° Increase nurses' roles in providing primary, preventative, mental health and long-term care. Advanced practice nurses will play a crucial role in guaranteeing that every American receives high-quality care. Nurses in community and primary care settings will see people when they first need care.

- ° Reduce barriers and move toward a level playing field among health professionals. Nurses will be able to

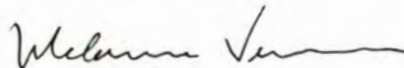
contribute on the basis of their skills and work to the full scope of their training. Nurses will work in partnership with other health providers to ensure high-quality care.

- ° Cut paperwork so that nurses can concentrate on providing care to patients -- not filling out forms.
- ° Provide incentives for nurses to work in underserved rural and urban areas.
- ° Rely on nurses to provide home-based and community care for older Americans, persons with disabilities, the chronically ill and other vulnerable populations, such as the mentally ill and children with special needs.

The President is committed to providing affordable, quality health care to every American. Nurses will play a pivotal role in making that happen.

The Administration looks forward to working with the nursing community to promote health care reform. Thank you again for writing to the First Lady, and thank you for caring.

Sincerely yours,

A handwritten signature in dark ink, appearing to read 'Melanne Verveer', with a stylized, flowing script.

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Women's Healm

PHOTOCOPY
PRESERVATION



file

Society for the Advancement of
WOMEN'S HEALTH RESEARCH

July 13, 1993

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Phyllis Greenberger, MSW

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Ph.D., R.N.
Professor, Center for Women's
Health, University of Washington

Lisa Muscatine
Office of the First Lady
White House
Old Executive Office Building
Room 158
Washington, DC 20501

Dear Lisa,

We enjoyed speaking with you about women's health research issues and hope that the information we discussed will be helpful to you in crafting a speech for Mrs. Clinton.

Enclosed is the material we discussed. You will find a history of women's health research issues and specific facts on women's health concerns in these documents.

Please let us know if we can be of further assistance.

Sincerely,

Susan Blumenthal
Susan J. Blumenthal, MD, MPA
Scientific Director, SAWHR

Phyllis Greenberger
Phyllis Greenberger, MSW
Executive Director, SAWHR

Chief, Behavioral Medicine Research Branch
National Institute of Mental Health

cc: Melanne Verveer



Society for the Advancement of WOMEN'S HEALTH RESEARCH

The Society for the Advancement of Women's Health Research, launched in 1990, brought to national attention the problem of the exclusion of women from major clinical research trials, and the consequent need for greater federal funding for diseases and conditions experienced by women. Today, the Society is the only national advocacy organization whose sole mission is to improve the health of women through research.

GOALS: The work of the Society is guided by five basic goals. These goals include:

1. To identify those areas of research which will have an impact on the health of women
2. To promote and encourage financial support, both public and private, for women's health research
3. To effect changes in policies and behavior to improve the health of women based on research outcomes
4. To create a milieu for change by informing policymakers, the public, educators and other professionals on research outcomes
5. To advance women as leaders in the health professions with the intent of increasing research in women's health and improving the health of women

The Society has achieved notable success in its brief three-year existence. During the watershed year of 1990, the Society served as a catalyst for major advances in women's health including a Congressional initiative, the *Women's Health Equity Act*, and the creation of the Office of Research on Women's Health at NIH.

At its first annual Scientific Advisory Meeting in the Spring of 1991, the Society convened twenty-five medical and health specialty organizations to discuss research priorities for women's health. Using the meeting findings as a springboard for discussion, the Society subsequently held a series of regional roundtables in which health care providers and practitioners, community leaders, and female consumers sought to further refine the women's health research agenda for the 1990's.

Spring 1992, the Society launched its *Women in Academic Medicine and Health Science* initiative by dedicating the second Scientific Advisory Meeting to increasing the participation and advancement of women in the medical and health specialties. This meeting set the stage for a set of four regional roundtables which kicked off in New York on October 5, 1992 and convened leaders in academic medicine and health sciences -- deans, department chairs, administrators -- who will develop and implement the recommendations.

The third annual Scientific Advisory Meeting is planned for June 1993 and will focus on the impact of the environment on women's health. Researchers and environmental groups have increasingly observed possible links between exposure to environmental substances and women's health problems. More research is clearly needed to conclusively establish a link between environmental factors and women's health status. Such research findings could suggest ways to reduce or eliminate harmful exposures, thus improving women's health through disease prevention.

Continuing the positive momentum, the Society developed the following membership opportunities which seek both to sustain the recent gains and to further the dialogue:

Corporate Advisory Council: consists of representatives of health related corporations which provide a unique opportunity for dialogue and cooperation among leaders in women's health, medicine, science, public policy and government, and those in health care and health research industries;

Medical/Health Advisory Board: consists of representatives of professional medical societies, professional trade associations and related health professions professional societies which function to develop and facilitate ongoing, interdisciplinary dialogue, to target women's health research needs and to keep abreast of developments across specialties and disciplines; and

National Policy Task Force: consists of individuals who provide a national, leadership constituency which will undertake the requisite, hard-hitting advocacy, public education and outreach strategy to ameliorate gender-based inequities in research funding.

IN 1993 AND BEYOND, THE SOCIETY WILL CONTINUE TO ADVOCATE THE TYPES OF
SYSTEMIC AND CONCEPTUAL CHANGE THAT ARE NEEDED TO ADDRESS
DIVERSE WOMEN'S HEALTH RESEARCH CONCERNS.

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Professor, Center for Women's Health
University of Washington

SOCIETY PUBLICATIONS LIST

Toward's a Women's Health Research Agenda: Findings of the Scientific Advisory Meeting

Women's Health Research: Opportunities and Strategies for Change

Toward's a Women's Health Research Agenda: Findings of the 1991 Women's Health Research Roundtables

JOURNAL

Journal of Women's Health, eds., Anne Colston Wentz, M.D. and Florence P. Haseltine, Ph.D., M.D.

