Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: Clinotn Campaign Volunteer Activities (2 pages)	n.d.	Personal Misfile
002. letter	Tipper Gore to Phyllis (1 page)	10/27/1992	Personal Misfile
003. letter	Atul Gawande to Phyllis Greenberger (1 page)	11/05/1992	Personal Misfile
004. letter	Hillary Rodham Clinton to Phyllis Greenberger (1 page)	12/01/1992	Personal Misfile

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 6205

FOLDER TITLE:
Women's Health [Folder 2] [2]

2013-0534-S
rc1572

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

MAYOR DALEY'S TASK FORCE ON WOMEN'S HEALTH

URBAN WOMEN'S HEALTH AGENDA

A Project of the Department of Health of the City of Chicago

Richard M. Daley
Mayor

Maggie Daley
Honorary Co-Chair
Mayor Daley's Task Force on Women's Health

Sheila Lyne, RSM
Commissioner of Health
Co-Chair, Mayor Daley's Task Force on Women's Health

Hedy M. Ratner
Co-Chair, Mayor Daley's Task Force on Women's Health

This report was written for Mayor Daley's Task Force on Women's Health
by The Sive Group, Inc.

March 1994

THE FIRST LADY

HILLARY –

I THINK IT WOULD BE A GOOD IDEA AT THE CONCLUSION OF THIS DISCUSSION, FOR YOU TO TAKE QUESTIONS FROM THE PRESS FROM WHERE YOU ARE SITING.

IT WOULD BE A 10-MINUTE PRESS AVAILABILITY THAT WOULD BE OPENED BY HETY RATNER.

IS THIS OKAY? JUST NOD YES OR NO TO ME.

LISA

OFFICE ON

Women's Health

PHS/OASH/OFFICE ON WOMEN'S HEALTH
HUMPHREY BUILDING, ROOM 730-B
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201
PHONE: 202-690-7650 FAX: 202-690-7172

TO: FAX PHONE NO. 202 456-6244

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

NAME: Melanne Verveer

OFFICE/ADDRESS: _____

TELEPHONE: _____

NUMBER OF PAGES TRANSMITTED (INCLUDING COVER): 18

FROM: Susan Brenneman / 202 / 690-7650

NOTE: Here are some materials we're prepared to highlight women's health accomplishments by the Administration for Pres. Will's events. Give me a call if you get a chance. Thanks, Susan

HIGHLIGHTS OF THE CLINTON ADMINISTRATION'S COMMITMENT TO WOMEN'S HEALTH ISSUES

* The United States has set an important precedent by being the first country in the world to establish a senior level health position dedicated to redressing inequities in the health care system that have put the health of American women at risk. Susan J. Blumenthal, MD, MPA, a national leader and expert in women's health, has been appointed the first Deputy Assistant Secretary for Women's Health within the Department of Health and Human Services. In this role, she provides the leadership, direction and support for a comprehensive women's health agenda and coordinates women's health policies and programs across agencies and offices of the Public Health Service.

* The National Action Plan on Breast Cancer represents this Administration's commitment to improve research, services and education on and about breast health and breast cancer. This plan provides an unprecedented opportunity to promote public-private linkages in an effort to fight breast cancer as a serious threat to the health of women today and in generations to come. Dr. Blumenthal's Office on Women's Health is coordinating implementation of the action items outlined in the National Action Plan on Breast Cancer.

* The President's health care plan represents meaningful change for women's health. Under this plan, every woman will have the security of insurance without regard to where they live, where or if they work, their level of income or their health status. A guaranteed basic package of preventive, diagnostic and treatment services is available, emphasizing, for the first time, preventive care.

* The 1995 Public Health Service budget includes a $1.8 billion request targeting women's health programs, including increases in research, prevention and treatment activities.

FACT SHEET

Draft, May 1994

Women's Health Issues

In recent years, the heightened awareness of longstanding biases against women—in terms of educational, economic, employment, and health-related opportunities—has catalyzed an expanded focus on women's issues. In the United States, the Department of Health and Human Services is pursuing a comprehensive and meaningful agenda for women's health.

Background

Addressing the inequities in social, economic, and health-related opportunities available to women is now a national priority. Women currently comprise 51 percent of the total U.S. population, 60 percent of the U.S. population over age 65, and more than 70 percent of the U.S. population over age 85. Women now represent 45 percent of the Nation's workforce and approximately two-thirds of all employed women have children under age 18. Although women's employment outside the home has become increasingly essential to economic survival of the family, women remain overrepresented in lower wage, hourly, and part-time positions (without health insurance coverage or other work-related benefits) and continue to earn only about 70 percent of what men earn for equivalent work. Furthermore, an increasing percentage of family households are headed by single mothers, many of whom are living below the poverty line.

Women's health, in the fullest sense, incorporates both the length and the quality of women's lives and reflects the diversity of their social, cultural, economic, and physical environments. Unfortunately, women continue to face serious threats to their physical and mental well-being in this country. For example, women who live in poverty and have less than a high school education—many of whom are women of color—have shorter lifespans, higher morbidity and mortality rates, and limited access to quality health care services. And despite living 8 years longer than men, women suffer poorer health outcomes and greater disability from disease than do men. Lack of attention to women's health issues in both research and clinical practices has resulted in serious gaps in knowledge about the causes, treatment, and prevention of disease in women.

Special Populations

Minority Women

Despite the social, economic, and cultural diversity among minority women's groups, many of these women continue to suffer disproportionately from premature death, disease, and disabilities. For example, minority women on average have lower life expectancy rates; greater prevalence of chronic illnesses such as cardiovascular disease, certain types of cancer, and diabetes; and higher maternal and infant mortality rates than do white women. Homicide and HIV/AIDS are rapidly growing problems among black and Hispanic young adult women in the United States. Socioeconomic disadvantages contribute to the greater frequency and severity of illness among minority women, as evidenced by limited access to quality health care, lower utilization rates for many preventive health services, and poor health status when compared to other groups of women.

Lesbians

Lesbians encounter a number of barriers to affordable and effective health care, including the inability to share partner health benefits, lower household income, and the problems of homophobia and heterosexism in the health care community. Adverse results of these and other barriers include lower rates for preventive health screenings as well as limited knowledge about the health status and health care patterns of lesbians. Due to high self-reports for cigarette smoking, alcohol use, excessive weight, and other risk behaviors, lesbians are at increased risk of developing cardiovascular disease, cancer, and a variety of stress-related conditions, including violence and substance abuse.

Adolescents

Adolescence represents a time when women make important choices about lifestyle behaviors—including diet; physical activity; use of tobacco, alcohol, and other drugs; and sexual activity—all of which impact their health and well-being throughout adulthood. A number of health-related conditions—such as eating disorders, violence, unintended pregnancy, HIV/AIDS, and other sexually transmitted diseases (STD's)—often compromise the quality of life of women during this life stage. There is growing evidence that the socialization of many young girls predisposes them to low self-esteem, which in turn influences the development of depression, addictive behaviors, and other mental disorders.

Older Women

Although women live an average of 7 years longer than men, they experience higher rates of poverty, suffer more chronic health conditions and disabilities, and are more likely to live longer without the support of family and friends. Older women are less likely than older men to have health insurance policies that supplement Medicare expenses and have fewer resources that must extend over a longer life span. Although coronary heart disease is the leading cause of death among American women, evidence shows that women undergo invasive cardiac assessments and treatments less frequently than men. Preserving the functional independence of older women is especially challenging given their heightened risk of developing arthritis, osteoporosis, urinary incontinence, and other chronic disabilities.

Priority Women's Health Issues

Maternal/Infant Health

Although the infant mortality rate in the United States has been brought to an all-time low, it is still higher than those of most other developed countries. This is attributable to a number of factors, including lack of prenatal care; poor nutrition; use of tobacco, alcohol, and other drugs; and adolescent pregnancy. The problem is most acute among black women; the mortality rate for infants of white mothers is 7.6 deaths per 1,000 live births and for infants of black mothers it is 18 deaths per 1,000 live births. In addition, minority women are at higher risk of maternal death than are white women.

Reproductive Health

In recent decades, there has been a tremendous growth in the number of live births to unmarried women, many of whom are adolescents. Between 1980 and 1990, the percentage of live births to unmarried women increased steadily from 18 to 28 percent. The majority of these births are occurring among women who have the least amount of economic security: adolescent and minority women. In 1991, contraception was used by 81 percent of sexually active women aged 15 to 19. However, of the approximately 1.1 million women 15 to 19 years of age who become pregnant each year, 85 percent do not intend to get pregnant. In 1990, the number of abortions reported to the Centers for Disease Control and Prevention (CDC) was 1.43 million, up from approximately 1.3 million in 1980.

Violence

Violence has become a critical health issue for young American women and is in fact more pervasive than statistics indicate because incidences are widely underreported. In 1991, homicide was the second leading cause of death among all women 15 to 24 years of age, and the leading cause among black women of that age. Suicide was the third leading cause of death among young white women that year. In addition, an alarming number of women of all ages are the victims of assaults, rapes, and other personal violence every year, often perpetrated by their mates or someone they know.

HIV/AIDS

HIV infection/AIDS is a rapidly growing problem among women. Women now comprise the fastest growing group of AIDS patients; from 1991 to 1992 the increase in the proportion of women reported to have AIDS was almost four times the increase among men—9.8 and 2.5 percent, respectively. Approximately 75 percent of women with AIDS are black or Hispanic. In 1992, for the first time, more women were infected with HIV through heterosexual contact than through intravenous drug use.

Sexually Transmitted Diseases

In part because young women and men have become sexually active earlier and are more likely to have multiple sex partners, the incidence of STD's among adolescent and young adult women in the United States is rising. Chlamydia, the most common treatable STD in the United States, causes an estimated 2.4 million new cases among women each year. Gonorrhea affects an estimated 400,000 women each year. Syphilis has increased significantly among women over the past decade; in 1991, nearly 20,000 cases of syphilis occurred among women, 85 percent of whom were black. The impact of STD's is particularly severe for women because infections often have few, if any, symptoms and may go untreated until serious problems develop.

Mental Health Issues

Mental health is crucial to women's well-being and the performance of life's tasks. Some of the most common mental disorders, including depression and anxiety disorders, strike approximately twice as many women as men. According to the 1989 National Health Interview Survey, the rate of serious mental illness (i.e., any mental disorder present during the past year that seriously interfered with one or more aspects of a person's daily life) was higher in women than men (20.6 compared with 15.5 per 1,000 persons). The lifetime risk for major depressive disorder is 20 to 25 percent for women, compared with 7 to 12 percent for men. It is believed that a complex combination of physiological, social, environmental, cultural, biological, and psychological factors contribute to why women experience depression at a higher rate than men. Women who have a history of substance abuse or physical or sexual abuse are particularly at risk for depression.

Substance Abuse

The abuse of alcohol and other drugs is a serious and growing problem among American women. In 1990, nearly one-third of Americans who abused alcohol were women, and surveys indicated that more than 5 million women used drugs at least once in the preceding month. Many women who abuse drugs or alcohol have histories of sexual or physical abuse, thus compounding their problems in obtaining adequate treatment. Women who abuse alcohol or drugs are at higher risk for tuberculosis, HIV/AIDS, and other sexually transmitted diseases. Women's substance abuse may affect not only their own social and physical well-being but, in the case of pregnant abusers, that of their children as well.

Cancer

Since the late 1980's, lung cancer has been the leading cause of cancer death among women in the United States. In the past 30 years, the lung cancer death rate among American women has increased nearly 400 percent, almost exclusively due to cigarette smoking. Estimates are that by 1995, nearly half of the women in the world who die from cigarette smoking will be American. During the 1990's, approximately 2 million women will be diagnosed with breast or cervical cancer and over one-half million women are expected to lose their lives from these two diseases. It is estimated that one in eight American women will develop breast cancer in her lifetime. As is the case with many other diseases, women of color have higher mortality rates for both breast and cervical cancer.

Cardiovascular Disease

Heart disease is the number one killer of American women. Nearly one in two female deaths in the United States is a result of cardiovascular diseases. Women develop heart disease later in life than men. Approximately 1 in 9 women between the ages of 45 and 54 has some clinical cardiovascular disease; the rate climbs to 1 in 3 at age 65 and older. Forty-nine percent of women who have heart attacks die within a year (versus 31 percent of men).

Chronic Disabling Conditions

In large part because they live longer than men, women are more likely to be affected by chronic disabling conditions such as diabetes, osteoporosis, osteoarthritis, obesity, urinary incontinence, and Alzheimer's disease. These conditions not only limit function but may be life-threatening; diabetes mellitus, for example, is among the top 10 leading causes of death for all women aged 25 and over.

HHS Actions

As part of its overall mission to promote and protect the Nation's health and to provide essential human services, HHS is pursuing a comprehensive agenda for women's health. Through its agencies and offices, and in coordination with other Government agencies and national and international organizations, HHS is undertaking a range of activities to promote the health of women across the lifespan, to empower women to make informed choices about their health, and to translate policy decisions into effective women's health programs.

HHS has established the following goals, which provide a framework for the Department's efforts in women's health:

- To support comprehensive, community-based health promotion/disease prevention programs for women.
- To promote access to a full range of gender-appropriate and culturally sensitive health care services for women of all ages, all racial and ethnic backgrounds, and all socioeconomic and educational levels.
- To strengthen and sustain research on diseases, disorders, and conditions affecting women and to strengthen and sustain research on methods to improve access to and quality and effectiveness of health services for women.
- To educate and inform women about relevant health issues and activities.
- To support health professional training in the recognition and management of women's health conditions.
- To promote the appointment of women to departmental, national, and international leadership positions that impact women's health and quality of life.

