

# Women's Health in the United States: Health Coverage and Access to Care



## Kaiser Women's Health Survey

May 2002

THE HENRY J.  
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# Women's Health in the United States: Health Coverage and Access to Care

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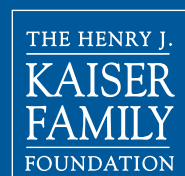
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# Executive Summary

Women are major consumers of health care services, in many cases negotiating not only their own care but also that of their family members. Their reproductive health needs, greater rate of health problems, and longer life spans compared with men make their relationships with the health system complex. Their access to care is often complicated by their disproportionately lower incomes and greater responsibilities juggling work and family. Because of their own health needs, limited financial resources, and family responsibilities, women have a vested interest in the scope and type of services offered by health plans, as well as in the mechanisms that fund health care services.

The Kaiser Family Foundation developed the *Kaiser Women's Health Survey* to learn more about the experiences of women with both their health plans and their health providers. This nationally representative telephone survey was administered to 3,966 women ages 18 to 64 in the spring and summer of 2001. Women who were nonelderly Latina, African American, uninsured, low-income, or on Medicaid were oversampled to improve our understanding of the challenges facing women who are most likely to fall through the cracks in the health care system.

## Key Findings

The health care system is not meeting the health needs of a sizable share of women. A significant portion of women cannot afford to go to the doctor and fill their prescriptions—even when they have insurance coverage. Women with health problems often have the hardest time getting care because of coverage restrictions, high costs, and logistical barriers, such as transportation. Women also have concerns about the quality of care they receive. A substantial proportion of women changed doctors

because of dissatisfaction with care. For many women, coverage and access to care are unstable. Health coverage, involvement with health plans, and relationships with doctors are often short lived, resulting in care that can be spotty and fragmented.

Selected crosscutting survey findings include:

### ❖ **Health care costs present significant problems for nonelderly women.**

- One-quarter (24%) of nonelderly women delayed or went without care in the past year because they could not afford it, compared with 16% of men.
- Almost three in 10 (28%) women found out-of-pocket costs to be higher than they would have expected them to be when they went to their doctor, a rate similar to that of men.
- Nearly one-quarter (23%) of women gave their plan a low rating on the out-of-pocket costs they incurred.

### ❖ **Affordability of prescription drugs is a primary concern for a sizable share of nonelderly women.**

- Half of nonelderly women used prescription drugs on a regular basis, compared with 31% of men.
- One in five (21%) nonelderly women did not fill a prescription because of the cost, compared with 13% of men. This was a problem for 40% of uninsured women, 27% of women with Medicaid, and 15% of privately insured women.
- About four in 10 women in fair or poor health (38%) did not fill a prescription in the past year due to cost; nor did one-quarter (25%) of women who used prescription drugs on a regular basis.



❖ **Women in fair or poor health—who have the greatest need for health care services—often experience major problems gaining access to care.**

- About one-third of nonelderly women (32%) had a health condition that required ongoing medical treatment, such as asthma, allergies, or arthritis, compared with 26% of men.
- Of the 16% of women in fair or poor health, half (49%) reported they needed to see a doctor in the past year, but did not.
- Transportation difficulties resulted in delayed care for 21% of women in fair or poor health, four times the rate of women in better health (5%).
- Nearly one-quarter of women in fair or poor health (23%) reported that their health plan refused to approve or pay for needed tests or treatment in the past two years; 57% of them either delayed care or never got treatment.

❖ **Women have significant concerns about the quality of care they receive.**

- Over one in five women (22%) expressed concerns about the quality of care they received from their physicians or health care providers, compared with 17% of men. This issue was a particular problem for women in fair or poor health (40%).
- Almost one in five women (18%) changed providers in the past five years due to dissatisfaction with care, twice the rate of men (9%).
- Overall, 14% of women gave their plan a low rating on the number and quality of physicians in the plan, as did the same share of men. This was a major concern for women with Medicaid (28%) and low-income women (21%).

❖ **Connection to the health system is unstable for many women.**

- Nearly three in 10 women (28%) reported they were uninsured at some point in the past year. One in five (19%) were uninsured at the time of the survey, and one in 10 (9%) had coverage at

the time of the survey, but were uninsured for some period in the past year. Rates were similar for men.

- Half of uninsured women (49%) lacked coverage for more than one year.
- Nearly half of nonelderly women had switched plans in the past five years. The leading reasons were employers changing plans (34%) or job changes for women or their spouses (30%). These statistics were similar for men.
- Among women who switched plans, 13% left their old provider and changed to a doctor affiliated with their new plan.
- Many women had relatively new relationships with their health care providers; one-third of women with a regular provider had been seeing that provider for two years or less.

These findings highlight the importance of viewing the health system through a woman's lens. Women's health is likely to be a silent victim of the recent economic downturn and rapidly increasing health care costs. In response to these major forces, employers may be more likely to drop dependent coverage, switch to less expensive or more limited plans, or raise worker costs for care. Because women are likely to be low-income and also rely on dependent coverage more often than men, they may have much to lose. Stable coverage likely will continue to elude many women.

With the rapid growth in prescription drug costs and limits on employer-based coverage, affordability barriers for women will undoubtedly rise. Fiscal pressures on employers, insurers, health plans, and providers are likely to create even more difficulties for women in affording and obtaining the range of health care services they require.

## Chapter Highlights

The following section summarizes the highlights of each chapter of the report. It presents the findings on women's health status, their health insurance coverage, their satisfaction and experiences with their health plans and providers, and their access to and use of health care services.

**Health Profile of Women:** Women's health status is influenced by factors such as age, income, and race/ethnicity. This survey sought to document the health conditions that women face and the factors associated with poor health among women.

❖ **Many women have health conditions that require ongoing treatment. The prevalence of most of these chronic conditions increases with age.**

- More than one in 10 women (13%) had a health problem that limited their ability to participate in everyday activities.
- Compared with women ages 18 to 44, women ages 45 to 64 were three times as likely to have cancer or heart disease and four times as likely to have arthritis or hypertension.

❖ **Low-income women are likely to have poor health status and activity limitations.**

- Low-income women were twice as likely as those with higher incomes to have fair or poor health status (23% and 10%, respectively) and conditions that limit activity (19% and 9%).
- They were at higher risk for experiencing health problems in their older years, when the combination of age and economic hardship takes its toll. Among low-income women ages 45 to 64, 49% reported arthritis, 41% had hypertension, and 32% had mental health concerns such as anxiety or depression.

❖ **Health status differs by race and ethnicity.**

- Latinas were the most likely to report fair or poor health (29%), and African American women were the most likely to report a health condition that limited their activity (16%).
- Among African American women ages 45 to 64, more than half (57%) reported hypertension and 40% had arthritis. One in six Latinas and African American women in this age group were diagnosed with diabetes in the past five years.

**Health Insurance Coverage:** Health insurance facilitates women's access to care by reducing financial barriers to care. Unfortunately, many women lack insurance or face obstacles in securing health coverage. This survey was designed to learn more about the status of health coverage for nonelderly women, focusing on who has coverage and who is at greatest risk for being uninsured.

❖ **A significant portion of women lack health insurance coverage.**

- One in five women ages 18 to 64 was uninsured, with the risk falling disproportionately on women with limited incomes; one-third of low-income women lacked coverage.
- Latinas were at very high risk of being uninsured; nearly four in 10 (37%) were without coverage. Younger women (between the ages of 18 and 29), those who were foreign born, and those who lived in the South or West were the most likely to lack coverage.
- Half of uninsured women (51%) lacked coverage for more than one year.
- Six in 10 (57%) uninsured women worked either full- or part-time.

❖ **Most women with health insurance receive it through work.**

- Employer-sponsored insurance was the predominant form of coverage for nonelderly women, with six in 10 covered by their own or their spouses' employer.
- Women were less likely than men to be covered by their own employers (33% vs. 53%, respectively) and more likely to be insured as a dependent (27% vs. 13%, respectively).

❖ **Medicaid, the state-federal health program for the poor, serves an important role for low-income women.**

- Nearly one in 10 nonelderly women (9%) received Medicaid coverage.
- Medicaid played an especially important role for poor women, covering one-third (34%).

**Health Plans:** A health plan's benefits and procedures can affect the types of providers and services that women can obtain. This survey focused on women's concerns about their health plans and the factors that influenced their decisions and determined their satisfaction with plans.

❖ **Women take a leading role in family coverage decisions.**

- Nearly six in 10 women reported that they were the primary decision-makers in their families about health insurance; 22% made the decisions jointly with their spouses.
- In selecting health plans, more than half of women rated as "very important" the benefits offered, selection of doctors, cost of plan, and reputation of the plan.
- The overwhelming majority of nonelderly insured women (82%) were enrolled in a managed care plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and 17% were in fee-for-service arrangements.
- Just over half of privately insured women (53%) were enrolled in a loosely-controlled plan where they had some flexibility to see a specialist without a referral or go out of network at higher cost. Almost one-third of women (30%) were in tightly-controlled plans.
- Among women enrolled in Medicaid, 82% were members of a managed care plan.

❖ **The majority of women are generally satisfied with their health plans.**

- Overall, few women gave their plans low ratings on issues such as the number of benefits (16%), ease of use (15%), and the number and quality of physicians in the plan (14%). Out-of-pocket costs were rated poorly by nearly one-quarter (23%) of nonelderly women.
- On many of these issues, women in poorer health, those on Medicaid, and low-income women had higher rates of dissatisfaction than other women.

❖ **A sizable share of women face difficulties in getting needed care because their plans deny payment or approval.**

- One in seven women reported that their plans denied coverage for care they thought they needed.
- Lack of plan approval for treatment or tests resulted in nearly one-half of women who were denied care either delaying or never receiving the services they thought they needed.
- About half of women (53%) whose insurance denied payment for needed services disputed their plans' decisions.
- Low-income women (33%) were twice as likely as higher-income women (15%) not to obtain the treatment they thought they needed.

**Health Providers:** A woman's relationship and satisfaction with her provider is a critical component of her health care. This survey explored women's relationships with their providers, focusing on both what worked well and women's chief concerns.

❖ **Women's reproductive and general health care needs make their relationships with their health care providers complex.**

- Nearly one in five women (17%) did not have a regular health provider, about half the rate of men (28%). Almost half of uninsured women (46%), one-third of Latinas (31%), and one-quarter of low-income women (24%) lacked a regular provider.
- About one-half of women had at least two routine providers, typically a primary care provider such as an internist or a general practitioner, along with an obstetrician or gynecologist (Ob/Gyn). The other half of women saw just one provider for regular care, typically a primary care doctor. Only a small fraction of women (7%) relied exclusively on an Ob/Gyn for all of their routine care.
- Despite the increasing pool of women physicians, only about one-third of women (31%) saw a female as their regular provider.

- Many women had relatively new relationships with their providers; one-third of women with a regular provider had been seeing that provider for two years or less.

❖ **A sizable minority of women—particularly those that faced the greatest health challenges—reported that they have difficulty communicating with their providers.**

- Women in poor health (18%) and Latinas (14%) were the most likely to feel that their doctor did not take the time to answer all their questions.
- Nearly two in 10 women (17%) reported that they did not understand or remember all of the information provided to them at their medical visit. This was particularly a problem for nearly one-third of women in fair or poor health.

❖ **A significant portion of women have changed doctors because they were dissatisfied.**

- Nearly one in five (18%) women had changed her doctor at some point in the past five years due to dissatisfaction, double the rate of men (9%).

**Access to and Use of Health Care:** Women's access to and use of the health system is influenced in part by their individual characteristics, health needs, and prior experience with both illness and the health system. It is also strongly influenced by insurance coverage and health system features. This survey examined the characteristics of women who faced the greatest challenges gaining access to health care and explored the factors that placed them at highest risk for experiencing barriers to care.

❖ **Most women (87%) had a health care visit in the past year, but where they got their care varied for different subgroups of women.**

- Latinas and uninsured women, both groups at higher risk for experiencing access problems and barriers to care, were the least likely to have had a doctor visit in the past year (31% and 24%, respectively).

- Women on Medicaid or who were uninsured (about four in 10 each) as well as African American women and Latinas (27% and 38%, respectively) were more likely to rely on hospital clinics and health centers for medical care than other women.

❖ **Many women do not receive recommended screening tests.**

- Only 35% of women 50 to 64 had a screening test for colon cancer in the past two years, 77% of women in the same age group had a mammogram in the past two years, and 56% percent of women 18 to 64 had a blood cholesterol test.
- Uninsured women and to a somewhat lesser extent, women on Medicaid were less likely than women with private coverage to obtain many of the recommended preventive screening tests.

❖ **Women experience multiple types of barriers to receiving health care.**

- The cost of care was a significant barrier to obtaining medical attention for women. Nearly six in 10 (59%) uninsured women, 42% of women in fair or poor health, and 31% of Latinas delayed or went without care because they could not afford it.
- Transportation barriers were experienced by 7% of women, but were especially salient for women on Medicaid (23%), Latinas (18%), and uninsured women (12%).
- Child care problems contributed to delays and postponement of care for 10% of women with children, and ranged from 17% of women on Medicaid to just 8% of privately insured women.

*The Kaiser Women's Health Survey* reports findings from a national telephone survey of 3,966 women ages 18 to 64 in the United States. A disproportionate stratified random sample was used to over-sample African American women, Latinas, those in low-income households (defined as having incomes below 200% of the federal poverty level), and those who were medically uninsured or Medicaid beneficiaries, so that sample sizes would be adequate to allow for subanalysis of these populations. The sample was then weighted using the Census Bureau Demographic Profile (from the March 2000 Current Population Survey) to adjust for variations in the sample relating to region of residence, sex, age, race, and education to provide nationally representative statistics. Interviews were conducted in either English or Spanish, depending on participants' preference. A shorter companion survey of 700 English-speaking men was conducted for the purposes of gender comparison.