- published quarterly by Mary Ann Liebert, Inc. Publishers

For additional information about the Society or to make a tax deductible contribution,
please contact the Society at 202/223-8224.



Society for the Advancement of
WOMEN'S HEALTH RESEARCH

**WOMEN'S HEALTH RESEARCH:
PERSPECTIVES AND PRIORITIES IN THE 1990'S**

FACTS AND RESEARCH NEEDS

compiled by

Susan J. Blumenthal, M.D., M.P.A.
Vice President, Board of Directors
Chair, Scientific Advisory Board

and

Tracy Johnson, M.A., Project Manager
Leslie Quillin, Research Assistant

CARDIOVASCULAR DISEASE (CVD)

- Heart disease is the *number one* killer of U.S. women (28% of all deaths); death rates are highest for women of color;
- Women who are diagnosed with heart disease are typically ten years older and sicker than men with the same condition; increase occurs after menopause;
- Research involving 22,071 male doctors found that moderate doses of aspirin may reduce men's risk to heart disease; benefit to women is unknown
- A long term study (*MR. FIT*) examining the relationship of cholesterol and heart disease was conducted on 15,000 men, but no women
- Hypertension -- a major risk factor in cardiovascular disease -- is 2-3 times more common in women than men and highest among African American women. Drugs to treat hypertension have primarily been tested on white male populations;
- Women receive less aggressive work-ups for heart disease and experience poorer outcomes from "standard" treatments.

Research Needs

- ✓ Clarify the role of estrogen and heart disease, particularly as it relates to menopause and Hormone Replacement Therapy (HRT);
- ✓ Determine cause of older age of onset (relative to men) of coronary artery disease -- estrogen? poor diagnostic methods? physician error?;
- ✓ Delineate psychosocial and behavioral risk factors to heart disease in women -- diet, obesity, exercise, smoking, poverty, stress, etc.;
- ✓ Identify effective strategies to reduce the risk of CVD in women;
- ✓ Examine the role of hypertension and cardiovascular disease; study hormonal-antihypertensive drug interactions;
- ✓ Explore differences in stroke incidence and patterns among women of color and women of different ages;
- ✓ Elucidate why certain medical procedures and testing are used less on female heart patients -- and why, when used, women have poorer *outcomes* -- than men with similar symptoms;

BREAST CANCER

- In 1992, an estimated 180,000 women were diagnosed with breast cancer and 46,000 women died of the disease;
- The incidence of breast cancer has been rising during the last thirty years -- from 1 in 20 in the 1950's to *1 in 8* in 1992; incidence has risen 32% since 1982;
- There is no known cause of breast cancer. Seventy percent (70%) of new cases are diagnosed in women who have no known risk factors for the disease;
- Options for breast cancer treatment -- surgery, radiation and/or chemotherapy -- have not appreciably changed over the last 30 years;
- Women of color have poorer outcomes than European American women;
- Breast cancer costs this country more than \$6 billion each year in medical costs and lost productivity.

Research Needs

- ✓ Investigate suspected risk factors and causes of breast cancer -- dietary fat, obesity, environmental contaminants (esp., estrogenic substances), genetic factors;
- ✓ Develop improved methods of early detection as well as *prevention*; determine whether changes in diet/environmental factors can prevent cancer growth;
- ✓ Determine the short and long-term benefits and risks of breast cancer among women taking oral contraceptive or undergoing post-menopausal hormone replacement therapy (HRT);
- ✓ Improve and expand treatment options -- breast-sparing surgery, tamoxifen and taxol;
- ✓ Explore the reasons for poorer outcomes for women of color, especially African American women, despite their lower rates of breast cancer incidence;
- ✓ Identify psychosocial factors and interventions that may modify the course of the illness with particular attention to ethnic, racial and socioeconomic factors;
- ✓ Examine psychosocial, economic and access barriers to obtaining regular screening
- ✓ Study the feasibility of creating a national tissue, tumor and devices bank.

OVARIAN, CERVICAL, and UTERINE CANCERS

- Unlike breast and cervical cancers, there is no early detection method for ovarian cancer; however, there is 90% survival rate even after 5 years when detected in Stage I (cancer confined to ovary);
- In 1992 alone, 21,000 new cases of ovarian cancer will be diagnosed; 13,000 women will die this year from this form of cancer;
- Ovarian cancer accounts for 52% of all gynecological deaths;
- In 1991, 13,000 cases of cervical cancer and 33,000 cases of uterine cancer were diagnosed;
- Women of color continue to die from cervical cancer at disproportionate rates;
- The incidence of uterine cancer is four times higher in postmenopausal women on "unopposed" (estrogen-only) hormone replacement therapy (HRT) than in women on combined estrogen and progestin therapies.

Research Needs

- ✓ Discover early detection methods (e.g., transvaginal and Doppler ultrasound) for ovarian cancer;
- ✓ Develop a synthetic form of taxol, a drug 40% effective in patients whose tumors have recurred or are resistant to other chemotherapeutic drugs;
- ✓ Develop strategies to improve the access to and use of PAP smears among women of color and other underserved populations;
- ✓ Elucidate the correlation between the human papillomavirus (HPV) and other STD's and an increased risk of cervical cancer;
- ✓ Understand the role of estrogen -- natural, synthetic (ERT, birth control pills) and exogenous (environmental substances) -- in the incidence and virility of reproductive cancers.