Among the steps taken to achieve these goals has been the appointment of the Deputy Assistant Secretary for Women's Health at HHS, who, through the Public Health Service's (PHS) Office on Women's Health (created in 1991), provides leadership and direction for the women's health agenda. The establishment of the Office of Research on Women's Health (1990) at the National Institutes of Health (NIH) and the Office for Women's Services (1992) at the Substance Abuse and Mental Health Services Administration also indicates the increased awareness of the specialized needs of women.

A cornerstone of the Clinton Administration's health care reform plan is the Health Security Act, which guarantees coverage to all women regardless of health status, marital status, employment status, or ability to pay. This legislation provides a comprehensive package of benefits, including clinical preventive services, reproductive health services, school health education services, long-term care services, inpatient and outpatient services, and a variety of mental health and substance abuse treatment services.

All PHS agencies with a focus on research—Agency for Health Care Policy and Research, CDC, Food and Drug Administration (FDA), and the NIH—have enacted policies to ensure that women are included in HHS-sponsored clinical research grant solicitations. The following PHS agencies are involved in activities related to women's health.

- The Agency for Health Care Policy and Research improves the effectiveness of health care services for women through scientific research programs (maternal-

infant health, hysterectomy, breast and cervical cancer screening, etc.) and through the development of clinical practice guidelines (cancer-related pain, depression, early HIV infection, mammography determinants, etc.).

- The CDC supports numerous health promotion and disease prevention programs for women. Recent programs have focused on breast and cervical cancer, HIV/AIDS and other sexually transmitted diseases, tobacco use, violence, reproductive health, and the health of older women.

- The FDA focuses on such issues as participation of women in early clinical trials, the safety of breast implants, the need for contraceptive products that protect against sexually transmitted diseases including AIDS, and the prevention of neural tube defects through increasing women's folic acid intake. FDA is implementing the Mammography Quality Standards Act, which ensures the availability of and access to quality mammograms. FDA also distributes consumer articles on women's issues.

- The Health Resources and Services Administration helps underserved and minority women through health education projects and health care provider training and by increasing access to primary and preventive health care for women at community and migrant health centers. Prevention of HIV/AIDS among minority women is a key focus of activities like the Training of Trainers Program, Early Intervention Strategies under the Ryan White CARE Act, and Advanced Nursing Education Grants.

- The Indian Health Service (IHS) provides health care services and assistance to American Indians and Alaska Native women in such areas as reproductive health, cancer, diabetes, maternal-infant health, and substance abuse. Pap smear registries with a tracking system and screening mammography services have been made a ilable in all IHS areas.

- The Substance Abuse and Mental Health Services Administration's (SAMHSA) Office for Women's Services identifies the need for women's substance abuse and mental health services, recommends policy, and promotes collaboration among the three SAMHSA centers focusing on mental health services, substance abuse prevention, and substance abuse treatment. In particular, SAMHSA works to ensure that the needs of minority women are addressed. It has identified six priority issue areas for women: physical/sexual abuse, women as mothers/caretakers, HIV/AIDS, aging women, women in the criminal justice system, and multiple diagnosis—multiple mental health and substance abuse problems.

- The Office of Research on Women's Health at the NIH works to strengthen research on disease and other problems that affect women, to ensure that research conducted and supported by NIH adequately addresses women's health issues, to ensure that women are represented in NIH-supported biomedical and behavioral studies, and to develop opportunities for the recruitment and advancement of women in biomedical careers.

- NIH's Women's Health Initiative is the largest clinical trial in U.S. history. It focuses on diseases that are major causes of death and disability among women—heart disease, cancer, and osteoporosis. The multiyear initiative attempts to redress the vast inequities that exist in

research including women and seeks to provide practical information to women and their physicians about hormone replacement therapy, dietary patterns and supplements, and exercise.

Conclusion

The Department of Health and Human Services' goals for women's health are providing a solid foundation within which to implement meaningful p licies and programs in numerous areas, including community-based prevention and treatment programs, research on women's health issues and services, education and information dissemination, and professional training in women's health issues. Through a combination of leadership, creativity, and determination, HHS is working to realize a healthier future for all women in the United States.

***

For Further Information...

Office on Women's Health
U.S. Public Health Service
Humphrey Building, Room 730B
200 Independence Avenue, SW
Washington, DC 20201
(202) 690-7650

Office of Research on Women's Health
National Institutes of Health
9000 Rockville Pike, Bldg. 1, Room 201
Bethesda, MD 20892
(301) 402-1770

Office for Women's Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Parklawn Bldg., Room 13-99
Rockville, MD 20857
(301) 443-5184

May 1994
DRAFT #2

WOMEN'S HEALTH PROGRAMS AND ACTIVITIES

Office on Women's Health
Public Health Service
U.S. Department of Health and Human Services

OVERVIEW

The Clinton administration is committed to a comprehensive, equality-minded approach to women's health. Key examples include:

* Susan J. Blumenthal, MD, MPA has been appointed the first Deputy Assistant Secretary for Women's Health, a senior level health position created by the Administration to redress inequities in the health care system which have put the health of American women at risk.

* Women's health concerns are at the center of the comprehensive benefits package included in the Health Security Act.

* The National Action Plan on Breast Cancer provides an unprecedented opportunity to promote public-private linkages in an effort to fight breast cancer as a serious threat to the health of women.

* The Administration's 1995 Public Health Service budget request sets aside $1.8 billion for programs directly targeting the health of women, reflecting a $145 million (9%) increase over FY 1994 funding. This budget request includes increases for breast cancer research, funding of the National Action Plan on Breast Cancer, research on female-controlled chemical barriers against HIV infection, as well as other research on health conditions affecting women. It includes an increase in the HRSA Family Planning Program that provides contraceptive and pregnancy services and routine gynecological screening to low income women.

BACKGROUND

* Medical research has often short-changed women.

* Heart disease is number one cause of death of women; women

are dying in increasing numbers from lung and breast cancer and AIDS.

* More women aren't getting necessary health care because they have inadequate insurance or none at all.

* Domestic violence affects millions of women.

* Minority and older women receive inadequate care.

INITIATIVES AND ACCOMPLISHMENTS:

* The United States has set an important precedent by being the first country in the world to establish a senior level health position dedicated to redressing inequities in the health care system which have put the health of American women at risk. Susan J. Blumenthal, MD, MPA, a national leader and expert in women's health, has been appointed the first Deputy Assistant Secretary for Women's Health within the Department of Health and Human Services. In this role, Dr. Blumenthal provides the leadership, direction and support for a comprehensive women's health agenda, and coordinates women's health policies and programs across agencies and offices of the Public Health Service.

* The Administration's Health Security Act guarantees comprehensive health services, including clinical preventive services and reproductive health care, to all women regardless of their health, ability to pay, or marital or employment status.

* All PHS agencies with a focus on research--including the NIH, FDA, CDC and AHCPR--have enacted policies to ensure that women are included in HHS-sponsored clinical research programs.

* In 1993, the FDA revised its 1977 guidelines to include women in early phase drug testing.

* The NIH Office of Research on Women's Health, whose mission is to strengthen research on women's health issues, was signed into law in 1993. The 1995 budget request for the office is $16.7 million, a 48 percent increase over the previous year.

* The Substance Abuse and Mental Health Services Administration supports an Office for Women's Services, which ensures that the substance abuse and mental health needs and services of women are appropriately addressed.

* The FDA plans to establish an Office of Women's Health to

advance the agency's women's health agenda. An FY 1995 budget request of $2 million was made to fund this office.

* National Action Plan on Breast Cancer:
HHS Secretary Donna Shalala convened a national conference on breast cancer in December 1993 to develop a comprehensive plan to research, health care and policy issues pertaining to the eradication of breast cancer. The outcome of this conference--the National Action Plan on Breast Cancer--affirms the importance of public-private collaborations to fight breast cancer and promote breast health. The Deputy Assistant Secretary for Women's Health, who heads the PHS Office on Women's Health, is responsible for coordinating the implementation of action items outlined in the National Action Plan on Breast Cancer. This will involve the participation of representatives of consumer, health care professional and scientific organizations as well as the Federal Government.

* The NIH Women's Health Initiative, the largest clinical research study ever conducted in either men or women, has begun to examine the major causes of death, disability and frailty in post-menopausal women: heart disease, breast and colon cancer and osteoporosis. This multiyear study will examine the effect of dietary patterns and supplements, exercise, hormone replacement therapy and other interventions on the prevention of these major disorders in women.

* The President signed into law the Family and Medical Leave Act.

* President Clinton issued an Executive Order lifting the ban on abortion counseling by Title X (family planning) program grantees.

* The Administration worked to have provisions on violence against women included in the crime bill...Congress has allocated more than $7 million to the CDC to launch an initiative on domestic violence.

* HHS held the first National Minority Women's Conference on the Status of Health in April 1994 and scheduled the first National American Indian and Alaskan Native Conference on the Status of Women's Health for May 1994.

BREAST CANCER

* The disease kills 46,000 women a year and is expected to strike one in eight women compared to one in 20 women just two decades ago; the annual incidence of the disease has

increased about 52 percent during 1950-1990.

* Breast cancer is an especially high-risk disease for older women, minority and low-income women.

* Thirty-eight percent of women over the age of 40 fail to have breast cancer screening.

HHS actions include:

* development and implementation of the National Action Plan on Breast Cancer, a goal-driven blueprint for stimulating public-private linkages on health care, research and policy issues related to breast cancer and breast health. The PHS Office on Women's Health is coordinating implementation of action items outlined in the National Action Plan on Breast Cancer.

* an FY 1995 budget request that includes $387 million for breast cancer research, 29 percent over FY 1994.

* $10 million in the FY 1995 NIH budget request for implementation of the Secretary's Breast Cancer Action Plan, which calls for a wide range of immediate actions to make progress against the disease.

* another FY 1995 budget request for $20 million to continue implementation of FDA's 1992 Mammography Quality Standards Act, which ensures all women access to safe and effective mammography services.

* another request for 46.9 million for CDC's State Breast Cancer Screening and Education program.

* another request for $320 million for Medicare coverage of mammograms.

HEART DISEASE

* Heart disease is the number one cause of death among all women and accounted for more than 30 percent of all deaths among women in 1991.

HHS actions include...

* the largest clinical trial in U.S. history -- part of NIH's Women's Health Initiative -- which includes studies of the effect of a low-fat diet and hormone replacement therapy on preventing coronary heart disease in post-menopausal women.

* assuring through the NIH's Office of Research on Women's Health that women are appropriately represented in NIH-supported research, including studies on cardiovascular disease in women.

MATERNAL AND CHILD HEALTH

* About 16 million women and nearly 10 million of their children lack access to primary health care services.

* While infant mortality in the nation is lower than ever, it is still higher than in most developed countries because of a lack of prenatal care, poor nutrition, drug use and adolescent pregnancy.

* There are 17.6 deaths per 1000 births of black infants compared to 7.3 deaths per 1000 births of white infants.

HHS actions include...

* HRSA's provision during 1993 of primary care services to some four million low-income women and more than eight million children, including the homeless and those in public housing.

* production in 1993 of HRSA's "Health Diary," the Maternal and Child Health Bureau handbook for expectant parents with advice on prenatal and infant care.

* an FY 1995 budget request for increases in NIH research in contraception/reproductive and pregnancy health.

FAMILY PLANNING

* Sexual activity rates among females aged 15-19 rose from 29 percent in 1970 to 42 percent in 1980. The rate for this age group among males rose from 66 percent in 1979 to 76 percent in 1988. These trends are creating upturns in unintended pregnancies and sexually transmitted diseases.

* Births to unmarried adolescents 15 to 19 years rose from 29.5 percent in 1970 to 68.8 percent in 1991.

HHS actions include...

* an FY 1995 budget proposal to create a new Office of Adolescent Health.

OFFICE ON

Women's Health

PHS/OASH/OFFICE ON WOMEN'S HEALTH
HUMPHREY BUILDING, ROOM 730-B
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201
PHONE: 202-690-7650 FAX: 202-690-7172

TO: FAX PHONE NO. 202 456-6244

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

NAME: Melanne Verveer

OFFICE/ADDRESS: _____

TELEPHONE: _____

NUMBER OF PAGES TRANSMITTED (INCLUDING COVER): 18

FROM: Susan Pennebaker / 202/690-7650

NOTE: Here are some materials we're prepared to highlight women's health accomplishments by the Administration for Para world events. Give me a call if you get a chance. Thanks, Susan

States who either abuse alcohol or are alcohol-dependent.

HHS actions include...

* two new residential treatment programs established by SAMHSA in FY 1933, one for pregnant and postpartum women, the other for high-risk women and their children.

* a substance abuse prevention demonstration program established by SAMHSA in FY 1994 focusing on adolescent women.

* a National Women's Resource Center funded in FY 1994 to provide information and referral services on substance abuse throughout the life cycle. The Center is sponsored by a number of HHS offices and agencies.

WOMEN AND MENTAL HEALTH

* Women are twice as likely as men to experience certain mental illnesses, including depression and panic disorders, and also suffer more often from phobias and eating disorders.

