

**A PROFILE OF WOMEN'S HEALTH: AN AGENDA FOR CHANGE**

**A CAPITOL HILL BRIEFING SERIES ON WOMEN'S HEALTH POLICY**

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**WASHINGTON, DC**

**MS. CINDY A. HALL:** Welcome. I'm Cindy Hall, President of Women's Policy, Inc. We welcome you to this fifth briefing in our briefing series on Capitol Hill on women's health, and we are so pleased with such a terrific turnout.

Today's briefing is intended to provide a review of public policy priorities in several areas of women's health, as Congress begins its second session.

As we will hear today from our distinguished panelists, there are a number of critical health issues facing women, issues that we hope will be part of the Congressional agenda this year.

Before we begin the program, I want to extend our special thanks to our co-sponsors of the briefing today, Senators Barbara Mikulski and Olympia Snowe and their staff, as well as co-chairs of the Congressional Caucus for Women's Issues, Congresswoman Judy Biggert and Juanita Millender-McDonald, and their staff.

I also want to thank the Kaiser Family Foundation, our partner in this series, particularly Alina Salganicoff and Zoe Beckerman.

My thanks also to the staff of Women's Policy, Inc., particularly Mary Anne Leary, Jennifer Lockwood-Shabat, Sandy Zimmet, and Alicia Bond.

And, a special welcome to a number of Board Members from Women's Policy, Inc., who are with us today; Marie Bass, our Board Chair, Founder Lesley Persily, Founding Board Members Dr. Susan Wood and Congresswoman Connie Morella, as well as Nikki Heidepriem, Karen Judd Lewis, and Dr. Elena Rios. Welcome.

Just a quick note that our weekly news report on issues following action—Congressional action on women and family issues is now available online at no charge. Just go to our website, [www.womenspolicy.org](http://www.womenspolicy.org) to subscribe.

The Kaiser Family Foundation is webcasting today's briefing. It will be available beginning around 5:00 today at [kaisernet](http://kaisernet)—excuse me, [kaisernetwork.org](http://kaisernetwork.org). Please let your colleagues know that they can listen to the hearing, either today or whenever time permits.

And finally, please don't forget to fill out the yellow evaluation forms in your packets. They help us to determine briefing topics of future interest and, we appreciate your suggestions as well.

I am very pleased now to introduce a strong women's health advocate in Congress, Congresswoman Connie Morella, who chairs the Subcommittee on the District of Columbia, and served as Co-Chair of the Congressional Caucus for Women's Issues during the 104<sup>th</sup> Congress.

A nationally recognized leader in women's health, Congresswoman Morella's legislative priorities include HIV/AIDS in women, osteoporosis, breast cancer, and domestic violence.

Congresswoman Morella.

**CONGRESSWOMAN CONSTANCE MORELLA:** Thank you, Cindy Hall.

Boy, I—thank you. I'm in the enviable position of representing the women in the Senate and the women in the House and, as a member of the Board of Women's Policy, Inc., it's just such a pleasure to be here. And, wow! What a tremendous number of people who've demonstrated their interest.

I do want to thank Cindy Hall and Women's Policy, Inc. I always say I gave at the office because Cindy was my legislative director, and MaryAnn Leary was in my office as my press person, and Sandy Zimmet was a chief legislative person. So, you see, I really did. So they put me on the Board and say, okay, maybe that will satisfy you, Morella.

But, I'm please so many Board members are here and, thank you Marie Bass and all the Board members.

Also, the Kaiser Family Foundation. I've been pleased to have been at some of the luncheons that they have sponsored, and this, I know, is the fifth of the sequence. And, so thank you so much Kaiser Family Foundation for doing this.

And, I know some of the other benefactors and sponsors are here, too, and I hope that they will pick up the ball, too, as new issues come up that we all want to learn more about.

You have a tremendous program today, with Dr. Misra giving the kind of what I call the keynote. You've got a great policy panel that are here, too. And I know we'll all leave feeling very—very motivated and energized, because there is an electricity here with the sisterhood of people who are here assembled, who do care about the prescription for good health.

I want to share with you kind of my sense of optimism. You know, September 11<sup>th</sup> filled us with grief and anxiety and sorrow and anger, but also with a sense of resoluteness that, as a country, we were all going to work together. And, indeed, I think this has been happening. America together, recognizing what a wonderful country we have.

Also, our nation had to change its focus from improving the quality of life to protecting what we had. And now, as we begin the second session of the 107<sup>th</sup> Congress, I think there's a sense of renewal; a more of a determination to move forward as a great nation, particularly after hearing the President's address last night. I'm pleased that he did spend a significant part of that address talking about health and the importance of that.

We also know that, in his budget, he's going to be increasing the amount of money for the National Institutes of Health. Going to be fulfilling, as we understand it, that commitment that many of us have been promoting for years, and that is that, within five years, the budget of the National Institutes of Health would be doubled. And, with a 16 percent increase that would come about.

Let me just tell you a little story of the fact that Ark Linkletter appeared in my district several years ago at a retirement community, Asbury (sp) Retirement Community, to celebrate their 70<sup>th</sup> anniversary. I thought he was dead, but he's not. Very much alive and very, very active, and really was a big hit with the group.

But, he was talking about people living longer and, of course, we know living longer—women live far longer than men do. Not in Afghanistan, where their life expectancy is only 45 years for women and 46 years for men. But, in our country, over 100 years of age. Most of those Social Security recipients are women.

But, so he talked about the need for long term care and how assisted living and home health care and all, and the quality of life being so important in terms of health. And, he mentioned going to an assisted living complex, where they had a nursing home part of it—component.

Went into the nursing home and he was in Alzheimer's wards, and he went up to a woman and he said, "Do you know who I am?" And she said, "No, I don't. But if you go to the front desk, they'll tell you."

I say that because, if you can hold back the advent of Alzheimer's by five years, you can save over \$5 billion a year. And that's the same with all of the health, and that's why this forum today is so very, very important.

So, I'm pleased with that. The National Breast and Cervical Cancer Early Detection Program. The President also proposed a \$9 million increase for funding the National Breast and Cervical Cancer Early Detection Program, which would be administered by the Centers for Disease Control and Prevention. I think you know about that. I won't go into any of those stats.

Cindy mentioned the Microbicides Development Act of 2001. She didn't mention it specifically, but she mentioned the work on HIV and AIDS. We hope to get your support to pass that very important Bill, which is 2405, to enhance education, but also enhance the development and research on microbicides to empower women.

Genetic nondiscrimination in health and insurance. We all know something about that, and the tremendous need for making sure that we do not have discrimination which would affect the quality of medical research. And I represent “human genome alley,” pretty much, you know, with NIH and all of those genetic mapping and biotechnology firms along that particular corridor. And they have been impaired, in terms of doing further research, because they have the concern of the discrimination that is possible.

