The Future of Women’s Health: Using Data and Research to Shape Policy and Programs

Alina Salganicoff, Ph.D.
Vice President and Director, Women’s Health Policy
Henry J. Kaiser Family Foundation

Community Dialogue
Using Data to Make a Difference in Women’s Health
July 9, 2013
What do we mean when we say “women’s health?”

Health conditions that:

• are specific to women,
• are more common or more serious in women,
• have distinct causes or manifestations in women,
• have different outcomes or treatments in women, or
• have high morbidity or mortality in women.

Women’s health research has come a long way...

Not really...
Women were purposefully and systematically excluded from clinical research thus no appreciation for sex differences.
A little history...changes in society and research have paved the way for women’s health

1972: Griswold v Conn. Strikes down state laws prohibiting contraception distribution to unmarried people

1973: Roe vs. Wade

1977: FDA bans “Women of childbearing potential” participating in clinical research (after thalidomide and DES tragedies)

1978: Pregnancy Discrimination Act enacted: bans workplace discrimination based on pregnancy

1982: NSFG: includes all women of reproductive age, not just married women...

1983: 1st lesbian TV character in “All My Children”

1985: 1st Public Health Service Task Force Report on Women’s Health issues
The importance of research in shaping policy continues to grow...

1991: HHS establishes Office on Women’s Health

NIH launches Women’s Health Initiative

1994: First Offices of Women’s Health established at CDC and FDA

1997: EPICC first introduced

1998: FDA approves Plan B, the first emergency contraceptive

1990: Dr. Antonia Novello first woman Surgeon General

1993: NIH Revitalization Act: requires inclusion of women in clinical research and analysis of results by sex

Family Medical Leave Act: unpaid family leave

1999: WHI arm terminated due higher breast cancer risk, lack of benefit

2000: Empowerment of women established as a UN Millennium Goal

2001: EPICC first introduced

2003: “Partial Birth” Abortion Act

2004: FDA Approves behind the counter access to Emergency Contraception, and HPV Vaccine

2009: Obama establishes Council for Women and Girls

2010: ACA signed into law

2011: IOM report on The Health of LGBT People

2012: Private plans must cover contraception, breastfeeding support, IPV screening

2000: Empowerment of women established as a UN Millenium Goal

2006: FDA

2007: Defund Planned Parenthood

2008: VOTE

2009: Stop the War on Women
So why do we still need to focus on women’s health?

- Sex matters! Different manifestation of disease and response to treatment
- Gender matters too!
  - Society
  - Economics
  - Work
  - Family roles and responsibilities
- Women have distinct health needs and health system use
- Raising the bar: Policy now requires “evidence”
What are some of the challenges in data collection and analysis?

- COST $$$
- Asking the right questions
- Establishing mechanisms to collect the data
- Collecting the right data
- Finding the right tools to analyze the data
- Taking the time to analyze and report the data
- Changing policy and practice is not easy, but increasingly requires an evidence base
Mental Health: Men and women have different challenges and different experiences

12 month prevalence of disorders by sex:

- **Eating Disorders**: Women three times as likely to have anorexia and bulimia
- **Pregnancy-related depression**: 60-80% of new mothers have “baby blues”
  - 1 in 10 have serious post-partum depression
- **Suicide**: Women are two to three times more likely to attempt suicide, but men die more often.

NOTE: *Substance Disorders includes nicotine addiction.
Figure 9

Women are more likely than men to experience cost related barriers to care

Percentage of men and women who say they or a family member have done each of the following in the past year because of COST:

- Put off or postponed getting needed health care
  - Men: 25%
  - Women: 34%*

- Skipped a recommended medical test or treatment
  - Men: 21%
  - Women: 29%*

- Didn’t fill a prescription
  - Men: 21%
  - Women: 28%*

- Cut pills or skipped doses of medicine
  - Men: 18%
  - Women: 14%

- Skipped dental care or checkups
  - Men: 32%
  - Women: 39%*

NOTE: *Indicates statistical significance at the 95% level.
Figure 10

Poorer women shoulder a greater burden of illness

Percent of women reporting that they were diagnosed with the following conditions by a physician in the last 5 years:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Women &lt;200% FPL</th>
<th>Women &gt;200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Asthma</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>25%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Women ages 18-65 who met physical activity recommendations* in 2009-2011, by race/ethnicity and poverty status

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Below 100% FPL (poor)</th>
<th>100-199% FPL (low income)</th>
<th>200% FPL or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic White</td>
<td>11%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>11%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>10%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>5%</td>
<td>8%</td>
</tr>
</tbody>
</table>

NOTE: *Met guidelines for aerobic & muscle strengthening activity according to 2008 guidelines.
FPL in 2011 was $18,530 for a family of three.
SOURCE: Center for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, Health Data Interactive.
Identifying challenges at the community level is now possible.

