MICROFILM DIVIDER

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SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

3048

2001 HOUSE GOVERNMENT AND VETERANS AFFAIRS

HCR 3048

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HCR 3048

House Government and Veterans Affairs Committee

☐ Conference Committee

Hearing Date 2/16/01

Tape Number	Side A	Side B	Meter #
1	X		0-485
Committee Clerk Signature	Robin L. Small		

Minutes:

REP. M. KLEIN called the hearing to order, with all members present except REP. GRANDE.

In favor:

REP. SALLY M. SANDVIG, DISTRICT 21

SANDVIG is one of the sponsors on the bill. Please see attached testimony.

REP. KASPER asks where the statistics came from, that SANDVIG is referring to. SANDVIG replies that it is in reference to the national statistics. Please refer back to her testimony.

In favor:

REP. JANET M. WENT, DISTRICT 3

WENTZ is also one of the sponsors on the bill. WENTZ introduces the bill to the committee.

No questions were asked of WENTZ.

Being there was no further testimony in favor or in opposition, the hearing was then closed.

Action:

REP. DEVLIN motioned for a DO PASS AND TO BE PLACED ON THE CONSENT CALENDAR, seconded by REP. MEIER. The roll call vote was taken with 14 YES, 0 NO and 1 ABSENT AND NOT VOTING. The motion carries. The CARRIER of the bill is REP. MEIER.

HCR 3048: DO PASS AND TO BE PLACED ON THE CONSENT CALENDAR 14-0

CARRIER: REP. MEIER

Date: 2-16-01

Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HCR 3048

House **GOVERNMENT AND VETERANS AFFAIRS** Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass Consent Calendar (Place On)

Motion Made By Devlin Seconded By Meier

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN KLEIN	✓		REP KROEBER	✓	
VICE CHAIR GRANDE					
REP BELLEW	✓				
REP BRUSEGAARD	✓				
REP CLARK	✓				
REP DEVLIN	✓				
REP HAAS	✓				
REP KASPER	✓				
REP KLEMIN	✓				
REP MEIER	✓				
REP WIKENHEISER	✓				
REP CLEARY	✓				
REP HUNSKOR	✓				
REP METCALF	✓				

Total (Yes) 14 No 0

Absent 1

Floor Assignment Rep. Meier

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 16, 2001 12:46 p.m.

Module No: HR-29-3667
Carrier: Meier
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HCR 3048: Government and Veterans Affairs Committee (Rep. M. Klein, Chairman) recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HCR 3048 was placed on the Tenth order on the calendar.

2001 SENATE GOVERNMENT AND VETERANS AFFAIRS

HCR 3048

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HCR 3048

Senate Government and Veterans Affairs Committee

☐ Conference Committee

Hearing Date March 23,2001

Tape Number	Side A	Side B	Meter #
1	X		0.0-5.8
Committee Clerk Signature			

Minutes: **Chairman Krebsbach** called the committee to order. The clerk called the roll. **Chairman Krebsbach** opened the hearing on HCR 3048 which is a concurrent resolution directing the Legislative Council to study the feasibility and desirability of creating a State Department of Health Division of Women's Health and an Advisory Committee on Women's Health. Appearing before the committee to introduce the resolution was **Representative Sally Sandvig,** district 21, primary sponsor of the resolution. A copy of her written testimony is attached. There were no questions from the committee however, **Senator Wardner** offered a comment. He noted that not taking away from what you are doing here, it really reminds him in our educational system, physical education and health classes over the years have deteriorated to do nothing things. He is thinking that every student should have a good class on these types of things, not just roll out a ball and play a game. That's okay too, but, there should be a plan for physical conditioning and the cardiovascular system for all our kids. One credit, they only have to go one year and after that depending on the school. It should be four years of physical

education with the health issue included. He indicated that he must preface this with everybody wants to put something into the curriculum, but, that was already there and it has deteriorated over the years. There was nothing further. There was no further testimony in support of, in neutral position on, or in opposition to HCR 3048. **Chairman Krebsbach** closed the hearing on HCR 3048. **Senator T. Mathern** moved a Do Pass on HCR 3048, seconded by **Senator C. Nelson.** Roll Call Vote indicated 6 Yeas, 0 Nays, and 0 Absent or Not Voting. **Senator T. Mathern** will carry the bill.

