WOMEN AND HEALTH CARE:

A National Profile

KEY FINDINGS FROM THE

KAISER WOMEN'S HEALTH SURVEY

THE HENRY J. KAISER FAMILY FOUNDATION

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JULY 2005

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Report Prepared By:

Alina Salganicoff, Ph.D.
Usha R. Ranji, M.S.
Kaiser Family Foundation

And

Roberta Wyn, Ph.D.
University Of California, Los Angeles
Center For Health Policy Research

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Over the past few decades, considerable progress has been made in improving women's health and in understanding women's unique roles in the health care system. The importance of health care cuts across all aspects of women's lives. Without good access to health care, women's ability to be productive members of their communities, to care for themselves and their families, and to contribute to the work force is jeopardized. As health care has moved to the forefront of the public policy arena, women are increasingly recognizing that they have much at stake in national health policy debates.

To better understand how women are faring in the health care system, particularly groups of women who have historically experienced barriers to care, the Kaiser Family Foundation conducted its first survey of women and their health in 2001. This survey was expanded and repeated in 2004 to delve deeper into women's experiences and further explore some of the challenges they face in their interactions with the health care system. The sample of the survey was also expanded to include women 65 and older, a vital and growing segment of the population in the U.S. The findings presented in this report are based on a nationally representative sample of 2,766 women ages 18 and older interviewed by telephone in the Summer and Fall of 2004. A shorter survey of 507 men was conducted for comparative purposes.

The 2004 Kaiser Women's Health Survey provides the latest data on major areas of women's health policy, including women's demographics, health status, insurance coverage, access to care, health care costs, relationships with providers, and family health issues. Across all of these areas, several key findings have emerged:

Women's health needs and health care utilization patterns change and evolve as they age. Over the course of women's lives, their use of the health care system reflects their changing health needs, from a focus on reproductive health in their younger years to an emergence of more chronic illnesses in the middle years, to higher rates of disability and physical limitations during the senior years.

- Most women in the U.S. are in good health with eight in 10 reporting excellent, very good, or good health. However, a sizable minority—nearly one in five (19%)—are in fair or poor health. This proportion increases with age, to nearly one-third of women 65 and older.

- Nearly four in 10 women (38%), have a chronic condition that requires ongoing medical attention, compared to 30% of men. Not surprisingly, incidence of chronic conditions increases with age. Nearly six in 10 women in their senior years are dealing with hypertension (58%) and arthritis (61%), and almost half with high cholesterol (45%).

- Many younger women also have chronic health problems. By the time women reach their middle years (45 to 64), three in 10 already have high cholesterol and arthritis, and even one in 10 women of reproductive age (18 to 44) say they have arthritis, hypertension, high cholesterol, and asthma or other respiratory condition.

- Women's health needs are also reflected in their provider choices. Virtually all elderly women (95%) have a regular provider, compared to three-quarters of women ages 18 to 44 and 90% of women 45 to 64. As they age, women are also less likely to visit an Ob-Gyn regularly. Only one-quarter (26%) of senior women report a gynecological visit in the past year and only 12% count an Ob-Gyn among their regular providers, compared to 47% of women in their reproductive years.

- Mental health is an often overlooked but critical aspect of women's health care. One out of every four women (23%) report they have been diagnosed with depression or anxiety, over twice the rate for men (11%). Even among senior women, who have lower rates than younger women, 16% are affected by these mental health issues.

- Between 2001 and 2004, reported prevalence of certain chronic conditions rose in the non-elderly population. Among the statistically significant changes were the rise in diabetes from 5% to 8% of non-elderly women, anxiety/depression from 21% to 24%, and obesity from 11% to 13%.

Health coverage—public or private—matters for women, yet it does not guarantee access to care. Most adult women have some form of either private or public health insurance. Women without insurance consistently fare worse on multiple measures of access to care, including contact with providers, obtaining timely care, access to specialists, and utilization of important screening tests.

- Nearly one in six non-elderly women (17%) are uninsured, as are 20% of men. Women who are Latinas, low-income, single, and young are particularly at risk for being uninsured.

