REMAPPING DEBATE
Asking "Why" and "Why Not"

Women as second-class (health) citizens

Original Reporting | By Mike Alberti | Gender equity, Health

June 13, 2011 — As Remapping Debate recently reported, new findings show that life expectancy for women has declined significantly in hundreds of U.S. counties over the course of the last generation. That trend is leading many to ask why so many states fail to put basic public health measures in place, especially since the absence of those measures — often thought of as "gender neutral" — exerts a profoundly negative and disproportionate effect on women.

> A professor of community health and social medicine said that numerous states have failed to adopt a variety of "basic" programs that have been shown to improve health outcomes.

"The lack of a range of programs, from smoking cessation programs to food access to insurance eligibility, falls harder on women," said Judy Waxman, vice president of health and reproductive rights at the National Women's Law Center (NWLC), a women's advocacy group. "So do cuts in those programs where they do exist. These are public health issues, and they are also very much women's issues."

While the Patient Protection and Affordable Care Act (ACA) includes several provisions aimed at improving public health in general and women's health in particular, most states have also cut their public health budgets since the recession began, including some — like Oklahoma, Tennessee, Missouri, and Louisiana — which consistently report poor health outcomes for women. And in many places around the country, efforts to increase funding for public health programs have come to naught. Even proposals that would cost the government nothing but would have a proven public health benefit— such as tobacco bans — have stagnated. In the face of these developments, many public health experts are worrying that things may get still worse for women.

A disproportionate effect

A new study from the Institute of Health Metrics and Evaluation (IHME) at the University of Washington shows that the life expectancy of women actually declined between 1987 and 2007 in over 300 U.S. counties. That compares to only six counties where life expectancy decreased for men in the same time period (though men in these same areas tended to have worse outcomes than men elsewhere).
The authors of the IHME study believe that certain behavioral risk factors — especially smoking, eating habits, and exercise habits — do account for much (but not all) of the decline. A variety of proven policy options for countering those factors exist, public health experts say, though many are not in place in

the states that saw declines.

According to Georges Benjamin, the executive director of the American Public Health Association, rising tobacco use deserves much of the blame for poor outcomes in women. “When women entered the workplace in the mid-’40s and early ’50s, they began to smoke more and more, and tobacco companies began to see them as customers,” he said. “So even now, while we’re seeing smoking rates in men decline, we see women catching up.

Benjamin added that the obesity epidemic has also hit women especially hard. According to data from the Centers for Disease Control, despite the fact that a greater percentage of American men are overweight than women, obesity rates are higher in women in every age group and racial and ethnic category except for white adults 60 or older.

> “We are seeing these devastating cuts right now in public health,” said Georges Benjamin of the American Public Health Association. “And we know that those cuts are going to disproportionately affect women.”

Socioeconomic factors

Though there is some debate over what portion of these gender disparities can properly be attributed to biological and cultural factors, Susan Wood, director of the Jacobs Institute of Women’s Health at George Washington University’s public health school, said that the evidence does undoubtedly show that public health outcomes are closely correlated with socioeconomic factors.

“We know that the poor are made up disproportionately by women,” she said. “Women are more likely to be single parents, and they are more dependent on publicly-funded programs like Medicaid. Cross that with issues of having access to healthy foods, [and of] living in safe places where they can get outside and exercise, and you see that there are reasons why you find these health disparities around the country.”

The importance of socioeconomic factors has led some women’s advocates, like Waxman, to turn their attention to programs such as Medicaid, the Supplemental Nutrition Assistance Program — commonly known as the food stamp program — and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The Affordable Care Act does set some “floors” for program eligibility below which states cannot fall, but there is great variation between states that provide only the minimum and those that are in the forefront of protecting the health of their residents. Waxman said that those states that provide less access deserve greater scrutiny.

Erica Lubetkin, a professor of community health and social medicine at the City University of New York, agreed that increasing access to care and healthy food was important, and added that numerous states have failed to adopt a variety of “basic” programs that have been shown to improve health out-

comes. Those include smoking bans in workplaces, bars, restaurants, and other public places; taxes on tobacco; required physical education and health education in schools; restrictions on unhealthy food being served in schools; and incentivizing physicians and nurses to practice in rural and underserved areas to increase access to care.

“I think the weirdest thing about this is that we know a lot about how to improve outcomes,” Lubetkin said.

State policy

In some states with poor women’s health outcomes, efforts have been made in recent years to enact public health legislation to improve the situation, but many legislative proposals have failed to get off the ground.

> “I am very cognizant that women are suffering especially in Oklahoma, but common sense legislation...that could really improve the lot of women doesn’t even get out of committee here.” — State Representative Jeannie McDaniel

In Oklahoma, for example, which saw some of the greatest declines in women’s life expectancy, Democratic state representative Jeannie McDaniel has introduced numerous public health bills over the past several years, few of which have been successful.

“I remember a few years ago when I learned that my granddaughters might live shorter lives than I will,” she said. “I am very cognizant that women are suffering especially in Oklahoma, but common sense legislation…that could really improve the lot of women doesn’t even get out of committee here.”

Last year, McDaniel introduced legislation to require that health education be taught at the middle school level, but the proposed bill failed to pass.

Oklahoma House Speaker Kris Steele, a Republican, said that while he had personally favored the measure, the Republican caucus in Oklahoma is loath to pass “unfunded mandates” on the school system. But Steele admitted that he, too, would be “very cautious” about raising taxes to make such a measure a “funded” one, even though he believed health education would be beneficial for both women and men in Oklahoma.

“In funding the various initiatives, it comes down to priorities,” Steele said. “We fund those things that are deemed as being vital or important.”