Date: 3/23/01
Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HCR 3048

Senate GOVERNMENT AND VETERAN'S AFFAIRS Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass - Consent Calendar

Motion Made By Sen. T. Mathern Seconded By Sen C Nelson

Senators	Yes	No	Senators	Yes	No
Senator Karen Krebsbach, Chr.	✓		Senator Carolyn Nelson	✓	
Senator Dick Dever, Vice-Chr.	✓		Senator Tim Mathern	✓	
Senator Ralph Kilzer	✓				
Senator Rich Wardner	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. T. Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 26, 2001 7:29 a.m.

Module No: SR-52-6666
Carrier: T. Mathern
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HCR 3048: Government and Veterans Affairs Committee (Sen. Krebsbach, Chairman) recommends **DO PASS** and **BE PLACED ON THE CONSENT CALENDAR** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HCR 3048 was placed on the Tenth order on the calendar.

2001 TESTIMONY

HCR 3048

Testimony HCR 3048
Representative Sally Sandvig
Before House GVA Committee

Chairman Klein and members of the House GVA Committee:

For the record I'm Representative Sally Sandvig from District 21 in Fargo and I'm here to introduce House Concurrent Resolution 3048 to you.

HCR 3048 came about as a result of Women In Government's Women's Health Care Platform that is to demonstrate the need for recognition and remedial action to provide the nation's women with fair and equal health care in three key areas: relevant care, relevant research, and relevant education. (see handout).

One of the objectives of the relevant education area is the establishment of permanent offices of women's health in the states to raise awareness of women's special health care needs and advocate initiatives to address them.

That is why this study resolution is before you.

There are inequalities in the standard of health care provided to women. They live longer, but not necessarily better. They are not getting the care they need and they are dying because of it. There has been little change in vitally important preventative care and cure issues.

The goal is to look at women's health as a comprehensive issue rather than one focused solely on reproductive issues. Emphasis should be placed on prevention, screening for cardiovascular disease, incorporating physical education in schools, educating women on diabetes, osteoporosis, eating disorders, domestic violence,obesity,depression and anti-smoking campaigns.

Nine states have created an office of Women's Health in statute. These are: California, Illinois, Indiana, Kentucky, Maryland, North Carolina, Ohio, Rhode Island, and Tennessee.

Research has shown that women's bone tissue is different than mens, their brain anatomy is different, drugs are metabolized in their livers differently, their GI tracts are different because it takes longer to digest and their bile composition is different. Their hearts beat faster and they have more fatal arrhythmia.

North Dakota received an unsatisfactory rating on the state by state report card in Making the Grade in Women's Health.

Please give this resolution a due pass recommendation and help North Dakota join the other states in addressing this issue.

Thank you.

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FACT SHEET

RELEVANT RESEARCH
RELEVANT EDUCATION
RELEVANT CARE

WHY WOMEN?

- Women account for 52 percent of the U.S. population.[1]
- Women make 70 – 90 percent of the healthcare decisions in American households.[2]
- Women spend almost two of every three healthcare dollars (Approximately $500 billion).[3]
- Women make more than 61 percent of physician visits.[4]
- Women purchase 59 percent of prescription drugs.[5]
- In long term care facilities, more than 75 percent of residents over age 75 are women.[6]
- Women are affected disproportionately by a number of diseases.

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[1] U.S. Census Bureau Data, 1996
[2] Smith Barney Research. The New Women's Movement:Women's Healthcare, April 1997
[3] Smith Barney Research. The New Women's Movement:Women's Healthcare, April 1997
[4] Smith Barney Research. The New Women's Movement:Women's Healthcare, April 1997
[5] Smith Barney Research. The New Women's Movement:Women's Healthcare, April 1997
[6] Smith Barney Research. The New Women's Movement:Women's Healthcare, April 1997

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FACT SHEET

RELEVANT EDUCATION?

Are healthcare providers taught about women's health?

- "When I went to medical school we were told the heart was just a muscle and it didn't have a gender. Now we know that cardiac tissue contains both male and female hormone receptors. We don't yet know why they're there, but we know that's one of the things we need to investigate. All the data that we have from science says gender can make a difference. We should at least apply that information whenever and wherever it's pertinent. In some instances, it may mean the difference between life and death."[1]

- Only 45 out of 125 medical schools have a staff member who coordinates training in women's health and gender-related issues.[2]

- Fewer than one-fourth of the medical schools in the U.S. offered an elective in women's health.[3]

- Ninety-one percent of U.S. and Canadian schools that that they do not have a basic science Women's Health curriculum[4]

- Traditional medical educational models are not adequate in addressing the effects of gender on health and disease at the basic science and clinical levels and across medical disciplines and educational levels.[5]