* One in seven women will be clinically depressed in her lifetime.

HHS actions include...

* an estimated $66.2 million during FY 1994 for NIH research on mental illnesses that affect women.

* PHS Office on Women's Health co-sponsorship of the "Promoting Healthy Behaviors in Young Women" Conference with the Society for the Advancement of Women's Health Research.

WOMEN AND SMOKING

* Since 1990, more women die each year from lung cancer than from any other cancer, including breast cancer.

* Twenty-two million U.S. women 18 and older (23.5 percent) are smokers.

HHS actions include...

* CDC funding of a 1994 conference on women and smoking

that will convene a national network of women leaders.

WOMEN AND AIDS

* Women are the fastest growing population with HIV infection today -- new cases usually result from heterosexual transmission.

* AIDS is now the fifth leading cause of death in women aged 25 to 44.

* Low-income women face major barriers to HIV health and support services.

HHS actions include...

* an increase in AIDS funding by 17 percent.

* a Public Health Service Task Force to recommend guidelines for the use of AZT in the treatment regimen of HIV-positive women to prevent transmission of the virus from mother to child.

* a CDC Prevention Marketing Initiative for AIDS that includes public service announcements targeted to 18- to 25-year-old women and men.

* Health and support services provided through the Ryan White CARE Act to disadvantaged women infected with HIV.

MINORITY WOMEN

* In 1991, the death rate from breast cancer was 31.9 percent, 19 percent higher than for white women.

* In 1992, AIDS cases per 100,000 population were much higher among black and Hispanic women than among white women.

* Minority women are at a higher risk of maternal death than white women.

HHS actions include...

* ensuring that grantees under the Ryan White CARE Act of 1990 develop accessible services for disadvantaged women with HIV/AIDS.

* an FY 1995 budget request of $2.5 million to fund the

AHCPR "Patient Outcome Research Team" project to evaluate ways to prevent low birthweight among infants of minority and high-risk women.

* a wide range of health care services to American Indians and Alaska Native women by the Indian Health Service.

* health education projects for women of color sponsored by the PHS Office on Women's Health.

* PHS Office on Women's Health co-sponsorship of the Healthwatch Symposium: "Beating the Odds: Challenges to the Health of Women of Color," New York Academy of Sciences.

HEALTH CARE REFORM

The President's Health Security Act provides comprehensive preventive and medical services to every woman across her life span regardless of employment, marital or health status. Specifically, it:

* eliminates discriminatory exclusions for pre-existing conditions and lifetime caps.

* guarantees free preventive services, including periodic health examinations, screening mammograms, pap smears, cholesterol checks and immunizations.

* guarantees coverage for reproductive and family planning services.

* will include longterm care, which will benefit older women and women caregivers.

* will remedy the unjust situation of only 40 percent of working women receiving insurance through employers compared to 59 percent of working men.

* will include more research on women's health issues.

###

fcli

Women's Checklist For Health Care Reform
The Health Care Security Act Meets The Criteria

Universal Coverage

- √ NOT dependent upon health status or health history
- √ NOT dependent upon marital status, employment status or ability to pay
- √ Discounts for low income families

Comprehensive Benefits

- √ No lifetime limits; no pre-existing condition exclusions
- √ Coverage for preventive care and prescription drugs
- √ Expanded sites for care

Preventive Health Care

- √ Emphasis on regular check-ups, early diagnosis and treatment
- √ Clinical preventive services for high-risk populations; age-appropriate immunizations, tests, and clinical visits
- √ Screening for breast and cervical cancer including routine mammograms, pap smears and pelvic examinations

Quality/ Choice

- √ Annual "report cards" of health care providers and health care plans including important consumer information: e.g., percentage of women who receive mammograms, number of babies delivered by Caesarean Section
- √ Option to change health care plans once a year

Reproductive Health Care

- √ Full-range of pregnancy-related services
- √ Family planning services
- √ Screening for sexually transmitted diseases

Medical Research Investments

- √ Increases funding for prevention research at the National Institutes of Health.
- √ Research priorities on women's health care concerns including osteoporosis and breast cancer

Long Term Care

- √ Home and community-based long-term care initiatives
- √ Expansion of nursing home coverage
- √ Increased quality and affordability of private long-term care insurance

WOMEN'S HEALTH

Women face serious obstacles to health care services in today's system. Women are less likely to have employer-based health coverage, and less likely to receive necessary care throughout the year, yet they typically pay more out of pocket for health care than do men. Women increasingly suffer from life-threatening illness such as breast and ovarian cancer, yet women's health concerns have traditionally anchored the bottom of our medical research agenda.

- Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs--jobs which often don't offer health insurance to employees.

- Women tend to live longer and require more long-term and home health services, but home care is often not available or affordable.

- Many women get health insurance through their spouse, and risk of being dropped if they divorce or if they are widowed.

The President's plan addresses women's health aggressively and comprehensively, guaranteeing all women coverage, regardless of whether they are healthy or sick, married or single, working or unemployed, wealthy or low income. And the President's approach will provide unprecedented coverage of preventive care, including mammography. It will cover a whole schedule of preventive screenings, tests and check-ups at no cost: protection available in only a few of today's insurance policies.

Universal Coverage for Private Insurance

- Under the Health Security Act, 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 hospital care, medical services, pap smears, diagnostic services, and prenatal care. It will also include prescription drugs, including oral contraceptives, and the full range of reproductive health services.

Preventive Health

- 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.

- These services include a schedule of preventive screenings, tests, and checkups covered in only a few of today's health insurance policies, and include regular clinical exams, Pap smears, mammograms and other preventive services.

- The comprehensive benefits package will also include coverage of mammograms for all women who need them, and free coverage for mammograms every two years for women over age 50--no matter which health plan --as an extra incentive for those most at risk. (see attached)

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 that are prevalent among women, 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.

Coverage of Mammograms and Other Preventive Services under The Health Security Act:

- **Coverage for all women:**
- Women of any age can receive clinical breast exams and mammograms at any time when the patient and doctor feel it is medically necessary or appropriate, and will pay a standard co-pay (for example, ten dollars) set by their plan.

- **Extra coverage for women at risk:**
- Women of any age who are defined to be at risk of breast cancer will receive additional visits, including clinical breast exams and mammograms, *with no cost sharing.*

- **Additional coverage of mammograms:**
- For certain age groups, at certain intervals, mammograms are free of any cost sharing, so there is no charge when a woman goes to the doctor for these services.

- As part of the preventive services package, all women age 50 and older would have routine mammogram screening every other year, free of charge. Again, any woman who needs more frequent mammograms would be covered, and would pay a co-pay.

- **Additional coverage of clinician visits:**
- Clinician visits, including clinical breast exams, are covered for all women, and additional coverage is available for women in certain age groups. Clinician visits are free once every three years for women age 20-39, and every other year for women from 40-64.

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

- **Under reform, new research initiatives will concentrate on the prevention of illnesses affecting women, including breast cancer, mental health, reproductive health and osteoporosis.**

May,1994

QUESTIONS AND ANSWERS

1) Doesn't the Clinton plan add more layers of government bureaucracy?

No. The President specifically rejected a government-run system in favor of guaranteed private insurance. America basically faces 3 choices:

- government insurance for everybody
- guaranteed private insurance (the President's approach)
- leaving people without insurance

The President's approach is guaranteed private insurance. Everyone will have comprehensive coverage that can never be taken away.

2) But what about these so-called "alliances"?

The purpose of them is very simple -- to give bargaining power to small businesses and individuals and take it away from the insurance companies. Today, the deck is stacked against small businesses and individuals. Small businesses are paying 35% more than big business for the same insurance, and individuals pay even more.

So we have these consumer-controlled alliances to allow people and small businesses to band together and get more consumer clout in the marketplace. Consumer-controlled -- that's the President's idea, not government-controlled.

Now, Congress will figure out exactly how they should be structured, but this is an idea that has bipartisan support. The insurance companies don't like it because it means they have less power, but that's what alliances are intended to do. And that's why the insurance industry is spending millions to weaken or destroy the idea.

3) One of those TV ads says that the President's plan will limit my choice of doctor. Is that true?

No, it's not. You'll be able to choose your own doctor and health plan. In fact, to make sure that you get the high-quality care you deserve, the President's approach actually increases the choices most consumers will have. Because you will choose your doctor and health plan -- your boss

won't and the insurance company won't. So you can choose any doctor and health plan in your community. Remember who's paying for these ads: the insurance companies -- who are trying to scare you and preserve their profits.

4) Won't this plan mean that I'll pay more and get less?

No. In fact, the independent Congressional Budget Office (CBO) analysis that the Republicans praised said that the President's plan would cost Americans less money and give them more health benefits. Young, healthy people may pay a little more -- but that's because we're prohibiting the insurance companies from charging older people more than younger people.

Under the President's approach, you'll be guaranteed affordable insurance you can depend on. We'll make it illegal for insurance companies to jack up your rates or drop you if you get sick, use lifetime limits to cut off your benefits, or take away your benefits. The insurance companies won't be allowed to bleed you dry.

And the President's proposal calls for comprehensive benefits, including preventive care and prescription drugs. Under the President's approach, no one -- not your boss, not your insurance company -- can take those benefits away.

5) Won't your employer mandate cause massive job loss and cause thousands of small businesses to go bankrupt?

There is no credible evidence to support that claim. The independent Congressional Budget Office (CBO) analysis that the Republicans praised said that the Clinton plan would not result in the loss of jobs, and would benefit all small businesses.

Studies predict that there will, in fact, be job gains as a result of the plan. The Economic Policy Institute predicts 258,000 manufacturing jobs created over the next decade, Lewin-VHI, a widely-respected, bipartisan firm, predicts over one million jobs created by providing long-term care, and the Employee Benefit Research Institute predicts that the President's proposal could produce as many as 660,000 jobs.

The President specifically designed his proposal to help small businesses -- the biggest victims of today's health care crisis. Small business owners will be able to get rock-solid, comprehensive coverage for their families and employees. And no longer will they be subject to insurers jacking up their rates or dropping their coverage when one employee gets sick. Because those insurance company abuses will be illegal.

6) Why do we need an employer mandate anyway?

If we want to guarantee every American health insurance, we've got to figure out how to achieve that goal. The President believes every job should come with health benefits. Most jobs do today because most employers accept this responsibility to provide worker health benefits. And yet 8 out of 10 Americans who have no insurance are in working families. We want everyone to have health benefits guaranteed at work. And under the President's approach, the government will provide discounts for small businesses, help cover the unemployed, and continue Medicare for older Americans. That's how we'll cover everybody.

7) When you try to cut costs and limit the amount premiums can rise, won't that just lead to rationing?

Absolutely not. The key to this is insurance company premiums can't continue to rise unchecked. Your money will go to buying you the highest quality of care and service, not padding the insurance company red tape. That's why there's a limit on how much insurance companies can raise your rates. In fact, it will be illegal for insurance companies to drop your coverage or take away your benefits. You'll be guaranteed affordable insurance you can depend on.

The President's approach is all about keeping you healthy. You'll have the right to choose your own doctor and health plan. We want to make sure you get high-quality care by giving you the choice, not your boss or insurance company.

8) I've got good insurance. What's in this plan for me?

First -- and most important -- you'll get something that no amount of money can buy in today's insurance market: guaranteed private insurance. Comprehensive coverage that can never be taken away. Second, you, not

your boss or insurance company, have the choice of doctor and health plan to make sure you get the high-quality care you deserve.

Third, unfair insurance company practices will be outlawed. 3 out of 4 insurance policies -- that's 133 million people -- have these lifetime limits which mean that your coverage could be cut out just when someone in your family is sickest. No more. No more jacking up prices when you get sick. You'll have affordable insurance you can depend on. Fourth, we protect Medicare. We'll cover prescription drugs under Medicare, and give new options for long-term care in the home and community. And fifth, everyone will have health benefits guaranteed at work, with the government providing discounts to small businesses and the unemployed. Even if you lose your job, you will never have to worry about losing benefits or being forced to change doctors.

9) Is it true that my doctor can be fined $10,000 for treating me outside the system?

A: No, that's not true. You can see any doctor you want and pay for any procedure or treatment. The $10,000 fine refers to the President's crackdown on insurance company fraud. Fly-by-night insurance companies will be fined if they try to dupe you by selling you "supplemental" benefits that you're already guaranteed by law.
[Note: By law, you'll be guaranteed the right to pay to see any doctor in the country, even if you are in an HMO.]

10) What's going to happen to my Medicare benefits?

A: Older Americans who receive Medicare will continue to receive all the benefits you do today. And you'll keep the doctor you now have. In addition, we'll strengthen Medicare by adding prescription drug coverage. Older Americans will also benefit from new long-term care options in their homes and communities, where they want to receive care.

11) What happens if the money runs out?

A: Today, when insurance companies go out of business, patients get struck without health care, and doctors don't get paid. The President's approach prevents that. It bans fly-by-night insurers, forcing the insurance industry to set aside funds to protect against bankruptcy or failure.

THE FIVE BIGGEST LIES
ABOUT THE PRESIDENT'S HEALTH CARE APPROACH

Lie #1: The President wants a government takeover of the health care system.

Truth: The President specifically rejected a government-run system. His approach builds on the current system, preserving what's right and fixing what's wrong. It's the least disruptive approach, building on today's system, where 9 out of 10 people get their insurance through their employer.

