Editorial: The Federal Budget and Women's Health

The health concerns of women and their experiences with health care services have gained considerable recognition over the past 5 years. In parallel, federally funded programs are playing a critical role in women's health through research, programs to improve access to care, and direct provision of services.

The substantial list of activities includes the Women's Health Initiative at the National Institutes of Health (NIH). Breast and cervical cancer screening is provided under Medicare and Medicaid, in addition to expanded coverage of pregnant women under Medicaid. The Public Health Service maintains programs on reproductive health and maternal and child health, as well as mental health services, substance abuse treatment, and testing, counseling, and treatment for the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). The Violent Crime Control and Law Enforcement Act of 1994 has provisions on violence against women. All these reflect new and greater responsiveness to women's health concerns.

These programs play an especially critical role in the health of low-income women and their families. At any point during adulthood, women are more likely than men to be in poverty. Their ability to purchase care is correspondingly limited and their health risks greater. In the face of the current vigorous efforts to reduce the federal budget, it is important to understand the critical role of federal funding in the lives of women and the consequences of underfunding, reducing or eliminating these programs.

Insurance Coverage and Access to Care

Although at the time of writing the outcome of current budget negotiations cannot be predicted, the focus and the greatest impact are likely to be on Medicaid and Medicare. Proposals include funding Medicaid through block grants to the states, moving beneficiaries into managed care, reducing payments to providers who serve Medicare and Medicaid beneficiaries, and increasing cost-sharing requirements of beneficiaries. These proposals have significant implications for women.

In 1992, more than 13 million women were uninsured.1 Were it not for Medicaid and Medicare, many more would have gone without insurance. Women account for 70% of Medicaid beneficiaries under age 64. One third of all births are covered by Medicaid.1 Medicaid also is an important source of coverage for family planning services, at $500 million in fiscal year 1993 for over 2.5 million recipients (written communication from Donna Shalala, US Secretary of Health and Human Services, to Louise Slaughter, New York state representative, May 1995) and other preventive services, including cervical and breast cancer screening and treatment of sexually transmitted diseases.

Underfunding Medicaid could lead to reduced numbers of low-income women covered for medical care, reduced services, greater out-of-pocket costs, and reduced willingness of health care providers to care for Medicaid patients. The risk that even fewer physicians will participate is real, with disproportionate effects on women. The women who rely on Medicaid for themselves and their families do not have the resources to pay for health care out of pocket. The 1995 income eligibility level for a family of three averages $4658, or 37% of the poverty threshold.2 Block grants and greater state flexibility also could reduce the numbers of the poor covered. Experience of the uninsured shows that persons who do not have the means to pay for care are much more likely to go without needed care.3
Health Care Services and Public Health

Public Health Service programs provide important women's health services, which run the gamut from prenatal care to cancer screening. Domestic categorical grant programs have borne the brunt of prior budget cuts and are likely to be under severe strain in the future. Cuts on the order of 15 to 30% could radically curtail the numbers of women getting these needed services (Shalala-Slaughter communication).

The National Breast and Cervical Cancer Early Detection Program was initiated at the Centers for Disease Control (CDC) in 1991 to develop effective systems for early detection of these conditions. Through this funding, states have developed and provided screening services, public education, quality assurance measures, surveillance systems, and state-level cancer control coalitions. The program serves women at risk for these conditions, with an emphasis on older, low-income, underinsured and uninsured women. A 15% budget cut would reduce the numbers of women screened by 350 000 over 5 years (Shalala-Slaughter communication).

To prevent domestic violence and rape, 8 demonstration sites around the country currently receive CDC funding to develop and test strategies. The potential to apply what is learned from these projects on a national level in the future would be lost if no funds were to be added for the purpose.

The CDC's infertility prevention program screens women for chlamydia and other sexually transmitted diseases that can cause infertility and chronic health disorders and facilitate transmission of HIV. Current plans to expand the program to four more regions, providing screening to 1.3 million women annually, could not be carried out if funding for the program were frozen (Shalala-Slaughter communication).

For maternal and child health, a 15% reduction in funding would eliminate prenatal care for 200 000 women and primary care for 400 000. In family planning, a similar cut would eliminate services for 600 000 women. Cuts in HIV/AIDS testing of 15% would reduce the numbers of women tested by 180 000 (Shalala-Slaughter communication).

Restructuring programs into block grants removes guarantees of coverage and services for women. Cervical and breast cancer, for example, could become part of a chronic disease block grant, leaving to the state the decision of how to set priorities among different chronic diseases.

Research on Women's Health

Of benefit to all women is the research on women's concerns that has been initiated over the past 5 years. At NIH, the Office of Research on Women's Health, established in 1990, and the Women's Health Initiative, established in 1992 as a 14-year, $625-million program, support biomedical research with the goal of preventing heart disease, cancer, and osteoporosis among women. Funding also ensures the inclusion of women in clinical trials. Significant reductions in NIH research on women's health would limit the initiation of new projects and curtail the expansion or continuation of current research.

Conclusion

Although the budgetary decisions for the next few years and even for this year are not predictable, the effects of cuts in funding are foreseeable. As outlined above, reductions in federal funding of health programs clearly have the potential to undermine seriously the progress made in women's health, particularly that of low-income women.

At a time of strong pressures to reduce federal spending, the issue becomes how to maintain the gains that have been made in women's health. The following questions should be answered about every budgetary proposal affecting women's health:

- Will it increase the numbers of uninsured women?
- Will it reduce access to needed care?
- Will it limit women's choices and their ability to obtain care from health care providers sensitive to their concerns?
- Will it increase financial burdens on economically vulnerable women?
- Will it reduce the use of preventive services?
- Will it increase unwanted births?
- Will it lower the quality of care?
- Will it reduce the ability of frail older women to live independently?
- Will it delay research discoveries that could protect women from mortality of breast cancer and heart disease, and the pain and incapacitation of osteoporosis?