- Thirty-four percent of Allopathic (MD) medical schools and 44% of Osteopathic (DO) medical schools do not offer courses in gender differences in medical decision making[6]

- Basic competency in women's health should be expected of all physicians.[7]

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[1] Dr. Raymond Woosley, Society for Women's Health Research 1998 Annual Report
[2] Society for Women's Health Research: American Medical Association Questionaire
[3] Montgomery K, Moulton AW,"Medical Education in Women's Health."J Women's Health 1992;1:253-254
[4] Women's Health in the Medical School Curriculum: Report of a survey and Recommendations, U.S. Department of Health & Human Services, June 20, 1997
[5] Council on Graduate Medical Education Fifth Report: Women & Medicine, U.S. Dept. Health and Human Services
[6] Women's Health in the Medical School Curriculum: Report of a survey and Recommendations, U.S. Department of Health & Human Services, June 20, 1997
[7] Council on Graduate Medical Education Fifth Report: Women & Medicine, U.S. Dept. Health and Human Services

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FACT SHEET

RELEVANT RESEARCH?

A history of exclusion in clinical trials in the last 50 years

General studies:

The Physicians Health Study	22,071 men	No Women
The Multiple Risk Factor Intervention Trial "MR FIT"	15,000 men	No Women

The Baltimore Longitudinal Study of Aging: No women participated between 1958-78 yet the report in 1984 was – and still is – considered "definitive."

Relationships between:

Type A behavior and heart disease	3,154 California businessmen	No Women
Alcohol and blood pressure	50 alcoholic men	No Women
Smoking and heart disease	300 white men	No Women
Cataracts and smoking	838 men	No Women
Enteric-coated aspirin and ulcers	23 men with ulcers	No Women
Aspirin and migraines	22,071 male physicians	No Women

Effects of:

Eating fish after a heart attack	2,033 men	No Women
Breathlessness as heart disease symptom	7,735 men	No Women
Diet and exercise increase of high-density cholesterol "the good cholesterol"	42 overweight men	No Women

Note: Until 1990 women were often barred from taking part in research studies because many scientists argued "their hormonal changes made them difficult to study." During the last ten years, women have finally begun to be included in clinical trials. Several key trials are the Nurses Health Study and the Women's Health Initiative at the NIH. Only since 1993 has Federal law required that women be included in drug trials.

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FACT SHEET

RELEVANT CARE?

Women are not "little men"

- Two thirds of patients who suffered arrhythmia are women. Women are twice as likely as men to black out or even die after receiving certain medications (potassium channel blockers) which slow down the heart's relaxation phase and increase the risk of arrhythmia.[1]

- Although more women than men die from cardiovascular disease, virtually all randomized controlled trials on risk and treatment are conducted on men.[2]

- Heart disease in women often goes undetected and untreated until the disease has become severe. As a result, 44 percent of women who have heart attacks die within one year compared to 27 percent of men.[3]

- Males' odds of receiving most procedures exceeded those of females by 115 percent for coronary artery bypass grafting, 86 percent for heart transplantation, 38 percent for defibrillator implants, 34 percent for angioplasty, 28 percent for pacemaker implants and 24 percent for hip replacement.[4]

- Despite decades of cancer research, relatively little is known about risk and prevention of breast cancer.[5]

- The risk of lung cancer is up to 70 percent higher in women than in men; the death rate for male smokers has leveled off, mortality rates for women continue to rise.[6]

- Women smokers are more likely to develop lung cancer than men smokers even when they smoke the same or fewer numbers of cigarettes for fewer years indicating their vulnerability to the carcinogens in cigarettes.[7]

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[1] Woosley, R. Professor and Chair of pharmacology at Georgetown University Medical School, SAWHR Scientific Advisory Meeting
[2] The Commonwealth Fund. Health Care Reform: What is at stake for women? July 1994 and American Heart Association. 1998 Heart and Stroke Statistical Update
[3] American Heart Association. Biostatistical Fact Sheet, 1996-1997
[4] Giacomini MK. Gender and ethnic differences in hospital-based procedure utilization in California. Archives of Internal Medicine 1996 Jun 10, 156 (11):1217-24.
[5] The Commonwealth Fund. Health Care Reform: What is at Stake for Women? July 1994
[6] Society for Women's Health Research 1998 Annual report
[7] Zang EA, Wynder EL. Differences in lung cancer risk between men and women:examination of the evidence. J Nat Cancer Inst 1996 Feb 21;88 (3-4):183-192

