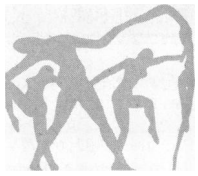

Women and Medicine

Women Without Health Insurance
Links Between Access, Poverty, Ethnicity, and Health

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In the United States, inadequate health insurance is a problem for men and women; for the young, the not-so-young, and the elderly; the poor and nonpoor; and for persons of all ethnic groups. It is especially problematic for particular groups, and certain gaps appear to be widening. In this article we focus on the problem of lack of health insurance for women. The problem is particularly severe for women of ethnic minorities, who are overrepresented among poor women. We describe the characteristics of the inadequately insured population and discuss the links for women between poverty, insufficient insurance coverage, inadequate health care, and poor health status.

Women are more likely than men to be poor and to live longer. These demographic and economic factors account for additional health care needs for women beyond special needs related to reproduction. A lack of adequate coverage for women and the economic problems that accompany insufficient access to care and aggravate its deleterious effects on health need to be addressed by public policy.

Characteristics of the Uninsured

From 9% to 18% of the entire population has insufficient health insurance.[1-3] The figure of about 37 million persons, or 15% of the population, is widely accepted as a current estimate of those who are uninsured for all or part of a given year.[4,5]

A greater proportion of the nonelderly population is uninsured because almost all US elderly are covered by Medicare. A recent study of census data has shown that 22% of Californians younger than 65 years are uninsured.[3] Other Western states with similar demographic and economic trends as those found in California may also exceed the national average for uninsured persons.

Considering all age groups together, the female population is slightly less likely than the male population to be completely uninsured (14.5% versus 14.8%, respectively).[5] This is probably explained by the higher proportion of women living below the poverty line as heads of household and therefore qualifying for Medicaid. Working women, however, are more likely than working men to be in low-paying positions (M. Tolchin, "Minority Poverty on the Rise Even as White Poor Decrease in the US," *New York Times,* September 1, 1988) or to be employed in the service sector, or both; such positions tend to have limited health insurance and other benefits.[6] Overall, the uninsured are primarily low-income working persons and their dependents.[3,7]

Young adults and children have the highest rates of uninsured status for both sexes.[2,3] For women, therefore, the problem of lack of health insurance is most severe in childhood and during the reproductive years. Of women aged 15 to 44 years, 17% are estimated to have no private or public health insurance.[8] During that age interval, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.

Severe tightening of restrictions for Medicaid qualification has resulted in a loss of coverage for many poor women and their children. Medicaid at one time provided coverage for 65% of the poor in the United States, but recent figures estimate that only 38% of the poor are covered by Medicaid nationally and in some states less than 25% of the poor are covered.[7] By 1982 California and many other states had discontinued Medicaid coverage for "medically indigent adults"—that is, those whose financial resources were judged insufficient to cover medical costs but who do not qualify for a categoric welfare program such as programs for the blind, disabled, or families with children. Federal regulations in 1984, 1986, and 1987 have tended to reverse some of the tightened eligibility criteria for pregnant women and young children.[9,10] A recent report by the congressional Office of Technology Assessment called attention to the problem of obstacles in the Medicaid application process

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itself that may provide disincentives to technically eligible women to enroll, which thus results in more women being uninsured.[9]

The problem of inadequate health insurance is most severe for minority women. For both sexes, non-Latino whites are far more likely than minorities to have private health insurance. In the US in 1982, 21.2% of nonelderly blacks had no private or Medicaid coverage compared with 13.5% of nonelderly whites.[5] In California, blacks, Latinos, and Asian adults are all more likely to be uninsured than are non-Latino whites.[3]