Foundation staff designed the survey in collaboration with Princeton Survey Research Associates (PSRA) and analyzed it with researchers from the University of California, Los Angeles. Fieldwork was conducted by PSRA between March 28 and July 29, 2001. The margin of sampling error is  $\pm 2$  percentage points for the total women sample,  $\pm 4$  percentage points for the men, and is larger for subgroups. Note that in addition to sampling error, there are other possible sources of measurement error, though every effort was undertaken to minimize these other sources. A copy of the survey instrument is available upon request.



# Introduction

## Background

Women are major consumers of health care services, in many cases negotiating not only their own care but also that of their family members. Their reproductive health needs, greater rate of health problems, and longer life spans compared with men make their relationships with the health system complex. Women have a vested interest in the scope and type of services offered, as well as in the mechanisms that fund health care services.

Reforms in the health delivery system, such as managed care, also affect women disproportionately because of their greater need to obtain care from specialists, particularly in their peak reproductive years. Because women have lower incomes than men, they may be more likely to be disadvantaged when health insurance premiums increase, the costs of prescription drugs rise, or when out-of-pocket costs grow.

The impact of these changes on women differs depending on their backgrounds. Women who are poor, uninsured, in ill health, and of color experience the greatest disadvantage in gaining access to health care services. But researchers are only now beginning to understand the extent of the disparities across these subgroups.<sup>1</sup>

It is against this backdrop of shifting public policies, a changing health care system, and persistent health care disparities among women, that the *Kaiser Women's Health Survey*—a nationally representative sample of nearly 4,000 women from across the United States—was conducted. This survey was designed to better understand how the health system is working for women, in terms of coverage and in meeting women's complex health needs.

## Methods

The findings in this report are based on data from the *Kaiser Women's Health Survey*, which was fielded between March 28 and July 29, 2001 in the continental United States. This nationally representative telephone survey was administered to 3,966 women ages 18 to 64. Interviews were conducted in either English or Spanish, depending on participants' preference. A shorter companion survey of 700 English-speaking men was conducted for the purposes of gender comparisons.

At least 20 attempts were made to complete an interview at every sampled telephone number, and calls were staggered over times of day and days of the week to maximize opportunities of making contact with a potential participant. All interview break-offs and refusals were contacted at least one additional time to attempt to convert to completed interviews. The average duration of each interview was 25 minutes.

The sample of women in this survey is based on a sample of disproportionate stratified random-digit telephone numbers. This survey also over-sampled African American and Latina women, as well as those in low-income households (defined as having incomes below 200% of the federal poverty level), so that sample sizes would be adequate to allow for subanalysis of these populations. This method was also intended to increase the number of women in the sample who were medically uninsured or Medicaid beneficiaries. The sample was then weighted using the Census Bureau Demographic Profile (from the March 2000 Current Population Survey) to adjust for variations in the sample relating to region of residence, sex, age, race, and education to provide nationally representative statistics.

The analyses were conducted using SAS, a statistical program for data analysis. Statistically significant differences were tested at the 95% confidence interval and are noted with asterisks in the exhibits. New variables that were created for this analysis are detailed in the appendix of this report.



# Health Profile of Women

## CHAPTER HIGHLIGHTS

- ❖ Many women have health conditions that require ongoing treatment. The prevalence of most of these chronic conditions increases with age.
- ❖ Low-income women are likely to have poor health status and activity limitations.
- ❖ Health status differs by race and ethnicity.





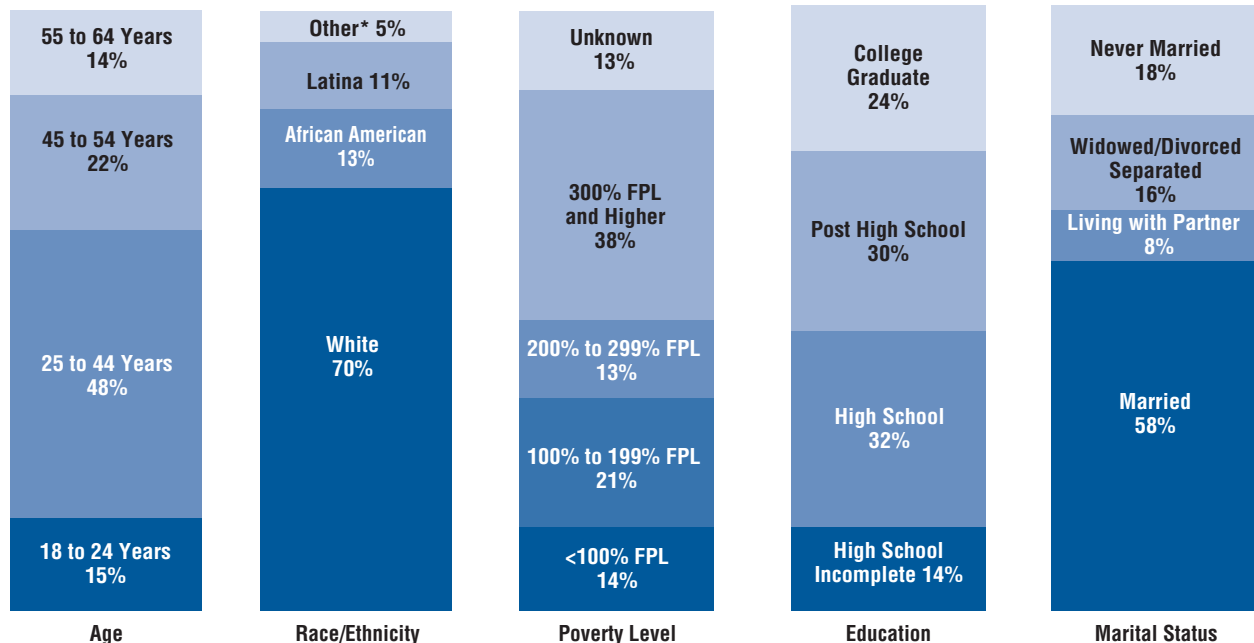
# Health Profile of Women

To understand women’s access to care and health coverage patterns, it is important to examine the context of women’s lives. Age, education, employment, race, and ethnicity are all factors in women’s health status, health seeking behaviors, and use of the health care system. This section attempts to answer the following questions: What are the major health concerns facing nonelderly women? What health conditions do women struggle with? What are the factors that are associated with poor health among women?

## Socio-demographic profile of women

Women’s relationships with the health care system are influenced by numerous demographic, economic, and work-related factors, as well as health system characteristics. Approximately two-thirds of nonelderly women were of reproductive age (18 to 44 years old), 22% were ages 45 to 54, and 14% were ages 55 to 64 (Exhibit 1). During their reproductive years, women have a greater need for obstetric and gynecological services. As they reach their middle years, managing chronic illnesses becomes a higher priority. White women still make up the overwhelming

**Exhibit 1: Selected Demographic Characteristics of Women, Ages 18 to 64**



\*Includes Asian, Pacific Islander, and those who classified themselves as “other.”  
 Note: 100% of the federal poverty level (FPL) was \$14,255 for a family of three in 2001.  
 Totals may not equal 100% due to rounding.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women’s Health Survey*, 2001.

majority of the female population. A large share of women, however, identified themselves as Latina, African American, Asian/Pacific Islander, or another racial, mixed race, or ethnic subgroup. In order to be responsive to the health needs of women, the health delivery system will have to be sensitive to the cultural and language needs of many of these women.

A sizable share of nonelderly women faced economic challenges, with approximately one-third (35%) in low-income families (family incomes below 200% of the poverty level). Although women's educational attainment has risen in recent years, 14% of women had not graduated from high school as of 2001, and one-third had completed high school, but had not taken any coursework beyond secondary education. More than half of women had some college or were college graduates. In the information age, women need to be sophisticated consumers of health information; those with low educational attainment are at a disadvantage.

The majority of nonelderly women were married, and an additional 8% were living with a partner. Sixteen percent were widowed, divorced, or separated. Nearly one in five women had never married. Women who do not marry face greater challenges in obtaining health coverage, because they do not receive dependent coverage through their spouses' employer. They typically only get coverage if they work and their employer offers coverage, if they have very low incomes and qualify for Medicaid by having children or being disabled, or if they can afford an individual policy.

### Women and their health status

Nonelderly women in the United States face a series of health challenges. Most women reported they were in excellent, very good, or good health (84%). Still, many women reported a variety of health issues. More than one in 10 women (13%) reported that they had a disability, health condition, or handicap that

**Exhibit 2: Health Status Indicators, by Age Group, Women Ages 18 to 64**

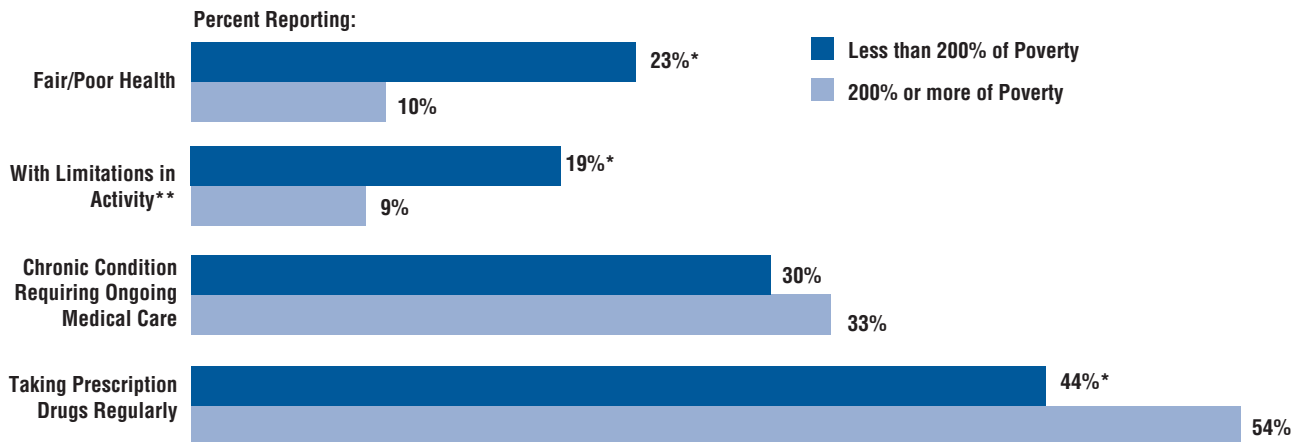
	All Women	Age Group	
		Ages 18 to 44	Ages 45 to 64
Fair/poor health	16%	12%*	23%
Disability or condition that limits activity	13%	9%*	19%
Chronic condition requiring ongoing treatment	32%	24%*	46%
Regular prescription drug use	50%	40%*	66%
Diagnosed medical conditions**			
Arthritis	17%	8%*	33%
Asthma	11%	11%	10%
Cancer	3%	2%*	6%
Diabetes	5%	2%*	11%
Heart disease	4%	2%*	7%
Hypertension	17%	8%*	32%
Obesity	11%	7%*	17%
Osteoporosis	4%	1%*	9%
Anxiety/Depression	21%	20%	23%

\*Significantly different from reference group (ages 45 to 64) at  $p < .05$ .

\*\*Conditions diagnosed by a physician in past 5 years.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

### Exhibit 3: Differences in Health Status, by Poverty Level, Women Ages 18 to 64



\*Significantly different from reference group (200% or more of poverty) at  $p < .05$ .

\*\*Limitations in activity are due to a disability, handicap, or chronic disease that keeps respondents from participating fully in school, work, housework, or other activities.

Note: 100% of the federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

limited their ability to participate fully in everyday activities, including school, work, or housework (Exhibit 2). A striking one-third of women (32%) reported that they had a chronic health condition that required ongoing medical treatment, compared with 26% of men (data not shown). Arthritis, hypertension, and anxiety or depression are prevalent conditions affecting women—with nearly one in five experiencing at least one of these conditions. In addition, 50% of women said they took at least one prescription drug on a regular basis, compared with 31% of men. The use of oral contraceptives and hormone replacement therapy, and high rates of chronic illness among women could explain some of the gender differences.

Age is a key determinant of differences in health status and needs, but certainly not the only critical factor. Socio-economic status also is a widely acknowledged factor related to health status, as is racial/ethnic background.<sup>2</sup> Key findings in this section highlight differences in health status by a woman's age, income, and racial and ethnic background.

#### Age group differences in health

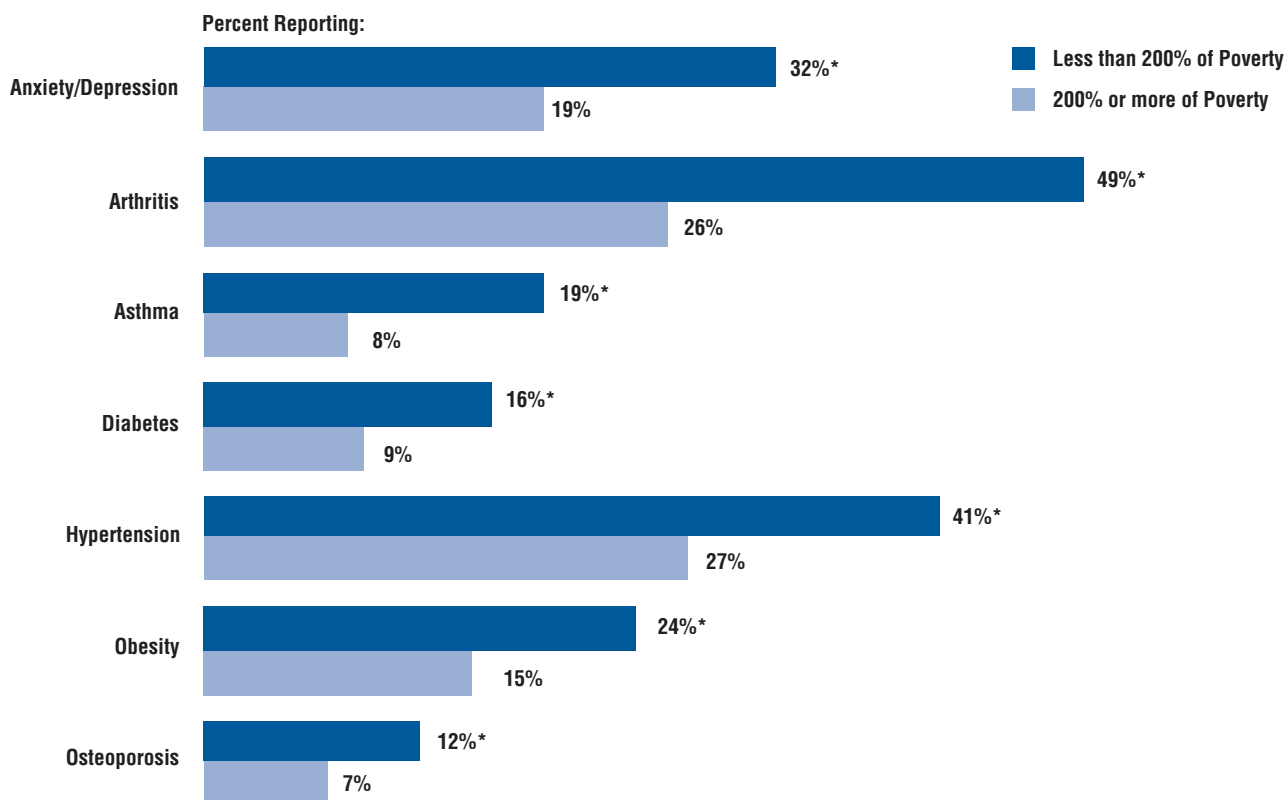
Women's health status and needs change as they age, requiring a health care system that is responsive to

these changing needs. Most younger women reported favorable health status and few had activity limitations. As women get older, however, health conditions that require ongoing care and management play an increasingly prominent role in their lives.

