Health-Care Access and Well-being

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Health is a critical element when evaluating one's status in life. Health and access to health care play a significant role within this report because of their impact on quality of life. Besides affecting quality of life, health problems can negatively impact a woman's ability to care and provide for her family. As long as health care is a commodity, health outcomes for women will be affected by women's earning potential. In Missouri, women earn 26% less than men,[i] and women are more likely than men to be employed in part-time jobs that fail to provide health insurance. The number of uninsured Americans rose by 4.4 million to 50.7 million between 2008-2009, the first increase in the number of uninsured Americans since data collection on this indicator began in 1987.[ii] Women are often single heads of households, raising children and solely bearing the cost of health care, education, housing, and food. As a result, many working women are caught in the middle: they earn too much to qualify for Medicaid yet cannot afford even basic health-care coverage.

Although women have a longer life expectancy than men, they do not necessarily live those extra years in good physical and mental health. In 2007, 54.7% of American women's deaths were due to the chronic conditions of heart disease, cancer, and stroke; these chronic conditions are the leading causes of death for both women and men in the U.S.[iii] Women frequently experience gender disparity in the medical management of chronic health conditions,[iv] which can lead to reduced physical functioning and quality of life in later years.

Women in Missouri understand that the health of their family and themselves directly affects their ability to have a chance at a better quality of life, better paying jobs, and, ultimately, economic autonomy. Health care is a great need for many Missourians and can be linked to economic freedom and stability for most citizens. Based on the information in this report, it is evident that policy to improve health-care access and initiatives to improve preventative health issues such as cardiovascular disease, diabetes, and unintended pregnancy will improve women's ability to achieve financial stability, workforce opportunity, and a better quality of life. In these depressed economic times, women in Missouri need and deserve the security of sound health care accessible throughout their lifespans.

Health-Care Access for Missouri Women

Definition: Health-care access is measured through women's access to public and private health insurance.

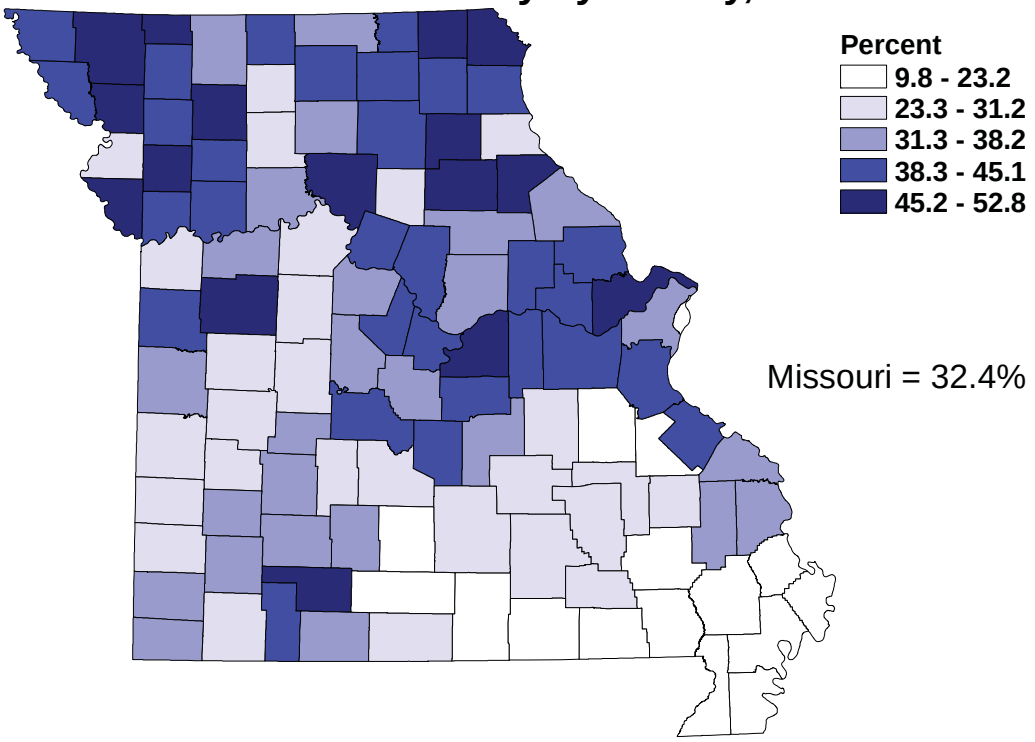
Significance: Insurance coverage is a key indicator for access and utilization of the health-care system. Women who lack consistent insurance coverage are more likely to go without preventative, basic, and even acute care. While a large number of women utilize these social programs, there has been little improvement to them since the state's Medicaid program was significantly cut in 2005.