LUNG CANCER

- The U.S. lung cancer death rate has risen more than 100% since the early 1970's;
- Since 1985, lung cancer has surpassed breast cancer as the major cancer killer of women; *all* of the increase is associated with smoking;
- Approximately one in three women smoke regularly or occasionally;
- In 1967, 17% of teenage boys and 10% of teenage girls smoke; today, smoking rates among the former have declined while rates among the latter (girls) have increased to surpass the boys;
- Teenagers are beginning to smoke at younger ages, with the age of initiation decreasing, especially among girls;
- Smoking prevention efforts have not focused on girls and women;

Research Needs

- ✓ Identify high-risk groups and develop targeted behavioral change strategies to prevent smoking and for smoking cessation;
- ✓ Better delineate gender-specific motivations for smoking -- e.g., a desire to be thin -- and develop prevention/intervention strategies accordingly;
- ✓ Explore the link between "second-hand" smoke inhalation and an increased risk of lung cancer in women;
- ✓ Identify the biological mechanisms of craving;
- ✓ Explore pharmacologic strategies to promote smoking cessation.

OSTEOPOROSIS

- Osteoporosis afflicts up to 50% of women over 45 years and 90% of women over 75 years;
- Osteoporosis causes over 1.3 million fractures of the hip, wrist and vertebrae each year; one third of women over 65 years will have at least one vertebral fracture;
- The disease causes deformities, loss of independence, and over 50,000 deaths among American women annually;
- One out of every five patients will die within a year of fracturing a hip.
- Health care costs associated with osteoporosis amount to \$7-10 *billion* annually.

Research Needs

- ✓ Determine the exact role of estrogen in calcium absorption, bone growth and remodeling;
- ✓ Reduce the side effects of Hormone Replacement Therapy (HRT); develop alternative treatments;
- ✓ Improve diagnostic techniques to detect bone loss; examine bone density measurement accuracy;
- ✓ Better delineate risk factors -- genetic predisposition, diet, exercise, history of eating disorders or substance abuse, environmental factors, ethnicity and socioeconomic status, etc. -- and develop risk reduction strategies;
- ✓ Determine whether dietary changes during adolescence and young adulthood may reduce women's risk to osteoporosis later in life.

IMMUNOLOGICAL DISEASES

- More than 1 in 10 people have a condition related to an immunologic illness;

AIDS:

- Women are the fastest growing demographic group affected by HIV infection;
- The risk of contracting AIDS is increasing so rapidly that it is expected to be the major cause of death among young women in the next decade;
- The Centers for Disease Control (CDC) has yet to include gynecologic conditions in its official definition of the disease;

Lupus Erythematosus:

- Lupus effects one of every 2,000 Americans and strikes women 10 times more frequently than men;
- Rates of lupus are 3 times higher among African American women than among Caucasian women;

Chronic Fatigue Syndrome (CFS):

- Between one to five million people in the U.S. suffer from CFS; over 60% of CFS victims are women.

Research Needs

- ✓ Identify the reasons why women of different ethnic and racial groups are more vulnerable to inflammatory immune disorders;
- ✓ Clarify the relationship between sexually transmitted diseases, urinary tract infections, and the incidence of AIDS;
- ✓ Determine gender differences in the risk factors, onset, course and treatment of AIDS; develop effective behavioral change strategies to prevent HIV in women;
- ✓ Identify the effects of hormones on the immune system function, including the effect of pregnancy;
- ✓ Evaluate the impact of psychosocial interventions on immune system function and on disease outcome;
- ✓ Determine the causes and exacerbating environmental factors of CFS;

REPRODUCTIVE HEALTH

- Sixty percent (60%) of U.S. women of reproductive age use contraception; less than 50% of these women are satisfied with their methods;
- Sterilization is the leading method of birth control among married women; men have only two choices for fertility control -- condoms or vasectomy;
- Abortion politics have contributed to a "chilled" environment for contraceptive study; the U.S. now lags two decades behind Europe in contraceptive research and development;
- The American abortion rate, 27.3 per 1000 women, is one of the highest in the industrialized world;
- Adolescents and young adults have higher rates of gonorrhea, chlamydia and human papillomavirus (HPV) than any other age group;
- The average woman now spends almost one third of her life in the postmenopausal period; research on women and aging is virtually non-existent;
- One out of eight couples experiences infertility problems.

Research Needs

- ✓ Increase knowledge about the role of estrogen and other hormones (and their regulation) in relationship to health and disease in women over the lifespan;
- ✓ Develop woman-controlled barrier contraceptives and expanded choices for men; develop effective viricides;
- ✓ Study RU486 and other antihormones as medical abortifacients or contraceptives;
- ✓ Support research on sexual attitudes and behavior; evaluate prevention strategies and programs vis a vis unintended pregnancy and STD's.
- ✓ Develop new methods of diagnosis and treatment of infertility;
- ✓ Develop methods to control hot flashes and other symptoms of menopause;
- ✓ Study the aging process in women; determine which factors promote health aging;
- ✓ Study the influences of environmental and psychosocial factors on reproductive function.

VIOLENCE

- Every 15 seconds an American woman is beaten in her own home; injuries from battering are the most frequent reason women go to the emergency room;
- Nearly one in three (30%) female homicide victims are murdered by a male partner, or former partner;
- Women are twice as likely to be injured by violence as by cancer; Three (3) million assaults on women occur each year;
- Over the past decade, homicide rates for women ages 25-34 have been on the rise while rates for men have decreased;
- Up to one third of all American women will be sexually assaulted in their lifetimes; an estimated one in four American girls -- and one in six boys -- experience sexual assault and/or incest during childhood and teen years;
- Survivors of sexual abuse often experience Post Traumatic Stress Disorder (also called, Rape Trauma Syndrome) -- a syndrome also experienced by many war veterans;

Research Needs

- ✓ Conduct studies to determine the prevalence of physical and sexual abuse in children and in adult populations;
- ✓ Conduct behavioral and biomedical research to ascertain the links between self-esteem, violent behavior, sexual aggression and battered-woman syndrome;
- ✓ Evaluate current and develop new intervention strategies and policies to reduce violence against women;
- ✓ Develop effective interventions for survivors of abuse;
- ✓ Determine the relationship of experiences of abuse to the development of mental and addictive disorders and its effects on interpersonal relationships;
- ✓ Evaluate the role of mass media in violent behavior;
- ✓ Perform attitudinal surveys among health providers, law enforcement and the military; provide training to identify abuse.