- Uninsured women are the least likely to have had a provider visit in the past year (67%), compared to women with either private (90%) or public insurance-Medicaid (88%) and Medicare (93%).

- Compared to women with insurance, uninsured women consistently report lower rates of screening tests for many conditions, including breast cancer, cervical cancer, high blood pressure, high cholesterol, and osteoporosis.

- Insured women also face barriers to care, including delaying or sacrificing care they think they need. One in six women with private coverage (17%) and one-third of women with Medicaid (32%) stated that they postponed or went without needed health services in the past year because they could not afford it.

Health care costs are increasingly acting as a barrier to health care for many women. One-quarter of women delay or don't get needed medical care because they cannot afford it. Furthermore, cost-related problems appear to have worsened since 2001. Many women also cannot afford prescription drugs. They do not fill prescriptions or resort to skipping doses and splitting medicines. These problems do not just affect uninsured women, but are also reported by some women with private health coverage.

- Over one-quarter of non-elderly women (27%) say they delayed or went without medical care they believe they needed due to costs, a significantly larger share than in 2001 (24%).

- Women (56%) are more likely than men (42%) to use a prescription medicine on a regular basis, and are also more likely to report difficulties affording their medications. In the past year, one in five women (20%) report that they did not fill a prescription because of the cost, compared to 14% of men. While the problem is greatest for uninsured women (41%), one in six women (17%) with private coverage and nearly one in five women with Medicaid (19%) also say they faced the same barrier.

- One in seven (14%) women also report that they skipped or took smaller doses of their medicines in the past year to make them last longer. Nearly one in 10 women say they have spent less on basic family needs to pay for their medicines.

Certain populations of women experience higher rates of health problems and report more barriers in accessing health care. Women who are poor, sick, uninsured, or a racial/ethnic minority are particularly at risk for experiencing barriers throughout the health system. For many of these women, health care problems exacerbate other challenges.

- Low-income women confront many obstacles to receiving timely health services. One-third say that they delayed or went without needed care in the prior year because they didn't have insurance. Half (52%) of poor women and 38% who are near-poor (100% to 199% of poverty) report they delayed or did not get needed health care because of the cost.

- Medicaid serves the poorest and sickest populations of women. Nearly nine in 10 (87%) women on Medicaid are low-income and one-third (34%) are in fair or poor health.

- Almost one in four women on Medicaid (23%) say they were turned away from a physician because the doctor was not accepting new patients, as did 18% of uninsured and 13% of privately insured women.

- Two-thirds of uninsured women (67%) report delayed/forgone care due to costs, four times as high as women with private coverage or Medicare.

- Uninsured women are the least likely to have a regular provider. Only half of uninsured women (50%) have a regular doctor, compared to 89% of privately insured women.

- Latina women are the least likely to have a regular doctor. One in three also report delaying or going without care in the past year because of cost.

- African American women are at elevated risk for certain health problems. Over one-third (37%) of African American women ages 45 and older report fair or poor health, 57% have arthritis, and 29% have diabetes, significantly higher rates than among white women.

Women who are sick face more obstacles in obtaining health care. Among the most counter-intuitive findings about the health system are the multiple challenges that women in poor health face—including costs, lack of insurance, and limited access to specialists—in obtaining comprehensive health care. These barriers compound sick women's already difficult circumstances, and may worsen their health by delaying detection and treatment.

- One-fifth (22%) of non-elderly women in fair or poor health do not have health insurance.

- Over one-third of women in fair or poor health (37%) say that they delayed or went without care in the past year because they couldn't afford it. One-third (34%) did not fill a prescription because they couldn't afford it and over one in four skipped or reduced doses to make them last longer.

- Compared to women in favorable health (12%), women in poorer health (27%) are twice as likely to report they couldn't get access to specialty medical care.

- One-third (31%) of women in fair/poor health express concern about the quality of care they received in the past year, compared to 18% of women in better health.

- Women in poorer health are also more likely to experience heavy stress from a range of health, economic, and family issues, including health problems of their family members, financial concerns, and career challenges.