Nearly one-quarter (23%) of women who were in their midlife (ages 45 to 64) reported their health as fair or poor, compared with 12% of women in their reproductive years (ages 18 to 44). Nearly one in 10 women in their reproductive years and nearly one in five midlife women reported they had a disability, handicap, or chronic condition that kept them from participating fully in school, housework, or other activities.

The high proportion of women who have a chronic condition that requires medical attention highlights the need for access to ongoing medical care. This issue was not only relevant to women in their midlife where nearly half (46%) had at least one chronic condition, but also was a concern for nearly one-fourth of women in the younger age group (18 to 44).

## Exhibit 4: Differences in Prevalence of Chronic Health Conditions, by Poverty Level, Women Ages 45 to 64



\*Significantly different from reference group (200% or more of poverty) at  $p < .05$ .

Note: Conditions diagnosed by a physician in the past five years.

100% of the federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Reliance on prescription drugs also increases with age. Nearly 40% of women in their reproductive years took prescription drugs on a regular basis, compared with nearly 70% of women between the ages of 45 and 64. The survey, however, did not collect information on the type of prescription drugs that women used.

Women in the survey were also asked about conditions that were diagnosed by a physician in the past five years. With the exception of asthma and anxiety/depression, the prevalence of chronic conditions increased with age. Notable was the growth in the rates of arthritis and hypertension, both of which affected more than four in 10 women in the 55 to 64 year age group (data not shown). It is also striking that about one in five women across all age groups experienced symptoms of anxiety or

depression, reinforcing the need for comprehensive mental health coverage for women.

### Income differences in health status

On most measures of health status, low-income women (family incomes below 200% FPL<sup>a</sup>) in the survey fared significantly worse than those with higher incomes (Exhibit 3). Low-income women were twice as likely as higher-income women to report being in fair or poor health. They were also twice as likely as higher-income women to have a disability or chronic condition that limits their activities, although the need for ongoing treatment due to a chronic condition was similar between income groups.

<sup>a</sup>The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Income differentials were even more pronounced among women ages 45 to 64, as rising health needs are compounded by the impact of sustained economic hardship. One-third or more of low-income women in this age group reported arthritis (49%), hypertension (41%), and anxiety/depression (32%) compared with 26%, 27%, and 19%, respectively, of higher-income women (Exhibit 4). Other commonly reported health conditions among low-income women were obesity and asthma.

## Racial and ethnic differences in health status

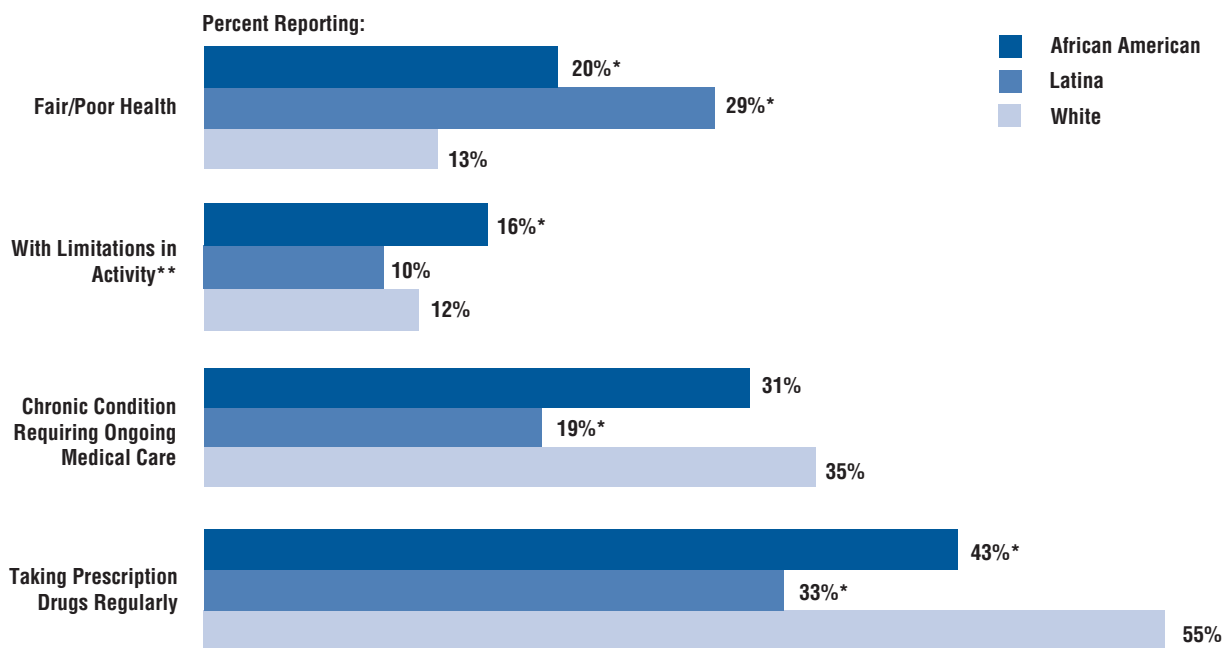
A significant body of research documents the existence of racial and ethnic disparities in health status.<sup>3</sup> However, the factors underlying these disparities are not well understood. This survey found significant differences in health status by race and ethnicity. Despite being a younger population, Latinas were the most likely to report being in fair or poor health, followed by African American women (Exhibit 5). African American women were the most likely to

have a condition that limits their activity, and were as likely as white women to report a medical condition that requires ongoing treatment, with Latinas the least likely. Among women 45 to 64, nearly one-half of African American and white women (49% and 46%, respectively) and four in 10 Latinas (40%) reported a chronic condition requiring ongoing medical treatment (data not shown). The rates of a medical condition needing ongoing treatment rose along with age for all racial/ethnic groups.

There were also significant differences in the use of prescription drugs by race and ethnicity, with 55% of white women, 43% of African American women, and 33% of Latinas reporting that they took prescription drugs regularly.

Selected conditions diagnosed within the past five years by a health care provider were also examined. Across all racial and ethnic groups, hypertension and arthritis were the most commonly reported diagnosed conditions for women ages 45 to 64 (Exhibit 6). African American women had the highest rates of reported hypertension (57%), followed by Latinas

**Exhibit 5: Differences in Health Status, by Race/Ethnicity, Women Ages 18 to 64**

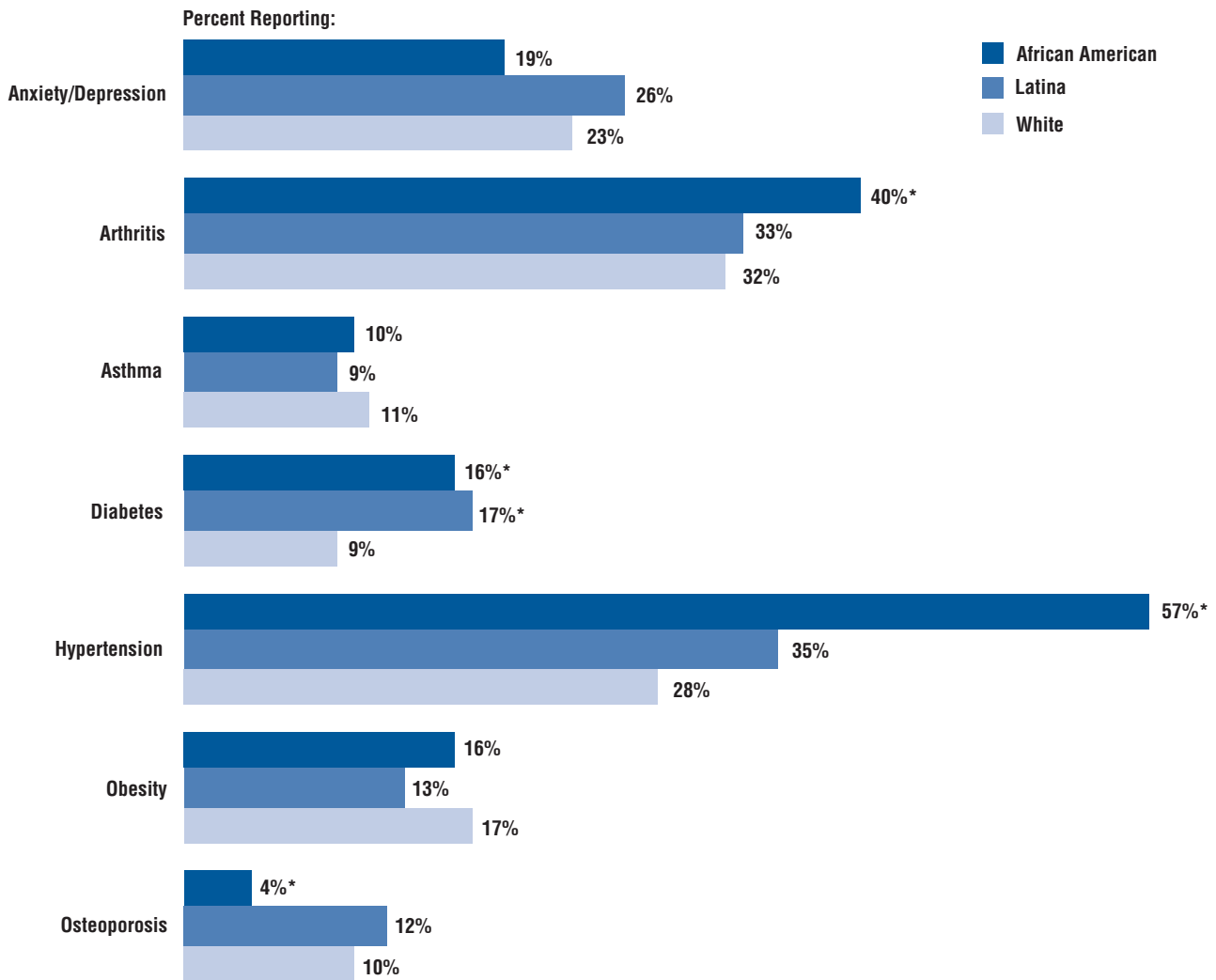


\*Significantly different from reference group (white women) at  $p < .05$ .

\*\*Limitations in activity were due to a disability, handicap, or chronic disease that keeps respondents from participating fully in school, work, housework, or other activities.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 6: Differences in Prevalence of Chronic Health Conditions, by Race/Ethnicity, Women Ages 45 to 64**



\*Significantly different from reference group (white women) at  $p < .05$ .

Note: Conditions diagnosed by a physician in the past five years.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

(35%), and white women (28%). Arthritis was also very common among all women in this age group, but was most prevalent among African American women (40%). Anxiety or depression affected a sizeable portion of women in this age group and cut across the racial and ethnic groups examined.

The true prevalence of these conditions could be understated because respondents were asked to

report only conditions that were diagnosed by a doctor. These conditions may have been present in women who did not visit the doctor or delayed care, but since they did not use medical services, their conditions were undiagnosed and therefore unreported. This may be particularly true for Latinas, who were more likely to lack insurance coverage and generally experienced more barriers to receiving care.



# Women and Their Health Insurance Coverage

## CHAPTER HIGHLIGHTS

- ❖ A significant portion of women lack health insurance coverage.
- ❖ Most women with health insurance receive it through work.
- ❖ Medicaid, the state-federal health program for the poor, serves an important role for low-income women.



# Women and Their Health Insurance Coverage

Health insurance facilitates women's access to care by lowering financial and other barriers. Unfortunately, many women lack insurance or face obstacles in securing health coverage, which can influence their ability to access the health care system and can have important implications for their health. Several findings in the survey point to differences in access to health insurance among subgroups of women. This section presents the status of health coverage for nonelderly women, focusing on who has coverage, the types of coverage, and who is at greatest risk for being uninsured.

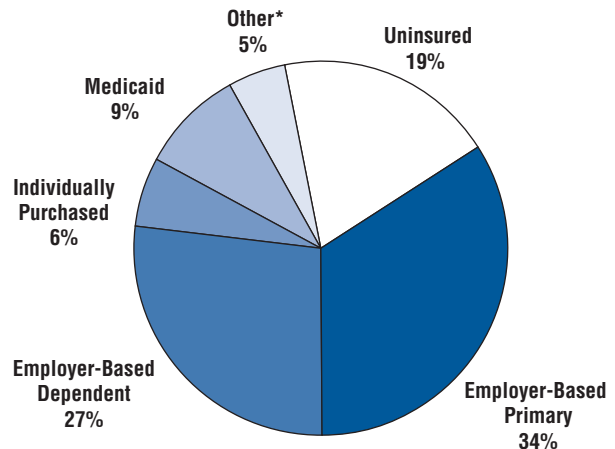
## Sources of health insurance coverage

Women obtain their health insurance coverage from several different sources. The majority of nonelderly women had job-based coverage (Exhibit 7). Women were less likely than men to have coverage through their own job and more likely to be covered as a dependent (also known as family coverage).