MENTAL ILLNESS

- Women are twice as likely as men to suffer from clinical depression;
- 1 out of 7 women will experience a major depression over her lifetime; an estimated 15% of these women commit suicide each year;
- The effects of drugs to treat mental illness (many of which have been tested primarily in men) have been shown to vary over the course of women's menstrual cycle and to interact with oral contraceptives;
- Seventy-five (75) percent of American women who experience clinical symptoms of depression are untreated;
- Some forms of anxiety disorder including panic disorder are more common in women;
- Nine out of ten (90%) cases of eating disorders occur in women; the rates of anorexia and bulimia have doubled over the past two decades.
- One in five (20%) of Americans are affected by mental illness over their lifetime; the costs to society are an estimated \$237 *billion* each year;

Research Needs

- ✓ Improved diagnostic and treatment strategies for mental illness;
- ✓ Identification of risk factors -- genetic, biological, psychosocial, and environmental factors -- and how they interrelate in the etiology of mental illness;
- ✓ Understanding of gender-related effects in drug response of commonly-prescribed drugs (psychotropic medications) used to treat mental illness;
- ✓ Evaluate the effects of the menstrual cycle function on the development and course of illness.

SUBSTANCE ABUSE

- Women use tranquilizers 2.5 times more often than men;
- Two-thirds all prescriptions for psychotropic drugs are for women;
- Women are 30-50% of the estimated 10 million alcoholics in the U.S.; significant numbers are cross addicted to other drugs;
- Alcohol increases the risk of breast cancer and heart disease in women; alcohol and cocaine are known to suppress female hormones;
- Approximately two infants of every 1,000 suffer from Fetal Alcohol Syndrome due to their birth mothers' alcoholism;
- Women are more likely to seek drug/alcohol treatment during pregnancy than any other time; yet for liability reasons, few treatment centers accept pregnant women;
- Current knowledge about addictive behavior and treatment strategies has focused on male populations.

Research Needs

- ✓ Develop women-centered treatment strategies for substance abuse;
- ✓ Better delineate the unique substance abuse patterns of women;
- ✓ Explore psychosocial, economic and cultural factors which influence women's addictive behavior -- past physical/sexual abuse, depression, sexism, racism, poverty, etc.;
- ✓ Examine and explain the metabolic differences of (abused) substances in men and women , including the effects of aging;
- ✓ Identify the biological mechanisms of craving and develop anti-craving pharmacologic interventions;
- ✓ Study the long-term physical and mental health consequences of alcohol and other substance abuse;
- ✓ Evaluate the short and long-term effects of alcohol and other drugs of abuse during pregnancy.

THE ENVIRONMENT AND WOMEN'S HEALTH

- Human health and disease depend upon the interaction between genetics and the environment over time;
- Alterations in the natural regulation of hormones such as estrogen (quantity or timing) may have negative effects on health and predispose women toward diseases such as cancer of the breast, ovary and uterus, osteoporosis, etc.
- Several ubiquitous environmental toxicants (e.g., DDT, PCBs) can mimic estrogen; excessive estrogen levels are associated with many of the above listed diseases;
- Heavy metal and pesticides are correlated with many diseases including neurologic disorders, autoimmune disease and osteoporosis;
- Many environmental toxicants are accumulated in fat tissue, are not readily excreted and lead to and an increased concentration of these compounds in women's bodies (women have higher fat composition than men) and potentially in increased health risks;
- Synthetic estrogen (DES) was administered to thousands of women, 1940-60; the drug has now been linked to reproductive cancer in female and male offspring;
- Few research dollars have been allocated to the study of the interplay of environmental and genetic factors which contribute to disease in women;

Research Priorities

- ✓ Conduct basic research to understand how estrogen and estrogen-like substances influence normal biological functioning and disease in women;
- ✓ Clarify the link between genetic mutations and gynecologic/breast cancers; investigate how environmental exposures contribute to such mutations;
- ✓ Explore the role environmental toxicants play in the health of women over a lifetime; develop risk reduction and prevention strategies accordingly;
- ✓ Examine the role of toxicants in fat stores and breast cancer/other diseases;
- ✓ Identify a genetic marker for DES carcinogenicity to predict risk in second and third generation off-spring of DES-exposed women;
- ✓ Determine whether a link exists between estrogens accumulated in the body and endometriosis.

ACCESS ISSUES -- HEALTH SERVICES RESEARCH

- Thirty-seven (37) million people are without health insurance presently; a majority of them are women and children;
- Women visit physicians more often, report more symptoms and take more prescription drugs than men;
- A doctor's recommendation is the single most influential factor in convincing women to undergo a mammogram screening;
- In Chicago, women wishing to use public health clinic services must wait an average of 135 days for a family planning visit, 82 day for a maternal visit and 104 days for a pediatric visit;
- Of the 1,552,000 residents in nursing homes in 1990, roughly 72% were women;
- It is estimated that more than 1/2 of all women and almost 1/3 of all men reaching age 65 in 1990 will spend time in nursing homes before they die;

Research Needs

- ✓ Pursue a better understanding of women's health seeking behavior and patterns; ensure that health care delivery systems/reform take these considerations into account;
- ✓ Evaluate health care outcomes for women in, and cost-effectiveness of, different health care delivery systems and settings -- HMO's, community clinics, inpatient care, etc;
- ✓ Delineate psychosocial, economic and cultural barriers to the utilization of existing services;
- ✓ Evaluate the adequacy of care delivered at nursing homes;
- ✓ Determine gender differences in the way people age and the factors that contribute to healthy aging; build these considerations into long term care provisions.