That Bill, incidentally, I’m the Republican co-sponsor of that. It has something like 256 co-sponsors. You think that’s enough for it to be able to come up for a vote?

Finally, I’ll just briefly mention the Women’s Health Office Act. Many of you have helped me enormously with all the legislation. But, that one in particular, many of you were pushing, to make sure that we have the permanency of the Offices of Women’s Health in so many of our federal agencies, five in particular, I know FDA and HHS and CDC, and many of the others.

I think it’s very important that we pursue those initiatives from breast cancer detection and eradication, promoting healthy behaviors, disease prevention, and make sure that they’re not passed over when we look at other issues.

So, I say to you today, I know it’s gonna be a very exciting session. I’m glad you’re here because, beyond this room, you will take what you have learned and use it in your own lives, but also use it in promoting what is best for the prescription for women’s health.

Finally, I want to introduce a staff person who’s just terrific, who follows these issues ever so closely. It’s Moira Shea (sp), and Moira is here. She was recently married but, before she was, she said, I have two beaus: the one I married and the dog that she has with her, Beau.

So, Moira, if you would just kind of be recognized here I’d appreciate that very much. Thank you very much, Thank you.

Thank you all very much. Go for it.

**MS. HALL:** Thank you, Connie, and we do look forward to working with you on so many women’s health issues.

I’m now pleased to introduce the Executive Director of the Jacobs Institute of Women’s Health, Martha Romans, who will introduce our next speaker and the Women’s Health Data Book.

**MS. MARTHA ROMANS:** Thank you. It’s really a pleasure to be here today. It feels like the baptism or the coming out party for the Jacobs Institute’s newest publication, the Women’s Health Data Book, co-published with the Kaiser Family Foundation. And, delighted with your interest in receiving it.

In addition to thanking Kaiser Family Foundation and Women's Policy, Inc., for holding this briefing, I want to say a special thanks to the Kaiser Family Foundation for supporting the project that put the Data Book together, and for Alina Salganicoff and Zoe Beckerman's involvement, which has been truly wonderful.

The Jacobs Institute of Women's Health works to make the healthcare system more responsive to women. And, one of the ways that we do that is through publications like the Data Book, that provide a comprehensive picture of the physical, the mental, and the social factors that affect women's health.

What's new about this particular third edition of the Data Book is really its expanded focus and the richness of data, that is now available on the different patterns of illness, the risk factors, and access to healthcare, among different subgroups of women.

We were able to provide, in this third edition, a much more detailed picture of differences by race, ethnicity, by age, by income, and by education.

The challenge in putting together a publication like this, as in the previous editions, was determining how to fit it all in. And we added 30 more pages, and I'm not sure how many more figures and graphs, but we had to make some crucial decisions. We think that you'll find it to be quite comprehensive.

We've tended to—we chose to focus on the conditions that are unique to women, certainly the reproductive health chapter emphasizes those issues. Conditions that both men and women share, but that are leading causes of illness or death among women. And, conditions for which there are different risk factors, or different treatments, or for which access to care is different for women than men.

We hope that you will find it to be an incredibly useful treasure-trove of information. I know from former days, working as a Capitol Hill staff member, you never knew from day to day what issue you were going to be dealing with. And I hope that you'll find you're able to turn to it, regardless of what's in the headlines on that particular day, and what speech you need to write for your boss, or what Bill that comes to your attention.

I want to give you the toll free number. On the back of the book, there is information on ordering additional copies. There's a toll free number for the Kaiser Family Foundation's publication hotline. It's 1-800-656-4533. If you require, or would like to receive additional copies.

I also wanted to mention that it's available on the Web and it's searchable on the Web by chapter. There's an index of all the tables and figures, so it's available at both the Jacobs Institute's Website, which is [www.jiwh.org](http://www.jiwh.org), and also at the Kaiser Family Foundation Website, [kff.org/women](http://kff.org/women).

And, in addition to the full text of the book there, there are copies of these three fact sheets. And, I know I worked for a member of Congress who said, put it on a three by five card. So these—this is the bulleted version. There are three of them. There's a fact sheet of overall highlights, there's a fact

sheet on women of color, and there's a fact sheet on adolescents. And, hopefully you'll find these useful. These, in addition, are on the Websites, too, so you can download and print them.

With that, I would like to introduce the woman who made it all possible, and that's Dr. Dawn Misra.

Two and a half years ago, when we started work on this project, and a fewer gray hairs ago, Dawn was an Assistant Professor at the Johns Hopkins University School of Public Health. She's now an Associate Professor at the University of Michigan School of Public Health. She holds a Ph.D. degree in Epidemiology from Columbia University, and we owe her an enormous debt of gratitude for pulling this all together. It's not easy, there were a lot of hard decisions to make, there's an enormous amount of information to review, and she really is the person who slaved through and got it right.

So, with that, I'd like to introduce Dawn Misra.

**DR. DAWN MISRA:** Thank you, Martha. I guess I would also like to thank the Kaiser Family Foundation and the Jacobs Institute of Women's Health for supporting this endeavor. In particular, I would also like to individually thank Martha Romans, who really stood by me through this whole process.

There's many, many people to thank, but we have an acknowledgments page in the book for that, and so I think I'm gonna get to the data for you.

I'm informed that one of our projectors isn't working and you do have the handouts with my slides in your folder, so you may want to pull that out for those of you who are sitting on the wrong side of the room, whichever that is.

Oh, they're on! Okay, good! Well, you can still enjoy them.

I'd like to hit the highlights. It would be fun if you all read it straight through, but that may be difficult and I want to tell you about some of the issues that we think are very important.

The first slide. This is just trying to give you an idea of the demographics of women by age. We've often thought about in the past of women's health in terms of reproductive health, and you can see from the graph, there are quite a few women in that reproductive health group of 15 to 44 years of age but, increasingly, we have more and more older women in this country, and that trend is only going to continue, particularly as baby boomers age. And so we need to also start thinking about women's health across the life span from the adolescents through older ages. Next slide.

This is a demographic slide that's going to show us about women's groups by age and race and ethnicity, and so we tried to break this down. You can see here that most women in the U.S. are still white. However, there are increasing proportions of women with minority background and, again, that's going to continue as we see census projections are for increasing numbers of women in proportion to women to be from minority groups.

We haven't shown poverty rates there, but we know that a lot of the reason that women of color have poor health is because of the higher rates of poverty and, throughout the book we have, as Martha mentioned, tried to show you the differences in women's health by poverty groups. Next slide.

This is showing the leading causes of death. What I wanted to focus on here was how things shift over the age groups, okay? So, if we start off with the youngest women, women 15 to 24 years of age, we have here the four leading causes, starting with accidents, followed by homicide, and then clearly drops down to cancer and suicide are the next two leading causes.