Incomplete insurance coverage for minority women is of particular concern because ethnic minorities, especially black women, endure a disproportionate burden of illness and thus have greater needs for health care. Blacks in the United States have twice the rate of infant mortality compared with whites.[11] Overall, age-adjusted mortality rates are higher for minority women than for their white counterparts.[12] While the incidence of breast cancer appears to be higher among white women, breast cancer survival rates are higher for white than for black women, who tend to be diagnosed at more advanced stages of disease.[13] Death rates from heart disease are twice as high for black as for white women. The black:white ratio for stroke mortality in women is 2.5:1.[13] When compared with white women, black women also have higher mortality rates from cirrhosis and diabetes mellitus and are at higher risk for tuberculosis, hypertension, and anemia. Mexican-born US women have a 38% excess death rate from diabetes compared with non-Latino white women.[14]

Insured Women May Have Incomplete Coverage

The problem is not only a lack of health insurance for women but insufficient coverage for women who do have insurance, whether Medicaid, Medicare, or private insurance. Although most Medicaid enrollees are children and young women, a relatively small proportion of Medicaid funds is spent on them. Nearly 67% of Medicaid expenditures go to cover costs for the elderly—primarily long-term care not covered by Medicare—or costs for care of the blind, mentally retarded, or physically disabled.[15]

Women who are theoretically covered for specific benefits under programs such as Medicaid may have difficulty obtaining care. For example, Medicaid reimbursement rates for delivery may be a third to half the rates of reimbursement by private insurance.[16] Because of Medicaid's inadequate, slow, and procedurally burdensome reimbursing of providers, it has become increasingly difficult for women on Medicaid to find private physicians who will provide their obstetric care. Nationally, 44% of physicians providing obstetric services will not accept Medicaid.[8] The West tends to have a lower proportion of obstetricians accepting Medicaid than do the Northern and North Central states, but it has a higher proportion than the South.[16]

While Medicare covers almost all elderly persons of both sexes, it provides little coverage for ambulatory or preventive services. Medicare provides almost no coverage for long-term care, which accounts for a significant portion of the health care needs of the elderly. Many elderly persons become impoverished as a result of nursing home expenses, ultimately becoming dependent on Medicaid.[15] The impoverishing effect of Medicare's lack of coverage of nursing home care affects women more than men because of their greater longevity. Elderly women are more likely than men to lack private health insurance to supplement Medicare because these benefits are often lost after divorce or the death of a spouse.

Private insurance often provides incomplete coverage. For both sexes, private health insurance increasingly comes with rising premiums, deductibles, copayments, and exclusions. Most indemnity plans favor acute curative or hospital care over ambulatory and preventive care, although most women, particularly young women, have a greater need for the latter. Many women with insurance have inadequate coverage for maternity care: 9% of women who have private insurance have policies that exclude coverage for maternity care.[8] Most (58%) health insurance plans for full-time employees impose waiting periods on women before they qualify for maternity care. More than half of those have waiting periods of three or more months.[8]

Inadequate Insurance Coverage Is Associated With Inadequate Health Care

A lack of sufficient insurance coverage affects women's use of health care. In general, uninsured persons use ambulatory medical care less than their insured counterparts.[1] Data from a large national survey show that the use of preventive services by older women is especially diminished: While the percentage of women having a Pap smear and the percentage of women having a breast examination by a physician during the previous year increased for women with insurance between 1976 and 1982, they declined for uninsured women.[17] Lack of insurance, most prevalent among socioeconomically disadvantaged women, was found to be the strongest predictor that women between 45 and 64 years of age would fail to receive appropriate screening tests.[17] Uninsured women, compared with insured women, have a relative risk for inadequate screening of 1.60 for blood pressure checkups, 1.55 for cervical smears, 1.52 for glaucoma testing, and 1.42 for clinical breast examinations.[18]

Uninsured women and women on Medicaid are less likely than insured women to obtain timely prenatal care.[2,16] A recent study by the US General Accounting Office (GAO) found that 63% of uninsured or Medicaid-covered women received incomplete prenatal care as defined by the Institute of Medicine's criteria.[16] The GAO study sample included women from diverse communities in the West and in the Midwestern and Eastern states. Pregnant women on Medicaid initiate prenatal care later than privately insured women and have an average of 8.7 prenatal visits compared with the average of 10.5 visits for all pregnant women.[8]

For pregnant women without sufficient private health insurance, many factors tend to delay a timely initiation of care. Even for the women who can meet eligibility criteria, the process of applying for Medicaid is lengthy, and it can be difficult to find a provider who will accept Medicaid. With limited options for care from private providers, and the closure or reduction of services of many community clinics in the past ten years,[4] the remaining publicly funded programs are increasingly operating beyond capacity.