WOMEN'S HEALTH RESEARCH: RESOURCE LIST

Congressional Caucus for Women's Issues

Lesley Primmer, Executive Director
2471 Rayburn House Office Building
Washington, D.C. 20515
P:202/225-6740 F:202/225-2593

Jacobs Institute of Women's Health

Martha Romans, Executive Director
409 12th Street, N.W.
Washington, D.C.
P:202/863-4990 F:202/484-5107

Publications:

The Women's Health Data Book

NIH Office of Research on Women's Health

Vivian Pinn, M.D., Director
Building One, Room 201
Bethesda, MD 20892
P:301/402-1770 F:301/402-1798

Publications:

Report of the National Institutes of Health: Opportunities for Research on Women's Health

Society for the Advancement of Women's Health Research

Phyllis Greenberger, Executive Director
1601 Connecticut Ave., N.W., Suite 801
Washington, D.C. 20009
P:202/328-2200 F:202/667-0462

Publications:

Towards a Women's Health Research Agenda: Findings of the Scientific Advisory Meeting

Towards a Women's Health Research Agenda: Findings of the 1991 Women's Health Research Roundtables

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Towards a Women's Health Research Agenda:

Findings of the Scientific Advisory Meeting

Convened by

The Society for the Advancement of Women's Health Research

1601 Connecticut Avenue, NW, Suite 801, Washington, DC 20009

202/328-2200

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6 Pages

Society for the
advancement of Womens
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*Society for the
Advancement of*

WOMEN'S HEALTH RESEARCH

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organization
whose sole mission
is to improve
the health of women
through research*

file women's health

2/25/94

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STATEMENT OF

**Dr. Samuel Broder
Director
National Cancer Institute
National Institutes of Health
Department of Health and Human Services**

on Mammography and Pap Tests

**before the
Subcommittee on Aging
Senate Committee on Labor and Human Resources**

Senator Barbara Mikulski, Chair

March 9, 1994

Statement of Dr. Samuel Broder
National Cancer Institute

Good morning, Madame Chair, and Members of the subcommittee. I am Dr. Samuel Broder, Director of the National Cancer Institute (NCI). Thank you for the opportunity to appear before you today to discuss NCI's research on breast cancer, the NCI position on screening for breast and cervical cancers, and the scientific basis for that position. Breast cancer and cervical cancer are two areas critical to women's health.

Cancer is the second leading cause of death among women in the United States. In 1994, about 250,000 women will die of all cancers combined, about 46,000 dying of breast cancer. It is the most common cause of death from any cause in women aged 40-44. Since 1987, breast cancer incidence, fortunately, has reached a plateau and has actually decreased slightly. However, from 1973 until 1987 the incidence of breast cancer showed a steady increase. Although there are now slight decreases, the situation is dire. Some of the past increase in incidence over the 1980s is attributed to increased detection due to mammography; the longer term increase is less well understood. We do not believe that the increase can be fully understood without more basic research.

Turning to cervical cancer, in 1993, 13,500 American women were diagnosed with this disease and 4,400 died. Fortunately, the incidence of invasive cervical cancer and the death rate have decreased in the United States over the past several years, because the Pap screening test can detect the pre-malignant or *in situ* stage. The Pap test, developed by George Papanicolaou, has been used since the 1940's. This test, like others, has limitations. The early stage can be effectively treated, and yet, even here, there are problems as sometimes the cells captured during the procedure are not the atypical ones. Beyond that, some women are not being screened at all and even among those who are screened, some are not being treated. Even when the cells are accurately gathered, not all tests are read and interpreted accurately. NCI has worked to improve the reading of the Pap test and has introduced the "Bethesda system" which has clarified and standardized reporting. Despite these problems, the Pap test is an excellent tool, even when its limitations are taken into account. As a result of our investment in basic research, we are making good progress on a possible vaccine against cervical cancer. The ability to create such a vaccine grew out of years of research on viral carcinogenesis.

The issue of mammography is an area of intense polarization between various groups at this time. The polarization has occurred not because of fundamental differences--we all share the concern that women are dying of breast cancer--but because we have different perspectives on this problem. The key question before us all is how to go about reducing the devastating toll of breast cancer and other cancers.

The NCI is a scientific institution, a biomedical research institution committed to generating the knowledge needed to reduce the suffering and death from cancer. While at times there have been bursts of enthusiasm for research advances that promised to cure cancer, we all recognize that cancer has not been cured. Today, there are exciting developments on many

fronts, particularly in basic research, but as we discuss these achievements, we must acknowledge that cancer poses an awesome research and therapeutic challenge. We must have no illusions on this point.

As a scientific organization, we know that individual opinions and practices may require adjustments or fundamental changes as we learn more facts about normal biology, more about the cancer cell and have more opportunity to assess diagnostic tools and treatments. At the same time, we have seen that yesterday's "incurable and fatal" disease can be tomorrow's medical triumph, and that a disease that terrorizes one generation may be only dimly remembered by the next generation. Two principles need to guide us wherever possible: the consensus of scientific peer groups and clinical trials as the instrument for consensus wherever possible.