He wants guaranteed private insurance for every American. And his approach would make two critical changes. First, it would guarantee comprehensive benefits that can never be taken away. And second, it would provide greater power for consumers and small businesses to choose quality health insurance at lower cost.

Lie #2: The President wants the government to choose your doctor and health plan.

Truth: You will be able to choose your own doctor and health plan. In fact, our approach actually increases the choices most consumers will have. Under the Clinton approach, all Americans will be able to choose from several kinds of health plans, no matter where they work. And everyone will have the option of a traditional fee-for-service plan, where you go to any doctor you want and pay individually for each test or procedure. And people will be able to switch plans every year if they're not satisfied with their care or service.

In fact, it's today's health care system that is limiting people's choices. In 1988 , 89% of employers offered fee-for-service plans but, by 1993, this number had dropped to 65%. [*"1992 Health Care Benefits Survey"*, Foster Higgins, 1992; *"Health Benefits in 1993"*, KPMG Peat Marwick]

Lie # 3: Price controls will cause rationing.

Truth: The President specifically rejected price controls. His approach does include a limit on how much insurance companies can raise premiums year to year. And the insurance companies are trying to scare you because that would limit their freedom to jack up rates. Rationing is a classic scare tactic; but experience shows that you can control health care costs and provide quality care.

This debate is about insurance companies that want to keep picking and choosing whom to cover or drop, and when to increase rates. The Clinton approach puts people in charge. It will be illegal for insurance companies to drop you, refuse you, or jack up rates because of your medical history or age.

Lie #4: The new system will be a bureaucratic nightmare.

Truth: Nothing could be more complex than what we have now. Today's patchwork system is the result of insurance companies competing to cover only the healthiest people.
The important thing is what happens to the consumer and the Clinton approach will make life easier for people. You'll know what you're getting without having to read insurance company fine print. And you'll have a Health Security Card and fill out one standard claims form -- without all the insurance company red tape -- when you go to the doctor's office. The Washington Post says the Clinton approach will create a "surprisingly simple" world for consumers.

Lie #5: Reform will be a job-killer.

Truth: High health costs today are killing businesses, large and small. The Clinton approach will help businesses compete by bringing costs under control. *The Wall Street Journal* called the Clinton approach "an unexpected windfall" for small businesses that currently provide insurance. And all small businesses will get increased bargaining power and discounts on the price of insurance.

In fact, analysts predict job gains as a result of our approach. An Economic Policy Institute predicts that 258,000 manufacturing jobs will be created over the next decade as high health costs drop. There will also be health care jobs created, as we guarantee coverage for everyone, with one Brookings Institution analyst predicting 750,000 jobs created in home health care alone. Some people will certainly be doing different things -- there'll be less people processing paper and more people giving care.

BACKUP FACT SHEET

People Without Insurance Each Year
58 Million

THE FACT: "The Bureau of the Census calculated that 50 million Americans lacked health insurance for at least 1 month during 1987. Lewin/VHI updated the census estimate, calculating that 58 million people were uninsured for at least 1 month in 1992."

THE SOURCE: "*Dynamics of People Without Health Insurance: Don't Let the Numbers Fool You,*" Journal of the American Medical Association (JAMA), January 5, 1994

People With Pre-Existing Conditions
81 Million

THE FACT: An estimated 81 million Americans under age 65 have medical problems for which insurance companies can charge higher premiums, exclude coverage or deny coverage altogether.

THE SOURCE: *"Health Insurance at Risk - The Seven Warning Signs"*, Citizens Fund, June 1991 [with data from National Center for Health Statistics *"Health Interview Survey"*, further data from the Health Insurance Association of America *"Source Book"*, and the latest Department of the Census *"Current Population Surveys"*]

People With Lifetime Limits on Coverage
133 Million

THE FACT: The Bureau of Labor Statistics *1991 Survey of Medium and Large Private Establishments* reports that only 1 out of 4 people have insurance policies without lifetime limits.

THE SOURCE: Table 45 -- Medical Care Benefits: *"Employee Benefits in Medium and Large Private Establishments"*, Bureau of Labor Statistics, 1991

CALCULATION: In 1992, 177.5 million Americans had private insurance, according to the Employee Benefit Research Institute analysis of the March 1993 CPS. Seventy-five percent of 177.5 million is 133 million.

If we don't pass health care this year.....

American families will pay more for health care with less secure benefits and diminishing choices. Many workers will continue to trade wage increases or stay locked in jobs that don't suit them just to hang on to the health benefits they've got.

- Health care spending per worker will be over $7,000 in 1994. By the year 2000, health care spending per worker will rise to $12,386, or 25 percent of compensation.

- Without reform, by the year 2000, American workers will lose almost $600 in wages each year just to keep their health benefits [Commerce Department]

American businesses will drop or pare back coverage, or continue to pay more for employee health benefits.

- One and a half million *fewer* full-time workers receive health benefits directly through an employer today, compared to 1988. [University of North Carolina, 8/92]

- In the future, 30 percent of small businesses currently providing insurance will drop their insurance coverage because of the high cost. [Health Affairs, Spring 1992]

Choices will decline for those with insurance, as employers try to stem rising costs by switching to managed care plans with a small number of "approved" doctors. And as more families find themselves without insurance, those with any history of illness will join the 81 million Americans labeled as having "pre-existing conditions".

- In 1988 , 89% of employers offered indemnity (fee-for-service) plans. In 1993, only 65% of employers offered such plans. [*"Health Benefits in 1993"*, KPMG Peat Marwick]

- Up to 30% of employees report that they are afraid to leave their job for fear of losing continuous health insurance coverage.

Doctors will have less and less control over their practices and the care they provide their patients, as people at insurance companies without medical degrees second-guess medical decisions and dictate "necessary care".

The federal budget will be overwhelmed by health care spending on Medicare and Medicaid. This will add to the deficit, raising the pressure to cut back on benefits in those programs. State budgets will also be increasingly eaten up by Medicaid, paring back on crime-fighting and education to pay for health services for welfare recipients.

- Two-thirds of the growth in federal spending between 1993 and 1996 will be accounted for by health care spending.

- In 1992, Medicaid spending totaled $102 billion, a 33% increase over 1991. By 1995, Medicaid spending is expected to reach $198 billion. (National Association of Budget Officers)

- In 1993, for the first time, states spent more money on health care than they did on tax-financed higher education. (National Association of State Legislatures)

HEALTH **JULIE KOSTERLITZ**

BACK TO THE FUTURE

From "A Decade of Health Care Reform," published in *National Journal* on April 30, 2004:

At 11:45 P.M. on Oct. 6, 1994—after months of rancorous debate and just 15 minutes before Congress was to adjourn and head home to face the electorate—the American Good-Enough-for-Now Health Care Reform Act passed. The vote in the House was 284-149 (and two abstentions); in the Senate, it was 79-20, with one Senator absent because of a heart attack sustained during a protracted filibuster.

Peter Kuper/INX

Enactment of an incremental reform measure had been something of a foregone conclusion since earlier in the year, when the chairmen of three House committees were able to eke out only slim majorities on their panels for legislation that would guarantee health insurance coverage to all Americans. A Senate committee defeated similar legislation by five votes.

A comprehensive reform bill was "simply too much of a burden on small business and the American taxpayer," said Rep. Kent Afford, the critical vote on the House Committee on Large and Popular but Expensive Entitlements. It was Afford, a southern Democrat then embroiled in a tough Senate race, whose opposition to the Democratic leadership bill was widely seen as a turning point in the debate.

AGENHCRA (pronounced *agon-hicra*)—as it became known—took a targeted approach to what ailed America most. Or, to be more accurate, to what ailed middle America most.

Middle Americans, Congress wisely noted, were largely happy with their health insurance and afraid of messing with it. In fact, the main thing that bothered them was that anyone with a hangnail risked being turned down for health insurance as a bad risk, or charged astronomical sums for it. Bad health, after all, can strike anyone, and even the insurance industry recognized that this "cherry picking" was not making for a good image.

And so, AGENHCRA required insurers to take all comers. And they couldn't charge the old or sick an arm and a leg for their policies either—henceforth they could charge only an arm.

Individuals and small businesses could join what would be called People's Insurance Purchasing Cooperatives to pool their risks and their purchasing power, thereby diminishing the extra premium that small employers once had to pay. The self-employed could take tax deductions for 100 per cent of their insurance costs. And for the poor and uninsured, there was the promise of a new network of community health centers, financed by cuts in the medicare program for the elderly and the medicaid program for welfare recipients. Insurance forms were streamlined, malpractice suits were banned. Waste, fraud and abuse were to be eliminated.

The relief among middle Americans was palpable. On Jan. 1, 1995, a million people who had previously been denied coverage because of poor health deluged the offices of health insurers from coast to coast. The coverage was expensive, but most of these bad risks weren't poor, and they were happy to pay.

But the flood of sick people into the system forced insurers to hike their rates to small businesses and individuals by 50 per cent more than they had intended. That caused hundreds of thousands of relatively young, healthy Americans to drop their coverage. Worried insurers complained about "reverse cherry picking" by consumers and doubled the next year's planned premium increases.

The individuals and small businesses who remained in the purchasing cooperatives didn't notice the rate hikes right away: Pooling had lowered their rates significantly the first year, and the second-year rate increase persuaded many of them to switch to lower-priced health maintenance organizations (HMOs).

In the meantime, HMOs discovered that they could make fabulous profits by getting lean and mean. That meant not only getting efficient, but also finding ways to turn away the uninsured. Doctors used to be able to take charity cases and pass along the costs to paying patients; now, though, they had budgets to meet and could no longer play Robin Hood.

And there were still plenty of uninsured people. Although the number dropped initially from 37 million to 36 million, most employers of low-wage workers found that buying insurance coverage was still uneconomical. Without help from their employers, lower-income people could not afford coverage. The unemployed were out of luck, too.

Uninsured people could go to the new community health centers and affiliated public hospitals. But these facilities were overwhelmed, with six-hour waits in the emergency rooms and three-month waits for office visits. With medicare and medicaid reimbursements slashed, many private doctors refused to see poor elderly people and welfare recipients; these patients showed up at the clinics, too.

Liberals proposed additional spending for the clinics, but the 1998 Don't-We-Already-Pay-Enough-for-Those-People Budget Act included no new spending for them. Deficit hawks noted that the budget for the clinics had grown at four times the projected rate. "I think we all want to provide a safety net for the truly needy," said Afford, by then a Senator and oft-mentioned candidate for President. "But we also live in an era of limits."

There were a few predictable horror stories—such as the Hispanic woman who died in childbirth on the lawn of a Miami hospital. Several Members of Congress proposed requiring health plans to treat charity patients. But the business community balked, saying that would lead to higher prices for insured patients and their employers. In the end, state governments had to raise taxes to keep the clinics afloat.

It wasn't until the millenium, when the purchasing cooperatives collapsed under the weight of their high-risk clientele and recession swelled the ranks of the uninsured by millions, that middle-class Americans took to the streets to demand universal health care coverage.

Sen. Afford dropped his presidential bid, retired from the Senate and joined a prestigious Washington law firm. ■

Women's Health Care

FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE WOMEN'S LEGAL DEFENSE FUND
WASHINGTON, DC
JUNE 23, 1994

DRAFT

[Acknowledgments: Judy Lichtman; Ellen Malcolm, Cathleen Chase, Tim Boggs; Pauline Schneider, whose career distinguishes our entire profession;]

It's a pleasure to be here in such familiar company. Whatever people say about there being an overabundance of lawyers in this town, this assemblage is a reminder that many lawyers do have hearts, and souls, and convictions.

We're all here today because we believe in the Women's Legal Defense Fund's capacity to enhance the status of American women. We believe, as the theme of this luncheon suggests, that women can shape the future.

Ellen and others have noted that we would not have a Family and Medical Leave Act without the hard work and leadership of this organization -- and without a President who was willing to sign the bill into law. We would not have civil rights laws that protect women from sex discrimination in the workplace, or laws that protect pregnant women from losing their jobs. We would not have made as much progress in highlighting the widespread problem of domestic violence, which we were again reminded of so tragically last weekend.

None of these accomplishments was easily won. Each required perseverance, energy, and faith that the goal was worth fighting for.

And each victory reinforced a great axiom about our country -- that, as a people, we have a wonderful history of giving, volunteering, participating, and helping take care of those in need.

When de Tocqueville wrote Democracy In America a century-and-a-half ago, he observed that Americans had a special talent for forming associations to do good. He was talking about churches, mercy hospitals, schools, other service institutions. Luckily that collective spirit is still alive in groups like the Women's Legal Defense Fund and others that are committed to strengthening the core values that shape American life.

Today we are in the midst of another long struggle, one that is testing that determination and that rich history of progress.

For 60 years he have talked about health care reform. We've discussed it, debated it, dissected it. We've done everything but achieve it.

Yet, over those same six decades, we have found a way to provide financial security to older Americans -- Social Security. We have found a way to help our war veterans secure a college education -- the GI bill. We have found a way to help cover the medical costs of older Americans -- Medicare.

Often against the objections of critics who bemoaned these programs, who wrote them off as "socialistic" government initiatives, we have proven that by reaching out to individual citizens we strengthen society as a whole.

The idea of caregiving, and the role it plays in our lives as individuals and as a larger community, is integral to our progress as a nation. But it's also essential to our appreciation of the many dimensions women show in their everyday lives.