Compared with men, women are more likely to work part-time and work in industries that are less likely to offer health insurance. Having dependent coverage leaves women vulnerable to losing insurance if they become widowed or divorced. It also places them at high risk for losing insurance if their spouses' employer opts to drop dependent coverage or raise the level of cost-sharing due to rising health care costs. This can make health care coverage unaffordable, and in many cases unavailable to many women.

One-third of women were covered through their own employer, compared with 53% of men, and 27% had dependent coverage, compared with 13% of men. Still, increasing workforce participation among women has boosted their rates of having insurance in their own name over the past decade.<sup>4</sup>

**Exhibit 7: Health Insurance Coverage of Women, Ages 18 to 64**



\*Includes Medicare, CHAMPUS, and unknown insurance.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Medicaid, the state-federal program for the poor, provides a safety net for many low-income women who do not have access to employment-based insurance or cannot afford individually-purchased coverage.<sup>5</sup> Medicaid covered 9% of women, three times the rate of men (3%). This is because women are more likely to meet Medicaid's restrictive eligibility requirements. Nonelderly women who are not mothers, pregnant, or disabled typically do not qualify, no matter how poor they are. Other forms of coverage, such as individually-purchased private insurance (6%), Medicare (2%), and government coverage offer by the military (CHAMPUS) and through the Veteran's Administration (3%), rounded out coverage sources for nonelderly women.



This patchwork of coverage options left 28% of women in the survey uninsured for at least some period of time in the past year. Nearly one in five women ages 18 to 64 (19%) were without coverage at the time of the survey and 9% were covered, but were uninsured at some point in the previous year.

Although employment-based coverage is the backbone of our health insurance system, access is limited for many groups of women, particularly those who are poor and sick. Higher-income women have better access to job-based coverage, while low-income women, and especially those with incomes below the poverty level, have limited access to this coverage source (Exhibit 8).

Medicaid provides a safety net for women with limited incomes, but provides assistance to only one-third of poor women (incomes below 100% of the poverty level), and a much smaller proportion of near-poor women (with incomes between 100% and 199% of poverty). Thus, even with Medicaid as an option for

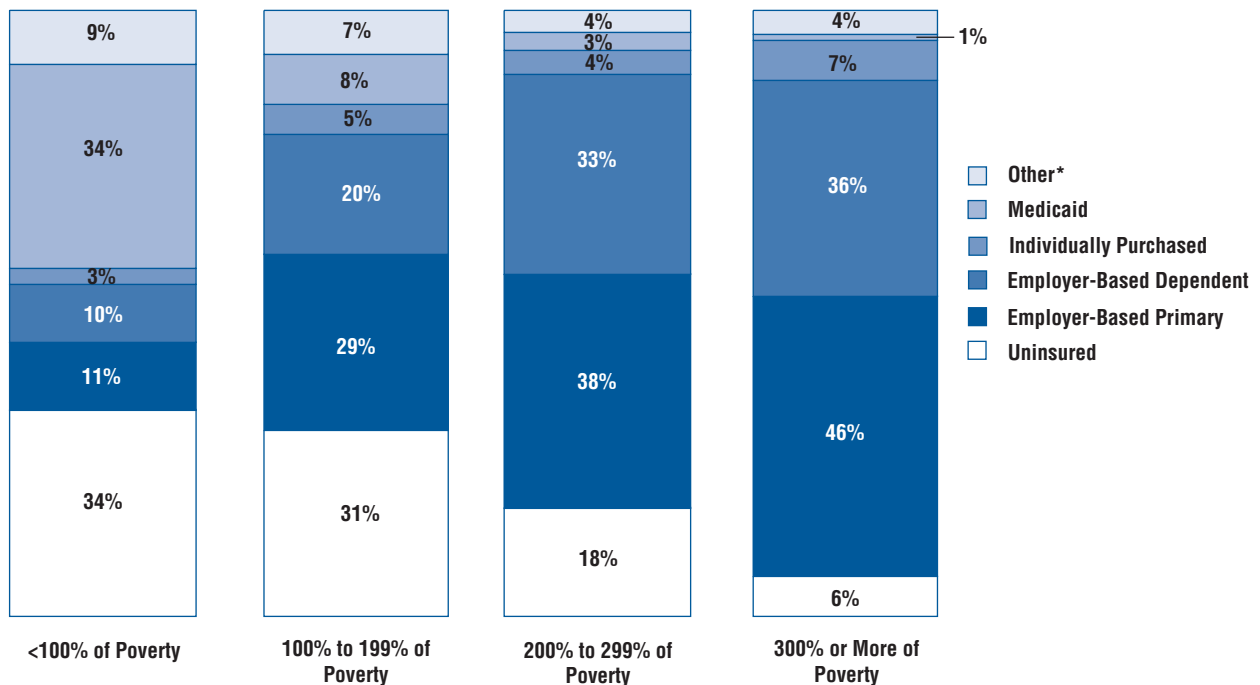
some, many low-income women remained uninsured, falling between the cracks of coverage options.<sup>6</sup> Lack of coverage is also a problem for women with somewhat higher incomes; nearly one in five women with family incomes 200% to 299% of poverty lacked coverage.

Other groups of women also were at high risk of being uninsured. Among them were younger women, those who were foreign-born, and those who lived in the West or Southern regions of the U.S. (Exhibit 9).

### Profile of women by insurance status

Uninsured women were five times more likely to be poor than privately-insured women with either employment-based or individually-purchased coverage (Exhibit 10). Women on Medicaid were the poorest as well as the youngest. In addition, uninsured women and women on Medicaid were more likely to have dependent children.

**Exhibit 8: Health Insurance Coverage, by Poverty Level, Women Ages 18 to 64**



\*Includes Medicare, CHAMPUS, and unknown insurance.

Note: 100% of the federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 9: Uninsured Rate of Women, by Selected Characteristics, Ages 18 to 64**

Demographic Group	Percent Uninsured	Demographic Group	Percent Uninsured
Total	19%	Nativity	
Age group		US-Born	17%
18 to 24 years	24%	Foreign-Born	34%
25 to 34 years	24%	Region of US	
35 to 44 years	19%	Northeast	14%
45 to 54 years	14%	Midwest	15%
55 to 64 years	13%	South	21%
Race/Ethnicity		West	23%
African American	20%		
Latina	37%		
White	16%		

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 10: Characteristics of Women, by Insurance Status, Ages 18 to 64**

	Total	Private Coverage **	Medicaid	Uninsured
	100%	100%	100%	100%
Income Level				
Poor	14%	5%	57%*	26%*
Near-poor	21%	17%	20%	33%*
Non-poor	52%	66%	9%*	25%*
No information	13%	12%	14%	16%
Age group				
18 to 29 years	26%	22%	43%*	35%*
30 to 49 years	49%	52%	38%*	46%*
50 or more years	25%	27%	18%*	19%*
Dependent children				
Yes	48%	45%	61%*	55%*
Employment				
Employed Full-time	50%	60%	17%*	35%*
Employed Part-time	17%	15%	17%	23%*
Self-employed	2%	2%	2%	4%*
Not employed	31%	23%	64%*	39%*
Health status				
Excellent/Very Good/Good	84%	90%	62%*	77%*
Fair/Poor	16%	10%	38%*	23%*

\*Significantly different from reference group (private coverage) at  $p < .05$ .

\*\*Employer-based or individually purchased.

Note: Poor is defined as 100% of the federal poverty level, which was \$14,255 for a family of three in 2001. Near-poor is 100% to 199% of poverty, non-poor is 200% or more of poverty.

Totals may not equal 100% due to rounding.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

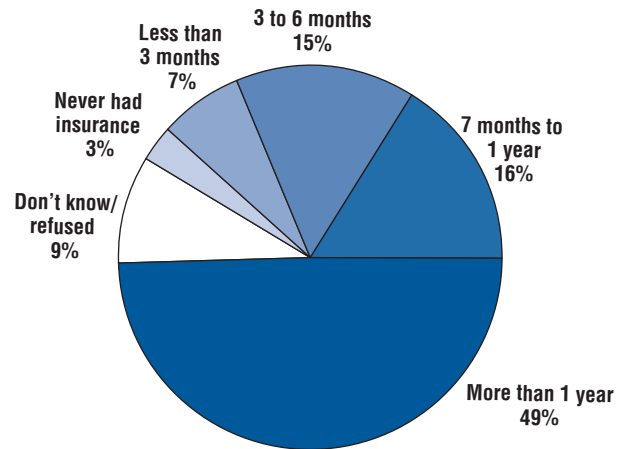
Women with private coverage were the most likely to work. But not all employed women had health coverage. Approximately six in 10 uninsured women worked, including about one-third who worked full-time. Over one-third (36%) of women receiving Medicaid were employed.

Aside from differences in socio-demographic characteristics by insurance status, there were also health status differences. Women on Medicaid and uninsured women were in poorer health than privately-insured women, compounding their need for adequate and affordable health coverage.

### Duration of lack of coverage

The length of time without health coverage has implications for a woman's connection to the health care system. One-half of uninsured women were without coverage for more than one year, and a small portion (3%) never had coverage (Exhibit 11). Among women who were privately insured at the time of the survey, nearly one in 10 (9%) were uninsured for at least some period in the preceding year. Among women with Medicaid, 20% reported being uninsured for some period in the preceding year (data not shown). This is likely due to Medicaid policies that require women to requalify for coverage, often every month. Even minor changes in family size or income can affect Medicaid eligibility.

**Exhibit 11: Duration of Lack of Insurance Among Currently Uninsured Women, Ages 18 to 64**



Note: Total may not equal 100% due to rounding.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.



# Women and Their Health Plans

## CHAPTER HIGHLIGHTS

- ❖ **Women take a leading role in family coverage decisions.**
- ❖ **The majority of women are generally satisfied with their health plans.**
- ❖ **A sizable share of women face difficulties in getting needed care because their plans deny payment or approval.**



# Women and Their Health Plans

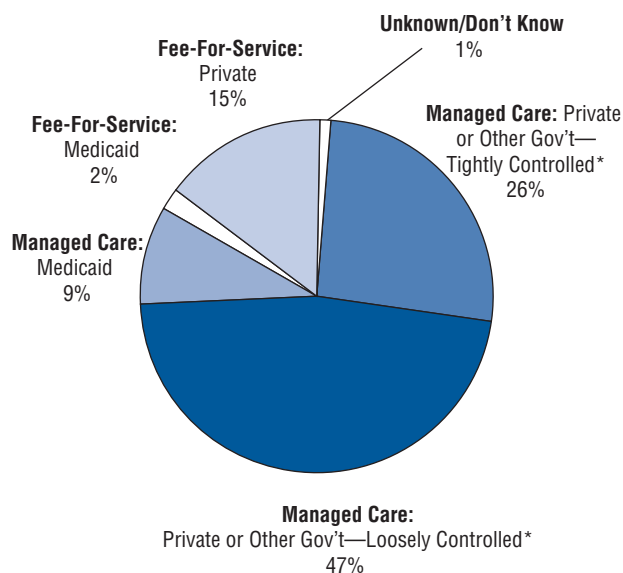
What health plans cover and how they operate are particularly important issues for women. Women are the primary decision-makers and coordinators of health care in their families, are the contact for health care providers for family members, and use more health care services than men. The types of health care plans available have changed substantially during the past decade, with rapid growth in managed care in both the private and public sectors. This increase in managed care has meant that for many consumers, selecting a plan is synonymous with selecting a group of providers and affiliated hospitals, since managed care plans place some restrictions on provider choice and limit the pool of providers to those in the network.<sup>7</sup>

## Health plan type

Approximately eight in 10 insured women were enrolled in some form of managed care plan (Exhibit 12). Nearly three-quarters were in private or other government<sup>b</sup> managed care plans, and 9% were in Medicaid managed care plans. Fifteen percent of women were in fee-for-service (either private or other government), and 2% were in Medicaid fee-for-service. Among privately-insured women, 83% were in a managed care arrangement, with 30% in plans that tightly control the available group of doctors and referrals and slightly over one-half in loosely-controlled<sup>c</sup> managed care plans (Exhibit 13). Medicaid managed care enrollment has grown rapidly over the past decade, mirroring the private sector, with 82% of covered women now enrolled in either an HMO or some type of primary care case management model.

**Plan choice.** Women take a leading role in making decisions about health care not only for themselves, but also for their families. Nearly six in 10 women (58%) made the primary decisions about choosing the health insurance plan for their families, and 22% made the decisions jointly with their partner or spouse. Many women do not have a choice since their

**Exhibit 12: Type of Health Plan, Insured Women, Ages 18 to 64**



\*Includes employer-based, individually purchased, and non-Medicaid government, such as Medicare and CHAMPUS.