Each of us has a role to play in this enormously important effort to save the lives of American women. I believe that NCI's role is the generation of knowledge, the sharing of that knowledge and translation of scientific knowledge into clinical reality at the community level. We could not advocate a treatment being continued if followup clinical trials showed that its benefits were initially overstated, that in truth, it brought no reduction in deaths in the real world. By the same rules, we must adhere to what we have learned about the value of mammography for women in various age groups. After a process of scientific evaluation, after extensive review of data from a number of clinical trials, after internal and external debate, and most important of all, after seeking the input and advice of our most respected non-governmental experts, we have an obligation to share the results of this process with the women of America. We owe it to them to provide the most accurate information available about screening and treatment of breast and cervical cancer at a point in time. In the case of mammography, a routine program of screening will definitely save lives. This technology has been proven in randomized clinical trials for women over age 50, and moreover there is a clear and unmistakable consensus on this point. For women under 50, neither condition applies at this time.

One point must be emphasized: this discussion does not address diagnostic mammography, where a doctor and woman are joined in following symptoms or other indications, such as a lump, pain, or swelling, of a possible malignancy. That is a different situation entirely. Here, in this discussion, we are focusing on the concept of screening in women who are free from known signs or symptoms.

It is important to note that mammography is only one of several screening technologies being examined by NCI. For example, a large clinical trial, the Prostate, Lung, Colorectal, and Ovarian (PLCO) trial, has begun to evaluate screening tests in these cancers. This study will assess the predictive value of the widely used test for prostate specific antigen (PSA) and less used technology such as ultrasound, CA 125 or flexible sigmoidoscopy. In women, for instance, the study is designed to determine if screening with pelvic examination plus serum CA 125 and transvaginal ultrasound can reduce deaths from ovarian cancer. Thus, for tests

such as PSA, we are not recommending its adoption as a routine screening tool until clinical trials and/or a scientific consensus permit us to do so.

The rank-and-file scientists who work in the National Cancer Program, both intramural and extramural, are superb and they are a dedicated group of men and women. They are working to find new ways to prevent, detect and treat breast and cervical cancer. NCI supports research aimed at locating important genes and genetic processes in breast cancer. Research is being carried out on specific inherited gene abnormalities and certain familial predispositions to breast cancer including benign proliferative breast disease; the Li-Fraumeni syndrome, in which family members inherit a mutation in the p53 tumor suppressor gene, located on the short arm of chromosome 17; and early-onset familial breast cancer, linked to abnormalities also on chromosome 17 referred to as Breast Cancer-1 or BRCA-1.

Collaborations with the National Center for Human Genome Research are designed to elucidate genetic information about breast cancer. On December 2, 1993, we were pleased to announce the finding of a gene for colon cancer that also appears to play a role in ovarian, uterine and several other cancers. When genes are found, tests can be developed to show which women are at risk. Sometimes the genetic discovery will aid in developing vaccines or new prevention strategies.

At times, conditions not typically thought to fall within a definition of women's health are of surpassing importance. Thus, the gene for Ataxia-Telangiectasia when carried by an otherwise normal woman can predispose her to radiation damage and breast cancer. As carcinogenesis studies progress, this information could be used to counsel women at high risk to avoid certain environmental exposures and to undertake individualized programs of screening and prevention. We are looking specifically at breast cancer and the interaction of various occupational and environmental hazards in the NCI Long Island Breast Cancer Study Project. This will provide information not only for New Yorkers, but for women everywhere.

Genetic discoveries will yield new molecular tests that might have high specificity. We are not waiting for these events to occur. We are working to refine our knowledge of the tools we have, including mammography and Pap tests. We are encouraging the development of new digital mammography techniques, which would also allow transmittal of images for consultation or diagnosis by specialists. New imaging techniques are being used to more accurately guide biopsies and surgery. Other methods are borrowing from space or defense department technology. We have high hopes for new technologies such as digital mammography and magnetic resonance imaging and other methods which enhance imaging. This is a very unusual time of flux in the science of breast imaging. We are continuing to stimulate the development of innovative methods of imaging the radiographically denser breast tissue of younger women--tissue that can be exceedingly difficult to image with conventional mammography. We continue to work toward simple screening tests, possibly blood tests, that would pick up molecular evidence of breast cancer or breast cancer susceptibility, and at the same time, might be the basis for new and effective therapies. Next

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month, NCI will co-sponsor with the American Cancer Society a workshop on research issues in breast cancer screening. Through the workshop, we will identify areas for further research and establish priorities for tackling these research questions.

NCI research has shown that the impact of cancer in general on minority and underserved populations is disproportionately great. This impact is certainly felt in breast and cervical cancer incidence and mortality rates. Even where incidence rates are lower for African-American women than for white women, as is the case with breast cancer in women ages 40 and over, the mortality rates of African-American women are higher. Cervical cancer incidence rates for African-American women are about twice the rates for white women, and mortality rates are about three times the rates for white women.

Screening and access to screening are only one aspect of this very complex situation, one that tangles economic issues, educational issues, access to screening and diagnosis and access to treatment with many other variables including genetic and environmental ones. Mammography has seemed to be a successful way to introduce some underserved women into the medical system. In some ways, it has become a metaphor for concern about breast cancer, even a way a woman could express her determination to protect her health. But mammography was never designed to do all that--it is a medical tool. Mammography was designed to screen for breast cancer and where it is efficient and there are other benefits, that is all to the good. Thus, for women over 50, mammography is an established screening tool. But there is extreme disagreement concerning women under age 50. Therefore, in this setting, we must state what we know and what we do not know.

A word about the history of NCI recommendations is in order. In 1987 the NCI developed Working Guidelines for the early detection of cervical and breast cancers. These guidelines provided the American public with a summary of the state of knowledge at the time.¹ The guidelines regarding screening mammography for breast cancer detection (which can be defined as a regularly performed mammogram for a woman with no presumptive evidence or symptoms of breast cancer) were as follows:

- ♦ The screening process should begin by age forty and consist of annual clinical examination with screening mammography performed at one to two year intervals.
- ♦ Beginning at age fifty both clinical examination and mammography should be performed on an annual basis.