The prospects for women's health have much improved in terms of research and services. These gains should not be sacrificed by short-sighted policies that ignore the human consequences of budgetary decisions. Without adequate funding, women's access to health care and the quality of health care services for women are at risk.  

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References

Editorial: The Evolving Epidemiology of Syphilis

Early in the 20th century, syphilis was a leading cause of cardiac and neurologic disease in the United States. Evidence of syphilis was present in 3% to 30% of autopsy cases.1 Penicillin therapy and intensive public health efforts in the 1940s made syphilis rare, with only 3.9 cases of primary and secondary syphilis reported per 100,000 population in 1956.2 Other developed countries have nearly eliminated syphilis.3 However, since the 1950s, this country has had successive epidemics with peaks approximately every 10 years. The maximum rates during these epidemics have been increasing, and in the last major epidemic, the rates peaked in 1990 at 20.3 per 100,000, the highest rate since 1949. Rates dropped to 10.4 per 100,000 by 1993 and continue to fall.

In this issue of the Journal, Thomas and colleagues report an analysis of syphilis trends in North Carolina from 1985 through 1993.4 As the syphilis epidemic progressed, with a greater than threefold increase, rural counties, minority populations, and women were increasingly affected. The results have implications beyond North Carolina because, in general, demographic trends of syphilis infection there reflect those of the United States as a whole, although the rural occurrence of syphilis, in particular, is characteristic of the South.2 As Thomas et al. report, these trends are thought to reflect a combination of decreasing male homosexual transmission due to safer sex practices and increasing heterosexual transmission due to the introduction of crack cocaine and the exchange of sex for drugs in minority populations. Crack cocaine use in rural areas and limited access to care are proposed explanations for the rural epidemic. Similar to the national trend, rates dropped in North Carolina to 28.4 per 100,000 in 1993.

Why should we care about syphilis? So prevalent at the beginning of this century, late symptomatic disease is now very unusual, presumably because in time most infected persons are effectively treated, either with intent for syphilis infection or inadvertently for another infection.5 (Exceptions are persons co-infected with the human immunodeficiency virus [HIV], in whom neurosyphilis may be an important cause of morbidity.)6 However, syphilis raises at least four other important public health concerns. First, as has long been known, congenital syphilis is an important cause of fetal wastage and perinatal morbidity. In the United States in 1991, there were 4422 cases reported, up from 410 in 1986.2 By contrast, in England and Wales in 1993, only 2 cases were reported.7 The more than 10-fold increase in congenital syphilis in the United States compares with an approximate doubling of the rate of primary and secondary syphilis in the same period. Although some of the increase in congenital syphilis was due to a change in the case definition, the occurrence of the syphilis epidemic in minority women with inadequate prenatal care is the more important factor.

Second, HIV transmission is thought to be facilitated by genital ulcer disease. Numerous studies find an increase in the risk of HIV transmission with syphilis of approximately 2- to 9-fold.8 While this remains an area in need of further study, treatment and prevention of syphilis and other sexually transmitted diseases in a population probably will also reduce HIV transmission.

Third, syphilis is, in principle, entirely preventable and potentially eradicable. Treatment of syphilis prevents transmission and subsequent new infections, and a population approach to treatment can reduce prevalence. Hence, as with other communicable diseases in which humans are the sole reservoir, an investment in disease elimination today may be rewarded with reduced disease and disease control costs in the future. The alternative may be continued endemic foci of infection and recurrent syphilis epidemics.

Finally, syphilis is an important public health marker. Beyond the biologic facilitation of HIV transmission, people and populations in whom syphilis is prevalent also are at high behavioral risk for sexually transmitted HIV infection. A syphilis epidemic accompanied the HIV epidemic in gay men and accompanies the HIV epidemic associated with crack cocaine.9 Targeting HIV primary prevention activities at groups with syphilis may be a particularly effective strategy. While the current decline in national syphilis rates could be due to treatment intervention or biologic immunity, population changes in behavior resulting from HIV primary prevention efforts may also be contributing. Congenital syphilis, too, is a public health marker; every case is a sentinel event indicating a failure of the preventive health systems and, most usually, a deficiency of prenatal care.

After the largest syphilis epidemic in this half of the century and a resulting reactive expansion in syphilis control efforts, syphilis rates are now either low or decreasing in most states. However, syphilis remains endemic in many metropolitan areas and in the Southeast. The changing dynamics of the disease afford an opportunity to reevaluate prevention control goals and strategies.

How can better understanding of current trends in epidemiology help in syphilis prevention? By identifying populations affected by syphilis, clinical services can be made more accessible, key determinants of continued transmission can be identified, and targeted interventions can be developed. The analysis of notifiable disease reports from North Carolina is a valuable first step in identifying populations at risk and generating hypotheses. However, each aspect of the changing epidemiology of the disease raises additional questions that analyses of notifiable disease data alone cannot answer.

Why did the reported male-to-female ratio change so substantially toward women? Are increased heterosexual and decreased homosexual transmission the principal factors? Does the recent focus on congenital syphilis prevention differentially favor screening and detection of cases in women? In segments of the populations currently most affected, more women than men are of reproductive age and therefore at higher risk for gonorrhea and HIV infection. However, these factors also may have reduced the clinical consequences of syphilis in women.

Editor’s Note. See related article by Thomas et al. (p 1119) in this issue.