Missouri Findings: Nearly one third of women with a household income less than 200% of the poverty level reported not having access to health insurance in 2008. The poverty threshold for a single-headed household with two children in 2008 was $17,346.[v] During the period between 2004 and 2008, Missouri Medicaid recipients ages 19 and over were more likely to be women than men. Women age 19 to 64 received Medicaid coverage for pre- and post-natal and delivery care as well as other acute health issues. The ratio of women to men over 65 who received Medicaid benefits, in addition to Medicare coverage, reflects the general trend of women living longer than men and the use of Medicaid to cover long-term care costs.

Regional Findings: Poor and working poor women in rural northern and suburban Missouri were far less likely to access public health insurance benefits than poor and working poor women in the central Ozarks, Bootheel region, and St. Louis city. In the best case scenario, 10% to nearly 25% of working-age women living in or near poverty were uninsured.

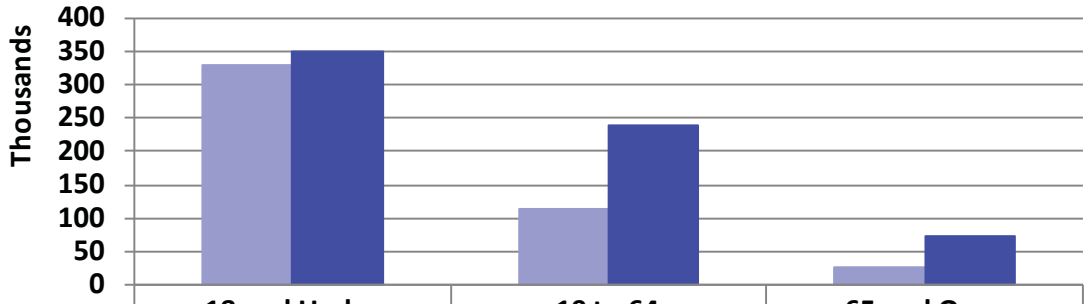
Policy Implications: Policy makers have not addressed the core obstacle keeping Missouri's low-

Percent Women (18-64) Uninsured with Household Income <200 Percent of Poverty by County, 2007



Source: US Census Bureau, Small Area Income and Health Insurance Estimates (SAIHE), 2007
Map Prepared By: University of Missouri Extension, Office of Social and Economic Data Analysis (OSEDA)
Map Generated On: 12, October 2011

Missouri Medicaid Recipients by Age and Sex 2004-2008



	18 and Under	19 to 64	65 and Over
Males	330,698	114,220	26,786
Females	349,608	239,354	73,687

Source: U.S. Census Bureau, 2004 - 2008 American Community Survey

income women healthy: the rising cost of quality health care. When combined with stagnating wages and a steady increase in job loss for Missouri's working women, it is clear the recession has had a significant impact on the status of women's health. It is not clear what impact the 2010 Affordable Care Act will have on women and girls in Missouri. For example, access to health insurance will be improved by the law's provisions permitting a young adult's ability to continue with parent's coverage until age 26; preventing insurers from denying coverage to those with preexisting conditions will also improve access. However, will the insurance be affordable? Are there enough providers? Will the insurance coverage include basic reproductive and primary health needs for women? What kind of cost sharing will occur? These are all significant questions that are still unanswered.

Infant Mortality

Definition: Infant mortality is defined as deaths that occur within the first year of life.