¹ It is important to stress that none of these guidelines pertain to diagnostic mammography, which is performed as a result of a clinical suspicion (such as a lump or nipple discharge). In the setting of a clinical suspicion, whether because of symptoms or physical findings, mammography is generally a necessary medical tool.

- ♦ Physicians should encourage women to perform monthly breast self-examinations.

At the time these guidelines were developed, evidence for screening was strongest in women ages 50-69, although the Health Insurance Plan (HIP) of Greater New York clinical trial had shown a reduction in cancer deaths due to screening in a group of young and older women all mixed together. The above guidelines were considered working guidelines with the intent to revisit them should any new information become available.

Similarly, the working guidelines for cervical cancer screening developed in 1988 are as follows:

- ♦ All women who are or who have been sexually active or who have reached the age of 18 years should have an annual Pap test and pelvic examination.
- ♦ After a woman has had three or more consecutive, satisfactory, normal annual examinations, the Pap test may be performed less frequently at the discretion of her physician.

Over the ensuing six years there has been no new information to contradict the basic message of the original guidelines on cervical cancer and the consensus among scientists has held firm. Over the last two to three years, however, several events have led to an ongoing re-evaluation of the breast cancer screening guidelines:

- ♦ First, an NCI-supported meeting entitled "Forum on Breast Cancer Screening in Older Women" was convened in April 1992. Among the recommendations was the following: "There was enough direct evidence to support a recommendation for universal screening in women sixty-five to seventy-four years of age. Because of the lack of direct evidence regarding screening efficacy and because of increasing occurrence of multiple chronic diseases in women seventy-five years of age and older, the Forum concluded that clinical judgment was necessary to weigh the relative benefits of co-morbidity and screening effectiveness for the individual patient in this age group ... Regarding the interval for mammography and clinical breast examination, the Forum concluded that there was no evidence to choose one interval over another, since apparently equally effective intervals have ranged from twelve to thirty-three months."
- ♦ Second, the Canadian National Breast Screening Study of screening women in their forties, published in November 1992, did not show a mortality benefit ascribed to mammography after seven years of follow-up. Dr. Anthony Miller presented a preliminary analysis of this study in closed session to the Board of Scientific Counselors of the NCI's Division of Cancer Prevention and Control (DCPC) as far back as October 1991.

♦ Third, an overview analysis of five randomized screening trials conducted in Sweden in the 1970's was reported early in 1993. The study found that the largest reduction of breast cancer mortality, roughly one-third, was observed among women aged 50-69 at randomization. Among women aged 40-49 at randomization, no statistically significant difference was observed.

I would like now to briefly discuss the process by which NCI came to the specific change under discussion today, but before doing so, I want to put to rest the concern that the NCI's position is influenced by political considerations or expediency.

This process was, in one way, initiated in 1991. It was obvious that there was a need to evaluate the new information in the context of the large body of evidence which had evolved since the landmark Health Insurance Plan (HIP) study of thirty years ago. Following a pre-publication, closed briefing in the Fall of 1991 on the Canadian mammography study, NCI began planning a major international workshop of breast cancer screening that was held in February 1993. Many of the scientists who performed the studies, as well as researchers in breast cancer screening fields, participated in this workshop. Results from all eight published randomized clinical trials of screening mammography were reviewed. At that workshop an overview analysis, a meta-analysis, was presented by New Zealand investigators of all the randomized screening trials in the world. This analysis raised questions regarding the benefit of screening women between the ages of 40-49. This workshop was open to both the press and the public. At that time, NCI provided information and resources to the media, interested voluntary, advocacy and health professional organizations, and the public, on the mammography screening studies that were being reviewed.

The final report of the workshop concluded:

♦ First, "The randomized trials of women ages 40-49 are consistent in showing no statistically significant benefit in mortality after 10-12 years of follow-up. For this age group, it is clear that in the first 5-7 years there is no reduction in mortality from breast cancer that can be attributed to screening. There is an uncertain and, if present, marginal reduction in mortality at about 10-12 years. Only one study provides information on long-term effects beyond 12 years, and more information is needed."

♦ Second, "For women ages 50-69, the evidence presented at the Workshop strengthens the scientific observation that screening leads to reduced breast cancer mortality. Every study presented found a protective effect for women in this age group. The Swedish studies suggest that a screening mammogram as infrequent as every 33 months reduces breast cancer mortality, at least in a population with a high compliance rate and in a setting with high-quality mammography. These data raise the possibility that a screening interval of every 12 months may not be necessary in this population."

♦ Third, "Women in their 70's are a high risk group for breast cancer. The currently available clinical trial data for these women are inadequate to judge the effectiveness of screening because the numbers of women were small, the compliance was poor, and the screening episodes were too few."

The Workshop charge was to critically review and summarize the scientific evidence, not to develop guidelines *per se*. In response to this analysis, NCI staff began the process of reviewing our Working Guidelines in the context of the new information. NCI has a responsibility to provide accurate, clear information to the public based on scientific evidence. This information clearly held an important public health message for all women and health care professionals.