Insurance coverage makes a difference and facilitates access to care

Percent of women reporting they have received screening test in past two years:

- **Blood pressure**: 96% (Private), 86% (Medicaid), 74% (Uninsured)
- **Clinical breast exam**: 84% (Private), 65% (Medicaid), 51% (Uninsured)
- **Blood cholesterol**: 71% (Private), 47% (Medicaid), 37% (Uninsured)
- **Colon cancer**: 42% (Private), 35% (Medicaid), 21% (Uninsured)

**NOTE:** Colon cancer screening among women 50 and older; *Significantly different from private, p<.05.

**SOURCE:** Kaiser Family Foundation, 2008 Kaiser Women’s Health Survey.
There are many barriers to care for women, but barriers are greatest among those with the fewest resources.

Percent reporting they delayed or went without care they thought was needed in past 12 months due to:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Less than 200% of poverty</th>
<th>200% of poverty and higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>No insurance</td>
<td>29%*</td>
<td>7%</td>
</tr>
<tr>
<td>No Doctor</td>
<td>23%*</td>
<td>8%</td>
</tr>
<tr>
<td>Couldn't find time</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>Couldn't take time off work</td>
<td>26%*</td>
<td>17%</td>
</tr>
<tr>
<td>Child care problems</td>
<td>17%*</td>
<td>8%</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>19%*</td>
<td>2%</td>
</tr>
</tbody>
</table>

NOTE: 200% of the federal poverty threshold was $35,200 for a family of three in 2008. *Significantly different (p<.05)

^Among women who are employed. ^^ Among women with children younger than 18 years living in household.

Site of care can make a difference for women

Percent of women reporting they have received screening test:

- **Mammogram in past 2 years**
  - **Women Health Center Patients**
    - Medicaid: 78%
    - Uninsured: 63%
  - **All Low-Income Women**
    - Medicaid: 93%
    - Uninsured: 45%

- **Pap Smear in past 3 years**
  - **Women Health Center Patients**
    - Medicaid: 79%
    - Uninsured: 70%
  - **All Low-Income Women**
    - Medicaid: 80%
    - Uninsured: 70%

**NOTE:** Mammography among women 50 and older;  
What does “medical/health home” mean for women?

Share of women reporting they have:

- **17%** of women lack a regular provider
- **More than four in ten (44%)** women report that they rely on two providers
  - For many women of reproductive age one is an Ob/Gyn
  - In middle age, women increasingly rely on other specialties

Most recipients of long-term services and supports are women, but is care designed in a way that is gender sensitive?

**Home Health Users**
- Women: 67%
- Men: 33%
- Total in 2008 = 2.5 million

**Nursing Home Residents**
- Women: 73%
- Men: 27%
- Total in 2008 = 1.5 million

So why are there still so many gaps in gender-based research?

• Assumption there are no differences beyond reproductive care
• Many believe that “controlling for sex” is sufficient; and do not conduct “sex stratified analysis”
• Lack of understanding of the influence of “gender” on use of the health care system and provider responses to women as patients
• Even less appreciation of the intersectionality between gender, race, and poverty
• Sample size? Is this an issue for gender?
• Not all funders require it (no requirement for AHRQ or private funders)
• Journals don’t demand it…but women (and men) should!!!
Looking Forward: Gender-based research will be essential to inform and strengthen ACA and health care delivery

- Reporting will be key: New standards for collecting and reporting data on race, ethnicity, sex, primary language and disability status, and LGBT populations.
- Monitoring and oversight are critical: New sources of data at local, state and national levels will also need to be sensitive to women’s concerns
- Asking the right questions is more important than ever
- New models of care will need to consider how best to serve women:
  - Accountable Care Organizations
  - Medical/Health Home
  - Medicare/Medicaid Dual Eligibles