These causes are primarily related to women's behaviors and women's mental health. When I say behavior, some of you may not pick up on that right way. The accidents is obvious. But, cancer here is primarily cervical cancer, which has been basically proven to be related to an infection that women can get, a sexually transmitted infection. And so, women's behavior, in terms of safe sex and things like that, very much influences the risk of this cancer.

When we shift to women 25 to 44 years of age, cancer becomes the leading cause of death here, followed closely by accidents. And then heart disease starts to come into the picture. And then we reach this next group of women, 45 to 64 years of age on the right hand part of the slide, we have cancer as the leading cause, followed by heart disease, followed by cerebral vascular disease, which includes stroke primarily.

And here, we're now switching to causes that we've seen some concerning trends with in terms of women's health. Obesity has been rising sharply over the past four decades in the U.S. Smoking rates among young women are going up quite a bit, and these do relate both to the heart disease and to the cancer issues, smoking relating to both.

And then, finally, in women who are older, over 65 years of age, heart disease is actually the leading cause of death, not cancer as many of us like to think about it. And then, finally, cerebral vascular disease. Next slide.

Okay. I really like this graphic. It's always pretty shocking when I look at it. Rates of—death rates from cancer has generally gone down in almost every single cancer for women and for men. But there is one discrepancy here, and I think you can see a line that's sharply increasing, and that's lung cancer. Rates of lung cancer deaths for women have been rising. And this is a very concerning trend. Okay, next slide?

Okay, now in terms of reproductive health issues, these are the U.S. pregnancy rates, and we have them by selected age groups. Not every single age group is in here, but we have the age groups where there's some interesting trends.

Overall, there has been a decline in pregnancy rates recently but, the decline is really happening primarily among younger women, as women are continuing to defer the age at first birth. So, we're

getting an older and older women having their first birth. And so the rates have actually been rising in women over 35, and actually over 30 years of age also.

Now, the abortion rates are also going down at the same time as pregnancy rates are dropping, so it's bringing both—or bringing the rates down here. Next slide.

This is adolescent birth rates, which have also been dropping. So, these are not just pregnancy rates, these are birth rates, so it combines sort of the pregnancy issue and others. And they have been seeing quite a dramatic drop here. We still, clearly, any adolescent pregnancy is of a concern to us in terms of that young woman's future and the baby's, but they have been going down quite a bit in the last few years. Next slide, please?

Now, we have trends in contraceptive use, which of course relate to the pregnancy and birth rates. We have seen overall increase in contraceptive use occurring and, really, condom use has been increasing since 1988, which is a very positive trend that we're seeing.

There has been a decrease in the use of the pill or oral contraceptives in young women. And, that seems to be offset primarily by an increase in the use of implants. So, women using things like Norplant, and so we've sort of seen a shift in what younger women are doing for contraception.

Finally, the sterilization rates have increased dramatically for married couples in the past 20 years. And now, we have about a third of married couples are choosing sterilization as their method of contraception. Okay, next slide.

Sexually transmitted infections remain a critical problem for women. These rates, as you can see here, actually have women on the top and men on the bottom, are for chlamydia. Women are at much increased risk for chlamydia compared to men, and the rates have been going up for both women and men, but you can see that it's declined for women. Next slide?

AIDS, of course, is a sexually transmitted infection of particular concern to us, and has high mortality and morbidity rates associated with it. And, this is another area where women's health is probably not going in the right direction. We're seeing an increasing proportion of AIDS cases that are occurring among women. So, women are making up a larger and larger share of the AIDS cases in the U.S. We can see here, it's gone from 7 percent back in '86, to now women representing nearly a quarter of the cases of AIDS.

Death rates, women are also not doing as well. Men, we seem to have done a lot of improvements in terms of death rates from AIDS, but women continue to lag behind and not showing as much benefit from the new AIDS treatments.

And, finally, this doesn't represent, too, what's going on for minority women. African-American woman are disproportionately affected even more so than women over all by—from AIDS. Next slide.

We also wanted in the book to include mental health. We don't think of health as just representing physical health. We do have a chapter on mental health. And, we have here some data on what's called the "Lifetime Prevalence." So, this is your likelihood of having one of these conditions over the course of your entire lifetime, so not within a given year, but over the course of your lifetime, what women have.

You can see that, for many of these conditions, women are more likely than men to have them. Major depressive episodes, phobias, which are fears, generalized anxiety disorders, with over one in five women likely to have a major depressive episode in their lifetime. So this is not a small number and not a low rate.

The rates where men have higher rates of these things are in drug abuse and alcohol abuse. There are slightly rates in men for this. Next slide?

Continuing on talking about mental health a little bit. One of our interesting findings when we were taking a look at some of the data was about older women and mental health. There's not as much data on it, but what we noticed is that the suicide rate, if you compare suicide rates across age groups. In fact, the suicide rate is highest among the oldest women, women over 65 and older women have higher suicide rates than young women do.

And, the reason we also don't notice this is because the other leading causes of death, like cancer and heart disease, are so much higher than the suicide rate and it kinds of swamps it out and we tend not to look at it. But, it certainly is a concern.

We're also seeing very high rates of depression symptoms and suicide in adolescents, especially Hispanic adolescents. The CDC now does capture information on a risk behavior survey, where they've listed a lot of these issues and we have some data in the book about it. And there are very high rates, up to 30 percent, for Hispanic young women in terms of having thoughts of suicide and considering suicide. So this is another area of concern. Next slide.

Okay, now we're turning to the health insurance coverage issues. So, we've talked a little bit about what produces health and what the health issues. Now, we're talking about the access to care and what kind of insurance women have. And this slide has two bars, one for men and one for women, of trying to see what kinds of insurance women have compared to men.

And, you can see that Medicaid plays an important role. We have almost one in ten women is—are served by the federal Medicaid program, federal--joint federal state program. And, a significant number of women have job-based coverage in their own name, but you can see, as compared to men, not quite as many. So, there's a little bit of a shift. A lot of women do have insurance coverage as a dependent primary through—as a spouse.

And then, there are a number of women who are uninsured and that number is a little bit lower than men, primarily because of the Medicaid issue.

One concern we have about this area is that, with rising costs in the workplace, employers are choosing often to limit benefits. And, sometimes what they do is they don't remove health benefits from the employee themselves. What they do is they restrict the dependent care benefits, or raise the premiums on the dependent care benefits, which you can see would be primarily more of an issue for women than for men in terms of health insurance coverage.

And this is showing us some of the trends that were shown in those bars. And so, what we can see is there's actually been a decline in Medicaid—an overall decline in Medicaid coverage. It had risen for a while from '87. It has been going down some now.

And, it's expected to continue with the de-linking of Medicaid from Welfare, which is now—aid to a family with dependent children is no longer there and there's been the temporary assistance with needy families, which is not connected to Medicaid anymore, so we expect to see some declines in—continuing declines in that.