Subsequently the following process has taken place:

- ♦ During the period from May through August 1993, the NCI PDQ Editorial Board, consisting of both NIH and non-NIH researchers, reviewed and endorsed Workshop results; the NCI staff developed draft guidelines/recommendations which were reviewed by the NCI Executive Committee; NCI staff also met with the American Cancer Society (ACS) to discuss principles underlying the NCI draft guidelines.
- ♦ In September 1993 the draft guidelines were reviewed and discussed by PHS agencies and selected participants from the February 1993 International Workshop on Breast Cancer Screening; NCI staff met with the ACS Breast Cancer Subcommittee, the National Cancer Advisory Board, and with individual members of the DCPC Board of Scientific Counselors to discuss proposed guidelines.
- ♦ During October 1993, NCI disseminated draft guidelines and other materials to agencies involved in earlier guidelines and voluntary advocacy groups, with a request for written comments and attendance at the then upcoming October 21 meeting of the NCI DCPC Board of Scientific Counselors.
- ♦ On October 21, 1993, the guidelines were reviewed by the DCPC Board of Scientific Counselors, who passed a motion recommending that the existing recommendations for women 50 years and over be maintained, and that for women under age 50 NCI provide a summary of existing evidence and data and suggest that these be discussed with each woman's physician or health care provider. In effect, the Board wanted to present the facts, without the pronouncement of a guideline.
- ♦ On November 22-23, 1993 the National Cancer Advisory Board passed the following motion: "Recognizing that there is controversy on the effectiveness of mammography for women under the age of 50 that calls for more research, the members of the National Cancer Advisory Board recommend that the National Cancer

Institute defer action on recommending any changes in breast cancer screening guidelines at this time."

♦ On December 3, after careful consideration of the conflicting advice of scientific experts, NCI released the following statement summarizing our position on breast cancer screening:

"There is a general consensus among experts that routine screening every 1 to 2 years with mammography and clinical breast examination can reduce breast cancer mortality by about one-third for women ages 50 and over.

Experts do not agree on the role of routine screening mammography for women ages 40 to 49. To date, randomized clinical trials have not shown a statistically significant reduction in mortality for women under the age of 50."

♦ On February 23, 1994, the National Cancer Advisory Board passed the following motion:

"Inasmuch as cancer research is the primary mission of the National Cancer Institute, the NCAB recommends that the NCI not involve itself independently in the setting of health care policy."

Several points are worth stressing. The current NCI position is in close alignment with the positions of several public and private organizations--e.g., the National Women's Health Network, the U.S. Preventive Services Task Force, the American College of Physicians, and the American Association of Family Practitioners. Moreover, there is a growing feeling among our advisory groups that NCI must stick to science and the generation of knowledge and allow other appropriate government agencies to take the lead in the formulation of guidelines that speak to reimbursement and related issues.

The change has been controversial, but the process has been open and candid. We have extended our outreach to many diverse groups, both scientists and consumer advocates. We have heard from women's advocacy groups who strongly oppose the use of routine mammography in women under 50 and those who with equal force hold the opposite view. NCI has been intensively reviewing the state of the science regarding mammography screening efficacy for at least two years. After the Workshop conclusions were clear, NCI conducted surveys and focus groups with women and health care professionals to anticipate issues which might help to prepare health professionals and the public for such changes.

Results from the surveys and focus groups indicated that women clearly understand that scientific debate on health issues is sometimes unavoidable.

The NCI maintains communication with many voluntary, advocacy and health professional organizations in the areas of cancer prevention, early detection, and treatment. NCI has redoubled its efforts to stay in close communication with these organizations and to assist where possible in minimizing the confusion that often occurs when recommendations change. And yet, we sometimes must differ even while we may at the same time respect and admire those who disagree with us.

On December 3, 1993, NCI released the new mammography statement and simultaneously communicated with all its own units including the Cancer Information Service--which answers inquiries via the toll-free 1-800-4-Cancer telephone number, the National Black Leadership Initiative on Cancer, the National Hispanic Leadership Initiative on Cancer, the Appalachian Leadership Initiative on Cancer; the Cancer Centers Public Affairs Network; and the Centers for Disease Control and Prevention to determine the strategies and tools needed to convey NCI's breast cancer screening messages in light of the latest scientific review. NCI immediately began updating its own publications and developing a consumer brochure that explains the new position on breast cancer screening for women 40 and over.

The NCI Division of Cancer Prevention and Control is planning a meeting of organizations within the Public Health Service to determine how best to work together on this issue and to organize an ad hoc committee of NCI staff as a first step to develop effective strategies to educate physicians and other health care providers on the new NCI mammography statement.

Perhaps most importantly, NCI staff will continue to meet with breast cancer advocacy groups and voluntary organizations, such as the American Cancer Society (ACS), to clarify issues, identify common ground--and there is common ground--foster cooperation, and explore joint communication efforts, where this is possible.

Madame Chair, I welcome your interest and the interest of this Committee and the Congress in this issue. Please allow me to repeat myself: Each of us has a role to play in this enormously important effort to save the lives of American women. This dialogue on mammography is part of the effort. NCI must generate and assess knowledge and then assist in translation of scientific knowledge into the care given at the community level. Science is not separate from life, it is our effort to understand life. NCI's recommendations must be based on scientific evidence to the greatest extent possible, and they must change as new information becomes available. Thank you, Madame Chair, for this opportunity to testify. I would be pleased to answer any questions you or other members of the committee may have.

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Motion passed by the National Cancer Advisory Board February 23, 1994

Motion: Inasmuch as cancer research is the primary mission of the National Cancer Institute, the NCAB recommends that the NCI not involve itself independently in the setting of health care policy.

Rationale: We make these statements in recognition of the fact that there are both governmental and private agencies that are better equipped to develop and implement health policy than is the NCI. However, the NCI is encouraged to present, publish, and communicate information relevant to its mission to the medical and scientific communities and to other areas of government as well as to the general public in relation to cancer causation, prevention, early detection/diagnosis, treatment, and rehabilitation. New research information often leads to changes in health policy and communication of such information in appropriate detail to all interested parties clearly falls within the scope of the National Cancer Program.

Vote: 13 yes; 0 no; 1 abstention