Health care reform is critical for women -- for health reasons, for financial reasons, but also for these social and cultural reasons. Women are loaded down with expectations and burdens about myriad roles they are expected to play, but too often their own needs are discarded or ignored. Our health care system is one place where we can begin to change that pattern.

In a more immediate sense, women have the greatest stake in health care reform because we are the primary caregivers in society, and also the medical decision-makers in most families. I can't remember ever discussing with my husband which pediatrician we should use, although it's a conversation I had with countless women friends and mothers.

I, and most of the women I know, are married to men who never want to go to the doctor and have to be at death's door before admitting they don't feel good. We -- the women -- end up pushing and prodding them to call the doctor's office for an appointment.

We're also the ones most often responsible for caring for aging parents. So along with whatever professional responsibilities we're juggling, we're also juggling responsibilities as mothers of children, as daughters caring for our own parents, as wives of husbands who are sometimes oblivious to their own health needs.

And somewhere in that mix we're supposed to find time to take care of ourselves.

Yet despite our regular contact with doctor's offices, hospitals, medical bills, and insurance regulations, we usually

have been treated as second-class citizens in our health care system.

When I first began looking into health care last year, I thought it was a very bad joke to discover in my briefing materials that the first clinical trials on breast cancer had been performed on men. I was so incredulous that I called to verify it and found out that, indeed, it was true.

Unfortunately that example was not a fluke, not an isolated case.

Coronary disease is the number one killer of women in America, but until recently women were routinely excluded from all clinical trials. Until recently, osteoporosis, which primarily afflicts women, was not considered a high priority for research. Nor was an often lethal disease like ovarian cancer.

And we still can't find lumps in women's breasts even though we have the technology to detect objects in spaces millions of miles away.

Women also have been excluded as professional caregivers. For decades, many of the finest medical schools in the nation perpetuated faulty stereotypes about women's health that were widely taken as gospel.

It wasn't all that long ago that women's health issues were viewed almost exclusively in the context of reproduction. Medical students were taught that women would contract endometriosis if they gave birth after 30. Symptoms of menopause were often discounted as psychosomatic or as evidence of emotional instability. In fact, little credence was given to the notion that women suffer from unique symptoms and illnesses that require different treatments from men.

Happily we've made some progress. Women's health is attracting more attention lately in the news media and in the medical and scientific communities.

Last summer The New York Times ran a graphic and shocking photo of a breast cancer patient on the cover of its Sunday, which left an indelible image in the minds of many people. Television news shows have devoted more time to educating the public about women's health concerns. And, in the scientific community, clinical trials are beginning to incorporate women more and more.

But we still have a long way to go. Too often today, women cannot get adequate coverage for themselves, let alone their families. Almost 16 million women and nearly 10 million children are not insured. Infant mortality remains higher here than in

most other developed countries, largely due to an absence of prenatal care.

A survey last year showed that in the preceding 12 months:

-- 44 percent of women did not receive a mammogram
-- 35 percent didn't receive a Pap smear
-- 36 percent didn't receive a pelvic exam
-- 39 percent didn't receive a physical

These are very disturbing statistics in a country as rich and civilized as ours.

If we do not achieve universal coverage, the needs of women will continue to be neglected and women will continue to shoulder the heaviest burdens.

[Anecdote: We don't insure burning houses]

[Anecdote: New Orleans woman with lump in her breast]

[Anecdote: Nevada women who couldn't get an epidural]

Every facet of the President's reform will benefit women in unprecedented ways.

Universal coverage that offers guaranteed private insurance to every citizen. Comprehensive benefits that stress preventive care, including prenatal care. Outlawing insurance practices that discriminate against people on the basis of pre-existing conditions or age. Choice of doctor and health care plans that will give women -- the primary decision-makers -- more control over their decisions. Enhancing Medicare so that prescription drugs are covered, which will help women, who tend to live longer than men.

And long-term care, a time bomb ticking away for every one of us in this room.

In the next few weeks and months, Congress' ability to achieve reform will be a strong signal of the progress we are willing to make as a nation.

We knew this would be a tough fight. We knew the opposition would resort to a desperate campaign of distortion and misinformation to throw us off track.

Like all the important causes the Women's Legal Defense Fund has fought for year after year, often against the odds, this one requires guts and a commitment to stick with it until we succeed.

Franklin Roosevelt achieved Social Security 60 years despite

fierce opposition. xxx pushed through Medicare in xxxxx.

[end to come]

###

Society for the Advancement of
WOMEN'S HEALTH RESEARCH
1920 L Street, NW, Suite 501, Washington, D.C. 20036

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: Clinotn Campaign Volunteer Activities (2 pages)	n.d.	Personal Misfile

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 6205

FOLDER TITLE:
Women's Health [Folder 2] [2]

2013-0534-S
rc1572

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. letter	Tipper Gore to Phyllis (1 page)	10/27/1992	Personal Misfile

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 6205

FOLDER TITLE:
Women's Health [Folder 2] [2]

2013-0534-S
rc1572

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. letter	Atul Gawande to Phyllis Greenberger (1 page)	11/05/1992	Personal Misfile

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 6205

FOLDER TITLE:
Women's Health [Folder 2] [2]

2013-0534-S
rc1572

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. letter	Hillary Rodham Clinton to Phyllis Greenberger (1 page)	12/01/1992	Personal Misfile

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 6205

FOLDER TITLE:
Women's Health [Folder 2] [2]

2013-0534-S
rc1572

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Clinton Presidential Records
Digital Records Marker

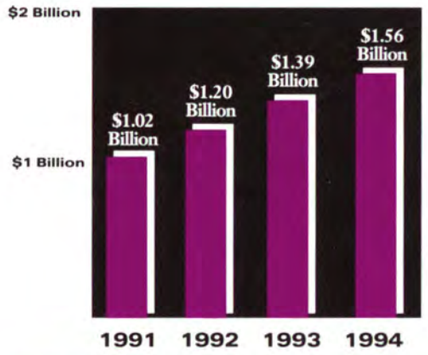
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

4 Pages
Society for the
Advancement of Womens
Health Research
Pamphlet

FUNDING INCREASES IN WOMEN'S HEALTH RESEARCH AT NIH



Since the establishment of the Society, funding for women's health research has increased approximately 60%.

Though the Society has made great strides in improving policy and securing greater funding for women's health research, overall funding allotted for women's health research remains inadequate.

PERCENTAGE OF FUNDING FOR WOMEN'S HEALTH RESEARCH AT NIH

Women's health research represented only 14.2% of NIH's research budget for 1994.

52% of the population receives barely 14% of federal health research funding.

For further information, please contact:

SOCIETY FOR THE ADVANCEMENT OF WOMEN'S HEALTH RESEARCH
1920 L Street, NW, Suite 510
Washington, D.C. 20036

Telephone 202-223-8224 ■ Fax 202-833-3472

Society for the Advancement of

WOMEN'S HEALTH RESEARCH

LEGACY OF NEGLECT

- Heart disease is the #1 killer of women in the U.S.
- Women are the fastest growing demographic group infected by the HIV virus.
- Depression afflicts women twice as often as men.
- 1 out of 2 women will develop osteoporosis . . . it is preventable.
- 1 in 8 women will suffer from breast cancer over her lifetime . . . yet options for treatment have not changed appreciably over the last 30 years.
- Many diseases such as lupus, multiple sclerosis, scleroderma and interstitial cystitis, disproportionately affect women . . . no one knows why.

When Medical Research Is For Men Only... Women Suffer!

– Business Week, July 1990

MEDICAL RESEARCH HAS TYPICALLY LEFT WOMEN OUT EVEN THOUGH WOMEN:

- Comprise 52% of the nation's population,
- Live longer than men,
- Suffer more from chronic illness,
- Utilize health care services more frequently,
- Are prescribed prescription drugs more often,
- Make three-fourths of the health care decisions in American households,
- Spend almost two of every three health care dollars (approximately $500 billion annually).

Health Research That Excludes Women Is Bad Science

– The Chronicle of Higher Education, October 1992

About the Society

Society Director Phyllis Greenberger, Rep. Nita Lowey, Rep. Patricia Schroeder, Tipper Gore, Rep. Louise Slaughter, Florence Haseltine, M.D. and Susan Blumenthal, M.D. at a Congressional reception hosted by the Society.

"A few years ago . . . a group of energetic women 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."

–First Lady Hillary Rodham Clinton, July 19, 1993

WHAT IS THE SOCIETY?

Established in 1990, the Society's mission is to improve the health of women through research. The Society grew out of a mounting concern that the health of all American women was at risk due to biases in biomedical research. Our organization fights for greater research funding not only for what are often known as "women's diseases," such as breast cancer, osteoporosis and reproductive cancers, but also for diseases traditionally associated with men, such as heart disease and lung cancer.

EQUITY IN RESEARCH

An estimated 50% of all research in this country is conducted by private industry; an additional 39% is funded by the federal government. As consumers and taxpayers, individuals provide 90% of all funding for medical research in America. As women, we are supporting a system that continues to give inadequate attention to our needs.

By working with key influences in the research community, the Society seeks to redirect research to include women and to further investigate women's health issues.

STRATEGY FOR CHANGE

- **PUBLIC POLICY AND ADVOCACY** The Society seeks to shape policy which enforces the inclusion of women in clinical trials and places an emphasis on increased funding for women's health issues. The Society also keeps the White House, Congress, the National Institutes of Health, the Food and Drug Administration and private industry informed of the primary issues affecting women's health.

- **PUBLIC AND PROFESSIONAL EDUCATION** It is essential that women consumers receive reliable, up-to-date information regarding health promotion as well as disease prevention, detection and treatment. In its public education activities, the Society plays an important role in translating complex scientific material into lay language. Through a variety of programs, the Society seeks to educate consumers and to promote their interaction with health care providers.

  The practice of medicine is driven by clinical research. In addition to developing new knowledge on women's health, it is imperative that physicians are informed of these findings. To educate the medical community, the Society sponsors conferences and produces publications including a proprietary scientific journal, *Journal of Women's Health*.

- **WOMEN IN SCIENCE** The Society advocates the advancement of women in science, believing that women should hold leadership positions in America's federal and academic research institutions and health professional organizations to help ensure appropriate representation of the women's perspective among decision-makers in the research community.

SOCIETY'S ACHIEVEMENTS

- Prompted the landmark 1989 Congressional review of the National Institutes of Health, which focused national attention on the exclusion of women from federally-funded medical research.
- Worked with Congress to establish the Office of Research on Women's Health.
- Assisted in drafting federal legislation mandating the inclusion of women in federally-funded clinical trials and calling for significant increases in funding for women's health research.
- Encouraged the Food and Drug Administration to strengthen guidelines in 1993 to promote the inclusion of women in privately-funded research.
- Received the 1993 "Trend Setter" Award for "bringing women's health research issues to the forefront in the public and private sectors" from the National Health Council.
- Served as vanguard for identifying and prompting support for areas of research, such as the first national conference examining environmental determinants in women's health and disease.

FIGHT FOR YOUR LIFE

If we are to find cures and treatments for the variety of devastating diseases and conditions affecting women, it is imperative that we continue the fight for more research that takes women's health needs into account. Together, we can work to erase gender inequities in medical research and improve our own health as well as that of our mothers, sisters, daughters and friends!

YES! I would like to support the women's health research movement; enclosed is my check for:

❑ $500* ❑ $250 ❑ $100
❑ $50 ❑ $25 ❑ Other

Name

Address

City

State/Zip Code

Phone

Please make checks payable to Society for the Advancement of Women's Health Research and mail to 1920 L Street, NW, Suite 510, Washington, DC 20036. The Society is a 501(c)(3) non-profit organization. Contributions are tax-deductible to the extent allowed by law.

* Contributions of $500 or more obtain Founding Membership in the Society's National Policy Task Force and receive complimentary copies of Society publications.

Society for the Advancement of
WOMEN'S HEALTH RESEARCH

WOMEN'S HEALTH FACT SHEET

- Women account for 52% of the U.S. population.
- Women make three-fourths of the health care decisions in American households and spend almost two of every three health care dollars (approximately $500 billion annually).
- Over 59% of physician visits are made by women, 59% of prescription drugs are purchased by women, and 75% of nursing home residents over the age of 75 are women.

Cardiovascular disease:

- Heart disease is the *number one* killer of U.S. women (28% of all deaths); death rates are highest for women of color.
- A long-term study (MR. FIT) examining the relationship of cholesterol and heart disease was conducted on 15,000 men, but *no* women.
- Women who are diagnosed with heart disease are typically ten years older and sicker than men with the same condition; a marked increase in incidence is observed after menopause.
- Hypertension -- a major risk factor in cardiovascular disease -- is 2 to 3 times more common in women than men and highest among African-American women. Drugs to treat hypertension have been tested primarily on white male populations.

Lung Cancer:

- If current trends continue, the death rate among women from smoking-related diseases will exceed that of men by early next century. Teenage women now smoke at higher rates than their male counterparts.
- Smoking lowers a woman's estrogen level and increases her risk for early menopause, pregnancy complications, and having a low-birth-weight baby. Women sustain more lung damage at an earlier age than their male counterparts. Some evidence suggests women find quitting more difficult than men do and that women smoke to be thin.
- Studies show doctors are more apt to give stop-smoking messages to male patients than to women, although such advice greatly increases the likelihood of quitting.

