The Changing Challenges of Women's Health for Society and the Health Care System

In the last 30 years, the roles and socioeconomic conditions of women have changed significantly with regard to employment, education, and professional opportunities. The shifting demographic profiles of women have created a new awareness of their health needs. These needs far exceed what society traditionally has viewed as women's health issues.

Lung cancer has replaced breast cancer as the most common cause of cancer death among American women. The lung cancer rate is linked to increased cigarette smoking and the lack of an effective therapy.

Higher rates of heart disease among women and the resulting mortality are thought to be a result of higher levels of stress accompanying women's growing responsibilities at home and at work.

The problem of teenage pregnancy is of crisis-level proportions as a result of early maturation and changing sexual behavior attitudes. This problem has long-range adverse impacts on the individual teen-ager's education, independence, and later opportunities, as well as on the baby in terms of low birth weight and mortality.

Women are living longer. Their health care needs are increasingly complex with regard to long-term care, chronic disease management, and the demands on the caregiver who provides home health care to aged family members. To these problems add the need for more effective prevention and treatment of osteoporosis, incontinence, alcoholism, and medication abuse.

The responsibility for improving the status of women's health in the United States is shared among women, society as a whole, and all its institutions. Women today increasingly take a greater degree of personal responsibility for their own health. They are taking informed steps to improve their health by adopting behaviors proven effective in preventing disease and promoting wellness. These include better communication with their health care providers, informed and safer use of medication, better nutrition with balanced diets, and active participation in health education programs.

Society and our social institutions, public and private, are responsible for raising the status of women's health. The needs are to improve the health care system, change attitudes toward women's health, and remove social and economic barriers to quality health care services and delivery. Research is needed on the serious, debilitating diseases which impact women, with the research results communicated freely to the public health community. We can develop more timely and understandable educational messages and programs to help women prevent disease and improve their well-being. Support networks within the community need to be encouraged and strengthened.

The National Conference on Women's Health was held in June 1986. It focused on the urgent women's health issues, providing a baseline of medical and scientific information on many aspects of these issues. The proceedings will soon be published as a special supplement to *Public Health Reports*, the journal of the Public Health Service. The presentations of the various recognized experts comprise a valuable contribution to the growing body of knowledge available to the public health community on women's health issues.

I regard the proceedings as the primary means for achieving the ultimate objective of the conference, which is to provide a resource and a stimulus for the development of educational messages and programs within local communities. Achieving that will realize the maximum benefits of our collective knowledge, and its application to the problems at hand and the work to be done.

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Advances in Indian Health Care

Three papers in this issue describe the Indian Health Service (IHS) and the people it serves. "The Organization of Health Services for Indian

People" describes the development of the IHS, its legal and administrative bases, and current structural elements. This organization has been widely studied and remarked upon as a model for so-called developing nations. The special and unique sovereign status of the various Indian tribes profoundly influences the IHS' programs, adding a complexity, responsibility, and pace that often frustrates those not familiar with, or sympathetic to, such an arrangement.

The authors of "The Indian Health Service Record of Achievement" outline the accomplishments of a unique health care system tailored by and for the service population of the IHS. Many of these accomplishments are striking, especially in light of the prevalence of serious risk factors present in all Indian communities.

In "The Indian Burden of Illness and Future Health Interventions" the authors examine the program changes necessary to deal with the conditions now prevalent in Indian communities, especially those attributable to lifestyle. By examining current mortality rates from the perspective of years of productive life lost, the IHS is in a position to direct resources toward the most urgent health problems in a much more systematic fashion.

These articles resulted from a study prompted by a directive from the Committee on Appropriations of the House of Representatives. The Committee asked the Administration to identify the "funding that would be required to bring the level of Indian health care services up to 'parity' with the U.S. population in general." This directive is a reflection of the widely held view that a gap exists between support for Indian health and that for the rest of the country. The IHS responded to the congressional directive by reviewing its priorities and activities within the context of the needs that must be met if past progress is to continue during the current revolution in health care.