Doctor-patient counseling about health risks and health promoting behaviors is lagging. Despite growing attention to the important role of early intervention and healthy behaviors in health promotion and disease prevention, a sizable share of women do not get counseling when they see the doctor.

- Over half of women (53%) cite health care providers as their primary source of health information; the Internet (15%), friends and family (16%), and books (7%) are relied upon to a much lesser extent.

- Despite women's reliance on providers for information, just over half of women (55%) say they have discussed diet, exercise, and nutrition with a doctor or nurse during the past three years.

- Fewer than half of all women report having had conversations about other health behaviors, such as calcium intake (43%), smoking (33%), and alcohol use (20%) with a provider in the past three years.

- Counseling about sexual health is particularly infrequent, even during women's reproductive years. Fewer than one in three (31%) women ages 18 to 44 say that they have talked with a provider about their sexual history in the past three years. Discussion of more specific topics, such as STDs (28%), HIV/AIDS (31%), emergency contraception (14%), and domestic or dating violence (12%) are also very limited.

Screening test rates for mammograms, Pap smears, and blood pressure have fallen slightly since 2001. Breast cancer, cervical cancer, and hypertension are all conditions known to be responsive to early detection and treatment. Screening tests are an important tool for early intervention, yet the use of some tests may be on the decline. Between 2001 and 2004:

- Mammography rates reported by women ages 40 to 64 dropped from 73% to 69%.
- Pap testing rates reported among women ages 18 to 64 fell from 81% to 76%.
- The rate of reported blood pressure checks dropped from 90% to 88% among women ages 18 to 64.

Women are the health care leaders for their families. Women take charge of the vast majority of routine health care decisions and responsibilities for their children, and on top of their everyday family obligations, over one in 10 women care for a sick or aging relative. Meeting these multiple obligations is demanding and leaves many women concerned about meeting all their family and work commitments as well as managing their own health.

- Eight in 10 mothers/guardians say they take on chief responsibility for choosing their children's doctors (79%), taking them to appointments (84%), and ensuring they receive follow-up care (78%). Mothers are also primarily responsible for decisions about their children's health insurance (57%).
- Similar to men, one in four women feel a lot of stress from career (24%) and financial concerns (23%). Women are significantly more likely than men to be very stressed about managing their own health needs and those of their parents.
- One in 10 women (12%), compared to 8% of men, cares for a sick or aging relative, often an ill parent. The majority of caregivers report that they perform a range of tasks, including housework (91%), transportation (83%), and various financial decisions (66%). Many also assist with medical and physical care, such as administering medicines or shots (58%), as well as routine activities such as bathing and dressing (42%).
- Caregivers themselves contend with a host of health challenges. Four in 10 are low-income, nearly half (46%) have a chronic health condition of their own, and one in five non-elderly caregivers are uninsured.
- A sizable share (29%) of caregivers provide assistance full-time, spending more than 40 hours per week as a caregiver. This is even more common among low-income caregivers, 44% of whom report assisting their relative for over 40 hours weekly.

The findings of the 2004 Kaiser Women's Health Survey underscore the high stakes for women in the health care system and reveal some of the system's gaps in meeting women's health needs. One in six non-elderly women is uninsured and faces considerable obstacles in gaining access to health care. The impact of out-of-pocket costs also poses a growing barrier to primary and specialty care for most uninsured women and one in six women with coverage. Furthermore, despite the renewed interest in prevention, the health care system still falls short in providing women with information and care. There appears to be limited conversations with providers about important health behaviors and many women also do not receive recommended screening tests, which can be critical for early detection and prevention of future disease.

Access to health care is a linchpin for women's economic and health security and family well-being. As policymakers, providers, patients, advocates, and researchers develop strategies to strengthen the health care system, it is critical that they recognize women's central role in the system and how much is at stake for women as a consequence of their decisions.

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.

