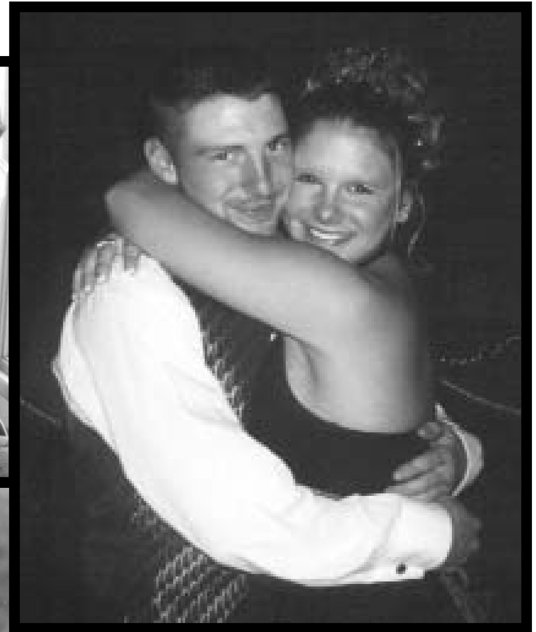
ACCESSING HEALTH CARE IN VERMONT:

A WOMAN-CENTERED APPROACH



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INTRODUCTION

This paper addresses the need of Vermont women to access affordable health care throughout their lives. Health care reform should reflect current Vermont data regarding gender gaps in insurance coverage and access to services, while preserving public policies that have made Vermont one of the most progressive states in the nation in providing access to healthcare for women.

The current debate on health care reform in Vermont has greater implications for women than men. Women are more likely to have low-income or part-time jobs that do not offer health insurance or to lose insurance as a result of divorce. Additionally, lack of paid sick leave often means they must choose between medical care and necessities such as food or heat. Even if women do have health insurance, the responsibility of being the primary caretaker for relatives both young and old often impairs their own access to health care. A woman's out-of-pocket health care costs are typically 68% greater than a man's during her childbearing years. More women than men move into old age alone, impoverished and infirm.

Efforts to contain health care services costs will affect women disproportionately. The health care workforce in Vermont is 79% women - the majority being home health aides, nursing assistants, nurses, clerical workers, technicians, and support service workers.

All Vermonters deserve access to preventive, primary, emergency, acute, and chronic care that is affordable and geographically accessible, in spite of the barriers inherent in rural living. For women, this must also include comprehensive reproductive health care and care that recognizes women's needs and vulnerabilities across their life span.

Public health policy which focuses on holistic and preventive approaches to health and wellness puts health care into the realm of basic needs and human rights. Paying attention to women and girls - from infancy to childhood to adolescence to maturity to old age - is sound, humane, and cost efficient.

The Vermont Commission on Women endorses the following statement of the President's Council on Bioethics: "Legislators can ensure that women's health needs, whether acute or chronic, preventative or curative, are addressed in a way that recognizes not only that in women's well-being resides the health of families, but that women in their own right deserve the best available health care, regardless of social status, race, age, level of ability and so on. In this context, access to health care becomes both vital and visionary. It is the first step on the road to wellness, and legislative action reflects this understanding."

DEFINING ACCESS

For some, universal access to health care means access to health insurance, with the underlying assumption that if one has insurance one has access to health care services. For others, universal access means access to health care services, regardless of payment source.

The challenge for all Vermonters is to strike a balance between what most people believe is fair, and what the community is willing to pay for.

ACCESS TO INSURANCE

Compared to women in other states, Vermont women are more likely to be insured. A higher percentage of working age women in Vermont have either employer-based insurance or Medicaid than the national average.