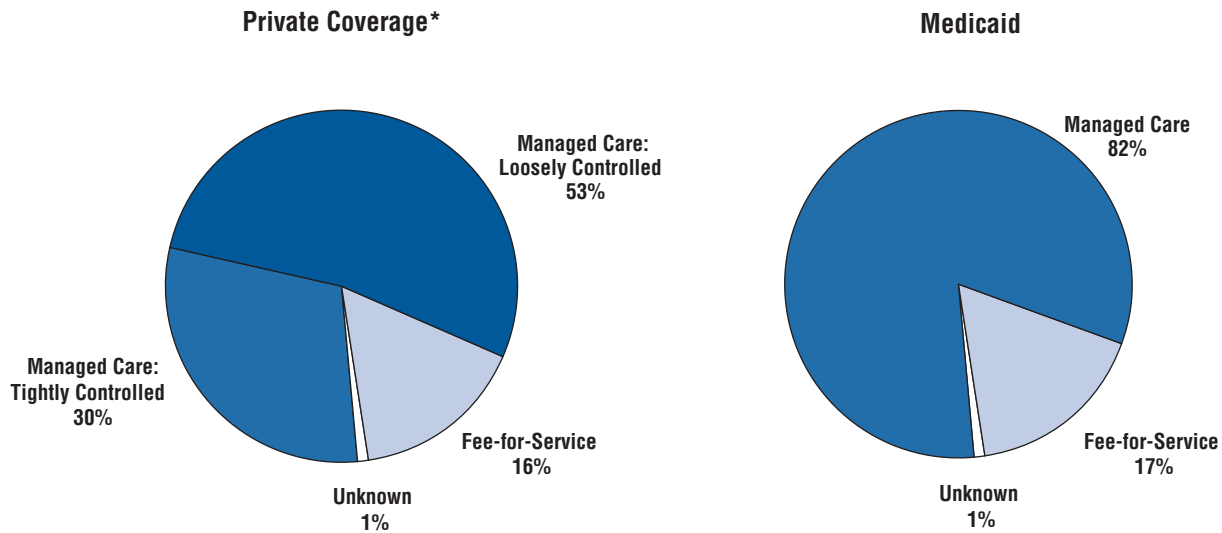
Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

employers or their spouses' employers only offer one plan. This lack of choice among plans further restricts a patient's choice of providers; the type of plans are often associated with certain networks of providers and going outside of network can have severe financial consequences. Among women who had job-based coverage, one-third (33%) had no choice in the selection of the health plan offered through their or their spouse's employer. Twenty percent of women could choose between two plans, and 36% could choose among three or more plans.

<sup>b</sup>Other government refers to government coverage besides Medicaid, such as Medicare or CHAMPUS coverage.

<sup>c</sup>See the Appendix for information on how tightly and loosely controlled managed care plans are defined.

**Exhibit 13: Type of Health Plan, by Insurance Status, Women Ages 18 to 64**



\*Includes employer-sponsored and individually purchased plans.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Plan selection factors**

Insured women who had a choice of health plans<sup>d</sup> were asked to rate the importance of several factors in their health plan selection. In selecting their health insurance plan, more than half of women rated as “very important” the benefits offered, selection of doctors, cost of plan, and reputation of the plan (Exhibit 14).

The package of benefits was the most important factor in plan selection. Three-fourths of women rated the benefits offered as a “very important” factor in plan choice, and a small proportion, just 4%, rated this reason as “not at all important.” Another key factor in plan choice was the selection of doctors. Approximately six in 10 women rated the doctors in the plan (57%) as a “very important” reason for plan selection. Similarly, the cost of the plan was rated as “very important” in plan decision-making by 56% of women with employment-based or individually-purchased coverage<sup>e</sup>. One-half of women identified the reputation of the plan as a “very important” selection factor.

Mentioned much less frequently as critical in plan choice were the recommendations of family or friends and the rating of the plan by an independent organization. About one-quarter of women identified these factors as “very important” and one-third

indicated they were “not at all important” in their decision making. There have been major efforts to get uniform plan comparisons into the hands of health care consumers. Findings from this survey suggest that independent comparison information is not presented in a way that is useful or maybe even available to consumers.

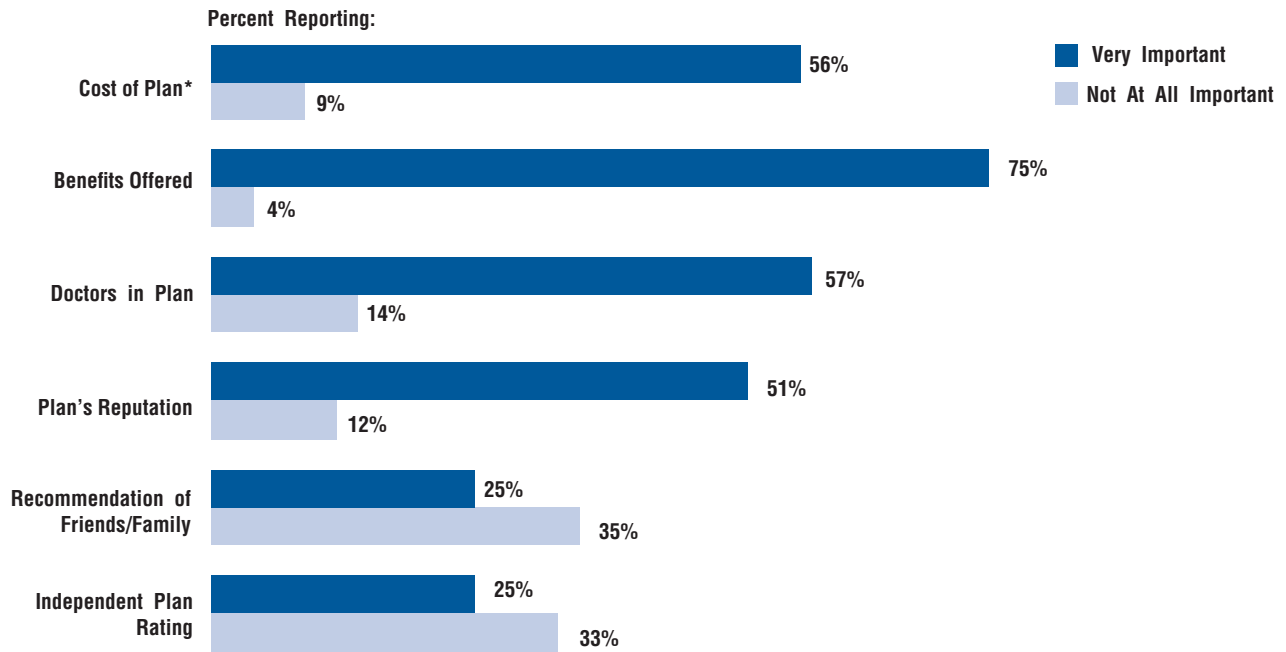
**Plan satisfaction**

The degree of satisfaction can be assessed by gauging how women rate certain features of a health plan, such as ease of use, benefits available, physicians in the network, and out-of-pocket costs. While most women rated their health plan as excellent, very good, or good, a significant minority gave their plans low ratings on these features (Exhibit 15). High costs, in particular, are a problem for nearly one-quarter of women who gave their plans a low satisfaction rating on their out-of-pocket costs.

<sup>d</sup>This includes women with employment-based coverage and Medicaid who had a choice of plan, and all women with individually-purchased coverage.

<sup>e</sup>Medicaid has no premium costs, so women on Medicaid were not asked this question.

**Exhibit 14: Importance of Selected Factors in Plan Choice Among Insured Women With Choice of Plan, Ages 18 to 64**



\*Includes only women with employer-based or individually purchased insurance.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 15: Percent Giving Health Plan a Low Rating, Insured Women Ages 18 to 64**

	Number of benefits it offers	Ease of use	Number and quality of MDs in plan	Out-of-pocket costs for MD visits
All women	16%	15%	14%	23%
Health status				
Excellent/Very Good/Good	14%	13%	13%	22%
Fair/Poor	23%*	24%*	24%*	28%*
Insurance status				
Medicaid	19%	20%*	28%*	18%*
Private Coverage**	15%	13%	12%	24%
Poverty level (FPL)				
<200%	19%*	19%*	21%*	26%
200% or more	13%	12%	12%	22%

\*Significantly different from reference groups (excellent, very good, good health; private coverage; and 200% or more of poverty) at  $p < .05$ .

\*\*Employer-based or individually purchased.

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Health status differences in satisfaction.** Women in fair or poor health, who were often high users of health care services, tended to be less satisfied with their plans than women in better health. Approximately one in four women in fair or poor health gave a low rating on benefits, ease of use, the number and quality of doctors, and out-of-pocket costs. Women with health problems often need specialty services that may not be commonly offered by plans. Their high use may also affect their ability to afford care. For example, a 20 dollar out-of-pocket charge for a health care visit may be a problem for women who are in poor health, have many visits in a short period of time, and must also pay for a share of their prescription drugs.

**Insurance differences in satisfaction.** Compared with women with private coverage, women on Medicaid were less satisfied with their health plans in two areas: ease of use and the number and quality of available doctors. Nearly three in 10 women on Medicaid gave a low rating to the number and quality of doctors, and one in five had problems with ease of use, indicating potential problems with access. Out-of-pocket costs were a concern for nearly one in five women on Medicaid, indicating that even the nominal cost-sharing permitted by Medicaid can be a problem

for some low-income women. Privately-insured women were even more dissatisfied with their out-of-pocket costs than women on Medicaid. Private plans can have steep cost-sharing requirements, and one in four women with private coverage gave low ratings to their out-of-pocket costs.

**Income differences in satisfaction.** Low-income women were generally less satisfied with their plans than higher-income women. They were twice as likely to give a low rating to the number and quality of doctors in their plan (21% vs. 12%), and at least one in five gave low ratings to the number of benefits, ease of use, and out-of-pocket costs. Dissatisfaction with out-of-pocket costs was similar for women of all income groups.

## Plan authorization issues

Many health plans, and especially managed care plans, require prior approval and referral for treatments and tests. Fifteen percent of insured women reported that within the past two years, their health plan refused to approve or pay for medical treatment or tests they thought should have been covered (Exhibit 16). Women in fair or poor health, who were the most likely to require specific treatments or tests that may not be commonly

**Exhibit 16: Percent Whose Plan Did Not Pay for Treatment or Tests in Past Two Years and Result, Insured Women Ages 18 to 64**

	All Women	Health Status		Poverty Level (FPL)	
		Excellent/ Very Good/ Good	Fair/ Poor	<200%	200% or more
Health plan refused to approve/pay for treatment or tests	15%	14%	23%*	17%	15%
Treatment outcome					
Obtained treatment right away	53%	56%	40%*	42%*	58%
Delayed treatment because of cost	24%	23%	31%	23%	23%
Never got treatment	21%	20%	26%	33%*	15%
Disputed plan's decision	53%	53%	52%	44%*	60%

\* Significantly different from reference groups (excellent, very good, good health; 200% or more of poverty) at  $p < .05$ .

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.



included in basic health plans, were less likely to have their tests or treatments approved or paid for than women in better health.

The lack of plan approval or payment for treatment or tests resulted in nearly one-half of women (45%) either delaying or never receiving these services. For women in fair or poor health, lack of plan approval resulted in nearly six in 10 either delaying treatment or not getting treatment. Low-income women were also disproportionately affected by plan refusal to pay for services, and were twice as likely as higher-income women not to obtain the treatment they thought they needed (33% vs. 15%).

More than one-half (53%) of women reported they disputed the plan's refusal to pay for the treatment or tests, with higher-income women (60%) more likely to do so than lower-income women (44%). This dispute may have ranged from merely asking the health plan to reconsider the denial to seeking external review of the plan's decision to deny coverage.

### **Switching health insurance plans**

For many women, long-term stability with a plan does not exist. Rising costs for employers, higher employee cost-sharing, volatility in the job market, and dissatisfaction with the plans themselves are all factors that contribute to plan switching. In fact, nearly half of nonelderly women (46%) switched from one insurance plan to another in the past five years. The leading reasons women gave for switching plans were that the employer providing coverage changed plans (34%) and that the women or their spouses changed jobs (30%). Only a fraction of women reported that they changed plans because they needed better or different options (6%) or needed a less expensive plan (6%). Among women who switched plans, 13% left their old provider and changed to a different doctor affiliated with their new plan. This can disrupt continuity of care because many women cannot afford to continue with providers who are not in their new networks.



# Women and Their Health Care Providers

## CHAPTER HIGHLIGHTS

- ❖ **Women’s reproductive and general health care needs make their relationships with their health care providers complex.**
- ❖ **A sizable minority of women—particularly those that faced the greatest health challenges—reported that they have difficulty communicating with their providers.**
- ❖ **A significant portion of women have changed doctors because they were dissatisfied.**



# Women and Their Health Care Providers

A woman's relationship and satisfaction with her provider is a critical component of her health care, especially for women with considerable health care needs. Studies have shown that a consistent relationship with a health care provider facilitates access to preventive screenings.<sup>8</sup> This section explores women's relationships with their providers, focusing on what works well and women's concerns regarding their physicians and other providers.

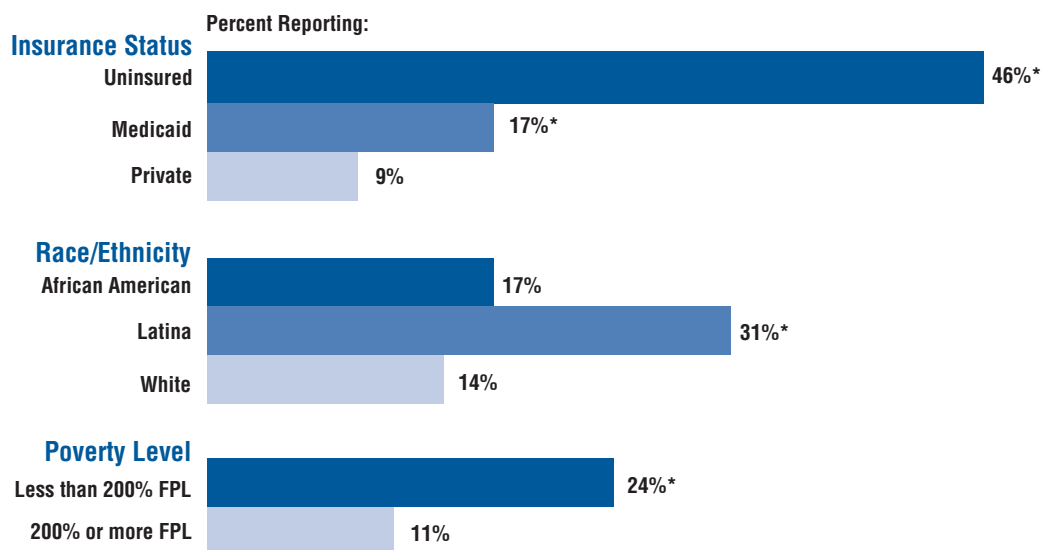
## Access to a regular provider

Women require regular communication with their health care providers to obtain preventive health services and to help them manage and treat the multiple chronic conditions they experience. Nearly one in five women (17%) did not have a regular health provider, about half of the rate of men (28%). Not surprisingly, uninsured women were five times more

likely to lack a regular provider than women with private coverage; nearly one-half of uninsured women had no regular provider (Exhibit 17). And while women on Medicaid were much more likely to have had a regular provider than uninsured women, still they were twice as likely as privately-insured women to lack a consistent health care provider. One in three Latinas also reported no regular connection to a provider. Low-income women were less likely to have had a regular provider (24%) than higher-income women (11%).