CHAPTER 1: THE DEMOGRAPHICS OF WOMEN

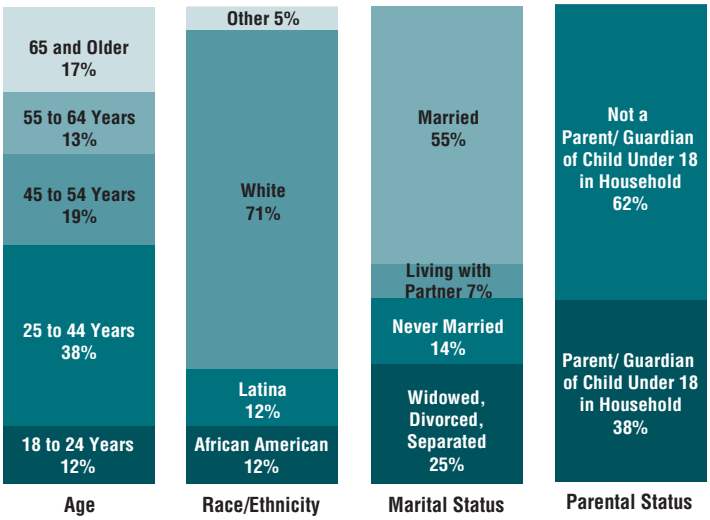
Women in the United States are an extremely diverse population. Their health needs, their insurance options, and how they use health care services are shaped by a wide range of factors including their age, income, race and ethnicity, level of education, family structure, and employment status, just to name a few.

Despite these differences, there are common health issues and concerns that all women face in their lives that cut across demographic and socio-economic characteristics. Chronic health problems, cancer, pregnancy, and disability are among the range of health concerns that can affect any woman. Often the major differences among women are the resources they have available in terms of health insurance coverage, income, and family and societal supports to address their health challenges.

This section provides information about the characteristics of adult women to serve as a backdrop for understanding women's diverse health needs and health experiences. Subsequent chapters in this report examine women's health issues by analyzing the differences experienced by women in many of these socio-demographic groups, with an emphasis on subgroups of women who are at greatest risk for poor health and impeded access to care.

Exhibit 1a

Selected Demographic Characteristics of Women, Ages 18 and Older



* Includes Asian, Pacific Islander, American Indian, Alaska Native, people of multiple races, and those who identified themselves as "other."

Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

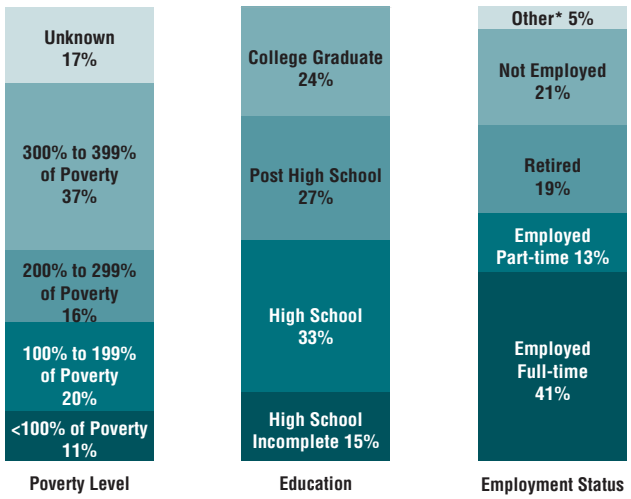
Women in the U.S. are an extremely diverse population. Fifty percent of women are of reproductive age (18 to 44 years old), 32% are ages 45 to 64, and 17% are ages 65 and older. Age is an important determinant of health status and health care utilization.

While white women account for the majority of the female population, a large minority of women are women of color—Latina, African American, Asian/Pacific Islander, or another racial, mixed race, or ethnic subgroup. There is a large and growing body of research that documents the differences and disparities in health status and health care use between white people and people of color.[1]

Marital status is associated with a broad range of health issues for women, including their health status, health coverage, economic level, and lifetime caregiving. Over half of women are married, one quarter are widowed, separated or divorced, 14% have never married, and 7% of women are living with a partner but not married. Nearly four in 10 women have children under 18 years living in their homes. These women also juggle meeting their family's health needs with their own health concerns and work responsibilities.

Exhibit 1b

Selected Socio-Economic Characteristics of Women, Ages 18 and Older



Note: 100% of the federal poverty threshold was $14,776 for a family of three in 2004. Some totals may not equal 100% due to rounding.