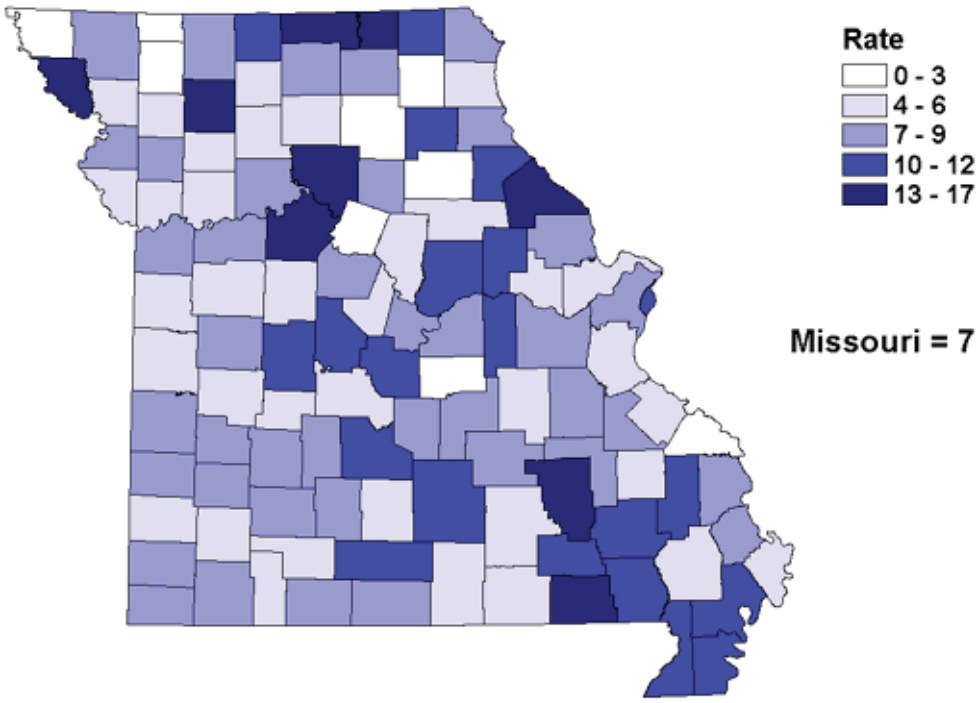
Significance: Early prenatal care is imperative for positive maternal and infant pregnancy outcomes. Nationwide, maternal and newborn care accounted for 26.7% of Medicaid costs in 2008.[vi]

Missouri Findings: Statewide, there were 7 infant deaths per 1000 live births during 2005-2009. In 2009, 48.4% of births in Missouri were to mothers who received Medicaid during pregnancy.[vii]

Regional Findings: High infant mortality rates are correlated with concentrated poverty. High infant mortality rates are clustered in the central Ozark and Bootheel counties, some of the poorest counties in the United States. High rates are also seen in other counties across the state that are characterized by high rates of poverty.

Policy Implications: It is critical for the state to ensure that there are providers within reasonable distances for women to access prenatal care. One of the more difficult issues in rural counties is to have

Infant Deaths per 1,000 Live Births by County, 2005-2009



Source: Missouri Department of Health and Senior Services, 2010
Map Prepared By: University of Missouri Extension, Office of Social and Economic Data Analysis (OSEDA)
Map Generated On: 14, August 2011

prenatal care available for the women that live there. Although there are large communities and academic centers that may provide prenatal care for uninsured and Medicaid patients, these facilities may require long travel distances for prenatal care and delivery. The results can be particularly dire for high-risk pregnancies or emergent perinatal care.

Breast Cancer

Definition: Breast cancer continues to be the most commonly diagnosed cancer among women in the United Sates.[viii] As screening for the disease and quality of treatment becomes more successful, breast cancer deaths become a proxy for lack of access to preventative care.