Steele himself introduced legislation in the last session that would have lifted a long-standing state

prohibition on any local law to ban smoking in public places or to tax tobacco. Oklahoma is one of only two states that has such a prohibition, and the state itself does not currently have any regulations on the books concerning tobacco use. But Steele withdrew the legislation before the end of the session, because he was not sure that it could pass the State Senate. He is planning on reintroducing the measure in the next session.

“We recognize that we have to get our women’s smoking rates down, that they’re way too high,” he said. “I just thought we weren’t ready this year.”

Michael Brown, a state representative in Missouri, has had similar problems passing public health legislation in that state. Recognizing that obesity rates are higher in Missouri than the national average, Brown has repeatedly introduced legislation to establish a state agency to study obesity in Missouri and to be accountable for lowering obesity rates.

That bill has, likewise, gone nowhere.

“I can’t understand it,” Brown said. “This is such a small first step that we need to take, before we take a bunch of bigger steps, and we can’t even do it. When I say obesity in committee, people sneer at me,” completely unwilling to face the issue, he said.

In the Kentucky legislature, Health and Welfare Committee co-chair Tom Burch said that, several years ago, when he saw that women’s smoking rates were rising, he introduced legislation that would raise tobacco taxes. “It got referred to the ag[riculture] committee,” he said. “When I went there to talk about it, the chair lit up a cigarette.”

What needs to change?

Legislators, public health experts, and women’s advocates identified a number of barriers that they faced in gaining ground on women’s public health issues. McDaniel said that the number one issue she has faced is that many people in Oklahoma saw legislation intended to increase public health outcomes generally, and particularly for women, as an infringement into the “sanctity of the family.”

Burch echoed that sentiment. “We have folks in Kentucky who see their wives and daughters as property, and think their proper place in the home, where the government has no right to go.”

Like others Remapping Debate spoke with, McDaniel emphasized the serious harm men suffer from the lack of priority accorded public health. Even so, she said, the societal status of women plays a large role in how frequently public health policy aiming to improve women’s outcomes is ignored.

“When women are treated as second-class citizens, then you don’t need to think about our needs as

much," she said, adding that by raising the status and recognition of women, it would become easier to make policy that affects them.

Lubetkin said that, in many parts of the country, measures to improve public health policy are seen, ironically, as "paternalism."

"There's always this conflict between individual rights and the collective good," she said. "I don't think gains will really be made until we realize that a little bit of paternalism can go a long way, and that might not happen until we accept that we are already paying for each others' behavior."

Many advocates stressed the importance of education, both in terms of raising the visibility of public health issues and also in terms of educating the public on the adverse effects unhealthy behavior.

"We have so much information, and we're getting more and more all the time, and we need to keep finding better ways to get this information to legislatures and to the public," said Waxman.

Waxman said that women's advocacy organizations had a large part to play in the effort to educate and influence officials and citizens about the ways in which inadequacies in public health policy affect women. But she added that the focus on most women's advocacy organizations has been on reproductive health, especially in recent years as a defensive response to an onslaught of anti-abortion, anti-contraception activity.

Lubetkin agreed. Broader public health issues besides reproductive rights are "kind of background issues," she said. "The advocacy community usually organizes itself around the most politically contentious issue."

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Terry O'Neill, the president of the National Organization for Women (NOW), one of the country's largest women's advocacy groups, said that NOW's main focus was in fact on defending reproductive rights, noting that securing reproductive freedom was, in her view, a crucial part of the larger battle to improve women's health.

"What states are doing [by passing laws that restrict access to reproductive care] is deciding that they can withhold health care from a class of people," O'Neill said. "Once you do that, you've decided that that class of people aren't as human as the men, and once you go down that road, it's easy not to care that women are not getting adequate services."

O'Neill said that because reproductive rights are under such strong pressure in the states, it was important for advocacy organizations to use resources defending them. Amy Allina, the program and policy director at the National Women's Health Network (NWHN), agreed.

While the NWHN does focus on reproductive rights and increasing women's access to health care, Allina said that while she recognizes the other public health issues that affect women, with limited resources, "we can't possibly work on every issue."

Remapping Debate contacted several other groups that are involved in women's rights advocacy — such as Families USA, the Guttmacher Institute, and the National Partnership for Women and Families — but those organizations declined to comment for this article, stating that the broader public health issues affecting women were not ones that they worked on.

Going forward

According to Waxman, the chief obstacle in passing public health legislation that could increase outcomes for women is apathy.

> "We have so much information, and we're getting more and more all the time, and we need to keep finding better ways to get this information to legislatures and to the public," said NWLC's Waxman.

"Everybody says they care about women's health and public health, and there are states who clearly care a huge deal about women's health, but there are others who just don't seem to care at all," she said, mentioning Oklahoma and Louisiana as examples of the latter. "If they cared, they would have much stronger policies in place."

While she stressed that states have a large responsibility for improving health outcomes for women, she also saw a role for the federal government to step in "when states simply won't do what they need to do."

In that vein, Waxman and many other women's health advocates see the ACA as a victory, because it contains several measures aimed at improving public health, and women's health in particular. Georges Benjamin of the American Public Health Association agreed that the ACA was a victory for women's health, but added that it should not make legislators and advocates complacent about the work that still needs to be done, either nationally or on the state and local level. "We are seeing these devastating cuts right now in public health," he said. "And we know that those cuts are going to disproportionately affect women. We need to make sure that we are going forward, and not backward."

Waxman added that, ultimately, the pressure on legislators was going to have to come from their constituents, and stressed the need to think of strategies that could mobilize grassroots energy. When asked for specific ways that the advocacy and academic community could more effectively galvanize public support, however, Waxman said, “I don’t know. We clearly need to do more, and do something different, but I’m not sure how.”

“We need to be doing everything we can do to make people care about these issues,” she added. “Right now, we need all the help we can get.”

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