Breast cancer:

- Options for breast cancer treatment -- surgery, radiation and/or chemotherapy -- *have not appreciably changed over the last 30 years*.

1920 L Street, NW Suite 510 Washington, D.C. 20036 Telephone 202.223.8224 Fax 202.833.3472

- In 1992, an estimated 180,000 women were diagnosed with breast cancer, and 46,000 women died of the disease. Seventy percent (70%) of new cases are diagnosed in women who have *no known risk factors* for the disease. Women of color have poorer outcomes.

Ovarian, Cervical, and Uterine Cancers:

- There is no early detection method for ovarian cancer. Yet, there is a 90% survival rate even after 5 years when detected in Stage I (cancer confined to the ovary).

- In 1992, 21,000 new cases of ovarian cancer will be diagnosed; 13,000 women will die this year from this form of cancer. Women of color die from this form of cancer at disproportionate rates.

- Nearly one-third of all American women will have had hysterectomies by age 60; this is the highest rate in the world. Ovaries do not usually need to be removed, but doctors (lacking any alternatives) often remove them to prevent ovarian cancer.

- The incidence of this cancer is four times higher in postmenopausal women on estrogen-only hormone replacement therapy (HRT) than in women on combined estrogen and progestin therapies.

Menopause:

- Menopause, unlike menstruation, is often viewed by the medical profession as a disease rather than as a natural part of aging.

- There is little research data available for women seeking nonpharmacologic techniques and alternative methods for symptom management of menopause. Data on pharmacologic treatments is only marginally more available and is often conflicting.

Osteoporosis:

- Osteoporosis, a debilitating disease characterized by loss of bone mass, afflicts up to 50% of women over age 45 and 90% of women over age 75; this disease causes more than 50,000 deaths among American women annually.

AIDS:

- Women are the fastest growing demographic group affected by HIV infection. AIDS is the leading cause of death of African American women in seven U.S. cities.

We recognize that we have merely touched upon a few of the great number of diseases and conditions that adversely affect women. Our aim is to highlight several of the alarming gaps in knowledge which make effective preventive methods, treatments, and cures impossible.

By bringing these inequities in research to the public eye, the Society strives to bring much needed attention and resources to women's health research.

Statistics were compiled from the following organizations: Congressional Caucus for Women's Issues (Washington, DC); Jacobs Institute of Women's Health (Washington, DC); NIH Office of Research on Women's Health (Bethesda, MD); the National Institute on Aging (Bethesda, MD) and the Society for the Advancement of Women's Health Research (Washington, DC).

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

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

1920 L Street, NW
Suite 601
Washington, D.C. 20036
202/223-8224

DINNER CREDITS

Anne Fleming
Stephanie Holtz
Producers

DeLancey Printing
Design Cuisine
Greenworks
Joseph E. Seagram & Sons, Inc.
Progressive Beauty System (Nexxus Products)
Viator Associates

SOCIETY STAFF

C. Lynne Beauregard
Program Director

Anita S. Bollt
Chief Operating Officer & Deputy Director

Stephanie Holtz
Development Director

Debra E. Isaacson
Staff Assistant

A'dell V. Lee
Administrative Assistant

Kristina Rosenthal
Program Assistant

Lisa F. Sloan
Director of Government Relations

PROGRAM

Maureen Bunyan

Leonard L. Ross, Ph.D.
Gala Chair

Robert Essner
Corporate Chair

Florence Haseltine, Ph.D., M.D.

Phyllis Greenberger, M.S.W.

"WOMEN OF BROADWAY"

MANY FACES

Many Faces, the painting on the cover of our invitation, symbolizes the uniqueness of conditions affecting women of all ages and ethnic backgrounds. Mindy Weisel, a nationally recognized painter, has donated the complete edition (25) of this original signed and numbered print to support the Society for the Advancement of Women's Health Research. This limited edition is available for a limited time through the Society. Each Iris artprint which measures 23.5" by 17" unframed, is available for $800. If you are interested in purchasing this wonderful piece of art to aid the Society and add to your collection, please contact Debra Isaacson at (202) 223-8224.

VIDEO CREDITS

DENISE FAUSTMAN, M.D., Ph.D.
Transplantation and Autoimmunity

Director of Immunobiology Laboratories of Massachusetts General Hospital/ Harvard Medical School. Research includes the investigation of transplant rejection, the pathogenesis of autoimmunity, and the creation of the first islet cell transplantation program for diabetes in New England.

SALOME WAELSCH, Ph.D.
Development Genetics

Dr. Waelsch was awarded the distinguished Presidential Medal of Science in 1993 for work in the field of developmental genetics. Currently a Distinguished University Professor Emerita in the Department of Molecular Genetics at Albert Einstein College of Medicine.

MARY HARPER, R.N., Ph.D.
Mental Health of the Aging

Coordinator of Long-Term Care Program at the National Institutes of Health/ National Institute for Mental Health/ Mental Disorders of Aging Research Branch. She has worked extensively in the psychiatric field with a concentration in mental health in older adults.

ETHEL SIRIS, M.D.
Metabolic Bone Diseases

Professor of Clinical Medicine at the Columbia University College of Physicians and Surgeons, Director of Osteoporosis Programs at the Center for Women's Health, and Associate Program Director of the Irving Center for Clinical Research at the Columbia-Presbyterian Medical Center in New York. Dr. Siris is engaged in clinical research, teaching, and clinical practice in the field of metabolic bone diseases, particularly osteoporosis and Paget's disease of the bone.

HISTORIC PHOTOGRAPHS:

Prints & Photographs Collection, History of Medicine Division
National Library of Medicine

CELL IMAGES:

PAMELA GEHRON ROBEY, PH.D.
Chief, Bone Research Branch
National Institute of Dental Research

JANET M. HOCK, B.D.S., PH.D.
Lilly Research Laboratories
A Division of Eli Lilly and Company

BREAST CANCER CELL SLIDES:
(courtesy of Medarex, Inc.)

MDX-210, Medarex's Bispecific antibody, is capable of linking the macrophage and the targeted breast cancer cell, triggering the macrophage to consume and destroy the cancer cell without the introduction of toxic or radioactive substances.

VIDEO OF "VIRTUAL BRONCHOSCOPY":

Virtual Reality Imaging:
DAVID J. VINING, M.D.
Assistance Professor, The Bowman Gray School of Medicine

DNA DOUBLE HELIX GRAPHICS:
Courtesy of **GENENTECH, INC.**
San Francisco, CA

The Society for the Advancement of Women's Health Research would like to thank Medical College of Pennsylvania and Wyeth-Ayerst Laboratories for their generous grants which the Society earmarked for the underwriting of all costs associated with this dinner. Thank you also to our many friends who have helped to make this evening a terrific success. While we are only able to list table purchasers here, we greatly appreciate the support of all who have joined us tonight.*

BENEFACTORS

Medical College of Pennsylvania
Wyeth-Ayerst Laboratories
Eli Lilly and Company

PATRONS

Berlex Laboratories, Inc.
BKB
Bristol-Myers Squibb Company
Burson-Marsteller
Chlorine Chemistry Council
Dow Corning Corporation
Edelman Medical Communications
Fannie Mae
Fox, Bennett & Turner
Genentech, Inc.
General Motors Corporation
Glaxo Inc.
GynoPharma, Inc.
Healthcare Leadership Council
Johnson & Johnson/Ortho-McNeil Pharmaceutical
Lederle Laboratories
Merck & Co.
Pfizer Inc
Procter & Gamble
U.S. Healthcare
Wang Associates Health Communications
Warner-Lambert
Zeneca Pharmaceuticals

** Table purchasers as of January 31, 1995*

CORPORATE ADVISORY COUNCIL

Abbott Laboratories
Berlex Laboratories, Inc.
Bock Pharmacal Company
Bristol-Myers Squibb Co.
Burroughs Wellcome Co.
Chicago Center for Clinical Research
The Chlorine Chemistry Council
Dow Corning Corporation
Eli Lilly & Company
Genentech, Inc.
Glaxo Inc.
Gynopharma Inc.
Johnson & Johnson
Lederle Laboratories
Medarex Inc.
Medco Containment Services, Inc.
Merck & Co., Inc.
Ortho-McNeil Pharmaceutical Corporation
Parke-Davis
Pfizer Inc.
Procter & Gamble
Sandoz Pharmaceutical Corporation
Serono Laboratories, Inc.
Smithkline Beecham
Solvay Pharmaceuticals
Syntex
The UpJohn Company
U.S. Healthcare
Wyeth-Ayerst Laboratories

MEDICAL/HEALTH ADVISORY BOARD

American Academy of Dermatology, Inc.
American College of Obstetricians and Gynecologists
American Medical Association
American Nurses Association
American Psychiatric Association
American Society of Maxillofacial Surgeons
American Society of Plastic and Reconstructive Surgeons
American Urological Association
Association of Women Psychiatrists
Gastroenterology Women's Coalition
Magee-Womens Hospital
Medical College of Pennsylvania
Society for Investigative Dermatology
Woman's Hospital of Baton Rouge
Women's Dermatologic Society

CELEBRATE WITH US

The Advancement of Women's Health Research

Established in 1990, the Society's mission is to improve the health of women through research. The Society grew out of mounting concern that the health of all American women was at risk due to biases in biomedical research. Our organization works for greater funding for basic research that incorporates gender differences as well as for increased attention to not only what are often known as "women's diseases," such as breast cancer, osteoporosis and reproductive cancers, but also diseases traditionally associated with men, such as heart disease and lung cancer.

The Society seeks to shape policy for the inclusion of women in clinical trials and increased funding for women's health research and works with the White House, Congress, the Public Health Service and private industry to address obstacles facing women's health research.

Executive Director

Phyllis Greenberger, M.S.W.

Board of Directors

President

Florence Haseltine, Ph.D., M.D.
Bethesda, Maryland

Secretary-Treasurer

Kathy Bryant, J.D.
Associate Director, Government Relations, American College of Obstetricians and Gynecologists

Lisa Burns
President, Burns McClellan

Maria Bustillo, M.D.
Associate Professor Ob/Gyn and Director Reproductive Endocrinology
Mt. Sinai Medical Center

James H. Cavanaugh, Ph.D.
President
HealthCare Investment Corporation

Colleen Conway-Welch, Ph.D., R.N., C.N.M., F.A.A.N.
Professor and Dean
Vanderbilt School of Nursing

John C. Fletcher, Ph.D.
Professor of Biomedical Ethics and Religious Studies, Univ. of Virginia

Freda Lewis-Hall, M.D.
Clinical Research Physician
Eli Lilly Corporation

Irma Mebane-Sims, Ph.D.
Bethesda, Maryland

Irene Pollin, M.S.W.
President and Founder
Linda Pollin Foundation

Gloria Sarto, M.D., Ph.D.
Professor and Chair
Dept. of Ob/Gyn,
University of New Mexico

Susan K. Sudman
Health Care Management Consultant

Anne Colston Wentz, M.D.
Professor, Department of Ob/Gyn
Northwestern University

Nancy Fugate Woods, Ph.D., R.N.
Professor and Director
Center for Women's Health Research
University of Washington

HONORARY COMMITTEE

Hon. Donna E. Shalala
Ruth B. Merkatz, Ph.D., R.N.
Susan Blumenthal, M.D., M.P.A.
Vivian Pinn, M.D.

Hon. Neil Abercrombie
Hon. Robert Andrews
Hon. Roscoe Bartlett
Hon. Max Baucus
Hon. Howard Berman
Hon. Joseph Biden, Jr.
Hon. Thomas Bliley
Hon. Peter Blute
Hon. Henry Bonilla
Hon. Barbara Boxer
Hon. Bill Bradley
Hon. Bill Brewster
Hon. Corrine Brown
Hon. Sherrod Brown
Hon. John Bryant
Hon. Benjamin Cardin
Hon. Michael Castle
Hon. John Chafee
Hon. William Clinger
Hon. William Cohen
Hon. Cardiss Collins
Hon. Pat Danner
Hon. Thomas Daschle
Hon. Rosa DeLauro
Hon. John Dingell
Hon. Julian Dixon
Hon. Robert Dole
Hon. Pete Domenici
Hon. Jennifer Dunn
Hon. Eliot Engel
Hon. Anna Eshoo
Hon. Vic Fazio
Hon. Russ Feingold
Hon. Dianne Feinstein
Hon. Jack Fields
Hon. Bob Filner
Hon. Barney Frank
Hon. Tillie Fowler
Hon. Elizabeth Furse
Hon. Sam Gibbons
Hon. Benjamin Gilman
Hon. Robert Goodlatte
Hon. Jim Greenwood
Hon. Tom Harkin
Hon. Mark Hatfield
Hon. David Hobson
Hon. Martin Hoke
Hon. Ernest Hollings
Hon. Amo Houghton
Hon. Kay Bailey Hutchinson
Hon. Jim Jeffords
Hon. Eddie Bernice Johnson
Hon. Nancy Johnson
Hon. Bennett Johnston
Hon. Marcy Kaptur
Hon. John Kasich
Hon. Nancy Kassebaum
Hon. Ted Kennedy
Hon. Barbara Kennelly
Hon. Jay Kim
Hon. Joseph Knollenberg
Hon. Frank Lautenberg
Hon. Rick Lazio
Hon. Sander Levin
Hon. John Lewis
Hon. Nita Lowey
Hon. Connie Mack
Hon. Carolyn Maloney
Hon. Edward Markey
Hon. Jim McDermott
Hon. Buck McKeon
Hon. Cynthia McKinney
Hon. Jan Meyers
Hon. Barbara Mikulski
Hon. Patsy Mink
Hon. Susan Molinari
Hon. Jim Moran
Hon. Connie Morella
Hon. Carol Moseley-Braun
Hon. Frank Murkowski
Hon. Patty Murray
Hon. Eleanor Holmes Norton
Hon. Michael Oxley
Hon. Frank Pallone, Jr.
Hon. Nancy Pelosi
Hon. John Porter
Hon. Deborah Pryce
Hon. Ralph Regula
Hon. Bill Richardson
Hon. Jack Reed
Hon. Harry Reid
Hon. Charles Robb
Hon. Ileana Ros-Lehtinen
Hon. Marge Roukema
Hon. Pat Schroeder
Hon. Paul Simon
Hon. Alan Simpson
Hon. Louise Slaughter
Hon. Olympia Snowe
Hon. Arlen Specter
Hon. Floyd Spence
Hon. Pete Stark
Hon. Ted Stevens
Hon. Gerry Studds
Hon. Karen Thurman
Hon. Peter Torkildsen
Hon. Edolphus Towns
Hon. Fred Upton
Hon. Pete Visclosky
Hon. Maxine Waters
Hon. Henry Waxman
Hon. Paul Wellstone
Hon. Lynn Woolsey
Hon. Ron Wyden
Hon. Don Young