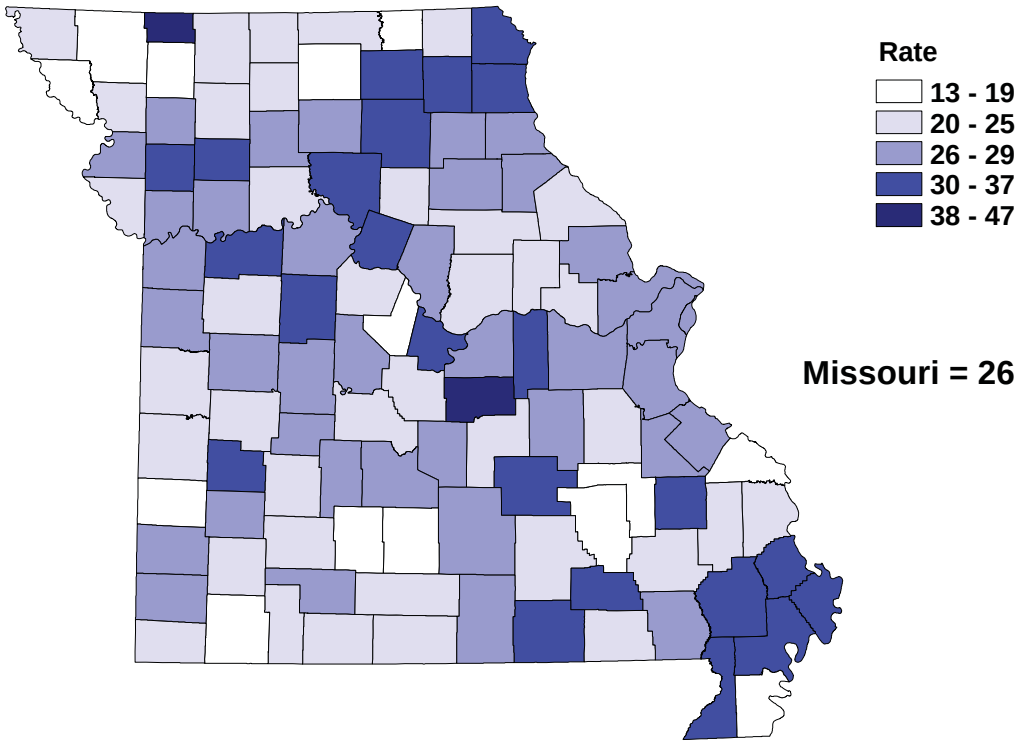
Significance: In 2010, an estimated 207,090 U.S. women were newly diagnosed with breast cancer, and nearly 40,000 women died from the disease;[ix] the 5-year breast cancer survival rate was 77.5 % for black women, compared with 91.4% for white women.[x]

Missouri Findings: During the period between 1998 and 2008, women in Missouri died of breast cancer at an annual average rate of 26 per 100,000. In 2007, Missouri ranked 10th among all states for fewest breast cancer deaths.[xi]

Regional Findings: The highest rates of breast cancer deaths (30 or more per 100,000) in Missouri all occur in relatively less affluent suburban and rural counties.

Policy Implications: Several recent studies have shown that in communities with fewer insured

Breast Cancer Death Rate Per 100,000 Females by County, 1998-2008



Source: Missouri Department of Health and Senior Services, Missouri Information for Community Assessment, 1998-2008
Map Prepared By: University of Missouri Extension, Office of Social and Economic Data Analysis (OSEDA)
Map Generated On: 26, August 2011

populations, breast cancer screening declines.[xii] Cost sharing is also a barrier for such preventative screening, and these costs may be prohibitive for moderate-income women who do not receive employer-sponsored health insurance and whose earnings are too great to qualify for Medicare.[xiii]