- Women are affected by the HIV virus in a different way than men.[8]
- Women wake up from anesthesia faster than men.[9]
- Women are affected with depression twice as often as men.[10]
- Despite depression's disproportionate impact on women, few if any of the nation's largest managed care organizations have gender-specific guidelines for the treatment of depression.[11]
- Eating disorders are 10 times more common in women than in men.[12]
- Women are three to four times more likely than men to suffer from lupus or other autoimmune diseases.[13]
- While fiber intake reduces the rate of colorectal cancer for men, it appears not to reduce a woman's risk of colorectal cancer.[14]
- Women are susceptible to alcohol-related heart damage at lower levels of alcohol consumption than men.[15]
- Symptoms of a heart attack manifest themselves differently in men and women. With men it is chest pain. Women are more likely to have more subtle symptoms such as abdominal pain, nausea and fatigue.[16] This difference frequently results in misdiagnosis.
- Medical treatment for neuropathic pain syndrome is often effective in treating chronic pelvic pain in men, but is rarely effective in women.[17]

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[8] Society for the Advancement of Women's Health Research: Why Women
[9] Glass, P., et al.Anesthesiology 1996 Sep;85(3A),A343.
[10] National Institute of Mental Health:What Every Woman Should Know, December 1994)
[11] Monica Oss et al. Managed Care Approaches and Models for the Treatment and Management of Depression:Specific issues for Women. Jacobs Institute of Women" Health Symposium December 5, 1997
[12] National Institute of Mental Health. Eating Disorders, 1993
[13] Society for the Advancement of Women's Health Research: Why Women
[14] Fuchs CS,Giofannucci EL, Colditz GA, Hunter DJ, Stampfer MJ, Rosner B, Speizer, FE, Willett, WC. Dietary fiber and the risk of colorectal cancer and adenoma in women. New Engl J Med 19999 Jan 21;340(3):169-176
[15] Fernandez-Sola J,et al Am J Cardiol 1997 Aug 15;80 (4);481-485
[16] American Heart Association, Women, Heart Disease and Stroke Statistics, 1997
[17] Wesselman,U,et al. "Gender Differences in Chronic Pain Syndromes of the Reproductive Organs," presented at NIH Gender and Pain meeting, April, 1998.

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Presented by Women In Government
Washington, D.C.
May 17, 2000

More women are working in better jobs and at higher pay than at any time in history.

Women hold more and higher public offices than any time in history.

Both of these results came after campaigns of commitment, sacrifice, hard work and inspired leadership.

But the commitment, work and leadership of the women of America cannot rest today. Why? Because their lives litorally depend upon another campaign—this one for equal health care.

Women In Government, an independent organization of women legislators, proposes a nation-wide campaign at the state level to dramatically increase the awareness of their fellow policy makers to the inequities of quality and quantity of health care, and the failure of the health care system to provide the needed research, access and communication necessary to overcome the persistent and flagrant problems that exist today.

Why A Women's Health Platform?

An important element of Women In Government's call for The Women's Health Care Platform in this election year is the premise that gender and parity in health care is fundamental to the overall good health of every American. More research on women's health will most certainly be beneficial to both genders. And a better informed patient population, without limits imposed by gender, race or economic condition, will lead to faster diagnosis, proper prevention and less expensive treatment and cure for such chronic conditions as hypertension, diabetes, kidney disease, cancer and osteoporosis.

Why Focus on Women's Health?

Women are different metabolically, hormonally and physiologically from men. Women have different patterns of health and disease. Some diseases are more common in women than in men, yet a great deal of public health care policy does not adequately address this basic fact.

Women are more likely to suffer from chronic diseases; more than one in five women have some form of cardiovascular disease and 80 % of those afflicted with disabling osteoporosis are women. Women are three times more likely to develop rheumatoid arthritis and two to three times more likely to suffer from depression. If they are smokers, women are 20-70 % more likely to develop lung cancer. And women are ten times more likely than men to contract HIV during unprotected sex.

Women are much more likely to provide health care to family members and make health care decisions. Nearly 90 % of all children who live with a single parent, live with their mothers. It is estimated that daughters and daughters-in-law provide the overwhelming majority of care for non-institutionalized elderly. Women spend two of every three healthcare dollars and outnumber men three to one in nursing homes. Even so, there is abundant evidence that women are under-treated compared to men and under-represented in health research.

While there has been some national attention on women's health care issues, notably during election years, and some legislative activity by the Congress on access issues, there remains little change in vitally important preventive care and cure issues.