And, the uninsurance rates have been trending upwards. You can see they actually were at 13—a little over 13 percent in '87 and now they're close to 20 percent. Next slide.

Another look at Medicare. So, that previous slide actually is focusing on women from 18 to 64, but women over 65, Medicare is the major player. And so we're looking at what the costs are for women who are on Medicare. We know that Medicare doesn't cover everything, and so there's out-of-pocket spending. And what you can see from this slide is that women spend a larger proportion of their income on out-of-pocket healthcare costs than men do in this group of Medicare enrollees.

And then it's particularly acute in vulnerable women. So, in the oldest women, which are women over 85, women who have an activity of daily living limitations, or some kind of a chronic health problem that limits their activity, they're more likely to spend even more—a higher proportion of their income on those costs.

And, if you're poor and you don't have any supplemental insurance to cover with Medicare, 43 percent are spending on out-of-pocket spending, or a proportion of their income. Next slide.

So, I want to finish up with some conclusions. First, I want to talk about the data. We've made some conclusions about where women's health is, but I want to talk about where the data are.

Martha had mentioned there is quite a bit more data available now than there was when the previous edition of the book was done. And, a lot of this is because of people who are in the audience who really pushed, I think, to get better data on women's health because we can't see where we're going if we don't know where we are. And, there are some areas where there have been tremendous improvements.

And, the first one I'm gonna highlight is in adolescents. The CDC does do an annual survey now on youth, and it really collects a wealth of data on adolescents. And, I think when we talk about women's health, we need to think about adolescent girls. And I think that the foundations of health are there and so having that data is critically important.

And what we've seen is young girls are increasingly, especially young white girls, taking up smoking, which is a major concern. Mental health issues, as I mentioned, are a big concern. So I think having that data is a tremendous improvement that the government has made.

The other area where there's been a big improvement in data is in violence against women. When we were able to do this chapter in this go around, we came up with quite a bit more data because there are now two special surveys that are helpful.

There's a National Crime Victimization Survey, that the Department of Justice administers. It's for both men and women. But, it provides detailed information about crimes that are not necessarily reported to the police, which picks up a lot of women's issues in that survey.

And there's also a National Violence Against Women Survey, that's being conducted now that supplements that even further, and they are considering repeating that survey. These are two important government initiatives that have given us a lot more data about women's health in this area.

There are challenges that remain. The mental health data are extremely old. We really need more current mental health data for women and for men.

Arthritis, which is a major issue for older women, we have very few current data on, and we really are concerned about the lack of data there. And then chronic reproductive health conditions, which include things like fibroids and endometriosis that don't kill women, but affect their quality of life. There's very little data but, again, NICHD has made efforts to try to increase that.

So I want to end with—next slide—conclusions about women's health. Women's overall health is difficult to assess, but where we have seen improvements and where we have areas of concern.

The improvements are, I think, the cancer survival rates have improved for every single cancer just about, except for lung cancer. But I think, again, that's an issue of changing behaviors by women. The cardiovascular disease risk factors. Hypertension and high cholesterol levels have dropped. Now, obesity has been climbing, but those other two risk factors have been declining quite a bit over the last several decades.

And homicide of intimate partners has gone down a little bit. That's not to say that domestic violence is not a problem. That is the most severe form of domestic violence, but we are seeing declines in that for women and for men. And challenges remain. I have a lot of concern about the obesity rates in the U.S. and diabetes rates, particularly for women. Smoking, especially in adolescents, mental health in adolescents, and finally access, utilization and quality of healthcare for women in the U.S. is of concern.

Thank you.

**MS. HALL:** We're going to have a little changing of the guard here.

Thank you so much, Dawn, for your wonderful presentation.

I am now going to turn it over to our moderator for the public policy panel, Dr. Alina Salganicoff, Vice President and Director of Women's Health Policy at the Kaiser Family Foundation.

**DR. ALINA SALGANICOFF:** Thank you, Dawn. You did really a great presentation, and you did a terrific job setting us up for the policy discussion. If we could just figure out--. It's a very tight squeeze here. We didn't have a chance to rehearse the choreography for this.

As is clear from Dawn's presentation, there really are multiple dimensions on women's health, so many that it's really difficult to know where to begin in our effort to improve women's health and their well-being.

In order to fit into a lunch time briefing, we had to limit our discussion to three topics. As you can imagine, the decision was not an easy one. After careful deliberation, we settled on reproductive health, mental health, and coverage and access.

We wanted to be responsive to many of the comments that we had gotten from you on earlier briefings, and also wanted to be relevant. And, one of the comments that we got was that you wanted information on issues that were on the Congressional agenda. So, we really tried to focus on that.

If there are other issues that you think we should focus on at other briefings, I really want to encourage you to let us know by filling out the yellow evaluation forms, and let us know the topics that you want us to cover.

What we're hoping to accomplish in our discussion panel today is to really focus on some policy issues that are really very alive on the Congressional agenda, that are important to women, issues that we sometimes don't think of as women's health issues.

TANF reauthorization, mental health parity, Medicaid coverage, Medicare prescription drugs. They may not be immediately obvious as women's health issues, but the impact of the changes on these programs and their policies will have a large and, in some cases, a disproportionate impact on women.

To help frame our discussion, we've invited three leading policy experts on these selected dimensions of women's health. We are extremely fortunate to have with us today Dr. Wendy Chavkin of Columbia University, Dr. Gwen Keita, of the American Psychological Association, and Sheila Burke, Under Secretary of the Smithsonian.

In the interest of time, I'm gonna skip their very impressive bios, but they are actually included in the folders and I encourage you to take a look. I'm also gonna ask that you hold your questions until all of the discussants have had time to present their remarks. We've left enough time at the end of—at the end to really have an open discussion on these issues.

To start us off, our discussant, Wendy Chavkin, will raise key issues in reproductive health. Dr. Chavkin is Editor-in-Chief of JAMWA, the Journal of the American Medical Women's Association, and Professor in Clinical Public Health and Obstetrics and Gynecology at Columbia University.

Most recently, Dr. Chavkin has been conducting research on the health implications of the 1996 Welfare law on women—looking at the health implications on women and children.

Clearly, the reauthorization of TANF, with its focus on reducing pregnancies to unmarried women, reducing teen birth rates, and targeted funding for abstinence-only sex education has far reaching reproductive consequences, particularly for low income women.

Wendy, I know you're gonna have a lot to say on this issue.

**DR. WENDY CHAVKIN:** But only a little time, so I'll try to behave under those circumstances.

While the population is aging, as Dawn pointed out, at the current moment, the majority of U.S. women are still of reproductive age. Over the past couple of decades, there have been some really dramatic changes in the profile of Americans that I would really like to underscore for you today.

The first is the dramatic rise in labor force participation by women and, particularly, by young women. More than two-fold since the 1950s and, now, two-thirds of women with preschool age children are working in the paid labor force.