Diabetes

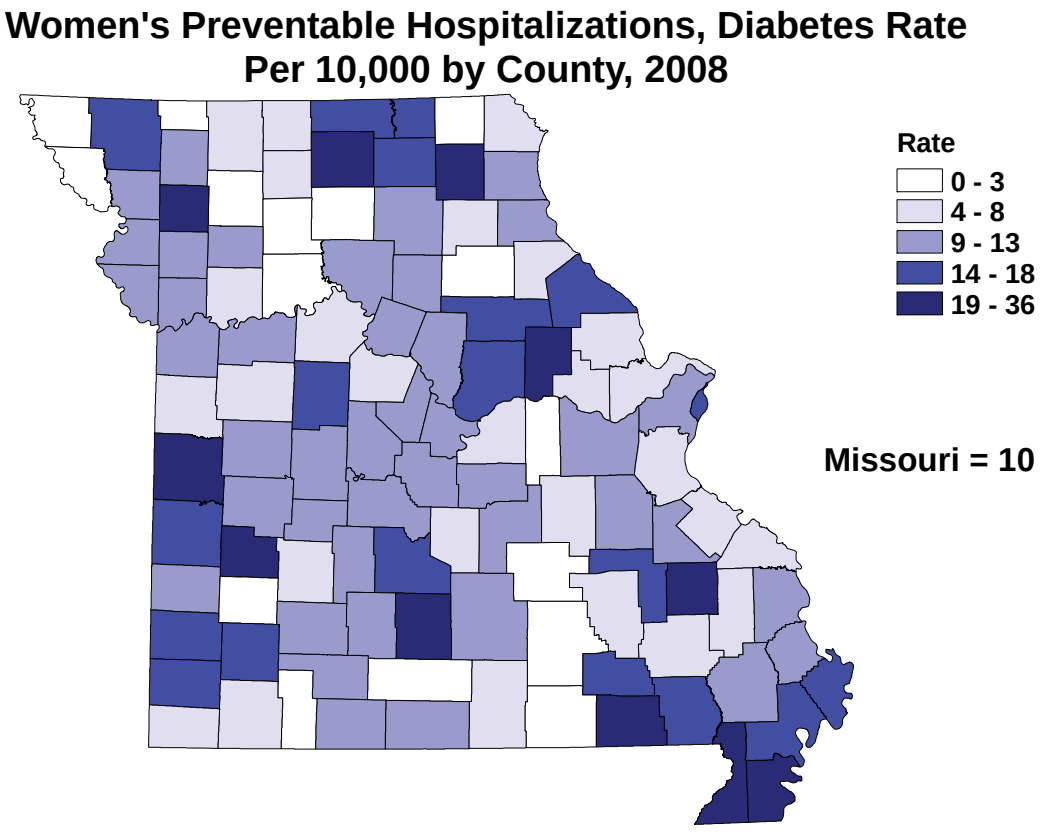
Definition: This indicator refers to the number of hospital and emergency room visits made per 10,000 women regarding diabetes and issues associated with diabetes.

Significance: Tracking diabetes-related care is a valuable proxy for health status because diabetes is both a predictor and precursor to many other health problems and effective preventive measures can reduce the incidence of diabetes and related health problems.

Missouri Findings: In 2008, approximately 10 per 10,000 women were hospitalized for complications related to diabetes.

Regional Findings: As with deaths from breast cancer, women in Missouri's most rural and poor counties are more likely to be hospitalized for diabetes-related symptoms than women in counties that are both more affluent and have greater access to primary care and prevention resources and activities.

Policy Implications: Diabetes can be viewed as a bellwether disease, indicative of communities that lack the resources, knowledge, and skills to support their citizens in maintaining a healthy diet and lifestyle that is effective in preventing the disease. Diabetes, specifically preventable hospitalizations for diabetes, is also a powerful proxy for geographic and economic access to quality preventative care to decrease prevalence of the disease itself and complications from diabetes.



Source: Missouri Department of Health and Social Services, Missouri Information for Community Assessment, 1998-2008
Map Prepared By: University of Missouri Extension, Office of Social and Economic Data Analysis (OSEDA)
Map Generated On: 16, April 2011