Health Insurance Status Women (19-64) 2002-3		
	VT%	US%
Employer	66	63
Individual	6	6
Medicaid	14	10
Medicare	2	2
Uninsured	11	19

CPS data reported by Kaiser Family Foundation at www.statehealthfacts.kff.org

However, these percentages do not reflect high premiums or out of pocket costs that may adversely affect a woman's access to services. In a recent survey of Vermont women business owners, participants reported their share of premiums ranged from zero to $1,309.39 per month! Less than half of those surveyed had plans that covered mammograms and annual OB/GYN exams without deductibles and co-pays. The trend towards higher deductibles and co-pays further decreases access to services.

While eighty-seven percent of survey participants reported they had health insurance, only 82% had prescription drug coverage, and only 50% had dental coverage. It is also interesting to note that 10% of women business owners surveyed had coverage through Vermont Health Access Plan (VHAP), Medicaid or Medicare.

There are also gender differences in types of health insurance coverage. An extensive telephone survey conducted in 2000 by Vermont's Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) found major differences between the types of insurance that working-age (19-64 years old) men and women have in Vermont. Women are more likely to have Medicaid, and men are more likely to be uninsured.

Health Insurance Status Vermonters (ages 19-64) 2000		
	%Women	%Men
Private	75	76
Medicaid	13	9
Medicare	3	3
Uninsured	9	14

BISCHA Survey 2000

Although it appears that working age women have almost the same percentage of private insurance as men, more than 50 percent of married women in Vermont have health insurance coverage through their husband's employment. When a death or divorce occurs, that coverage is often lost.

For the estimated 13 percent of Vermont women who are divorced, a federal law called COBRA allows divorced spouses of employees of private employers (with 20 or more employees) to continue group coverage for up to 36 months following divorce. The health plan is allowed to charge the full individual premium, plus 2 percent. Many divorced women cannot afford those premiums. In addition this law does not cover the vast majority of businesses in Vermont that have fewer than 20 employees. Current Vermont law only extends "COBRA-like" benefits for six months for spouses/widows of small business employees. Divorce often plunges women into poverty, and they must turn to public insurance or become uninsured.

Older women are more likely to be poor and dependent on public programs for health services. They often use up their resources caring for spouses or family members and end up in poverty. In the year 2000, 58% of Vermonters

over age 65 were women, and the percentage increases dramatically with age. In 2005, 70.2% of Vermont nursing home residents were female (higher than the national average of 68.4%).

Until recently there was no prescription drug coverage for seniors. Vermont, through VHAP and other pharmacy programs, has greatly expanded access to medications for the elderly, disabled, and those with low incomes. However the new Medicare drug benefit has birthed a bureaucratic nightmare for many seniors.

For women of all ages who are uninsured or under insured, there are some publicly-subsidized programs that provide access to health care services, such as family planning programs, and federally-funded community health centers (FQHCs) that offer free care or have a sliding fee scale depending on income.

The Ladies First program is a federally-funded grant program through the Vermont Health Department that pays for annual mammograms, clinical breast exams, pelvic exams, Pap tests, instruction in breast self-exam, and cardiovascular disease risk factor (cholesterol, high blood pressure, diabetes) screening. Ladies First also pays for repeat mammograms, ultrasounds, biopsies, and colposcopies.

> *"There is compelling data on the typical trajectory to poverty between the ages of 65 and 85. In those two decades a healthy, middle-class woman spends considerable money on her husband's long-term care, is widowed and left to manage on the meager benefits of a surviving spouse, spends almost a third of her income on medical expenses not covered by Medicare, assumes she'll never wind up in a nursing home and then does…That's the heart of the Medicaid story…It's the 'poor widow' scenario, and it's just horrible."*
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> *June 27, 2005*
> *New York Times*

ACCESS TO HEALTH CARE SERVICES

Many people assume that having private insurance or being eligible for publicly-funded insurance or special programs guarantees access to health care services. This is not true, especially for women.

Many young women are unable to access important reproductive health care services. Barriers include lack of transportation and fear that their privacy will not be assured. Emergency contraception is not available in Vermont without a doctor's prescription. Abortion services after 16 weeks are not readily available in Vermont, and Medicaid does not pay for out-of-state abortion services for Vermonters.