The black/white educational gap is narrowing regarding high school education, but Hispanic women are still lagging far behind.

The male/female wage gap is still persisting. Women now earn about 76 cents to the male dollar, as opposed to 73 cents, which was the previous. And a significant income and wage gap continues to persist along racial and ethnic lines.

Age at marriage and at first birth are now delayed, and there has been a big increase in single parent families, most of which are headed by women. This is largely attributable to divorce, although secondarily to an increase in out of wedlock childbearing. And poor women have responsibilities for taking care of both old and young sick family members at a disproportionate rate, compared to women who are better off.

As Dawn mentioned, both pregnancies and birth rates are declining. This is dramatically true for teenagers and, very importantly, most true for black teenagers. Births and pregnancies are also

declining for women in their 20s and, as Dawn mentioned, increased for older women, particularly—here we can see again, some of these income and racial differentials that so permeate American society. It is white, college educated and more affluent women who are having babies in their late 30s and 40s. In fact, more than half of college educated white women are now having their first births after the age of 30.

Contraception. Female sterilization continues to be the number one method in the United States and is increasing, followed by oral contraceptives. I'd like to underscore for you that condom use has been increasing, particularly by younger women, women in their 20s.

Yet, despite all this good news about how much everybody's contracepting, more than half of the pregnancies in the United States are unintended, and about a third of the births in the United States are unintended.

About half of this group of unintended pregnancies end in abortion although, again, as Dawn mentioned, both—abortion rates for every age and racial ethnic group have been declining.

The United States, unfortunately, continues its very poor international showing regarding infant mortality and we continue to have a black infant mortality rate that is double that of the white. What people are less familiar with is that our pregnancy associated mortality rate, known as maternal mortality, not only has been at a plateau and, again, compares poorly to other highly developed countries, but the black/white gap there is four-fold.

To date, the only interventions that have been demonstrated to narrow this gap are access to contraception and legal abortion. This black/white maternal mortality gap intensifies as women get older, as black women continue to bear a disproportionate burden of chronic illness, like hypertension and diabetes, that increases with age.

The bad news continues along these patterns having to do with race, ethnicity, and income, when we take a look at sexually transmitted disease and HIV. These same patterns prevail, with black women and poor women at the most extreme risk. And, something that I must underscore for you is that it is young women of minority status who are particularly at risk for HIV, and whose infection rates have been rising.

So, American women are working at the same time as they're having young children, yet income gaps persist by race and by gender. Age at marriage and first birth are delayed. There's an increase in single parent households, an increase in divorce, and an increase in out of wedlock childbearing.

A sharp decrease in fertility, which is most pronounced for teenagers, and the only group with an exception to this is that older affluent group, who are having very delayed births.

While the majority of U.S. women use contraception, at least somewhat, we still have about half of our births are unintended. And, as I've said, racial and ethnic and income patterns persist for risk for HIV and STDs for infant mortality and for maternal mortality.

So what does all this mean in terms of policy? Well, the dramatic changes in reproductive child bearing and family formation behavior are long term trends. They've been going on for decades and they characterize all of the highly developed world. In fact, countries that are going through development processes are following suit.

Along with these trends are increases in women in paid employment and these declines in fertility, high rates of divorce, and out of wedlock childbearing. I think it's very important to understand the long term and highly prevalent nature of these trends, so that we can design policies that might be effective and avoid policies that we can predict will be ineffective.

For example, since Alina mentioned that I've been doing work around Welfare reform, there have been several policies within that legislation that were designed to reduce out of wedlock childbearing, like the Illegitimacy Bonus, a policy which was designed to give states rewards for decreasing their out of wedlock childbearing rates, without an increase in abortion. This—and it's meant to go to five states.

This year, they could not even find five states to give the award to, and ended up giving awards to states that showed less than a 1 percent decline because, while all the rest of the states have continued these patterns of increases.

The Family Cap is another program in the Welfare Bill designed to discourage childbearing by women receiving benefits by not giving benefits to any subsequently born children. Those studies evaluating this have shown that they have not been effective. But, what has happened is that we have tens of thousands of children living in families with lower per capita incomes.

So, in—I would like to end by saying that we should concentrate on increasing access and knowledge and successful utilization of contraception, particularly for those at highest risk of adverse outcomes. And I have two specific suggestions.

One is comprehensive education regarding STD and pregnancy prevention. I would say that abstinence-only education has to be understood to be dangerous in the face of the life threatening differentials in mortality associated with pregnancy and with HIV, imperiling the lives of young women.

Also, I would urge that we consider policies to make sure that contraceptives are covered in people's health insurance plans which, currently, half of plans do not cover. While the states have shown some leadership in this regard, about a third have put into place some kind of policies, legal precedent and the Equal Opportunities Commission, Employment Commission, have determined that failure to mandate that contraceptives be covered constitutes gender discrimination. I would suggest that it also constitutes a grave public health risk.

So, in sum, I urge that we try to concentrate our policies so that we help American women and men live well in these new realities.

Thanks.

**DR. SALGANICOFF:** Thank you very much, Wendy.

Next, we're fortunate enough to have with us Dr. Gwen Keita, who's the Director of Women's Programs—the Women's Programs Office at the American Psychological Association. She's gonna discuss the public policy implications and challenges of key mental health issues that are facing women.

As we heard from Dawn in her presentation, women are disproportionately affected by depression and other mental health conditions. They need adequate coverage for treatment, for prevention, and a delivery system that can meet their need. And Dr. Keita's gonna tell us more about this important issue.

**DR. GWENDOLYN KEITA:** Good afternoon. Let me first start by thanking the Henry J. Kaiser Family Foundation and the Women's Policy, Inc. for inviting me here today to be a part of this very distinguished panel on women's health.

I would also like to commend the Foundation and the Jacobs Institute of Women's Health for their collaboration on the Women's Health Data Book, and for including chapters on both mental health and health behaviors.

My brief remarks will focus on the importance of mental health and its contribution to overall health, the need for increased access to mental health services for women, increased funding for women's mental health at the National Institutes of Health, and increased funding for education and training programs for mental health providers, and for health services at the Substance Abuse and Mental Health Services Administration.

Mental disorders are indeed a critical and costly problem facing the United States and the world; a problem whose pain, disability and suffering is largely underestimated. And you saw some of that from the stats that were presented earlier in the program.

A major report on the global burden of disease by the World Health Organization, the World Bank, and the Harvard University School of Public Health, underscored this problem when noting that 5 of the 10 leading causes of disability worldwide were mental health conditions. For women, depression was the leading cause of disease burden in both developed and undeveloped regions.

Approximately one in five women will experience an episode of major depression during her lifetime, and women are at least twice as likely as men to have a major depressive episode.

Significant personal costs are associated with depression, including life lost by suicide, increased morbidity from medical illness, and attendant risk for poor self care, and reduced adherence to medical regimes.