*Includes those who are disabled, students, and unknown work status.

Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Income, education, and employment status are all associated with health status, insurance coverage, and access to care. A sizable share of women face socioeconomic disadvantage—nearly one-third (31%) are from low-income households (less than 200% of poverty[2]) and half (48%) have only a high school education or lower. And while slightly over one-half of women report they work—41% employed full time and 13% part time—19% of women are retired and one quarter are not in the labor force.

CHAPTER 2: THE HEALTH OF WOMEN

Women in the U.S. are overall a generally healthy population, and most report that they are in good health. A sizable minority, however, deal on a daily basis with a wide range of chronic conditions such as arthritis, diabetes, and depression. Many of these are health problems that require ongoing medical attention and that can limit their ability to work or otherwise interfere with their participation in daily activities.

The health of women is one of the strongest determinants of whether and how they will use the health care system. While there are considerable differences in the type and extent of certain conditions between men and women, there are also major differences in the prevalence of certain health problems among subgroups of women. Typically, women who are poorer or older are the most at risk, but this is not always the case.

This section presents the key findings from the Kaiser Women's Health Survey on the health concerns facing women across their lifespans. Special attention is given here to differences in the health of women based on their age, income level, and racial/ethnic background. This section also examines the prevalence of anxiety or depression among women.

Exhibit 2a

Health Status Indicators and Chronic Health Conditions, Women and Men Ages 18 and Older

Indicators	Women	Men
Fair/Poor health	19%	21%
Have disability or condition that limits activity	14%	13%
Have chronic condition requiring ongoing treatment	38%	30%*
Condition^		
Arthritis	26%	17%*
Asthma/Other respiratory	15%	8%*
Cancer	6%	4%
Diabetes	10%	8%
Heart Disease	7%	10%*
High Cholesterol	22%	24%
Hypertension	26%	22%
Obesity	13%	4%*
Osteoporosis (Women 45 and older)	16%	~
Stroke	2%	1%
Thyroid	11%	~

*Significantly different from women, p <.05.

^ Percent of women reporting that condition was diagnosed by physician in past 5 years.

~ Men were not asked this question.

Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

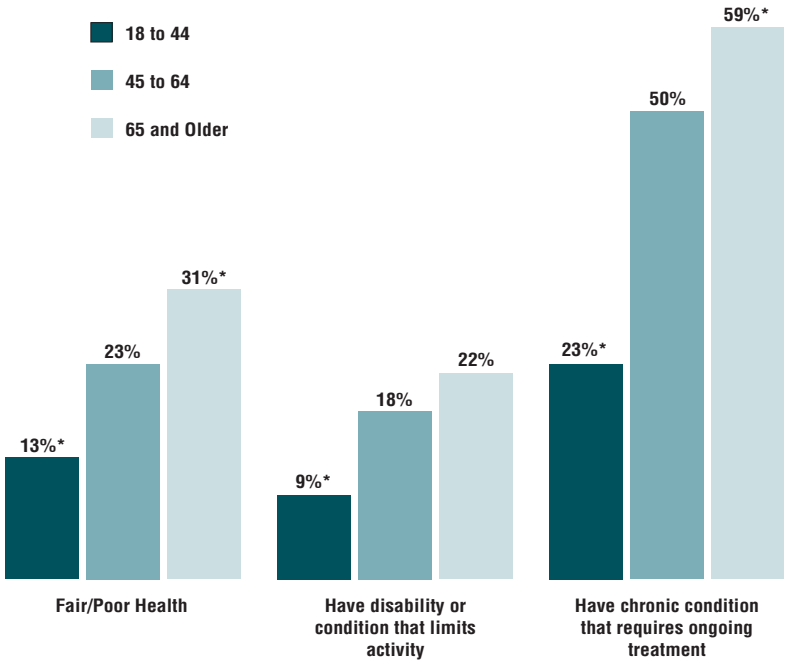
Most women in the U.S. are in good health with eight in 10 reporting excellent, very good, or good health. However, a sizable minority—nearly one in five (19%)—report fair or poor health.