Although working-age women may be eligible to apply for Medicaid, there are many stumbling blocks. For example, paying monthly premiums for VHAP or Dr. Dynasaur (coverage for pregnant women and for children under the age of 18) may be a lower priority than rent, food, or heating bills. Several recent studies have confirmed that increased premiums and co-pays reduce participation. Re-enrollment is cumbersome.

Complicated Medicaid applications present obstacles to women with low-literacy levels. The extremely complex and confusing new Medicare drug benefit presents similar obstacles. Compounding this situation is the problem of finding a provider who will accept Medicaid, VHAP, or Dr. Dynasaur patients. This leaves some women without a "medical home" for preventative or on-going care. Health implications can include delayed diagnosis of heart disease (the number one killer of women), undiagnosed breast and cervical cancer, compromised pregnancy prevention, or lack of prenatal care.

Vermont's geography presents special health care access challenges for older women, particularly those who live alone and are in need of multiple services. Because it is expensive to deliver these services, women in rural areas often end up in nursing homes.

There are other less visible barriers that impede access to care for women and their families. Lack of education often results in weak planning and decision-making skills. For women at all income levels, domestic violence, depression, and issues around weight often create impediments to accessing health care services.

Some men prevent their partners from leaving the house or refuse to let them speak privately with a health professional, making it difficult for women to seek relief from abuse.

Access to inpatient substance abuse treatment and mental health services may be difficult for women who are the sole custodial parent for their children.

In the last ten years, the incarceration rate for Vermont women rose by 540%. Facility caseworkers report that the majority of these inmates have substance abuse and/or mental health problems. Medical staff describe the need for more drug treatment facilities and continuity of care in order to facilitate rehabilitation. The majority of women enter facilities on a prescription medication. An extensive lag time exists between admission and a medical appointment, so the women are without their medications for a period of time, or may have their medications discontinued. Discharge planning is another area in need of improvement, so that women have access to health care and prescriptions when they return home.

> ***"Even at relatively low levels, cost sharing is a serious barrier for low income families who face financial pressures from all directions."***
>
> ***Do No Harm***
> ***PICO Research Report***
> ***Sept 12, 2005***

Women provide the majority of informal care to spouses, parents, friends and neighbors. In fact, the value of informal care that women provide ranges from $148 billion to $188 billion annually in the United States. Numerous studies have found that women care givers have higher rates of depression and cardiovascular diseases, are much less likely to fill their own prescriptions, and are twice as likely to deny their own medical care as were non-caregivers.

Many women cannot afford to take unpaid time away from work to go to the doctor. Less than 50% of businesses in Vermont offer paid sick leave as a benefit. Vermont's Family and Medical Leave Act does allow workers unpaid leave for routine doctor's visits for themselves and their family members. However, under this law the allotment of hours is limited, so many women, including those with paid sick leave, use these hours to accompany their children or elderly relatives to appointments - neglecting their own health care.

THE SCOPE OF WELLNESS

Women need access to acute, chronic, and preventive medical care in settings that foster trust between provider and patient. Medical protocols must be adjusted to meet the unique needs of women throughout their life cycle, particularly during pregnancy.

Acute needs range from short term conditions, such as urinary tract infections, STDs, or the flu, to serious and potentially life threatening conditions, such as pneumonia, intimate partner abuse (the leading cause of injuries to women ages 15-44), and falls (the leading cause of hospitalizations - with hip fracture affecting older women most).

The incidence of chronic illness in women increases in every age group across the life span. In fact, public health officials report children in the U.S. today may be the first generation not to live as long as their parents.

Statistics indicate that 1 in 5 Vermont children are overweight. Their diets are low in healthy foods and they do not have enough exercise - risk factors for coronary artery disease and diabetes later in life. Vermont children also report high tobacco and alcohol use compared to children in other states, which can lead to chronic lung and liver disease.