Control of Fertility among Missouri Women

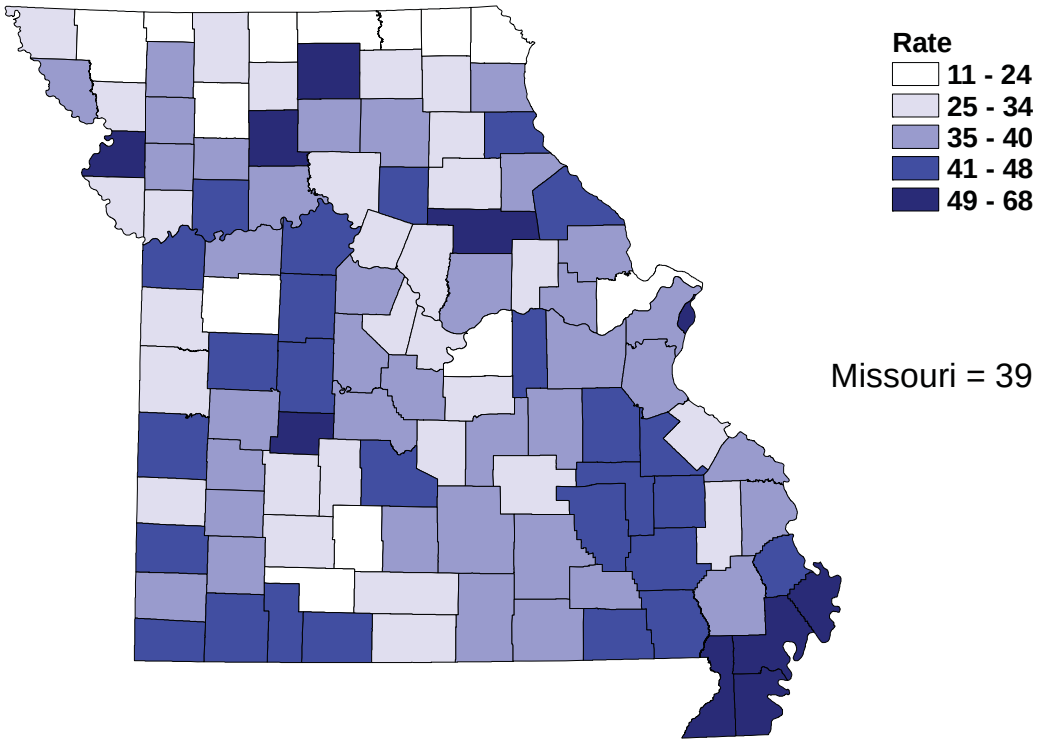
Definition: To understand the capacity of women in Missouri to control their reproductive lives, two rates are reported: unintended pregnancies per 100 live births, and abortion rates per 1,000 pregnancies. Abortion rate data reflect induced abortions as well as spontaneous abortions (i.e., miscarriages).

Significance: Women need and deserve the ability to control the size of their families. With many families having lost jobs and or health insurance, access to reproductive health and contraception is changing. Economic recessions have a significant impact on the timing and spacing of children. According to a survey conducted by the Alan Guttmacher Institute, 3 out of 4 women worry more about money and providing for their families than they did a year ago.[xiv] In addition, 64% of the women surveyed agreed they would not want to have a child in the current economic climate.

Missouri Findings: In 2008, 39 pregnancies of every 100 live births in Missouri were described by mothers as "unintended." As a state, the abortion rate in 2008 was 124 abortions per 1,000 pregnancies. While not all abortions are elective, and not all elective abortions are due to an unintended pregnancy, when these two indicators are considered together, roughly 40 to 50% of all pregnancies were reported as unintended.

Regional Findings: Women in rural northern Missouri counties are the least likely to report births as unintended and the least likely to report terminating pregnancies, while generally, women in counties south of the Missouri River are the most likely to describe a pregnancy as unintended but least likely to abort a pregnancy. Missouri counties, such as Adair, Nodaway, Boone, Clay, Cass, St. Charles, and Greene, which combine relative affluence with relative greater levels

Unintended Births Per 100 Live Births by County, 2008



Source: Missouri Department of Health and Senior Services, Missouri Information for Community Assessment, 2008
Map Prepared By: University of Missouri Extension, Office of Social and Economic Data Analysis (OSEDA)
Map Generated On: 26, August 2011