Among women with a regular provider, one in three had relatively new relationships with them (two years or less in duration), one-quarter have had a relationship lasting between three to five years, and 45% had been going to their provider for more than five years (Exhibit 18). Latinas were more likely to have had newer relationships with their regular

**Exhibit 17: Women Without a Regular Health Care Provider, by Selected Characteristics, Ages 18 to 64**



\*Significantly different from reference groups (private coverage, white women, 200% or more of poverty) at  $p < 0.05$ .

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 18: Length of Time with Provider Among Women with a Regular Provider, Ages 18 to 64**

Length of time with provider	Total	Race/Ethnicity			Poverty Level (FPL)	
		African American	Latina	White	<200%	200% or more
Less than 1 year	13%	12%	18%*	13%	14%	12%
1 to 2 years	18%	21%	21%	17%	20%*	17%
3 to 5 years	24%	23%	26%	24%	25%	24%
More than 5 years	45%	44%	34%*	46%	40%*	47%

\*Significantly different from reference groups (white women; 200% or more of poverty) at  $p < .05$ .

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

providers as were low-income women, possibly reflecting the fact that they were more likely than other women to have received their care from clinics or health centers where it is often difficult to see the same provider at each visit.

**Characteristics of providers**

Women's health and reproductive needs often define how they use the health system, which is considerably different from how men use the system. The majority of women, regardless of age, see a family practitioner as their regular provider (Exhibit 19). There is considerable variation, however, across age groups in other types of providers seen. As women age, their

use of an internist as a regular provider increases as Ob/Gyn use declines. A small proportion of women (5%) see a physician's assistant or nurse practitioner as their regular provider.

Despite the increasing pool of women physicians, most women reported that their regular provider was a man. Only one in three women had a female regular provider.

Women's health often has been characterized as fragmented because of the division between reproductive health and other health care services, and the use of multiple providers. Although there is no consensus on the most optimal arrangement for

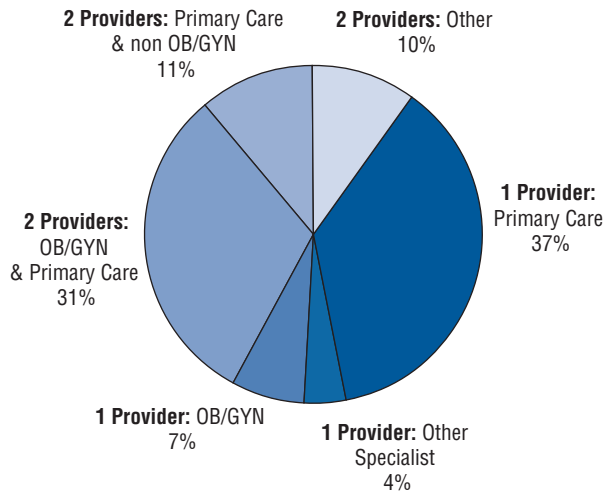
**Exhibit 19: Type of Regular Provider, Gender, and Additional Routine Provider, Women Ages 18 to 64**

Type of provider	All Women	Age Group	
		18 to 44	45 to 64
Family practitioner	63%	64%	62%
Internist	13%	9%*	20%
Obstetrician/gynecologist	11%	14%*	6%
Physician assistant /nurse practitioner	5%	6%*	3%
Other medical specialist	6%	4%*	7%
Don't know	2%	2%	2%
Main provider female	31%	33%*	29%
Additional routine provider	51%	50%	53%

\*Significantly different from reference group (ages 45 to 64) at  $p < .05$ .

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 20: Number and Specialty of Providers Used by Women With a Regular Provider, Ages 18 to 64**



Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

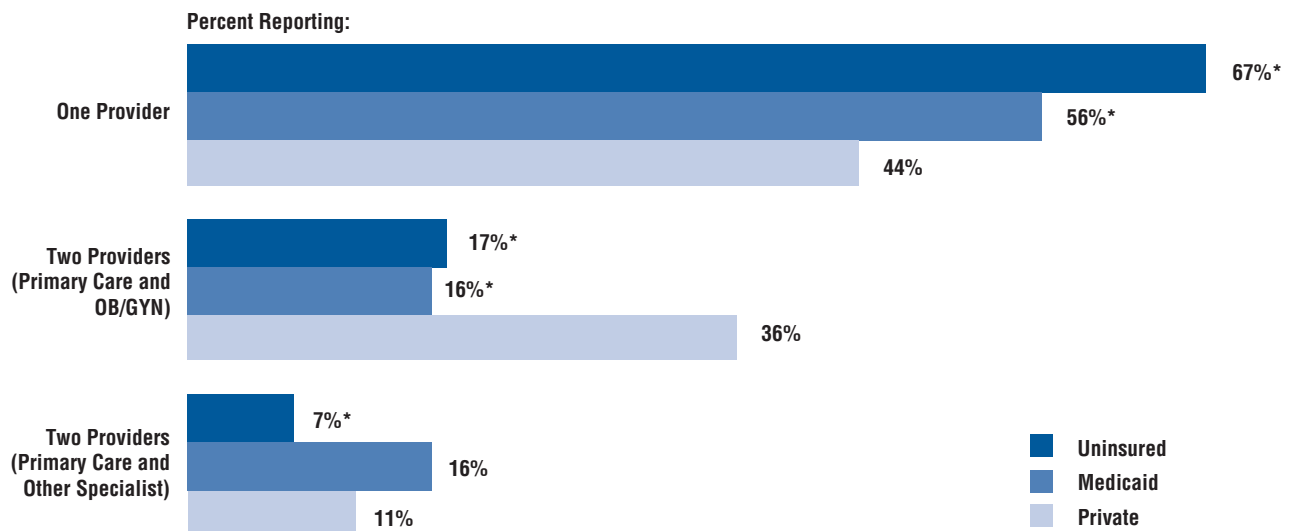
women, they need to have both their reproductive health needs and general health addressed. Women who routinely get care from an Ob/Gyn and a primary care practitioner are more likely to receive preventive

services, such as Pap smears and clinical breast exams, than women who rely on a single provider for their care.<sup>9</sup>

Approximately one-half of women had at least two routine providers (Exhibit 20). A common pattern was to have a combination of primary care and Ob/Gyn providers. One-third of women had this arrangement. An additional 11% of women relied on some combination of primary care and other medical specialists. Overall, 37% of women relied on a single provider who was in primary care, such as an internist or a family practitioner. Only 7% of women had an Ob/Gyn as their only regular provider, and 4% had another medical specialist as their sole regular provider.

The number and type of provider varied significantly for different subpopulations of women. Women with private insurance were more likely to rely on multiple providers than uninsured women or those with Medicaid (Exhibit 21). Among women with a regular provider, those who were uninsured were the most likely to rely on just one provider. Privately insured women were twice as likely as other women to have both a primary care physician and an Ob/Gyn.

**Exhibit 21: Number and Specialty of Regular Provider, by Insurance Status, Women Ages 18 to 64**



\*Significantly different from reference group (private coverage) at  $p < 0.05$ .

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

## Experiences with providers

A woman's interaction with her health care provider is an important component of her care. Exhibits 22 and 23 address this issue among women who had a doctor visit in the past two years, examining the adequacy of time with the doctor, their comprehension of information, out-of-pocket costs, and quality of care.

**Questions answered.** Women rely on their health care providers to answer their questions during a consultation, which can have important repercussions as they adhere to treatment regimens or address apprehensions over emerging health conditions. Overall, few women (10%) reported that their doctor did not take the time to fully answer their questions (Exhibit 22). However, Latinas (14%) were more likely than African American or white women not to have all their questions fully answered. This may be related to language barriers and cultural differences or expectations. There were also differences by health status; almost one in five women in fair or poor health reported that their doctors did not usually take time to answer all their questions. This is worrisome since women in fair or poor health were likely to have more health concerns than women in better health.

Adequacy of time spent with a provider varies by insurance status and regular provider, with uninsured women and those without a regular provider more likely than others to feel time constraints in the medical visit. Uninsured women (14%) and those without a regular provider (20%) were also less likely to have their questions answered than women with any form of coverage or a regular provider, perhaps reflecting the lack of continuity in care or their relationship with their health care provider (Exhibit 23).

**Comprehension of information.** Another important component of health care is understanding the information given by a provider during a visit. However, 17% percent of women reported that in the past two years they had not understood or remembered information they received. Latinas (20%) were significantly more likely than African American women (14%) to have left a doctor's office without understanding or remembering their doctor's instructions. For some Latinas, these differences may be related to language or cultural barriers.

Women in fair or poor health, who likely require more complex information, also experienced more difficulties. Nearly one in three (30%) reported they

### Exhibit 22: Experiences with Provider in Past Two Years, by Race/Ethnicity and Health Status, Women Ages 18 to 64

	All Women	Race/Ethnicity			Health Status	
		African American	Latina	White	Excellent/ Very Good/ Good	Fair/Poor
Doctor did not usually take time to answer all questions	10%	8%	14%*	9%	8%	18%*
Left doctor's office and did not understand or remember some of the information given	17%	14%	20%	17%	15%	30%*
Out-of-pocket costs of doctor visit higher than expected	28%	26%	31%	28%	26%	36%*
Concerns about quality (in past year)	22%	24%	34%*	20%	19%	40%*

\*Significantly different from reference groups (white women; excellent, very good, good health) at  $p < .05$ .

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 23: Experiences with Provider in Past Two Years, by Insurance Status and Regular Provider, Women Ages 18 to 64**

	Insurance Status			Regular Provider	
	Private Coverage	Medicaid	Uninsured	Yes	No
Doctor did not usually take time to answer all questions	8%	11%	14%*	8%	20%*
Left doctor's office and did not understand or remember some of the information given	15%	23%*	21%*	16%	26%*
Out-of-pocket costs of doctor visit higher than expected	24%	23%	49%*	25%	47%*
Concerns about quality (in past year)	20%	29%*	27%*	20%*	33%*

\*Significantly different from reference groups (private coverage; has regular provider) at  $p < .05$ .

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

left a doctor's office and did not understand or remember the information provided, twice the rate of women in better health.

Comprehension or recollection of medical information also is associated with insurance status and whether women have a regular health care provider. Among women with Medicaid coverage and those who were uninsured, one in five had not understood or remembered information given during a doctor's visit, a higher rate than that of women with private coverage (15%). This may be related to other factors, such as the site of care, the complexity of their medical treatments, health status, or educational attainment. Similarly, about one-quarter of women without a regular provider (26%) reported that they did not remember or understand all the information from a medical visit.

**Out-of-pocket costs.** Twenty-eight percent of women reported higher than expected out-of-pocket costs for a doctor visit. This share was higher for women in fair or poor health, with a striking 36% reporting such costs. Not surprisingly, uninsured women were twice as likely as insured women to experience higher than expected costs (49% vs. 24%), but still one-quarter of insured women had

higher costs than expected. Women without a regular provider also had higher out-of-pocket costs than those with a regular health care connection.

**Concerns about quality.** More than one in five women (22%) said they had concerns about the quality of care they were receiving, compared with 17% of men (data not shown). Women in fair or poor health (40%) and those without a regular provider (33%) had high rates of concern about the quality of care they were receiving. One-third of Latinas also said they had concerns about quality of care, higher than whites or African Americans. Women on Medicaid (29%) and women who were uninsured (27%) also had quality concerns at significantly higher rates than women with private coverage (20%).

**Changes in providers due to dissatisfaction**

Changing providers because of dissatisfaction with care received is fairly common among women. Nearly one in five (18%) had changed doctors sometime in the past five years for this reason (Exhibit 24). In contrast, the rate among men is half that of women, with 9% changing their doctor in a five-year period (data not shown).

### Exhibit 24: Changed Provider in Past Five Years Due to Dissatisfaction with Care, by Insurance Status, Health Status, and Poverty Level, Women Ages 18 to 64

	Insurance Status				Health Status		Poverty Level (FPL)	
	All Women	Private Coverage**	Medicaid	Uninsured	Excellent/ Very Good/ Good	Fair/ Poor	<200%	200% or More
Changed doctor in past five years because of dissatisfaction	18%	19%	16%	15%*	17%	25%*	16%*	20%

\*Significantly different from reference groups (private coverage; excellent, very good, good health; 200% or more of poverty) at  $p < .05$ .

\*\*Employer-based or individually purchased.

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Women in fair or poor health, who were generally higher users of health care, were more likely to have changed doctors (25%) than women in better health (17%). Their need for effective management and ongoing contact with the health care system may make their satisfaction with their doctor more critical. Women with higher incomes were more likely to change their doctor than lower-income women, and privately-covered women were more likely to change than uninsured women. This could be because higher-income or privately-covered women have more resources on which to draw.





# Women's Access to and Use of Health Care

## CHAPTER HIGHLIGHTS

- ❖ **Most women have had a health care visit in the past year, but where they got their care varied for different subgroups of women.**
- ❖ **Many women do not receive recommended screening tests.**
- ❖ **Women experience multiple types of barriers to receiving health care.**



# Women's Access to and Use of Health Care

Women's access to and use of the health system is affected by a broad range of factors. Access is influenced in part by a woman's personal characteristics and prior experience with both illness and the health system. It is also strongly influenced by insurance coverage, health needs, and health system features. Studies have found that many of these factors have important repercussions that can result in disparities among different groups of women.<sup>10</sup> This section examines the characteristics of the women who faced the greatest challenges gaining access to health care and explores the factors that placed them at risk for experiencing barriers to care.

