Women's Health: A Course of Action

Introductory Remarks

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IT IS CLEAR THAT interest in health issues of women is enormous.

In April 1983, the then-Assistant Secretary for Health, Dr. Edward Brandt, established a Public Health Service (PHS) Task Force on Women's Health Issues charged with assuring that the health needs of women throughout the nation were being effectively addressed, preparing a report on the status of women's health in the United States, and making recommendations regarding issues related to women's health.

The Task Force consisted of personnel from the PHS. The Task Force presented a report to Dr. Brandt in October 1985. From the very beginning, the Task Force realized that, since the members were all Federal employees, it needed a broader view of what the women of the United States felt were issues and problems regarding women's health.

To this end, the Task Force decided to seek the views of women across the entire country. It held a series of 11 regional meetings to which were invited representatives of women's groups and organizations and other interested and concerned women, as well as representatives of state, local, and community health services and health providers. The meetings were held in Boston, New York, Philadelphia, Atlanta, Chicago, Kansas City, Dallas, Denver, Seattle, San Francisco, and finally in Washington.

The Task Force also encouraged submission of and actually received many written comments and ideas. Women from all over the country provided thoughtful, sensible ideas and comments. They contributed incisive and often unique information and perspective.

The theme that seemed to dominate all those sessions was that women's health is directly related to their access to sound information and quality medical care. A number of significant issues were addressed at almost all of the regional meetings. These included those aspects of the health of women which can be permanently affected by certain social issues: the fact that mental health aspects of physical disease can often be overlooked by physicians; the need for creative approaches to health care, particularly in the area of long-term care; and the need, finally, for sound information by women themselves but also by their providers (nurses, nurse practitioners, physicians, midwives) so that they could serve their patients appropriately.

These participants all agreed that women's health relates to more than medical issues. Cultural, social, and economic factors determine to a great extent the ease with which women can enter the health care system and receive proper treatment.

Some of the factors influencing whether women have access to, and can participate in, the health care system have, unfortunately, been experienced by grandmother, mother, and daughter within a single family. Where women live, and the attitudes of care givers, also influence the accessibility and quality of the services and treatment they receive.

In most cases, the participants seemed to indicate that, while they thought that the American medical care system was excellent, they were concerned about the access to that care, sensitivity during the provision of such care by health care givers, and the need for further information.

With this background, the Task Force, which later became the Coordinating Committee for the Public Health Service, set out to do its job. Tasks were divided into four main issues: concerns about the social factors affecting women's health; physical health and well-being of women; the health concerns of older women; and the issues related to alcohol, drug abuse, and the mental health of women.

Each group undertook a large study, prepared a report, and made a series of recommendations which were integrated into the final set of recommendations from the Task Force. These final recommendations were presented with certain concerns. The Task Force wanted to be sure that the recommendations were related to those that could be addressed by the PHS, including those related to a PHS document that had been previously printed, "Promoting Health/

Preventing Disease: Objectives for the Nation." It also wanted to provide recommendations that could be best addressed by other Federal agencies and by State and local governments. We have recommendations that can be best addressed by the private sector and voluntary organizations. And finally and most importantly, the Task Force presented recommendations which women themselves can best address.

Women's Health: A Course of Action

Social Factors Affecting Women's Health

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THE REPORT OF THE Public Health Service (PHS) Task Force on Women's Health began with a chapter on the social factors affecting women's health. It is really the societal context within which we live that shapes our definitions of health and illness, shapes the way we try to maintain health or deal with illness, defines our access to health services, determines the cost of those services, and influences the character of the service we receive.

When we consider women's health, a natural first level of study is to compare it with men's health, and there we find our initial paradox: You and I probably will live 7 to 8 years longer than our male counterparts, but we will log more doctor visits, more disability days, higher rates of illness, and greater use of health services—even when the statisticians control for pregnancy-related conditions. The biologists postulate some reasons for this paradox, but not all the answers lie in biology—some of them are the result of the way we live.

In the studies that were done for the PHS Task Force on Women's Health, we who worked on the Social Factors Committee reviewed a wide range of research on demographic, economic, and social conditions that affect morbidity and mortality. Our report highlighted findings in five areas:

- cultural and social values and attitudes
- the relationship of economic status to health
- labor force participation, occupation, and health status
- family, household structure, social supports, and health
- interactions with the health care system

Some social factors that influence the health behavior of women and men have a differential effect, and some of the factors seem to be part of the bedrock of our socialization and sex role behaviors. For example, women's greater willingness to report symptoms and seek health services leads to early identification and treatment of illnesses and thus protects our health. We women take fewer risks than men, and that tends to protect us from many accidents and injuries, but the other consequence is that we do not enter into as many competitive activities that lead to fitness and mastery of the environment. In addition, some postulate that society's expectation of more passive and dependent behavior on the part of women is associated with the fact that depression is so much more prevalent among women than among men.

Other social factors influencing our health behavior shift with changes in our society, and we do not always know what direction those influences will take. In recent years we have seen some major changes that influence women's health. Among those changes, we believe that the most important are (*a*) the increasing rates of poverty among women, (*b*) the entrance of large numbers of women into the labor force, and (*c*) the increasing proportion of older women. All of these changes have implications for women's health status, their health behaviors, and their access to health services.

We know that economic disadvantage is associated with health disadvantage, and we know that women are economically disadvantaged relative to men regardless of age, race, ethnicity, education, or employment status. Moreover, we know that the economic gap between women and men is widening, and that more and more women live in poverty. Poor people are likely to face frequent illnesses because of poor nutrition, poor living conditions, high levels of stress, and reduced access to health