The Keswick Conference presented the following facts that compelled Women In Government to call for renewed and aggressive action:

- Clinical trials have demonstrated that mammography screening can reduce breast cancer deaths by as much as 39% in women aged 50 – 74[1].

40% of women 40 years and older have not received a mammogram within the last two years[2].

- If cervical cancer is detected early (pap test) the likelihood of survival is almost 100% with appropriate treatment and follow up[3].

Nearly 25% of women have not had a pap test in the past 3 years[4].

- Women are 60% more likely to die within a year following a heart attack than men[5].

Compared with men, women are less often referred for diagnostic cardiac catheterization[6]. In terms of treatment, women are slightly 2 times less likely

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[1] Kerlikowski, K.;Grady,D.;Rubin,S.M.;et al. Efficacy of Screening mammography. A meta-analysis. *Journal of the American Medical Association* 273:149-154, 1995

[2] National Health Interview Survey (NHIS),CDC,NCHS 1998)

[3] Schiffman, M.H.;Brinton,L.A.;Devesa,S.S.;and Fraumeni,J.F.,Jr.Cervical cancer.In:Schottenfeld,D.,and Fraumeni,J.F.,Jr. (eds). *Cancer Epidemiology and Prevention*, 2nd ed. New York:Oxford University Press, 1996, 1090-1116

[4] National Health Interview Survey (NHIS),CDC,NCHS 1998)

[5] Gillum,R.F.;Muscolino,M.F.;and Madans,J.A.Fatal MI among black men and women. *Annals of Internal Medicine* 127:111-118,1997

[6] Villarino CB,Fenster PE. "Coronary Heart Disease," *Prim Care Update OB/GYNs 1994*; 1:150-155

than men to receive angioplasty and almost 2 1/2 times less likely to receive bypass surgery[7].

- Drug therapy in women may be compromised by a limited availability of medications such as restrictive formularies (a list of drugs to which physicians are restricted) used by 92% of Managed Care Plans[8]. Limiting drugs - "one size fits all"- does not provide Providers with the full range of drug options and may be detrimental to a woman's health due to suboptimal or failed therapy because of an inappropriate drug.

  Some pain medications (known as kappa-opiates) are far more effective in relieving pain in women than in men[9]. Women respond less well to the antidepressant tricyclics and better to SSRIs than do men[10]. Even common drugs such as antihistamines and antibiotics can cause different reactions and side effects in women and men[11].

- One of every two women will have an osteoporosis-related fracture after age 50[12].

  Only 9 % of female Medicare beneficiaries have had a bone density test (to diagnose osteoporosis and assess fracture risk) in the last two years, and only 5.4% had one in 1998[13]. Standardized coverage of bone density tests, however, were implemented in 1998 for five qualified groups of individuals.

  Women can lose up to 20% of bone mass in the 5-7 years post menopause. A number of FDA-approved therapies exist now that are approved for the prevention and/or management or treatment of osteoporosis. These include hormone replacement therapy (only 38% of women age 50 and older had been counseled on the risks and benefits of Hormone Replacement Therapy -- HRT),[14] bisphosphanotes, Selective Estrogen Receptor Modulators (SERMs) and calcitonin.

- Colon Cancer is the third-highest cause of cancer deaths among women[15].

  Only 25% of women age 50 and older reported having been screened for the disease in the past year[16].

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[7] American Heart Association 1999 Heart and Stroke Statistical Update

[8] Data from 1998; *Managed Care Digest Series* 1999, Hoechst Marion Roussel

[9] Tershner,S.A. et al; Gender Affects Response to Kappa-Opioids. *Pain 2000;85:153-159*

[10] Schatzberg:The modulatioin of monoamine neurotransmitters by estrogen: Clinical Implications. The American Psychiatric Assn. 152nd annual meeting. Washington, DC 1999

[11] Society for Advancement-Annual Women's Health Research Update

[12] Chrischilles, E.A. and others "A Model of Lifetime Osteoporosis Impact." *Arch Intern Med* 151, no. 10 (October 1991):2026-32. Melton, L.J. 3rd. "How Many Women Have Osteoporosis Now?" J Bone Miner Res 10, no. 2 (February 1995): 175-7

[13] Healthcare Financing Administration data, Osteoporosis Public Policy update, National Osteoporosis Foundation/ Volume 5 Winter 2000

[14] The Commonwealth Fund, 1998 Survey of Women's Health

[15] Landis,S.H.;Murray,T.;Bolden,S.;and Wingo, P.A. Cancer statistics,1999.CA:A Cancer Journal for Clinicians49(1):8-31,1999

[16] The Commonwealth Fund 1998 Survey of Women's Health

- Women who visit an OB/GYN are more likely to receive recommended preventive services such as a pelvic exam, a pap test and a breast exam[17].