Fourteen percent of women have a disability, health condition, or handicap that limits their ability to participate fully in everyday activities. Nearly four in 10 women (38%), have a chronic condition that requires ongoing medical attention, compared with 30% of men.

Women in the survey were asked about selected chronic health conditions that were diagnosed by a physician in the past five years. The most prevalent—affecting approximately one in four women—are arthritis (26%), hypertension (26%), and high cholesterol (22%). While women are generally affected by the same types of chronic health problems as men, there are some important differences in the prevalence between the sexes. Women are more likely than men to say they have arthritis, asthma, and obesity.

Exhibit 2b

Health Status Indicators, by Age Group, Women Ages 18 and Older



* Significantly different from 45 to 64, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

As women age, their health status can deteriorate and increase their need for ongoing medical care. Midlife (45 to 64) and older women (65 and older) are more likely to be in fair or poor health, have limitations in activity due to health, and have chronic conditions requiring medical attention, compared to women in their reproductive years (ages 18 to 44).

Six in 10 women ages 65 and older and half of women ages 45 to 64 have a chronic condition that requires ongoing medical treatment. Even in the younger age group, nearly one-fourth have at least one chronic condition that requires continuing medical care.

Exhibit 2c

Chronic Health Conditions, by Age Group, Women Ages 18 and Older

Condition^	18 to 44	45 to 64	65 and Older
Arthritis	9%*	32%	61%*
Asthma/Other respiratory	12%*	18%	16%
Cancer	3%*	8%	10%
Diabetes	5%*	13%	20%*
Heart Disease	2%*	8%	18%*
High Cholesterol	10%*	29%	45%*
Hypertension	10%*	33%	58%*
Obesity	10%*	18%	13%
Osteoporosis	~	11%	26%*
Stroke	<1%	2%	9%*
Thyroid	6%*	14%	16%

*Significantly different from 45 to 64, p <.05.
^Percent of women reporting that condition was diagnosed by a physician in past 5 years.
–Women ages 18 to 44 were not asked this question.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

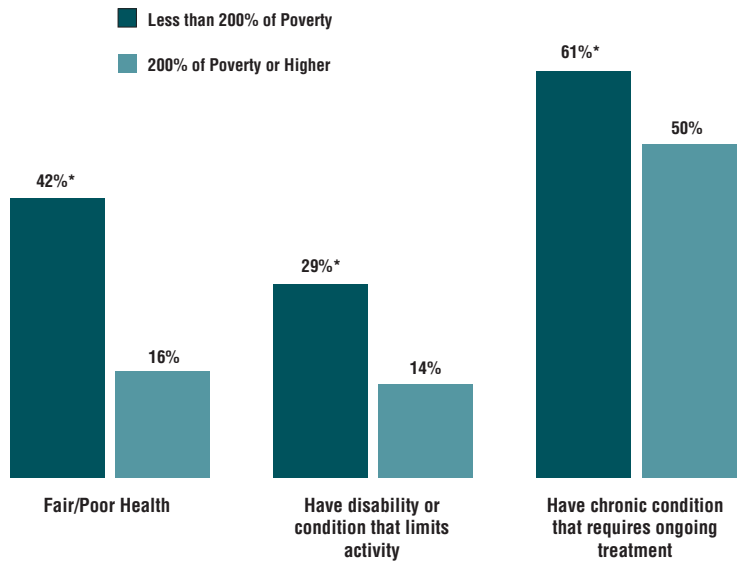
The prevalence of most chronic health conditions also increases with age. The most common conditions among midlife and older women are arthritis, hypertension, and high cholesterol.

Other conditions also affect a notable fraction of women. Among midlife women, 18% report asthma, 14% have thyroid problems, and 13% report diabetes. For older women, approximately one in four have osteoporosis (26%), diabetes affects 20% of women, 18% report heart disease, and 16% have thyroid problems. These are all conditions that typically require ongoing medical management, often with prescription drugs.

While the presence of chronic conditions is lower in women ages 18 to 44, approximately one in 10 report asthma (12%), high cholesterol (10%), hypertension (10%), obesity (10%), and arthritis (9%).