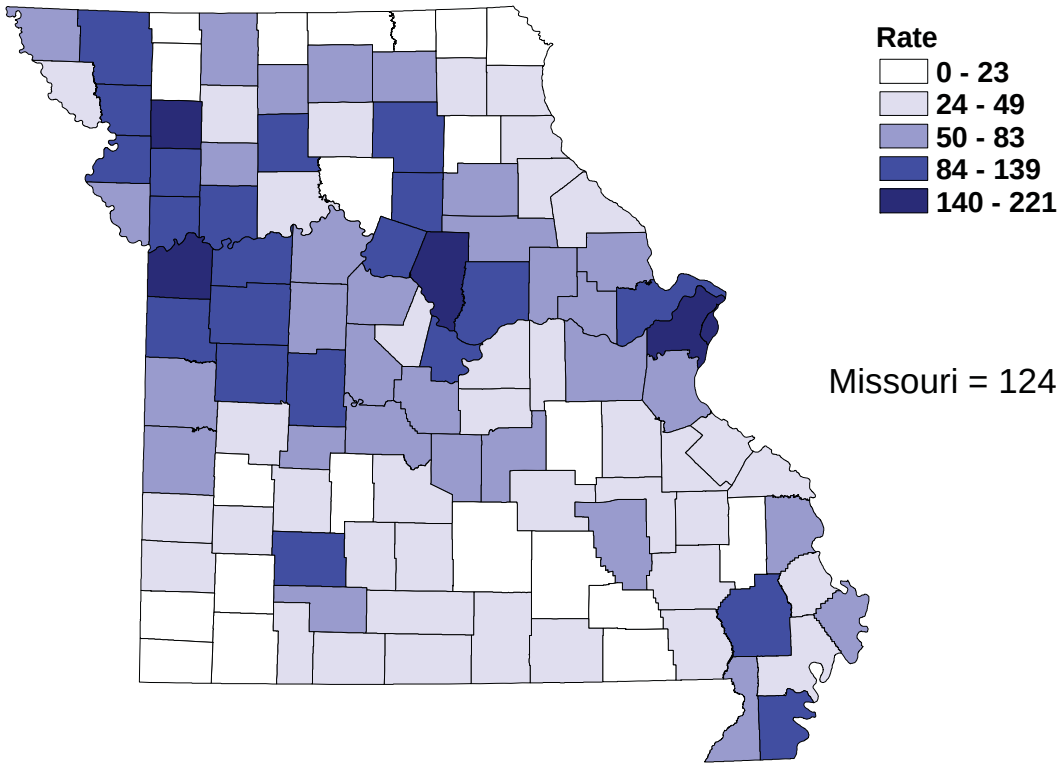
of educational attainment, are counties where women are less likely to describe a pregnancy as unintended—indicating a relationship between control over fertility and higher socioeconomic status.

Policy Implications: Regardless of individual beliefs about abortion, access to reproductive health care is necessary for ensuring the general health of the female population. Unintended pregnancy is a significant public health problem. This problem could be alleviated by responsible and supportive reproductive health policy that assists women in controlling their fertility and the size of their families. Unintended pregnancy affects the physical, emotional, and economic well-being of women and their families. Women with unintended pregnancies are less likely to obtain timely or adequate prenatal care and are at increased risk for low birth-weight babies and infant mortality.

In addition to these concerns, women with unintended pregnancies are less likely to attain educational goals and economic self-sufficiency. Access to comprehensive health-care services for women in the state of Missouri can decrease the number of abortions, thereby reducing the cost and burden on the state. Such policy changes will ultimately allow women and their families to better prepare and focus on their future goals.

Overall, women's fertility control impacts their participation in the workforce, ability to complete education, immediate health needs, as well as long-term health needs for their family.

Abortion Rate Per 1,000 Pregnancies by County, 2008



Source: Missouri Department of Health and Senior Services, Missouri Information for Community Assessment, 2008
Map Prepared By: University of Missouri Extension, Office of Social and Economic Data Analysis (OSEDA)
Map Generated On: 25, August 2011

Health-Care Access and Well-being Conclusion

This report creates a vivid picture of how Missouri women's health-care needs and ability to obtain care differ around the state. The gap between the health outcomes of insured women and women who lack access to care is wide.