DINNER COMMITTEE

Jeffrey M. Anders
Catherine P. Bennett
Lynn Blitzer
Sandra K. Bregman
Gerald S.J. Cassidy
Eleanor Clift
Colleen Conway-Welch, Ph.D., R.N.
Sandra J.P. Dennis
Debbie Dingell
Isabel Dunst
Barbara Fabiani
Carl Feldbaum
Marjorie Crawford Finkelnburg
Tara Federici
Rhoda Glickman
Ginny Grenham
Judy Harris
Carolyn Hobson
Priscilla Houghton
Leo C. Jardot
Millie Kondracke
Morton Kondracke
Vicki Levin
Nancy Loving
Priscilla Mack
Alan Madison
Sacha Millstone
Toby Moffett
Dorothy Moss
Lynda L. Nersesian
Ann Marie O'Keefe
Mary Rose Oakar
Teel Oliver
Norm Ornstein
Corrine Parver
Carol Pensky
Irene Pollin, M.S.W.
Sheila Raviv
John Reilly
Cokie Roberts
Michael Roberts
Gerry Sikorski
Ann Simpson
Robin Smith
Lynn Shapiro Snyder
Deborah Steelman
Catherine Stevens
Sheila Tate
Nancy E. Taylor
Susan Holloway Torricelli
Susan S. Walden
Margaret Warner
Janet Waxman
Sheila Wellstone
Judy Woodruff

Society for the Advancement of
WOMEN'S HEALTH RESEARCH

First Lady Lauds Society's Efforts

> "A few years ago...a group of energetic women 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."
>
> First Lady Hillary Rodham Clinton
> July 19, 1993

In a speech at the Iris Cantor Center for Breast Imaging in Los Angeles, the First Lady credited the Society's efforts to bring to the forefront the disadvantages facing women regarding health funding, research and treatment.

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," Mrs. Clinton said. "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?"

The First Lady also addressed the lack of understanding surrounding hormone therapy and menopause, and the need for further research in areas such as drug therapies and RU-486. She stressed the "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."

Mrs. Clinton fully supports the Society and other organizations dedicated to eliminating the inequities that currently exist in our health care system. "If we have the technology, as we do, sophisticated enough to direct missiles to targets thousands of miles away," she said, "we ought to work to have technology sophisticated enough to detect every fatal lump in a woman's breast..."

The Society is delighted to receive the recognition of the First Lady and promises to continue its efforts to improve women's health through research. We are dedicated to making women's health not merely a priority but a reality by shaping and stimulating new directions in public policy which emphasize women's health and women's health research.

1920 L Street, NW Suite 510 Washington, D.C. 20036 Telephone 202.223.8224 Fax 202.833.3472

LHJ Picks

The Ten Most Important Women In Medicine

Bernadine P. Healy, M.D.

Flossie Wong-Staal, Ph.D.

Florence P. Haseltine, Ph.D., M.D.

Less than a generation ago, women accounted for only a fraction of the professionals who made up the nation's health-care establishment. But that has changed. Today, most medical-school classes are 40 percent female. And female doctors, scientists and policy makers have quickly crashed through the glass ceilings of research labs, university medical departments and the nation's top hospitals and health institutions.

Who are the most powerful women in medicine today? *Ladies' Home Journal* asked that question of more than a hundred agencies and institutions across the country. The top choices:

Setting the national agenda

If we can detect missiles in space, we ought to be able to pick up a small lump in a woman's breast," says **Susan J. Blumenthal, M.D., M.P.A.**, the country's first-ever Deputy Assistant Secretary for Women's Health. She oversees all women's-health programs and policies within the U.S. Public Health Service, including research at the National Institutes of Health (NIH), in Bethesda, Maryland, and drug approval at the federal Food and Drug Administration. Trained as a psychiatrist (she still practices in her spare time), Blumenthal, forty-four, is also one of the founders of the Society for the Advancement of *(continued)*

Women's Health Research, whose goal is to increase spending on research involving women.

Advocate for the aged

By the year 2010, one of five Americans will be over age sixty-five, a fact that **Christine K. Cassel, M.D.**, forty-nine, director of the Center on Aging, Health and Society at the University of Chicago, doesn't let anyone forget. She continually urges her colleagues to find better ways to treat the chronic diseases that afflict the elderly. "There is still very little known about how to take care of the most common medical problems in elderly people," says Cassel, who is researching whether small doses of certain hormones can postpone the disability that often accompanies old age.

A women's policy maker

As director of the Center for Population Research at the NIH, **Florence P. Haseltine, Ph.D., M.D.**, fifty-two, has set policy and found funding for research on population growth, the reproductive sciences, infertility and the development of contraceptives. A board-certified obstetrician and gynecologist, Haseltine also helped found the Society for the Advancement of Women's Health Research. "Women's health has been recognized only gradually as an area of special concern," she says.

First woman to head NIH

When **Bernadine P. Healy, M.D.**, was appointed by President Bush in 1991 to head the NIH, the agency that funnels approximately $11 billion a year to biomedical researchers, she found herself in a man's world. More than 80 percent of the top officials were men. "Advancing women's health is sort of our modern-day suffrage movement," says Healy, fifty, who pushed through the Women's Health Initiative, the largest and most extensive study ever devoted to women's health. Currently, she is senior policy adviser for The Cleveland Clinic, in Ohio.

Probing cancer's psychic folds

While most cancer researchers have doggedly pursued new ways to physically eradicate cancer from the body, **Jimmie Holland, M.D.**, a psychiatrist, has pursued another line of thinking. As a pioneer in the field of psycho-oncology, which deals with the emotional well-being of cancer patients, Holland, sixty-six, heads the program in psycho-oncology at Memorial Sloan-Kettering Cancer Center, in New York City. She is now studying how emotions affect the outcome of cancer treatments.

An outspoken breast researcher

Knowledge is power, and most women have been denied real knowledge about their own breasts," says **Susan M. Love, M.D.**, co-founder of the National Breast Cancer Coalition and director of the Revlon/University of California at Los Angeles Breast Center. With a feminist slant, Love, forty-seven, has become one of the most outspoken advocates for breast-cancer research. Author of *Dr. Susan Love's Breast Book* (Addison-Wesley, 1990), which covers everything from breast-feeding to mastectomy, Love urges women to demand change in the way the male-dominated medical field treats women. Taking a lesson from the AIDS movement, she says, we need to "take to the streets and yell and scream."

Directing dollars to women's interests

Vivian W. Pinn, M.D., is the first full-time director of the Office of Research on Women's Health, a newly established arm of the NIH. It's a role that requires a person who can fight the male establishment, *(continued)*

How They Stay Healthy

How do the top women in medicine stay healthy? Primarily, by doing exactly what they tell the rest of us to do. Here, some of their secrets.

On eating sensibly: All experts advise a low-fat diet; some—like Bernadine Healy and Susan Blumenthal—also take vitamins. Nanette Wenger, who enjoys gourmet cooking, makes elaborate sauces using a vegetable base instead of a fat base.

On checkups: Florence Haseltine had unexplained stomach pains for five years before doctors diagnosed a thyroid problem. "I go for my yearly checkups, and if I don't like what the doctor says, I keep going back until I get an answer," she says.

On exercising: Finding time to work out is difficult for these super-busy women, but each of them makes it a priority. For Christine Cassel, it means getting up at five o'clock in the morning two or three days a week. For Nanette Wenger, it means riding the stationary bike at eleven P.M. while she watches the late-night news.

On relaxing: "You have to make time to do some things that are just for you," says Susan Blumenthal. "Our psychological state has an impact on our brain function, which has an impact on our immune and endocrine systems."

On hormone-replacement therapy: "I do take hormone-replacement therapy, but I am not saying that because I do, every woman should. Until we have all the information, each woman should consult with her own physician about whether it is in her best interest or not," says Vivian Pinn. Adds Susan Love: "Each woman has to weigh the pros and cons in her own life."

A healthy benefit for women

Three women of three different ages and lifestyles spoke informally Monday of their own attitudes to women's health issues while waiting to rehearse songs they'd perform later that evening at a black-tie benefit, which raised $500,000 for the Washington-based Society for the Advancement of Women's Health Research.

All three were New York-based performers from different Broadway shows of note who are in good health. Their thoughts reflected well the range of hopes and problems that gave rise five years ago to the society's broad-based initiative promoting gender equality in medical research.

"I remember when Happy Rockefeller got breast cancer and people starting talking about the subject for the first time. Had I known more about the subject then, I would be further ahead — I would have started on something or another sooner," said **Rita Gardner**, referring to still-controversial hormone-replacement therapy.

A member of the original cast of "The Fantasticks," now in its 35th year, she currently is with the national tour of "Kiss of the Spider Woman" and flew in from Montreal for the night.

"There are so many scary issues now," suggested **Darcie Roberts**, 21, of Broadway's "Crazy For You." "I'm constantly amazed at the lack of information, and young girls are so vulnerable. It's frightening not knowing what new diseases are out there, although ... it's also a lot easier now to walk into a group of women and start talking about such things."

"I get asked to do so many benefits in New York, usually for AIDS, that I thought when I heard about this group, 'Hooray.' So many women's health issues get swept under the rug," said **Liz Callaway**, 33, mother of a young son and member of Broadway's "Cats."

Photo by Karen Ballard/The Washington Times

Darcie Roberts enchants the crowd with a song from "Crazy for You" at the Society for the Advancement of Women's Health Research gala.

"Women's health always is seen as the issue of reproduction," said **Phyllis Greenberger**, executive director of the society and its staff of eight. "And it isn't, although there still is a lingering idea that it is." The scope of their program includes "convincing women that not all diseases are breast cancer but how different diseases affect women differently."

Funds raised Monday would go toward office expenses and new software, she said, but the "two issues this year are obstacles to getting women in clinical trials and the factor of liability. A lot of time, tests for new devices are done on women who are healthy, which can mean more risk when there are adverse reactions."

Has there been any backlash lately from white males charging discrimination?

"No, we aren't women against men but the idea of women needing to be included in research and testing," she said.

Among the men attending the event, which was held in the Mellon Auditorium, were political analyst **Norman Ornstein** of the American Enterprise Institute ("I'm here because of Phyllis") and Rep. **John Dingell**, Michigan Democrat, who said his interest in women's health was "saving it from the Republicans."

Rep. **Patricia Schroeder**, a longtime supporter, appeared in an elaborately patterned cardigan sweater, flowing tunic, pants and boots: "This is black-tie in Denver," the Colorado Democrat said to well-wishers as she made the rounds.

— **Ann Geracimos**

It's sickening

Research on diseases affecting women remains underfunded or ignored totally. But that's beginning to change. Slowly. Very slowly.

By JENNIFER MASSE
Photography by Anthony Cericola

The folks at Mediscience Technology Corp. (MTC) are virtually beaming. The Cherry Hill-based company recently established a collaborative research agreement with General Electric to develop photonic, or light-based, diagnostic devices for medical applications.

Peter Katevatis, chief executive of publicly-traded MTC, couldn't be happier. This agreement puts the company one step closer toward product commercialization, pending FDA approval.

The company is a pioneer in mediphotonics, an emerging medical technology that utilizes the characteristics of light to detect cancer and other forms of disease. Not only can this non-surgical technology detect cancer in breast and gynecological tissue, but it can identify tissue that has even the potential to become malignant.

That could represent the difference between life and death for women with ovarian cancer; because of inadequate screening techniques, nearly 75 percent of ovarian cancer cases are not discovered until after the disease has spread beyond the ovaries.

Experts believe that light-based technology will have a huge impact on early detection of cancer. If found early enough, cancer has up to a 90-percent cure rate.

This is good news for everyone, and especially for women: Research on many women's diseases has historically been either underfunded or ignored totally.

Slowly, however, that is beginning to change as more attention is placed on women and their particular health needs. And since women are living longer than ever now, those needs are becoming greater.