Major depression, even without concurrent medical illness, impairs social and physical functioning; in some cases, more severe than serious medical conditions such as hypertension, diabetes and arthritis.

Depressed individuals utilize the health system more than their non-depressed colleagues—or counterparts. Parental depression has costly consequences for children. For example, offspring of depressed parents have a significantly increased risk for major depressive disorder and anxiety disorders, and markedly poorer overall functioning, as well as increased risk of general medical problems and psychiatric hospitalizations.

Depression also incurs a significant economic burden, resulting from disability and consequent loss of income.

Serious adverse life events, such as child abuse, domestic violence, and other forms of violence, including terrorism, are clearly implicated in the onset of depression. And women are three times more likely than men to experience depression in response to stressful events. So, as we think about the aftermath of 9/11, it is important to consider the particularly heavy burden of our nation's women.

It is not surprising then that poverty has been linked to higher rates of depression. Poor adults are twice as likely to experience new episodes of major depression as adults who are not poor. The events of 9/11 are also adding to the numbers of the poor, largely through the increasing rates of unemployment. Unemployment over the past months has disproportionately affected women, especially ethnic, minority, and low income women.

With the change in demographics of American society, there was increasing concern about minorities' women's rates of depression. Although ethnic minority women experience rates of depression comparable to white women, ethnic minority women are at greatest risk of not having their depressions recognized. The dearth of culturally competent professionals, and also of research addressing the efficacy of successful treatments for ethnic minority women, continues to be a concern.

So that my talk doesn't totally depress everyone here, let me quickly add that there are effective treatments for depression, and for most of the other mental health conditions. Unfortunately though, many women never receive treatment. The number of women seeking care represents only a portion of those who are depressed and, even when depression is recognized and care is sought, a range of barriers can impede women from receiving the treatment they need.

In addition to stigma, which we have heard quite a bit about, financial barriers are a major problem. The financial burden of mental healthcare is one of the most significant factors affecting women's access to, and utilization of, mental health services.

So, what can we do? What can you do?! You can pass the Domenici-Wellstone Parity Bill. This legislation would require private health plans of large employers that provide mental health benefits, to do so without arbitrary limits that are not also used on medical/surgical benefits.

You can enact patient—a Patients' Bill of Rights. Legal accountability and health insurance reform would ensure that patients receive quality care and that managed health plans are held accountable for their actions. If passed, health plans would no longer deny needed mental healthcare without fear of being liable for a significant monetary damages.

We can also increase funding in appropriations for women's mental health research at the National Institutes of Health, especially for (inaudible) populations of women, including ethnic minorities, lesbians, adolescents, older women, and pregnant and postpartum women. And increase funding for education and training for mental health professionals, and for services at the Substance Abuse and Mental Health Services Administration.

We can indeed reduce the burden of mental health in America—of mental illness in America, and improve the lives of millions of women and their families. We have the tools, we just need to put them to use.

Thank you.

**DR. SALGANICOFF:** Thank you, Gwen. I'm glad you gave us some things to do, because it was getting a little—depressing.

Next we are incredibly lucky to have with us a leading national expert on health coverage and access issues, Sheila Burke. The fact that it's hidden by her current title as Under Secretary for American Museums and National Programs at the Smithsonian.

Sheila spent many years working on the Hill, many of them as Chief of Staff to Senate Majority Leader Bob Dole. Most recently, she was Executive Dean at the John F. Kennedy School of Government at Harvard.

Sheila's gonna highlight for us some of the health policy challenges in improving health coverage and access for women.

**MS. SHEILA BURKE:** Thank you very much. As in fact, someone who spent 20 years on the Hill, I'm watching the clock for all of you staff types, and I'm gonna run through this fairly quickly and leave, hopefully, some opportunity for us to talk.

Let me also join by—in thanking the Jacobs Institute and the Kaiser Family Foundation for bringing us all here together. At full disclosure, I'm on the Kaiser Board, so I'm just happy as punch that you're all here today.

But, also because I truly believe that the opportunity to have the information that we have before us, and the extraordinary work that Dawn did on the fact book. For anyone who has to live in a data-demanding world, that we all do, and produce information that allow our bosses to make decisions, it is this kind of information that make our lives much easier. So my thanks to all of them for the fine work that they've done.

Dawn sort of completed her initial comments by touching on the issues of coverage, and it is that issue that I am going to return to for a few moments, and talk a little bit about access and coverage. And I'm gonna basically talk about three things: One, the nature of the challenge that we face; secondly, why it matters, why it is that we care about coverage, what difference it makes in people's lives; and then, finally, on some of the solutions that are at least in play of things that we talk about in these issues.

The challenges are not—are not minor, in terms of the coverage issues. They are ones that have bedeviled us for years. Those of you who are as old as I am, have been around many times over this debate over coverage and issues over the last few years.

Access to coverage is a challenge for millions of women. While most women in fact obtain coverage, as we find from the [Data Book](#) and information available to us, through either themselves through their employers, or through their spouses' employers, a significant share of women remain uninsured.

Nearly one in five non-elderly women, and most of my comments will in fact be focused on that specific group, because Medicare in fact has done such an extraordinary job for women over the age of 65, but for essentially one in five non-elderly women are, in fact, uninsured.

That is essentially about 18 percent of that population, 15.2 million individual women in that age group. Those at greatest risk for uninsurance are in the age group of 18 to 29. They are predominantly low income, those under the age—under the poverty line, 200 percent of poverty line.

And they are uninsured at a rate that is in excess of three times as great as non-poor women. So that the focus of much of our interest and activity and concern are, in fact, on women in a particular age group, as well as within a particular economic group.

This group are likely to be single, parents, they are largely low educational attainment. They are largely women of color. They have poorer health and they have less access to care.

So, as we examine the solutions to address this particular issue, we need to keep an eye on the factors that are predictive in terms of those who are at greatest risk. It is age, it is income, it is race, it is ethnicity, it is family structure, and it is work status.

Changes taking place in both the public and private sectors have had, in fact, a real impact on access to care and coverage. Certainly, the increasing cost of coverage that we've all seen, in terms of increasing health insurance premiums, have led to an erosion of the employer-based coverage system or, as has been suggested, the reduction in the coverage that is offered to employees, either dependent coverage,

or the kinds of services or a dramatic increases in out-of-pocket costs that are expected either with respect to premiums or with respect to cost sharing.

It has clearly had a dramatic impact on those workers who are lower income, who are at greater risk of not having had coverage offered. But if they are in period of time with an economic downturn, they are very often the ones that are first to be affected in terms of the retrenchment of employer coverage.

The current economic downturn that has led to the discussions about issues of unemployment, and issues of coverage that we've seen debated in both the House and Senate, suggest to you that it is in fact a growing problem in terms of the number of individuals who will be exposed, and women are at particular risk.