The three articles in this issue of *Public Health Reports* have been adapted from the report to the Congress—"Bridging the Gap: Report of the Task Force on Parity of Indian Health Services" and from two other unpublished background papers used in preparing that report: "Comparative Health Service Indicators of the IHS and U.S. Populations: Final Report of the Indian Health Service Data Comparisons Project" and "Indian Health Conditions." These three documents represent a sustained professional effort of many people associated with the Indian Health Service, Centers for Disease Control, National Institutes of Health, National Center for Health Statistics, National Center for Health Services Research and Health Care Technology Assessment, Health Care Financing Administration, Office of Technology Assessment, academia, and other persons involved in various tasks related to the studies.

In addition to these IHS reports, two other recent Federal studies describe Indian health problems and suggest future courses of action for IHS. The congressional Office of Technology Assessment (OTA) report, "Indian Health Care"(*1*), was issued in April 1986, 9 months after publication of the report of the Secretary's Task Force on Black and Minority Health (*2*).

These various reports provide the most comprehensive recent description and analysis of the conditions and health issues facing Indian people as they move toward the end of the 20th century. The reports, not surprisingly, vary in tone and emphasis because of the differing approaches used and, to some degree, because different Indian populations were considered for each. For example, the report of the Task Force on Black and Minority Health uses national census data and health statistics to study all U.S. Indians, whereas the OTA and IHS reports focus primarily on those Indian persons eligible for services from IHS. There continue to be insurmountable difficulties in defining and accurately enumerating various Indian populations. This, combined with many other factors affecting the 507 federally recognized Indian entities in the United States, allow for only broad generalizations. Nonetheless, all these reports document that (*a*) Indians lag behind the U.S. population in income, health, and other socioeconomic indicators, (*b*) certain disease and death rates for Indians are higher than for the U.S. population at large, and (*c*) poverty appears to be related to death and disease rates for Indians, as it does for other special groups in the United States.

The OTA and IHS reports also describe substantial improvements in access to quality health services and corresponding improvements in the health status of the IHS service population. Despite these achievements, however, unmet health needs among Indians persist and will require

continued, undiminished services for the foreseeable future.

Future improvements in Indian morbidity and mortality comparable to those of the past 30 years will require adequate levels of "traditional" preventive and curative services coupled with an attack on specific problems with targeted programs of health promotion and disease prevention. Accordingly, the IHS' future planning, extramural arrangements, applied research, and information systems will have as their purposes (*a*) continuing a community-based approach to prevention and treatment of disease; (*b*) eliminating risk factors that lead to disease (such as diabetes and hypertension); (*c*) facilitating dietary changes, smoking cessation, exercise, reduced alcohol consumption, and other healthy behavior; and (*d*) developing targeted interventions in the causes of the alarming death rates for injuries, violence, and alcoholism.

Among current endeavors that are strengthening these IHS purposes are health promotion and disease prevention activities designed to reduce years of productive life lost; a process of allocating resources that considers the health status of specific populations; targeting certain programs, such as dental services, to persons between 5 and 44 years old, the age group in which the impact of prevention is greatest; establishing priorities for sanitation services; strengthening injury prevention programs that employ specially trained community health aides; and primary care protocols which emphasize health assessment and timely followup to prevent unnecessary illness and disability.

To achieve more efficiency and economy throughout the IHS, a concerted effort will also be made to encourage alternative financing mechanisms in various settings for health care delivery. The health care system in the United States is undergoing a virtual revolution, with dramatic increases in prepaid health plans (HMOs and capitated systems). In many instances, these plans seem to provide a broader range of services for less money and emphasize the benefits of prevention and out-of-hospital care. It is hoped that the IHS can embrace the successful aspects of these new financing mechanisms in order to get quality care to more people during a time of limited resources.

In the future, IHS activities will be evaluated for their effectiveness in improving health status rather than in units of service provided. In cooperation with Indian tribes, IHS planners will consider the health conditions that merit highest priorities in developing services and allocating resources. They will reevaluate the number, type, and design of IHS facilities in light of those priorities. The result of these actions should be the continued improvement of the health status of American Indians.

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References

1. Office of Technology Assessment: Indian health care. April 1986.
2. U.S. Department of Health and Human Services: Report of the Secretary's Task Force on Black and Minority Health. Vol. 1. Executive summary. U.S. Government Printing Office, Washington, DC, August 1985.