In fact, the Washington DC-based Society for the Advancement of Women's Health Research, a non-profit organization, was launched in 1990 to bring to national attention the need for greater funding for research into women's health issues.

It also promotes disease-prevention. According to the society's research, the causes of such women-centered diseases as osteoporosis and breast cancer, as well as heart disease, may begin at an early age. That's one reason Merck & Company, Inc. was eager to provide the initial funding for the development of a national educational symposium directed toward teenagers and women in their early 20s.

According to the society, as many as one half of the two million deaths occurring in the United States each year could be prevented if women quit smoking, limited alcohol consumption, developed proper eating habits, got regular medical exams and vaccinations, and refrained from unsafe sexual conduct.

One disease that is preventable through proper nutrition is osteoporosis, which affects 50 percent of

women over age 45 and 90 percent of women over 75.

"Osteoporosis is associated with tremendous costs, increased disability and even death," says Dr. John L. Abruzzo, professor of medicine in the division of rheumatology at Thomas Jefferson University and director of the Jefferson Osteoporosis Prevention and Treatment Center.

"That's why it's so important to stress prevention."

In fact, the National Osteoporosis Foundation says that the average American receives only 30 to 40 percent of the calcium needed to build strong bones.

"All the cola, iced tea and high-protein foods that kids consume now are raising the chances that they will develop osteoporosis in their later years," says Susan Ward, MD, a rheumatologist at Jefferson Hospital. "If teenagers could only see the effects of osteoporosis—the severe pain, the fractures and the shrinkage—they would take in more calcium at a younger age. We recommend children, teens and young adults shoot for 1,200 mg of calcium per day."

Another preventable disorder with horrifying statistics is cardiovascular disease. It is the number-one killer of American women, adding costs in excess of $9 billion annually to the healthcare system.

"Between the ages of 30 to 50, heart disease is less common in women, although it can show up in young women whose families have a history of high cholesterol," says Dr. Albert N. Brest, a cardiologist at Thomas Jefferson University Hospital.

That's because estrogen acts as a protective shield, helping to prevent heart attacks in women before they reach menopause.

"After age 70," says Dr. Brest, "men and women have basically the same incidence of heart disease."

Experts say that reducing the amount of dietary fat, coupled with exercise, will greatly reduce a woman's chance of developing heart disease. So will cessation of smoking, especially while on birth control pills.

BUT BEING PROACTIVE TO PREvent disease is only half the battle, most experts agree. More research is needed for diseases affecting women, from ovarian cancer to breast cancer although, to be sure, women are encouraged by significant strides in research there, such as the identification of BRCA-1, the breast-cancer-causing gene. And research is underway into the causes and prevention of endometriosis, which affects up to half of all women over age 30. It is believed to be a major cause of infertility—and of many of the 600,000 hysterectomies performed in America each year, the largest number of any country in the world.

Endometriosis is a condition that occurs when endometrial tissue, the tissue that lines the uterus and is shed during menstruation, grows outside the uterus.

"Endometriosis is a major public health problem in America," says Dr. Christos Coutifaris, MD, PhD, associate director of the University of Pennsylvania Medical Center's Division of Human Reproduction, a specialist in the area of endometriosis. "Right now there's nothing available for early screening.

"But things are being done," Dr. Coutifaris says. "It's slow, but in time things will change.

"Those of us in women's healthcare think it's long overdue."

Still, most experts agree, the best method of disease prevention is practicing good health habits every day. ■

HEALTH CARE POLICY

Volume 3, Number 6 THE BUREAU OF NATIONAL AFFAIRS, INC. February 6, 1995

Women's Health

EMPLOYERS SHOULD MAKE COMMITMENT TO ISSUE, HILLARY CLINTON ASSERTS

Hillary Rodham Clinton asked employers Feb. 1 to make a commitment to meeting women's health needs through their own initiatives or in partnership with the federal government.

"Women's health doesn't just affect women, it affects all Americans," Clinton said at the Women's Health Summit sponsored by the Federal National Mortgage Association in cooperation with the Washington Business Group on Health and the Society for the Advancement of Women's Health Research.

"Women usually function as the primary caregivers for children and aging parents in our society and women now comprise a large percentage of our workforce," Clinton said. Therefore, ignoring women's health needs will result in problems for families, workplaces, and the whole society, she told the business leaders and health care professionals attending the meeting.

Clinton lauded FannieMae, the second largest corporation in the nation and the largest provider of home mortgage funds, for its leadership role in the area of women's health, its "commitment to family-friendly benefits," and its workplace wellness programs. Clinton said she hoped other companies would follow FannieMae's example in providing benefits such as free mammograms for female employees.

Clinton also called for a renewed public-private partnership to address women's health needs. Government and corporations "need to cooperate and leverage each other's efforts so we can all promote greater health, greater happiness, and greater productivity," she said.

"The unpleasant truth is that the health of American women should be better than it is today," Clinton remarked. In terms of research, education, and treatment, women's health concerns have too often been discounted or ignored, she added.

However, in recent years progress has been made in focusing attention on these issues, Clinton said. She described a number of women's health initiatives undertaken by the Clinton administration, including the creation of the Office of Women's Health at the Department of Health and Human Services.

Since President Clinton took office, funding for breast cancer research at the National Institutes of Health has increased 65 percent, to $379 million in 1995, Clinton said, with additional research and training grants funded through the Department of Defense. She announced that the Defense Department is working with the Central Intelligence Agency and the Office of Women's Health to apply defense related technology to improve breast cancer screening methods.

These initiatives came about not by "arbitrarily slashing programs," Clinton said in a reference to budget cuts proposed by the Republican-controlled Congress.

"Women's health is a particular concern of the president and he has made it a priority in his budget," scheduled to be released the week of Feb. 6, Clinton said. Nearly $2 billion has been set aside in this year's Public Health Services' budget for women's health, she said, including breast cancer research, family planning programs, and research on diseases that primarily affect women such osteoporosis.□

HEALTH CARE POLICY

REPORT

Volume 3, Number 4 THE BUREAU OF NATIONAL AFFAIRS, INC. January 23, 1995

Pharmaceuticals

GENDER ANALYSIS DATA RAISES ISSUES OF INFORMED CONSENT, FDA OFFICIAL SAYS

Although the Food and Drug Administration has determined that all new drug applications must include gender analysis data, the agency still is dealing with the issue of what constitutes informed consent and demands by "deeply ill patients" to be admitted into clinical trials, Ruth Merkatz of FDA's Office of Women's Health said Jan. 19.

At a forum sponsored by the Society for the Advancement of Women's Health Research, Merkatz told attendees that FDA was scrutinizing informed consent forms to determine whether manufacturers have balanced the elements of inclusiveness and exclusiveness, and how the forms deal with a subject's choice of contraception.

Informed consent is difficult because investigators are faced with possible conflicts of interest as they seek informed consent from individuals. In addition, the concept of experimentation versus treatment is confusing, Merkatz said, and there is a controversy over whether consent forms should say anything at all about any health-related benefits of a trial or say only that individuals will benefit from participation.

Other difficulties associated with obtaining informed consent include the challenge of constructing a consent form that gives details of participation that can be understood by individuals who are asked to give consent, she said. Informed consent also raises the issue of preparing individuals to accept the fact that something can go wrong in a clinical trial, according to Merkatz.

Similarly, participation in clinical trials by people who are desperately ill raises a question of whether their participation is based on informed consent or should be considered "grasping at straws." While FDA's attitude toward the desperately ill is "coming around" to better balance the need to protect human subjects with a need for expedited entry into clinical trials, institutional review boards are less open, Merkatz said, calling IRBs "the last bastion of paternalism."

Under guidelines developed in 1977, women of childbearing age were restricted from participating in clinical trials to prevent possible birth defects. In the 1980s, questions about women's health prompted questions about how the guidelines affected the information-gathering process during drug development trials. Attitudes toward women's participation in clinical trials also changed over time as gender bias became more widely recognized, Merkatz said, adding that the principle of autonomy—allowing women to make decisions about assuming risk—also helped effect a change.

Besides educating staff at FDA on issues related to women's participation in clinical trials, she said the agency will hold a workshop in conjunction with industry, academics, and consumers on gathering gender analysis data in clinical trials. Merkatz also said the agency would propose new regulations amending requirements for investigational new drug applications and NDAs to keep track of gender analysis data.□

Biotech's Key Role in Women's Health

BY AMANDA FUENTES

NEW YORK—Most women don't know very much about biotechnology, but this young industry could save and prolong their lives.

Among other things, it is developing new and powerful tools to treat breast, cervical and ovarian cancers, osteoporosis and other serious threats to women's health and well-being. These are just a few of the many research initiatives that promise to change the way doctors detect and treat diseases that affect hundreds of thousands of American females.

"Despite all the medical advances in recent years, women are still waiting for help with many of the diseases that terrify them the most," said Holly Atkinson, M.D., executive vice president of Reuters Health Information Services. "Biotechnology holds the promise of early detection, targeted treatments and even prevention."

Atkinson was among the speakers at a recent roundtable discussion titled "Biotechnology: Innovations in Women's Health care." Other speakers, including noted scientists and industry leaders, reported on pioneering efforts to block the progression of breast and cervical cancer by interfering with the replication of malignant cells; to fight breast and ovarian cancer by activating the natural cell-killing mechanisms of the immune system, to safely control the effects of menopause with compounds that mimic the natural action of sex hormones, and to detect the early inset of osteoporosis—the bone-thinning disease that disproportionately affects women—using advanced immunoassays.

The roundtable was co-sponsored by the Biotechnology Industry Organization (BIO) and the Society for Advancement of Women's Health Research (SAWHR).

Phyllis Greenberger, president of SAWHR, said the tools of biotechnology "offer real hope for improving the future of women's health." Although women live longer than men, she said, they suffer more from chronic illnesses, utilize health care services more often, represent a greater portion of the uninsured, obtain prescription drugs more often and are less likely to be included in clinical research trials.

Recent Transformation

In recent years, medical science has been transformed by the application of such revolutionary discoveries as recombinant DNA technology, monoclonal antibodies, and polymerase chain reaction. Scientists are now applying these new technologies to women's diseases that have not yet yielded to more conventional approaches.

In breast cancer, for example, some major advances have been made in early detection but not in effective treatment for advanced diseases. In 1993, more than 182,000 American women were diagnosed with breast tumors and 46,000 women died of the disease.

Many cervical cancers also defy treatment. Some 13,500 women were diagnosed in 1993 and 4,400 died of cervical cancer.

Holly Atkinson, M.D.

Alison Taunton-Rigby, president and CEO of Mitotix, Inc., described how biotechnology has given Mitotix scientists new insights into the cell cycle, the process by which cells divide and replicate, and the targets for therapy that this process represents.

Taunton-Rigby and her colleagues are developing potentially specific drug treatments designed to block the action of enzymes that regulate the cell cycle in malignancy. With specific targets such as breast and cervical cancer, the researchers believe the drugs may be more potent and less toxic than conventional therapies for these cancers.

Donald Drakeman, president and CEO of Medarex, Inc., presented a different but equally novel approach to treating cancer, including breast and ovarian tumors. This approach concentrates on directing and enhancing the body's natural disease-fighting system. According to Drakeman, Medarex clinical investigators are seeing promising results with paired monoclonal antibodies that target breast and ovarian cancer cells and activate the body's own immune killer cells to come and destroy them.

As ovarian cancer is difficult to detect and is often diagnosed too late to be treated successfully, there is a particularly urgent need for effective treatment. Each year in the United States, 24,000 women are diagnosed with ovarian tumors and 13,600 die of the disease.

Critical Roles

More and more women are discovering that the female sex steroids—estrogen and progesterone—play critical roles not only in reproduction but also in many other important physiologic processes. After menopause, diminished hormone production causes a wide variety of physiologic problems ranging from hot flashes to osteoporosis. Estrogen-replacement therapy has proven highly effective in relieving many of the worst effects of menopause but it leaves women at increased risk of uterine cancer.

Robert Stein, M.D., senior vice president and chief scientific officer of Ligand Pharmaceuticals, reported that his company is trying to improve this situation with a high-tech approach to drug discovery that combines the techniques of biotechnology with pharmaceutical approaches.

Ligand's goal, he said, is to develop compounds that will mimic the natural action of hormones, but with a greater degree of selectivity. He added that advances in understanding the molecular basis of hormone action have provided a blueprint for the development of new therapies: compounds which will interact with intercellular receptors to provide the many health benefits of the hormones, while diminishing the risk of harmful side effects.

Mary Lake Polan, M.D., chairman of the Department of Obstetrics and Gynecology at Stanford University School of Medicine, reported on her work with Metra Biosystems to develop improved diagnostics for osteoporosis and other degenerative conditions of bone and cartilage such as rheumatoid arthritis and osteoarthritis.

As many as 25 million Americans suffer from osteoporosis, a serious disease in which bones become brittle and increasingly susceptible to fracture. From 1.3 to 1.5 million bone fractures occur annually as a result of osteoporosis. Finding reliable methods for early detection is a major challenge in dealing with this ailment.

To develop a convenient, inexpensive and sensitive test for measuring bone resorption, Polan and the Metra researchers focused on molecules that are released from the bone as it is resorbed. These by-products find their way into the urine and the researchers developed a sophisticated immunoassay to measure the levels.

Like many other applications of biotechnology, this diagnostic test seems likely to make real progress against a major threat to women's health.