## Physician visit in past year

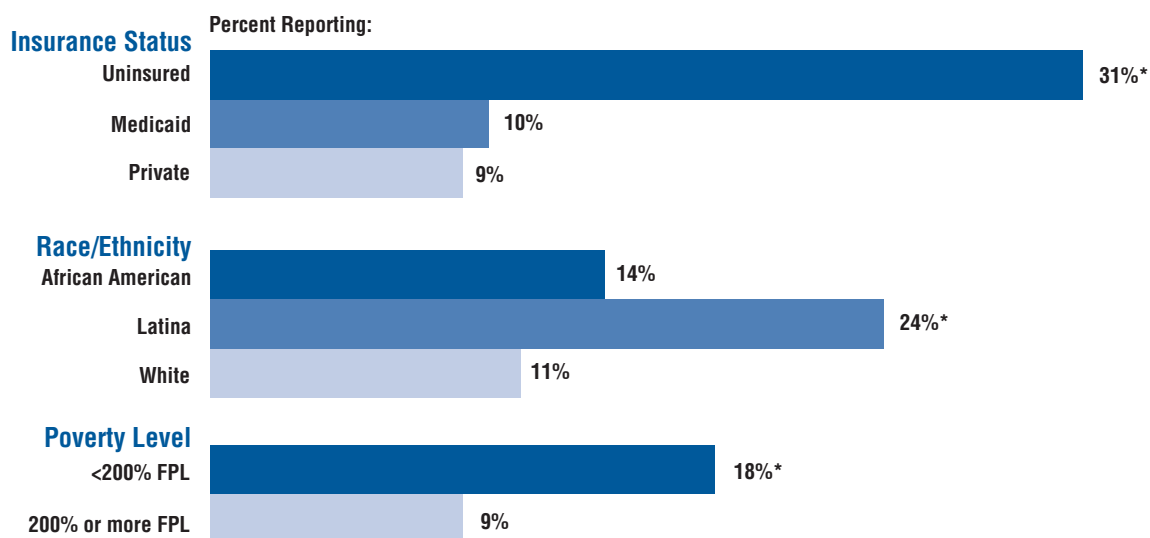
A doctor visit in the past year is a broad measure of access to the health care system. Women without recent access to medical care are less likely to get

recommended preventive services and screenings that can have long-term implications for their health. Most women (87%) have seen a health care provider in the past year. Uninsured women were three times more likely not to have seen a provider in the previous year (31%) than their insured counterparts (Exhibit 25). Latinas also were less likely to have had a doctor visit in the past year. Nearly one in five low-income women (twice the rate of higher-income women) had not had a visit in the past year.

## Where women get care

Where women obtain care is influenced by a wide range of factors, including insurance coverage, variations in types of care available, race/ethnicity, and financial resources (Exhibit 26). Among women receiving routine care in the past two years, the most common site of that care was a doctor's office (75%), while 21% used a clinic or health center, 2% used an

**Exhibit 25: Women Without a Visit to a Health Care Provider in the Past Year, Ages 18 to 64**



\* Significantly different from reference groups (private coverage, white women, 200% or more of poverty) at  $p < 0.05$ .

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

emergency room, and the remainder relied on other sources.

The site of care differed based on women's insurance status. Women with Medicaid or who were uninsured were more likely than privately-insured women to obtain routine care at hospital and other clinics or health centers and less likely to obtain care at doctor's offices. Although few women overall used hospital emergency rooms for their regular care, it was more common for women on Medicaid and the uninsured to rely on emergency rooms than privately-insured women.

Differences in site of care were also evident across racial and ethnic groups. White women were more likely than African American women and Latinas to receive care at a doctor's office, while clinics and health centers were more commonly reported as sources of care for women of color. Latinas were also somewhat more likely than other women to obtain their care at hospital emergency rooms. These differences may be related to disparities in health insurance coverage. Also, African Americans and Latinas have fewer financial resources, constraining their access to more costly private sources of care.<sup>11</sup>

Family income also appears to be associated with site of care, with low-income women nearly twice as likely

as higher-income women to have used a clinic or health center for routine care. They were also more likely than higher-income women to rely on emergency rooms.

### Preventive screening

Women's health can be improved or maintained by early detection of disease through preventive screenings. Women are encouraged to obtain a physical breast exam as a screen for breast abnormalities, and 78% reported receiving a clinical examination within the past two years, with few differences by age group (Exhibit 27).

Among women ages 40 to 64, 73% reported they had a mammogram within the past two years. In recent years there has been considerable controversy surrounding the role of screening mammography for women. There has been disagreement among experts about the appropriate age to start routine mammograms and the effectiveness of screening mammograms in general. There is no consensus about the effectiveness of annual mammograms for women in their 40s, and this group does have lower screening rates than women ages 50 to 64.

There is, however, more agreement over the value of other screening tests. Pap tests have been

**Exhibit 26: Site of Care, by Insurance Status, Race/Ethnicity, and Poverty Level, Women Ages 18 to 64**

	Insurance Status				Race/Ethnicity			Poverty Level (FPL)	
	All Women	Private Coverage**	Medicaid	Uninsured	African American	Latina	White	<200%	200% or More
Doctor's office	75%	84%	54%*	51%*	68%*	51%*	80%	63%*	82%
Hospital/other clinic or health center	21%	14%	36%*	41%*	27%*	38%*	17%	30%*	16%
Hospital emergency room	2%	1%	7%*	4%*	3%	7%*	1%	4%*	1%
Other location	2%	1%	2%	4%*	2%	2%	2%	3%*	1%

\*Significantly different from reference groups (private coverage; excellent, very good, good health; 200% or more of poverty) at  $p < .05$ .

\*\*Employer-based or individually purchased.

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 27: Preventive Screenings in Past Two Years, by Age Group, Women Ages 18 to 64**

Screening Test Obtained	All Women	18 to 39 Years	40 to 49 Years	50 to 64 Years
Physical breast examination	78%	76%*	79%	80%
Mammogram (women ages 40 to 64)	73%	NA	69%*	77%
Pap test	81%	85%*	80%*	76%
Blood pressure check	90%	88%*	92%	92%
Colon cancer screening (women ages 50 to 64)	35%	NA	NA	35%
Blood cholesterol test	56%	44%*	63%*	75%
STD screening	21%	34%*	10%*	6%

\*Significantly different from reference group (ages 50 to 64) at  $p < .05$ .

NA: Not applicable for this age group.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

established as effective screening tools to detect early changes in cervical tissue and early stage cervical cancer. Eight in 10 women had a Pap test in the past two years, with rates declining as women age. Blood pressure checks—used to detect hypertension, a leading risk factor for heart disease and stroke—were common across all ages of women, with nine in 10 women screened overall. Colon cancer screening rates (recommended for women ages 50 and over) were low, with approximately one-third of women ages 50 to 64 screened in the past two years. More than one-half of women have had a blood cholesterol test to detect elevated blood cholesterol—associated with higher risk of developing coronary heart disease—within a two year period. Cholesterol screening rates increase as women age, rising from 44% of women ages 18 to 39, to 75% of women ages 50 to 64. Overall, 21% of women reported that they thought that they had been screened for sexually transmitted diseases, with rates higher in the younger age groups (18 to 29 year olds have the highest rates at 46%, data not shown).

Uninsured women and, to a lesser extent, women on Medicaid, were less likely than women with private coverage to obtain many of the preventive screening tests recommended for women ages 18 to 64 (Exhibit

28). These disparities are of concern since undetected illnesses can become more damaging if left untreated. As an example, uninsured women ages 40 to 64 (43%) were nearly half as likely to obtain mammograms than their privately-insured counterparts (80%). Similarly, privately-insured women (64%) were more likely than those with Medicaid (43%) or the uninsured (35%) to obtain blood cholesterol tests.

Screening for sexually transmitted diseases is the one exception to the disparities in screening. Women on Medicaid were the most likely to be screened, and they and uninsured women have higher screening rates than those with private coverage. This may relate to site of care, since these women often rely on family planning clinics and publicly-funded health centers, which may be more likely to conduct these tests than private office-based physicians.

### Delays in seeking or not getting needed care

A significant portion of women delay care or do not get care they feel they need. This can have a major impact on health because emerging or chronic health conditions may remain undetected or untreated.

**Exhibit 28: Screening Tests in Past Two Years, by Insurance Status, Women Ages 18 to 64**

Screening Test Obtained	All Women	Health Insurance		
		Private Coverage**	Medicaid	Uninsured
Physical breast examination	78%	84%	68%*	59%*
Mammogram (women ages 40 to 64)	73%	80%	72%	43%*
Pap test	81%	86%	78%*	69%*
Blood pressure check	90%	94%	88%*	78%*
Colon cancer screening (women ages 50 to 64)	35%	38%	34%	19%
Blood cholesterol test	56%	64%	43%*	35%*
STD screening	21%	16%	43%*	25%*

\*Significantly different from reference group (private coverage) at  $p < .05$ . \*\*Employer-based or individually purchased.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Financial barriers, access barriers, and other logistical factors can cause women to delay or not get needed care (Exhibit 29).

**Financial barriers.** Affordability of care is a critical issue for many women, but is especially significant for

low-income women. Overall, approximately one-quarter of women reported they delayed or did not get health care in the past year because they could not afford it, a significantly higher rate than men (16%). Low-income women were more than two times

**Exhibit 29: Reasons for Delaying or Not Getting Needed Care in Past Year, by Insurance Status, Health Status, and Race/Ethnicity, Women Ages 18 to 64**

	Total	Insurance Status			Health Status		Race/Ethnicity		
		Private Coverage**	Medicaid	Uninsured	Excellent/ Very Good/ Good	Fair/ Poor	African American	Latina	White
Could not afford it	24%	13%	29%*	59%*	20%	42%*	25%	31%*	22%
Hard to take time off	24%	25%	21%	25%	23%	27%	26%	25%	23%
Could not get appointment with doctor wanted to see	22%	21%	25%	21%	20%	28%*	21%	23%	21%
Transportation	7%	4%	23%*	12%*	5%	21%*	10%*	18%*	5%
No child care***	10%	8%	17%*	15%*	10%	15%*	11%	15%*	9%

\*Significantly different from reference groups (private coverage; excellent, very good, good health; white women) at  $p < .05$ .

\*\*Employer-based or individually purchased. \*\*\*Among women with children.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

as likely to have reported they delayed care in the past year than non-poor women (Exhibit 30). Lack of insurance contributed to delays or foregoing needed care for a significant share of low-income women, with nearly one-third reporting this problem.

For uninsured women, health care costs are particularly troubling; six in 10 delayed or went without care due to costs, more than four times the rate of privately-insured women (13%). Three in 10 women (29%) with Medicaid also reported financial barriers to securing care, which suggests that co-payments, no matter how small, may be an obstacle for low-income women. Women reporting fair or poor health, who would be expected to need additional medical attention, were twice as likely as healthier women (42% vs. 20%, respectively) to delay or forgo care because they could not afford it. Among the three racial/ethnic groups, Latinas (31%) were significantly more likely than other women to experience financial barriers to obtaining care.

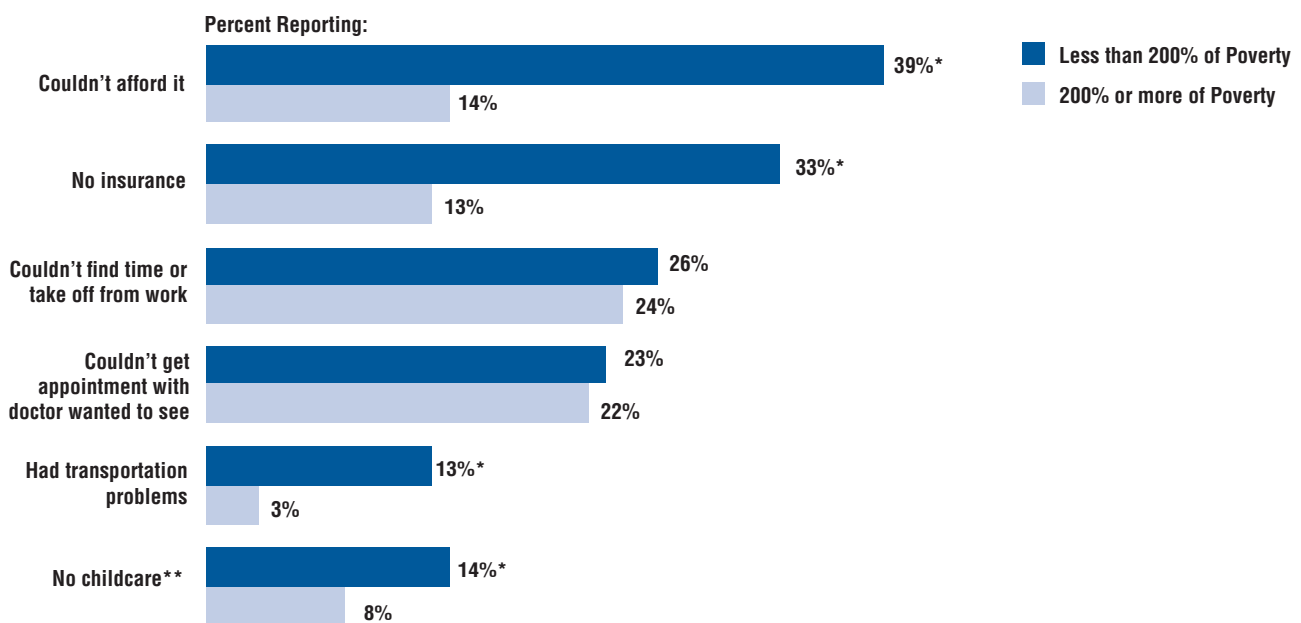
**Time factors.** Women's multiple roles as mothers, caregivers, and workers place tremendous time

pressures on their lives, which can have an impact on whether or not they get or postpone care. One in four women (24%) cited limited time or difficulties in taking time off from work as reasons for delaying or foregoing care.