For uninsured women and those on Medicaid, the strains on existing public programs mean not only longer waiting times to secure an appointment but on-site congestion with increased waiting-room delays, harried providers with insufficient time for each patient, and little opportunity to provide personalized care. All factors combine to create additional

disincentives to seeking care and obstacles to high-quality care (Table 1).

Inadequate Health Care Is Linked With Poor Health Status

Inadequate health care, especially for children and for pregnant women, is documented to result in poorer health status. A particularly clear example is the association between prenatal care, low birth weight, and infant health status. Initiating prenatal care after the first trimester is associated with adverse pregnancy outcomes and especially low birth weight, which in turn is associated with serious short- and long-term morbidity and mortality.[19] Appropriate prenatal care is associated with improved birth weight distribution for all ethnic groups. The US infant mortality rate is among the highest of the industrialized countries, including many countries with far lower per capita incomes. A total of 17 states in the United States, including Alaska, Arizona, California, Idaho, Montana, New Mexico, Utah, Washington, and Wyoming, experienced increases in infant mortality in 1985.[20] Between 1984 and 1985, neonatal mortality rose in Arizona, California, and Colorado and black neonatal mortality rose nationally.[20]

Failures in primary prevention, for both sexes, are thought to account for 15.1% of premature deaths in the United States.[21] It is estimated that a 30% decrease in the mortality from female breast cancer is obtainable with breast self-examination, physician examination, and mammography.[21] Cervical screening every three years can lead to a 70% to 95% reduction in cervical cancer mortality.[21]

Demographic and Economic Factors Increase Women's Health Care Needs

Data on health care use show that, in general, women use more health care services than do men. Women have higher rates of illness, have more days of disability, and use more health services than men, even when pregnancy-related services are controlled for.[11] These differences have been ascribed to "women's diseases" (breast cancer, menstrual irregularities, and other gynecologic conditions), to the effect of women's illness behavior (more willingness to admit symptoms or to visit a physician), or to sex-specific differences in access to care or response of the health care provider.[11] We think that important demographic and economic differences between women and men provide additional explanations for women's greater use of health services and greater reported disease incidence.

Most important, poverty is associated with a poorer health status for both sexes,[20,22-24] and more women than men are poor. Almost 78% of the poor in the United States are women and children, and three quarters of the elderly poor are women.[11] Almost a fifth of women aged 65 or older live below the poverty level ("The New Poorest," *The Economist,* September 13, 1986, p 24).

Minority women are far more likely to be poor than their non-Latino white counterparts. A third of blacks and more than a quarter of Latinos live in poverty. The US Census Bureau recently reported increases in the percentages of blacks and Latinos living below the official poverty level, while white poverty declined slightly (M. Tolchin, "Minority Poverty on the Rise Even as White Poor Decrease in the US," *New York Times,* September 1, 1988).

Another trend aggravating the economic differential is the increasing number of households now headed by women. Between 1960 and 1982, the number of families headed by women more than doubled, and these families were 4.5 times more likely to be poor than a male-headed family or that of a married couple.[6] More than half of families headed by Latino or black women live in poverty in the United States. Women are heads of household for 23% and 41% of Latino and black families, respectively ("The New Poorest," *The Economist,* September 13, 1986, p 24).

