INTRODUCTION

Over the past few decades, much progress has been made in improving women's health and in understanding women's unique roles in the health care system—as patients, as providers, as caregivers. In many areas, there is evidence of positive movement in the health and well-being of women in the United States. Most women report good health and are satisfied with their health care. For a sizable minority of women, however, the benefits of the many advances in health care have been beyond their reach. They struggle with poor health, face considerable economic and societal barriers in obtaining health care, and are forced to make difficult tradeoffs between addressing their own health concerns and fulfilling commitments to their jobs and their families' many needs. For some women, the loss of a job, a bout with illness, or a disability striking an aging relative can result in a dramatic change in their economic and health care security.

One of the goals of the Kaiser Family Foundation's work in women's health policy is to put a women's lens to the major health policy concerns that face society. Women live longer, use more health care services over the course of their lives, and are the major decision-makers on health issues for their families. While health care policy is critical for men and women, its outcome is often not gender neutral. Women's complex health needs, disproportionate reliance on publicly funded health programs like Medicare and Medicaid, lower incomes, and multiple roles and responsibilities make the stakes in health policy even higher for women. How the problem of the uninsured is addressed, whether cost containment policies are implemented, and how quality is monitored and improved are all fundamentally important women's health concerns, because women have so much at stake in terms of their roles as patients and mothers, partners, and daughters.

To better understand the implications of different policy choices, particularly for groups of women who have historically experienced barriers to care, in 2001 the Kaiser Family Foundation conducted its first nationally representative survey of women and their health. The focus was on women's health status, their health insurance coverage, their access to care, and their relationships with their health care providers. This survey was expanded and repeated in 2004, with the goal of learning more about several of the challenges that were raised by the findings from the last survey. The 2004 Kaiser Women's Health Survey probes more deeply into some of the affordability issues that women face, preventive care and provider counseling, the extent of prescription drug use, the use of reproductive health services, and the health experiences of menopausal women. It was also expanded to include the experiences of women 65 and older.

This report is the first publication of the ongoing analysis of the 2004 Kaiser Women's Health Survey. Subsequent analyses examining other important women's health issues will be released over the coming year. The goal of this report is to present a profile of women and the health system and to discuss women's health care within the context of their lives. It focuses on women's health status, their health insurance coverage, their use of and access to care, affordability concerns, and women's family health responsibilities. In order to better understand the unique challenges facing different subgroups of women, the findings are generally presented for women of different ages, incomes, races and ethnicities, health status, and insurance types. As different health policies are forwarded, evaluated and ultimately adopted, it is our goal that the information presented in this report will be used to inform the debate and inspire further research on these issues.

The first section of this Key Findings report presents the demographic and socio-economic characteristics of women ages 18 and older in the United States. The second chapter presents findings on the health status and health needs of women. An overview and profile of women's health insurance coverage are presented in Chapter 3. Chapter 4 examines women's access to care and Chapter 5 presents the key findings on the impact of health care costs on women's access to care and prescription drugs. Chapter 6 examines women and their health care providers with a focus on counseling. The role of women in overseeing the health care of their families and the impact that responsibility has on their health and well-being is presented in Chapter 7. Finally, Chapter 8 examines the changes between the 2001 and 2004 women's health surveys.

METHODS

The findings presented in this report are based on data from the 2004 Kaiser Women's Health Survey, which was fielded between July 6 and September 26, 2004 in the continental United States. This nationally representative telephone survey was designed and analyzed by Kaiser Family Foundation staff in collaboration with Princeton Survey Research Associates International (PSRAI) and researchers from University of California, Los Angeles. The survey was administered to 2,766 women ages 18 and older. Interviews were conducted in either English or Spanish, depending on participants' preference. A shorter companion survey of 507 English-speaking men was conducted for the purposes of gender comparisons.

The 2004 questionnaire is largely based on the 2001 Kaiser Women's Health Survey, but was expanded to examine in more depth issues such as cost barriers, counseling and prevention, work and family health, and menopause. While much of the core surveys are directly comparable, there are many new questions in the 2004 version. In addition, in 2001, the survey was administered exclusively to the non-elderly population, women ages 18 to 64. In 2004, the sample was expanded to include seniors, women ages 65 and older, allowing the examination of important health care issues facing older women.

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 to provide nationally representative statistics, using the Census Bureau's 2003 Annual Social and Economic Supplement (ASEC), which included all households in the continental United States. This was done to adjust for variations in the sample relating to region of residence, age, education, race/ethnicity, and marital status.

Post-data collection statistical adjustments require analysis procedures that reflect departures from simple random sampling. PSRAI calculates the effects of these design features so that an appropriate adjustment can be incorporated into tests of statistical significance when using these data. The margin of sampling error is +/-2 percentage points for the total women sample, +/-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. Sampling tolerances at the 95% confidence were used to evaluate statistically significant differences between proportions and are noted with asterisks throughout the report. A copy of the survey instrument is available upon request.