Clearly, the increase in private coverage to deal with the issues of the uninsured that we face today is unlikely in the short run.

On the public side, we have also faced real challenges in terms of coverage. Medicaid enrollment has, in fact, fallen. For essentially, largely attributed to the changes in Medicaid that resulted from the changes in Welfare coverage that occurred in the '90s that we just discussed.

Clearly, the direct impact of the break between cash and the receipt of essentially coverage, that is that linkage between what was the old AFDC program and the Medicaid eligibility, the break in that automatic linkage had a dramatic impact, and one I think that in fact was not anticipated at the time to be as deep as it was. As someone who was present during the discussions that took place.

But, further complicating that picture, which has already been difficult in the last few years, is the economic downturn that many states are facing. And we are increasingly beginning to hear from the states and from governors about their desire to retrench on their existing programs, let alone the question of expanding those coverage.

A great deal of the discussion today around the issues of labors. For example, when desire of many states to have access to increased waiver authority under their Medicaid programs are not necessarily for the opportunity to expand that coverage and to broaden the base which, in fact, was some of what we've seen in the last few years. The attempt to reach out to families and to other youth. But, in fact, to have the opportunity to retrench on coverage.

And, again, I don't anticipate in the near term that trend changing. Again, as the states are across the country seeing real issues in terms of their budgets. And, as we all know, Medicaid of course is one of the single largest aspects of any state's budget and, as pressure grows, clearly there's a desire to reduce that.

The Medicare, of course--Medicare, of course, is also quite critical. It does not have the challenges in terms of eligibility changes, but it has clearly had the challenges in terms of the breadth of coverage, but chiefly with respect to the coverage of drugs, and in respect to the coverage of long-term care in terms

of the need for these individuals, the pressure in the budget side is prevented increases on those sides, which are particularly relevant to women, which I'll touch on in a moment. But why it matters, the importance of coverage is pretty well documented.

Can I have that—you flew right past it.

As is evidenced on the slides that's been up before you, there are clearly impacts on the access of coverage to whether or not people actually access care. It has a direct impact on whether they seek out care, whether they have regular doctors visits, whether they've had clinical breast exams, and whether they've had pap tests.

So there is clearly a linkage between coverage and access to care, and the presumption that the absence of insurance has no direct impact has clearly been proven not to be the case.

In terms of sources of coverage, it is quietly—quite patchwork. Job-based coverage, obviously, covers a large number of women, about two thirds of the non-elderly. Medicaid covers about 8 percent of the non-elderly, but a disproportionate share of low income; 23 percent of low-income women are covered by the Medicaid program.

Individual coverage is really the protection for a very small number of women, about 4 percent. And, of course, Medicare coverage, in excess of 90 percent of the population over the age of 65. Employer coverage is critical, but it is under siege, as I've noted, for a variety of reasons, but again, remember my earlier comment about the retrenchment that's likely to occur.

So we turn to, in my final paper, are the issues of the presence of the public programs as part of this solution. Clearly, in the case of Medicaid, it has played an enormously important role, as evidence on this slide. You can see that Medicaid has an enormous presence among women because of the way it is targeted. What this story doesn't tell is who's not taken care of by Medicaid.

So, not only is there a question of retrenchment of coverage, but it's the people that are not already protected and they are largely singles and childless couples. So women, irrespective of whether they are very low income are not picked up by the program, unless they are in a particular targeted category and have children, are pregnant.

So Medicaid is enormously important as we look at this program in terms of its contributions. Its role for women is quite evident in terms of the number of women it currently covers, the wide range of services that it covers as well, as well as clearly improving access to physicians and preventive services.

Medicare, as well, is enormously important, particularly given the underage cohorts. As is mentioned, the number of women, as we go up in the age range, clearly increases as a dominant in terms of Medicare. But again, the Medicare challenges that we face in terms of the absence of certain services has a real impact on its value as well. And here we see in terms of prescription drug ranged by gender,

increasingly women are actually dependent upon this program to finance those services and, in fact, it's not available in all cases.

And then finally, an example of the impact that women have on the system, and the needs that we have is the distribution of nursing home residents and home health users by gender. Again, not surprising, given that the fastest growing age cohort that we see are those over the age of 85 (inaudible) and they are predominantly women.

So again, as you look at solutions to the problem of coverage, access matters, coverage matters, and the principle solutions in the short-term are likely to be the public financing programs as we see challenges on the coverage front on the private side.

**DR. SALGANICOFF:** Thank you, Sheila. Thank you all the panelists for really a wonderful series of presentations.

We have a few minutes left and maybe we can stay a little bit later. Of course some questions. I would ask, if you have a question, if you could please just come up to the mic. Also, people will be milling around. Staff members will be—if you have questions on cards.

**MS. PAULA CABSIRE (sp):** Hi. My name's Paula Cabsire. I am representing the Women's Health Coalition.

I just wanted to comment that, Dawn, if we were—as many of the speakers have said, it's very depressing to hear these kinds of statistics and if we were hearing about these kinds of statistics in a third world county, then we would say, of course there's a high rate of depression among women.

And, I just—I would just like to suggest the following, that what we've heard about today is that women are still being oppressed in all kinds of ways, financially, socially, I'm sure one of the reasons that there's so many fewer men in nursing homes and getting home healthcare is because women are taking care of them at home, like so.

So we've got—and still got all this oppression of women in various ways leading to understandable depression. But then what happens is, we send women who are insured to see psychotherapists who put them on drugs, or who talk about how their mothers messed them up, instead of talking about how to get rid of the sources of oppression of women so that that depression won't develop.

And so I think more education of what's really needed from mental healthcare providers is really important.

**DR. SALGANICOFF:** Okay. Thank you very much.

**MS. DIANNA ZUCKERMAN (sp):** I'm Dianna Zuckerman with the National Center for Policy Research for Women and Families.

Two of our speakers talked about the link between healthcare and welfare reform and, Gwen, you didn't. I don't think you mentioned it, but we do know that a lot of women who are having trouble finding jobs in the welfare system are depressed, or have mental illness, or have chronically ill children, or some other issues that are related to that.

So, I wondered if any of you had any recommendations pertaining to the reauthorization of welfare reform and the implications of what changes might be helpful for women's health?

**DR. KEITA:** Let me just say that I didn't mention it because we had eight minutes.

**DR. SALGANICOFF:** It feels that we could've done one session on each of these topics.

**DR. KEITA:** But, I think that is an extremely important point. When you think about the fact that about the bottom one-third of women on welfare are unable to move into these jobs because of their mental health and substance abuse problems. These women are going to have to be able to get treatment, have to be given time and, also, that will help them be able to probably move into other jobs, but they are going to need support when they have those jobs.