Missouri's poorest women qualify for state Medicaid in numbers that are disproportionate to men. However, even with this access to subsidized care, many low-income women still have poorer health outcomes in pregnancy and with some chronic conditions such as diabetes and heart disease.

Unfortunately, women who earn enough to exceed the income requirements for Medicaid and do not have employer-based health benefits are forgoing preventive care. Two factors may be contributing to this: the high cost of screening and treatment, and the lack of understanding of the benefits of preventive health care.

The health and well-being of women directly impacts their ability to improve their status in other areas of their lives, including their economic security, education, and ability to provide for and care for their families. While health insurance reform was passed in 2010, it remains unclear how these reforms will impact women in Missouri. One thing is clear: public policies that improve access to primary and preventive health, including reproductive health, will help women reach their fullest potential in all aspects of their lives and will improve the overall health of Missouri families for generations to come.

WPA Policy Recommendations:

Support and expand women's health programs that provide primary preventive care, including screening and reproductive health services.

Expand programs that provide family planning services.

Improve access to Medicaid and private providers that provide prenatal care particularly in those areas of the state that have the poorest pregnancy outcomes.

Support programs that improve women's health and decrease the smoking and obesity rates among women.

[i] U.S. Census Bureau, Quarterly Workforce Indicators (QWI), Public Use Data, 2009.

[ii] DeNavas-Walt, C., Proctor, B. D., & Smith, J. C. (2010). *Income, poverty, and health insurance coverage in the United States: 2009.* (U.S. Census Bureau Current Population Reports, P60-238). Washington, DC: U.S. Government Printing Office.

[iii] Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. Retrieved from http://www.cdc.gov/injury/wisqars/leading_causes_death.html.

[iv] Blomkalns, A.L., Chen, A.Y., Hochman, J.S., Peterson, E.D., Trynosky, K., Diercks, D.B., Brogan, G.X., Boden, W.E., Roe, M.T., Ohman, E.M., Gibler, W.B., Newby, L.K., & CRUSADE Investigators. (2004).

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[v] U.S. Census Bureau, Poverty Thresholds 2008. Retrieved from http://www.census.gov/hhes/www/poverty/data/threshld/thresh08.html.

[vi] AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2008.

[vii] Missouri Department of Health and Senior Services, Bureau of Vital Statistics. (2009). Community Health Profiles: Prenatal. Retrieved from http://health.mo.gov/data/livebirths/data.php.

[viii] Center for Disease Control, United Stated Cancer Statistics (USCS), 2007 Selected cancers ranked by state. Retrieved from http://apps.nccd.cdc.gov/uscs/cancersrankedbystate.aspx#text.

[ix] National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program. SEER stat fact sheet: Breast. Retrieved from http://seer.cancer.gov/statfacts/html/breast.html.

[x] National Cancer Institute; Surveillance, Epidemiology, and End Results (SEER) Program. Fast stats. Retrieved from http://seer.cancer.gov/faststats/index.php.

[xi] Center for Disease Control, United Stated Cancer Statistics (USCS), 2007 Selected cancers ranked by state. Retrieved from http://apps.nccd.cdc.gov/uscs/cancersrankedbystate.aspx#text.

[xii] Adams, E.K., Florence, C.S., Thorpe, K.E., Becker, E.R., & Joski, P.J. (2003). Preventive care: Female cancer screening, 1996-2000. *American Journal of Preventive Medicine*, 25, 301-307.

[xiii] Sabatino, S.A., Coates, R.J., Uhler, R.J., Breen, N., Tangka, F., & Shaw, K.M. (2008). Disparities in mammography use among US women aged 40-64 years, by race, ethnicity, income, and health insurance status, 1993 and 2005. Medical Care, 46, 692-700.

[xiv] Guttmacher Institute (September 2009). A real-time look at the impact of the recession on women's family planning and pregnancy decisions. Retrieved from http://www.guttmacher.org/pubs/RecessionFP.pdf.