Elderly persons of both sexes have more disability and use more health services than the nonelderly. Women live on average eight years longer than men.[11] The continuing increase in the longevity of women has its own economic consequences and contributes heavily to women's burden of medical disability. At the close of the 20th century in the US, it is estimated that 35 million persons will be aged 65 or older and, of these, 20 million will be women.[11]

TABLE 1.—*Insurance Problems of Women*

14.5% completely uninsured
Greater poverty and longevity of women create additional health care needs
Minority women have less insurance and more illness
Lack of coverage for ambulatory preventive care, including unmet needs during reproductive years
Bureaucratic barriers to receiving Medicaid
Many ob/gyns will not care for pregnant Medicaid patients
Long waiting periods before insured women are eligible for pregnancy benefits
Some insurance plans (9%) exclude pregnancy care

TABLE 2.—*Health Problems of Women Due to Inadequate Insurance Coverage*

Less screening for breast cancer, high blood pressure, cervical cancer, and glaucoma
Delayed prenatal care with associated adverse perinatal outcomes
Higher rate of impoverishment due to inadequate Medicare coverage for nursing home care

Conclusions

A lack of sufficient health insurance coverage is a serious problem for women, especially for poor and low-income working women, minority women, and women of reproductive age (Table 2). Many insured women, including pregnant women with private or public coverage and elderly women, are underinsured. Inadequate health insurance is associated with inadequate health care, which is in turn associated with worsened health status.

Women have special needs for health care, associated with reproductive health. The greater poverty and the greater longevity of women are also factors that determine additional health needs for women, independent of obstetric and gynecologic issues. The relationships between women's poverty, health insurance coverage, and health status imply that those with the greatest health care needs are least likely to have financial access to care.

The inadequacy of coverage for perinatal care has been particularly well documented. Because perinatal services tend to be relatively inexpensive and politically popular, insufficient perinatal services for large numbers of women in this country suggest a far more extensive problem of inadequate care for women and for the entire population.

Differences between whites and minorities in health in-

surance coverage and in socioeconomic status are widening. Ethnic gaps are also widening for key health status indicators such as maternal mortality, low birth weight, and neonatal mortality.

As long as there are women or men who are underinsured or completely uninsured, it will be important to study and to document differences in health care use and in health status measures related to health insurance coverage. Currently, routine reporting of most health data does not include markers of access to care such as health insurance coverage or socioeconomic status. This lack of data makes it difficult to determine the relative contributions of poverty, a lack of access to care, and of other factors to the striking ethnic differentials in health status for women. The absence of relevant information then serves to hide the issues that require decisive action at the policy and program levels.

A rational response to the unmet health needs of inadequately insured women will require not only scientific data but political will. It will require addressing not only lack of access to medical care but the broader social inequities that are barriers to health for women, minorities, and all poor persons.

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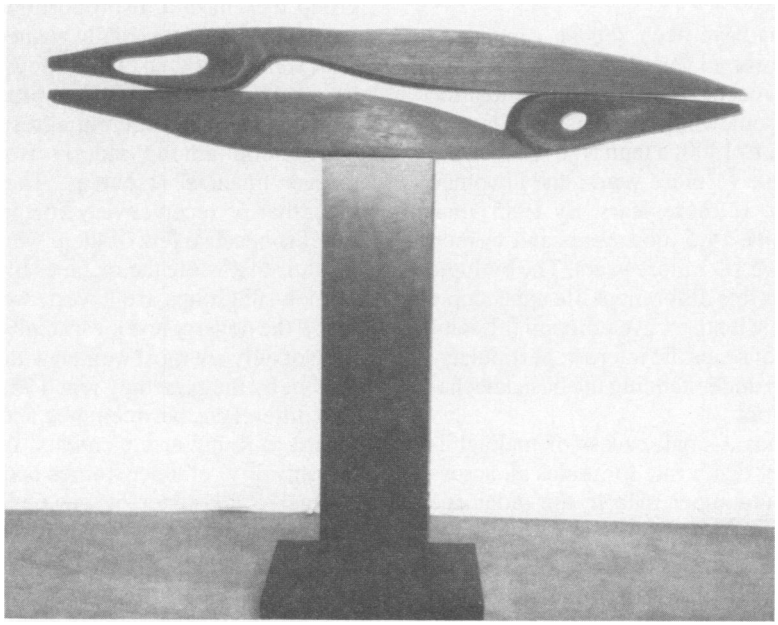

In Balance

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