**DR. CHAVKIN:** Can I answer that, Alina?

We've been actually taking a look at precisely this question, with a focus on women who have chronically ill children. And, I think that there are many opportunities in the reauthorization process to try to address the fact that there are going to be a group of women who have long-term problems, and that they either are going to require exemptions or special safety net provisions, because they cannot become self sufficiently employed in the current time limit.

We've also found that this group is concentrated, not only amongst those women who are not leaving TANF, but we're finding that they are also appearing in those people who are applying for TANF.

**MS. ZUCKERMAN:** Okay. Thank you.

**UNIDENTIFIED WOMAN:** Hi. I'm with Congressman Barbara Lee's office and, to sort of piggyback on talking about one of the issues in welfare reform. We've just introduced legislation, which is HR3469 out the Family Life Education Act that would overturn, effectively, the absence only until marriage provisions.

Can you talk a little—with—why HIV rates, especially amongst young women and young girls. Can you talk a little bit about how comprehensive approaches in schools to get children at a younger age can help to decrease HIV/AIDS, teen pregnancy, other STIs, etc.?

**DR. CHAVKIN:** I don't know that they're going to reduce teen pregnancy, because teen pregnancy's been dropping for a long time on its own. Something I really want people to understand. It's a long-term trend.

The evidence to date, and I'm happy to provide you with sort of citations afterwards, are that the only programs that seem to have an effect on the host of parameters you outlined are those that provide comprehensive sex education, along with the other stuff like after school programs and educational opportunities, etc. You need both pieces.

**DR. SALGANICOFF:** Any other questions? I have some written ones here.

I guess this one is for Sheila. Where do you see possible common ground for addressing the problem of the uninsured?

**MS. BURKE:** I actually think we saw the, sort of stars align when we saw the passage of CHIP. And, it was really the identification of a group of people who were viewed as being particularly vulnerable.

There was some sensitivity as to whether or not we essentially chose one low-income group over another as being more worthy than another. But I think the areas of opportunity are where there seems to be some interest in commitment to particular populations and increasing coverage, both on the public and private side.

I think an opportunity for a program that has both a private sector solution, through the use of some tax incentives, whether they're credits, refundable credits, or vouchers, along with a response that deals with the very low-income population, for whom those solutions don't seem to make sense.

So building on the public programs, whether it's on CHIP or whether it's on Medicaid, there are obvious populations. The parents of children that already covered, the siblings of individual children that are already covered, and essentially moving them in by expanding in terms of the age groups.

But, I think the solution comes by a combination of public and private sector solutions, and not assuming that a single private answer will solve the problems of those populations, nor a single public financing program.

I don't think starting with universal national health insurance in today's environment is a likely solution, but one that acknowledges the concerns on the left with respect of public financing, and the concerns on the right with respect to the access to the tax code. I think it's a place to start.

**MS. ILENE LONGSTREET (sp):** My name is Ilene Longstreet. I'm actually here because of my own interest in women's healthcare, but I happen to be with the Business and Professional Women USA here in Washington.

I have sort of an observation and then a question at the end.

What I heard today said that predominantly, or disproportionately, women have responsibility for performing the contraceptive act as it were. Women are disproportionately getting—taking the lead in becoming sterilized. Women are being paid between 23 and 26 percent less than men, depending on which study that you read. Two-thirds of the women who are—have children who are pre-school age are in the work force, and women are disproportionately living in per-capita households.

Because of that, I can certainly as a woman understand why women would be anxious, depressed, and committing suicide. But, what I am wondering is what is driving all those men to drink twice as much and to abuse the drugs. Because I just can't see what the big problem is.

My real question is, this is sort of related to health because, in my opinion, and I'm speaking for myself, women who work and take care of the children, and take care of the family, and take of, in my case, four 80-year old aunts and a mother, who are all in various states of decline.

I also know that it is still legal by federal law—it is still legal for me, not that I would be, for me to be asked about whether I intend to have any children, whether I do have any children at home, and what my marital status is in a job interview.

I had no idea that federal law had not ended that process and yet it has not. It has said you cannot discriminate against women based on sex or age or race or pregnancy, but it does not preclude an employer from asking you your marital status, nor does it preclude your being asked about how many children you have at home and your daycare services, or whether you're intending on having any. It just says they can't discriminate against you. But you can't prove that they're asking men the same question.

This just recently came to my attention and I would be interested to know from anyone in the room who's representing a Congressman or a Senator, or any other person who has knowledge of this, if there is the potential to close this gap in the law that indeed discriminates against women?

**DR. SALGANICOFF:** Clearly, by the murmurs across the room, it kind of came as a shock, I think, to a lot of women in here.

**UNIDENTIFIED WOMAN:** I will tell you that, in federal law in the Civil Service Act, it is—the federal government is not allowed to do it, but it's all right for the private sector to do it, however.

**MS. NIKKI HEIDPRIEM:** I'll take a shot at that. I think it is not that it is legal to ask those things, it is illegal to discriminate if you are asked those things and then don't get the job, then that's evidence that you can use in a lawsuit that it was discrimination. I don't know that it's per se legal to ask those things, but those are certainly pieces of the case that you would make. So, I think most employers that I know do not ask those questions.

**MS. LONGSTREET:** I would agree with that. Most employers don't, but many, many do and the problem is, is that you cannot prove—you cannot prove that men are not being asked the same questions because they—you have no access to their interview. And this is going on across the country.

**MS. NIKKI HEIDPRIEM:** You would have access to their interview forms if there is a paper interview and you sue, then you do have access through your discovery and you would find that out.

**MS. LONGSTREET:** That's true but, in real life, it's just what gets asked during the interview.

I just pointed out that there is enormous potential for this to occur everywhere in this country in—outside of public service.

**DR. SALGANICOFF:** Okay. Well, thank you.

We're going to take one final question. Willamena?

**MS. WILLAMENA LAY:** I'm Willamena Lay with the Joint Center for Political and Economic Studies. I have a comment, and it relates more to welfare reform than to the health discussion that we've been having.

Most states' welfare rolls were dominated by white women back in 1996 when the welfare reform was passed. At present, most states know they're dominated by women who are not white, meaning mainly black women, non-Hispanic women, Hispanic women, other non-white groups of women.

And, the point that I would make here is, in thinking about who authorizes welfare, we have to be very careful that we don't get caught up in the (inaudible). The euphemisms that we tend to fall back on when speaking about racial ethnic groups of women, especially women who are getting assistance from the federal government, that some people may think they should not be getting.

**DR. SALGANICOFF:** Thank you. An important thing to recognize.

I really want to thank Dawn for doing a fabulous presentation and for putting together the Data Book. It was a real pleasure to work with her in putting it together. I'm very appreciative of that.

And I'd also like to thank our excellent panel. We've really had—I wish we would've had a little more time. Maybe next time we'll dedicate an afternoon to these topics.

Thank you. It's been a great session.

And please fill out the yellow evaluation form. Thank you.

END

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