Successful diagnosis and treatment of chronic illness requires an ongoing partnership between patients and clinicians. Recent data indicates the percentage of Vermont women who postponed or didn't get care because of cost or lack of insurance ranged from 24 to 37 percent. Chronic illnesses include arthritis, osteoporosis, cardiopulmonary disease (including emphysema and chronic bronchitis), diabetes, cardiovascular disease (including hypertension and stroke), Alzheimer's, various types of cancer, and obesity-related illness. Although Alzheimer's affects

men and women at nearly the same rates, the number of women living with the disease at any one time is twice as high as for men simply because women live longer.

Mental health care is an especially important area for women. Compared to men, women are more affected by depression (including postpartum), and mood disorders (anxiety, panic attacks, eating disorders, and post-traumatic stress). Poor young women are more at risk for depression because of past exposure to trauma such as sexual abuse and crime victimization. Unfortunately, there is no universal screening instrument available to detect early stage substance abuse in women. Sadly, women may be less willing to seek treatment for mental disorders and substance abuse fearing loss of their children. Although women are twice as likely as men to attempt suicide, they are less likely than men to succeed.

Women in Vermont, as elsewhere in America, continue to have high rates of unplanned pregnancies. They need access to family planning services, emergency contraception, and legal abortion services, including non-surgical medical abortions.

Health education and disease prevention are efficient and cost-effective ways to maintain and regain wellness across the life span. Unfortunately, these programs are often the first casualty of cost-containment efforts. Women need health care services that educate them about the impact of substance abuse, poor diet and little exercise, toxic agents, firearms, sexual behavior, motor vehicle accidents, and eating disorders. Early and adequate prenatal care, beginning in the first trimester, contributes to better outcomes for both mothers and babies. Education must also include dental, visual, and hearing health - often overlooked in favor of more immediate, acute care issues.

Women have special medical screening needs. Risk for osteoporosis, breast, and cervical cancers are dramatically reduced through the use of mammography and Pap smears. Blood glucose screenings for diabetes, as well as cholesterol and blood pressure checks are crucial.

Safe sex education, screenings that cover mental health issues, dental care, vision exams, violence and substance abuse prevention programs, and family planning are also important elements of care for women.

> ***"Women patients present myriad health concerns which are unique to women (such as pregnancy), predominate in women (such as osteoporosis or depression), or manifest themselves differently in women (such as heart disease). Women's health care must reflect this complexity, and be as comprehensive and complete as that delivered to the rest of the population. Women's family roles must be recognized as potential barriers to their receiving care, and appropriate enabling services-such as childcare and transportation-must reflect these responsibilities."***
>
> ***American Medical Women's Association***

PUBLIC POLICY RECOMMENDATIONS FOR VERMONT

***PRESERVE* the following women-friendly policies and programs:**

- Mental health parity
- Community rating
- Coverage of mammography
- Contraceptive coverage
- The Ladies First program
- Increased eligibility and benefits for low income adults, seniors, people with disabilities, and their care givers
- Income protection for spouses of nursing home residents
- Expanded eligibility for women needing treatment for breast or cervical cancer
- Support for family planning centers and funding of abortion services within the current law
- Support for federally-funded community health centers (FQHCs)

***IMPLEMENT* the following policies and programs that would improve access for women:**

- Support paid sick leave so that women won't have to choose between basic necessities and essential medical care
- Establish gender responsive community-based mental health and substance abuse programs for women with young children
- Provide comprehensive mental health and substance abuse programs in the correctional system
- Permit pharmacists to dispense emergency contraception
- Expand COBRA mandates to small businesses for insurance coverage post divorce
- Ensure affordable premiums and co-pays for low-income Vermonters
- Provide dental coverage for low income adults
- Implement comprehensive health education programs for schools, communities, and the workplace

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