Exhibit 2d

Health Status Indicators, by Poverty Level, Women Ages 45 and Older



Note: 200% of poverty was $29,552 for a family of three in 2004.
* Significantly different from 200% of poverty or higher, p <.05.
Data source: *2004 Kaiser Women's Health Survey*, Kaiser Family Foundation.

Women who are low-income are in poorer health than women with higher incomes. There is a large body of research that documents the association between poverty and poor health status.[3] In this survey, the most striking income differentials are found among women 45 and older.

Low-income women are nearly three times as likely to report fair or poor health. Over one-quarter report a disability or condition that limits participation in daily activities and six in 10 have a chronic condition that requires ongoing medical care, which may be harder to obtain for women with low incomes (see Exhibit 5b).

Exhibit 2e

Chronic Health Conditions, by Poverty Level, Women Ages 45 and Older

Condition^	Less than 200% of poverty	200% of poverty or higher
Arthritis	52%*	34%
Asthma/Other respiratory	25%*	15%
Cancer	10%	7%
Diabetes	27%*	10%
Heart Disease	17%*	8%
High Cholesterol	42%*	31%
Hypertension	52%*	36%
Obesity	18%	16%
Osteoporosis	18%	14%
Stroke	9%*	3%
Thyroid	12%	15%

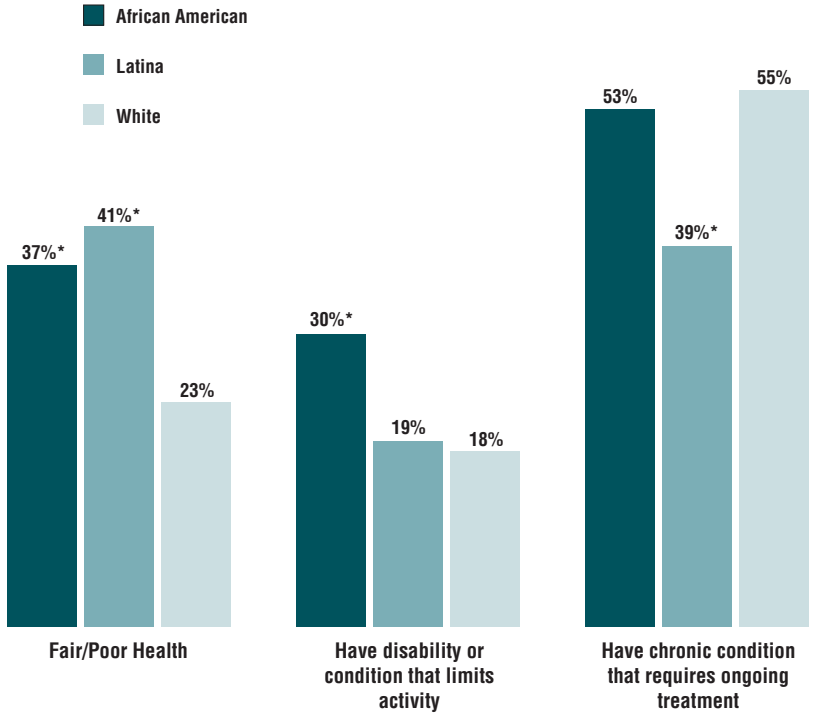
Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
^Percent of women reporting that condition was diagnosed by a physician in past 5 years.
*Significantly different from 200% of poverty or higher, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Low-income women are also more likely to experience a broad range of chronic health problems than their higher-income counterparts. Among women ages 45 and older, those with low incomes have considerably higher rates of several chronic conditions than higher-income women. Arthritis and hypertension affect over half of low-income women in this age group. Furthermore, their asthma rates are one and a half times as high as those for higher-income women (25% vs. 15%), and diabetes rates are two and a half times higher (27% vs. 10%).

Among younger women (ages 18 to 44), the income disparity is evident although less marked. Low-income women of reproductive age have higher rates of hypertension (13% vs. 8%), heart disease (4% vs. 1%), depression (30% vs. 20%), asthma (17% vs. 9%), and similar rates of the other conditions when compared to higher-income women (data not shown).