**Provider appointments.** An inability to get an appointment with a specific doctor caused 22% of women to delay or not seek needed care. No significant differences were seen by insurance status or racial or ethnic background. However, women in fair or poor health (28%) reported more delays or nonreceipt of needed care than women in better health (20%) (Exhibit 29 and 30).

**Transportation problems.** Transportation also was a factor in whether women delayed or went without needed care. This issue is four times as likely to affect low-income women than higher-income women. Uninsured women (12%), and to a greater extent women with Medicaid (23%), were more likely than women with private coverage (4%) to report transportation concerns as reasons for delaying or foregoing care. Women in fair or poor health (21%)

**Exhibit 30: Reasons for Delaying or Not Getting Needed Care in Past Year, by Poverty Level, Women Ages 18 to 64**



\*Significantly different from reference group (200% or more FPL) at  $p < 0.05$ . \*\*Among women with children.

Note: The federal poverty level (FPL) was \$14,255 for a family of three in 2001.

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

were four times more likely than women in better health (5%) to report transportation issues as barriers to receiving care. African American women (10%) and Latinas (18%) were significantly more likely than white women (5%) to experience transportation barriers (Exhibits 29 and 30).

**Child care issues.** Among women with children, one in 10 reported that lack of child care was a factor in delaying or foregoing health care services in the past year. Women with Medicaid and uninsured women were particularly affected by lack of child care because their financial resources restrict their options. Latinas were more likely to report that problems obtaining child care resulted in delayed health care.

### Barriers to care

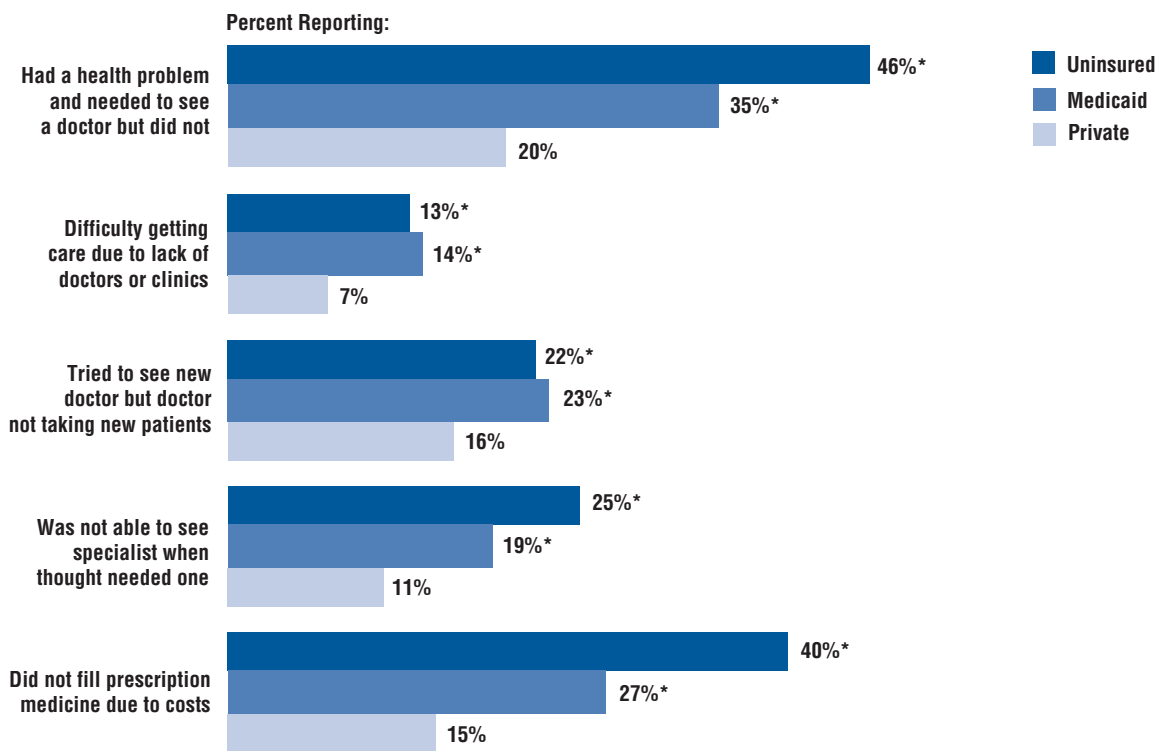
The barriers that women experience in accessing the health care system were diverse, and include financial and structural problems. Women were asked about several specific concerns with health care that

capture their experiences with gaining entry to the system, getting access to a specialist, and the costs of care.

**General access problems.** One-quarter of all women interviewed (27%) reported there was a time in the past year when they needed to see a doctor but did not. Uninsured women and those with Medicaid were more likely than privately-insured women to have a health problem and not see a doctor (Exhibit 31). And nearly one-half of women in fair or poor health reported they were unable to see a doctor when needed, twice the rate of women in better health (49% vs. 22%). About one-third of both African American and Latina women did not see a doctor despite having a health problem, rates significantly higher than those of white women (Exhibit 32).

**Provider availability.** Lack of available providers impedes access to care. Approximately one in 10 women reported difficulty getting care due to a lack of available doctors or clinics, and 18% reported they tried to see a doctor, but that the doctor was not taking new

**Exhibit 31: Barriers to Care in Past Year, by Insurance Status, Women Ages 18 to 64**



\* Significantly different from reference group (private coverage) at  $p < 0.05$ .

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

**Exhibit 32: Barriers to Care in Past Year, by Health Status and Race/Ethnicity, Women Ages 18 to 64**

Women responding affirmatively that:	Total Women	Health Status		Race/Ethnicity		
		Excellent/ Very Good/ Good	Fair/ Poor	African American	Latina	White
General access problem Had a health problem and needed to see a doctor but did not	27%	22%	49%*	32%*	32%*	25%
Provider availability issue Difficulty getting care due to lack of doctors or clinics	9%	7%	16%*	9%	12%*	8%
Tried to see new doctor but not taking new patients	18%	17%	25%*	16%	19%	18%
Referral issue Was not able to see specialist when thought needed one	15%	12%	29%*	20%	22%*	12%
Cost of care concern Did not fill prescription medication due to cost	21%	18%	38%*	25%	20%	21%

\*Significantly different from reference groups (excellent, very good, good health; white women) at  $p < .05$ .

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

patients. Barriers related to provider availability were more common among women with Medicaid coverage, the uninsured, women in poorer health, and Latinas. Women with Medicaid coverage (14%) or who were uninsured (13%) were also more likely than privately-insured women (7%) to report lack of doctors or clinics as a barrier to receiving care.

**Referral issues.** Access to specialty services is an important component of care for many women. Overall, 15% of women reported needing to see a specialist but not being able to do so. This concern is especially evident among uninsured women. Women in fair or poor health—who may be more likely to need specialty care—were more than twice as likely as women in better health not to see a specialist when they thought it was necessary. African American and Latina women were also more likely

than white women to report not seeing a specialist when they needed one (Exhibit 32).

**Cost of prescriptions.** In addition to medical visits, women need to obtain necessary prescriptions. However, one in five women reported they did not fill prescriptions due to costs, a rate that was significantly higher than men (13%). For the uninsured and women in fair or poor health, the rate is extremely high, with approximately four in 10 not filling a prescription because of cost. Even though Medicaid typically covers prescription drugs, many states charge a co-pay or limit the number of prescriptions that beneficiaries may fill in a month. More than one-quarter of women covered through Medicaid reported that at some point over the past year they did not fill a prescription due to cost.





# Conclusion

The findings from the *Kaiser Women's Health Survey* show that women have intimate and often complicated relationships with the health care system. For those who are young, relatively affluent, and in good health, the survey shows that the health system generally meets their needs. However, the survey found persistent problems with health care access and satisfaction among the most vulnerable segments of women—those with health problems, those with low incomes, women of color, and the uninsured.

The need for effective care is evident: one-third of nonelderly women had a health condition that required ongoing medical care, and one-half were taking at least one prescription drug on a regular basis. While many facets of the system work, it is often women with the greatest need for health services who face the most barriers in getting care.

**Financial costs related to health care present significant problems for nonelderly women.** One in four women delayed their care or went without care in the past year because they could not afford it. This was a particular problem for women without health insurance, with nearly one-half facing financial barriers that affected their access to the health care system. Lack of affordability leads to disparate access to the health care system between groups of women when all need timely and appropriate medical care throughout their life spans. These findings improve our understanding of the role that financial barriers play in limiting women's contact with the health care system and reinforce the need for women to have affordable care. An important first step would be to assure that women have access to affordable, quality care through the availability of public or private coverage.

**The cost of prescription drugs, even for women with health coverage, remains a major concern for many women.** With prescription drugs as the fastest rising component of health care spending, and

few options currently available to effectively reduce drug costs, this issue is likely to increase in importance. Half of women use prescription drugs on a regular basis, yet during a one-year period, one in five women did not fill a prescription because of the cost. While this problem is most striking for uninsured women, even insured women with Medicaid or private coverage faced financial barriers. Even when prescriptions are covered, co-payments can add up quickly, especially for women who need multiple medications. This may help explain why a high proportion of women in poor or fair health did not get a prescription filled because of the costs. Deferring care and medications can lead to health complications in the long run.

**Women in fair or poor health, who have the greatest need for health care, experience substantial problems obtaining health services.**

Women with health problems were among the most likely to report that they had trouble affording care, paying for prescription drugs, getting referrals to specialists, finding available health care providers, and finding transportation to care. Their more frequent contact with the health care system and the associated costs have magnified the access problems for these women.

While the majority of women felt that their health care providers answered their questions, women in fair or poor health were less likely to feel their questions were answered. Furthermore, many did not understand or remember all of the information provided to them during their visit, suggesting that health care providers need to reinforce information and ensure that patients understand the information they are conveying. Providers should take into account the cultural and ethnic diversity of women with health problems, and be aware that different approaches to communicate information may be necessary. Furthermore, logistical barriers such as

child care concerns and transportation posed problems for many women, but these issues may not be recognized as barriers to care by most health care providers or plans.

**Women report significant concerns about the quality of their medical care.** Approximately one in five women expressed concern about the quality of the care they received. Quality concerns were higher among women in fair or poor health, who have more ongoing and complex medical care needs than healthier women. For one in five women, dissatisfaction with care led them to change providers within the past five years. Quality issues can relate to the process of care, health outcomes, satisfaction, or even health plan features. More research needs to be done to better understand what issues are of most concern to women and how these can best be addressed.

**Many women face challenges to establishing or maintaining a stable connection to the health system.** Women's reproductive and chronic care needs make their relationships with their doctors or health care providers critical. Health insurance can support those relationships by reducing financial and other barriers to obtaining consistent, timely, and affordable care. Many women lacked an ongoing relationship with a provider, which can limit access to health care services and result in erratic or fragmented care. Among women with a regular provider, many had relatively new relationships with these providers. Even health plan coverage was not stable for many women. Nearly one-half of women had switched health plans in the past five years, primarily due to employers switching plans or job changes, and this resulted in changes in health providers for over one in 10 women.

Although many factors influence women's access to care, health insurance coverage is fundamental. Compared with men, women have lower incomes, are more likely to work in part-time jobs, and are more likely to be covered as dependents—all factors that can lead to unstable coverage. Among uninsured women, approximately one-half had been uninsured for a year or more.

For low-income women with children or with disabilities, Medicaid continues to serve as a safety net. There has been increasing national interest and even some state-level expansions to broaden the reach of public insurance coverage to parents of low-income children covered by Medicaid or the State Children's Health Insurance Program (S-CHIP). The recent economic downturn, however, has limited the government funds available to finance further expansions. A combination of private and public sector solutions is needed to provide coverage to the nearly one in five women who are uninsured.

To improve the health and well-being of American women, particularly those in greatest need, it will be necessary to work toward structuring a health system that meets their diverse requirements. As it stands today, many of our nation's most vulnerable women fall through the gaps in our health system: they are not getting needed care, they do not have stable coverage, and health costs often present insurmountable barriers to care. As policy makers, health plan administrators, and health care providers develop and design system reforms, the impact of changes in policies and practices on women—particularly those facing the greatest health care challenges—should be considered as part of the national debate.



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# Appendix

## Variable Definitions

**Race/ethnicity:** Information about race and Latino origin was used to construct three broad racial/ethnic groups, African Americans, Latinas, and whites. The sample size was too small to report information about Asian American/Pacific Islander women.

**Poverty level:** This variable was based on information about total household income and family composition using the 2001 federal poverty level thresholds established by the U.S. Bureau of the Census (located at: [www.census.gov/hhes/poverty/threshld/thresh01.html](http://www.census.gov/hhes/poverty/threshld/thresh01.html)).

**Managed care:** Among insured women (covered through employment-based, privately purchased, or non-Medicaid government coverage), the following managed care designations were assigned:

**Tightly controlled managed care** was assigned if the following conditions were met: (1) the plan charges less if you choose your doctor from a list (and more if you go to a doctor not on the list); AND (2) the plan requires you to sign up with a specific primary care doctor or group of doctors who provide all of your routine health care; AND if one or both of the following were met: (3) the plan requires you to have a referral by a primary care doctor before you can see a medical specialist; OR (4) the plan requires you to have approval or a referral before they will pay for any of your costs for visiting a doctor who is not in the plan.

**Fee-for-service** was assigned to those women who answered “no” to the questions 1 through 4 above or “no” to all the questions they answered.

**Loosely controlled managed care** was assigned to the residual women, that is, those who answered yes to some of the questions 1 through 4, but did not meet the criteria for tightly controlled managed care.

**Medicaid managed care** was assigned to those women on Medicaid who answered any of the following questions: (1) the plan requires you to sign up with a specific primary care doctor or group of doctors who provide all of your routine health care; OR (2) the plan requires you to have a referral by a primary care doctor before you can see a medical specialist; OR (3) the plan requires you to have approval or a referral before they will pay for any of your costs for visiting a doctor who is not in the plan. Women who answered “no” to all of these questions, or “no” to all of the questions they answered, were assigned fee-for-service Medicaid.



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