  75% of women enrolled in HMOs say they cannot see their OB/GYN without a referral[18].

- In the 2000 Federal Budget, less than 15 % of the National Institutes of Health budget was devoted to women's health research[19].

- It wasn't until 8-10 years ago that the NIH and the FDA were required to include women and minorities in clinical trials[20] (in tests for "Type A" behavior and heart disease, 3,154 California businessmen - no women were included; in tests for aspirin and migraines, 22,071 male physicians - no women).

- The proportion of uninsured women aged 18-64 rose from 14% in 1993 to 18% in 1998[21]. Women, aged 55-64 are 30% more likely to be uninsured than men of the same age[22].

What Should Be Done?

Even as some of our political institutions wrangle over complex and often emotionally charged health issues, the public call for improved health care, particularly for women, has grown. Women In Government's commissioned national survey of attitudes reveals not only a demand for equal health care availability that transcends party lines, but a willingness on the part of women and men to pay higher health insurance premiums to gain that objective. This is why we believe the time is right to initiate this effort.

Women In Government supports a new initiative for the year 2000, The Women's Health Care Platform, to present to legislators and policy makers demonstrating the need for recognition and remedial action to provide the nation's women with fair and equal health care.

Given the abundant evidence of need, the Women's Health Platform – Women's Health Care Campaign 2000 – is a call to action to policymakers to lead the way to equality in three key areas: relevant care, relevant research and relevant education.

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[17] Bartman BA, Weiss KB,J Women's Health, 1993,2:261-268
[18] The Commonwealth Fund 1998 Survey of Women's Health
[19] Society for Women's Health Research; Source:NIH
[20] National Institutes of Health:Problems in Implementing Policy on Women in Study Populations (GAO/T-HRD-90-38, June 18, 1990)
[21] The Commonwealth Fund 1993/1998 Survey of Women's Health
[22] U.S. Census; Health Insurance Historical Table; CPS 1998

Relevant Care

- Provide equal access to quality health care, including state-of-the-art medical advances and technology;
- Increase the number of women covered by comprehensive health care insurance, including primary and preventive health care, for all women;
- Prevent serious health problems by timely diagnosis and treatment programs;
- Promote strategies to increase patient access to recommended diagnostic and screening tests, preventive health regimens and recommended treatments;
- Encourage unimpeded access to women's health providers, including OB/GYNs, women's health nurse practitioners and nurse midwives;
- Create and promote public/private partnerships (health plans and medical societies) to bring about programs designed to improve the scope and quality of women's health care;
- Improve communications between providers and patients.

Relevant Research

- Continue to expand participation of women in clinical trials;
- Increase government and private research on women's health issues and the differences between men and women and how they impact quality health care;
- Conduct more health outcomes research to demonstrate the value of women's health care interventions and preventive health measures in both the long and short-term.

Relevant Education

- Expand medical and nursing school curricula in the area of women's health; educate about gender biology;
- Support public education campaigns to increase women's awareness about their unique health risks, how to negotiate the complexities of today's health care system and demand/obtain the best care available;
- Conduct public health campaigns via state and local departments of public health with private sector partners to focus on key women's preventive health issues, e.g. the impact of menopause on women's health, mental health, osteoporosis, etc.;

- Urge the establishment of permanent offices of women's health within the federal government (FDA, CDC and HHS) and state governments to raise awareness of women's special health care needs and advocate initiatives to address them;

- Foster development and dissemination of publicly available information on the quality of health care and health outcomes that improve women's ability to choose the best women's health care plan;

- Expand state and federal screening programs targeted at lower-income women to include a full range of known risk factors.

What is Next?

The women of the United States have overcome time, tradition and even great distress to claim what is just and right. It is time for that determination and courage to be focused on the issues of health and health care.

Women In Government has drafted a "Sense of the House and Senate" resolution which will be introduced in every legislative body in session this year and next. The Resolution is designed to provide a statement of political courage and intellectual honesty to recognize these issues and to call on each state to take appropriate actions to win the cooperation of every element of the health care community – doctors, researchers, educators, medical journalists, patients, policy makers and regulators – and adopt the elements of The Women's Health Care Platform.

Women In Government has no desire to mandate change, but to challenge their colleagues to overcome one of the great injustices in this nation.

###