Exhibit 2f

Health Status Indicators, by Race/Ethnicity, Women Ages 45 and Older



* Significantly different from white women, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Race and ethnicity are also associated with differences in health status and in the prevalence of certain chronic conditions, but there is no single pattern.

Among women 45 and older, African American women (37%) and Latinas (41%) are more likely to report being in fair or poor health than white women (23%). African American women are the most likely to report a disability or condition that limits their activity (30%), and are as likely as white women to report a medical condition that requires ongoing treatment (53% and 55%, respectively). In contrast, 39% of Latinas report a chronic condition requiring ongoing care.

Exhibit 2g

Chronic Health Conditions, by Race/Ethnicity, Women Ages 45 and Older

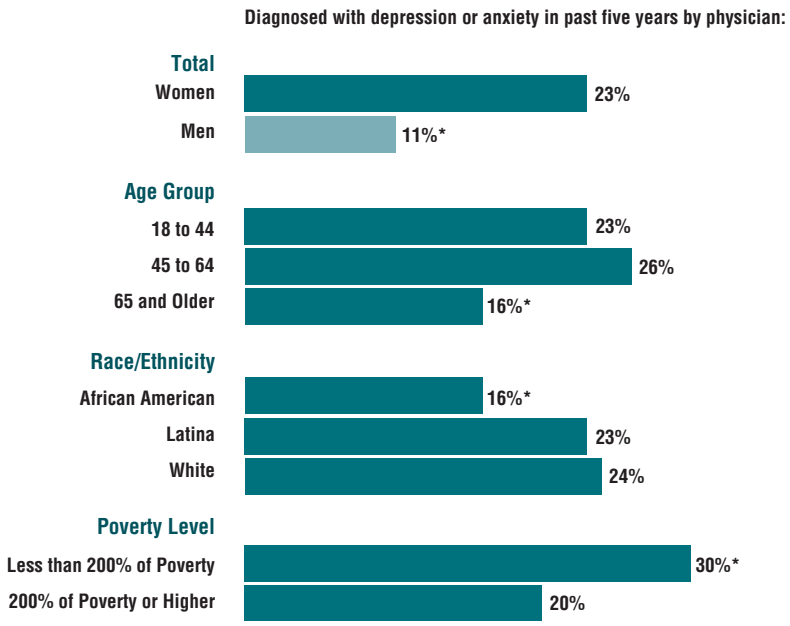
Condition^	African American	Latina	White
Arthritis	50%	40%	41%
Asthma/Other respiratory	21%	18%	16%
Cancer	9%	6%	9%
Diabetes	29%*	22%*	13%
Heart Disease	15%	9%	11%
High Cholesterol	42%	32%	34%
Hypertension	57%*	48%	39%
Obesity	19%	14%	16%
Osteoporosis	6%*	8%*	18%
Stroke	3%	7%	4%
Thyroid	13%	15%	15%

*Significantly different from white women, p <.05.
^Percent of women reporting that condition was diagnosed by a physician in past 5 years.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Hypertension and arthritis affect upwards of half of African American women 45 and older. High cholesterol (42%) and diabetes (29%) are also relatively common in this population of women. Similarly, nearly one-half of Latinas 45 and older have hypertension, one-third have high cholesterol, and slightly over one in five have diabetes. Compared to women of color, white women have similar rates of arthritis, lower rates of diabetes, and higher rates of osteoporosis.

Exhibit 2h

Depression and Anxiety, by Selected Factors, Women Ages 18 and Older



Note: 200% of poverty was $29,552 for a family of three in 2004.
*Significantly different from reference group (Women, 45 to 64, White, 200% of poverty or higher), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Anxiety and depression affect approximately one-quarter of all women (23%), twice the rate for men (11%). Even among seniors, who have lower rates than younger women, 16% are affected by these mental health issues. The mental health status of women is often overlooked, yet it plays a crucial role in their overall health and well-being.

White women report higher rates of depression and anxiety than African American women (24% vs. 16%). Almost one-third of low-income women report these mental health problems, a higher rate than women with family incomes at or over 200% of poverty.

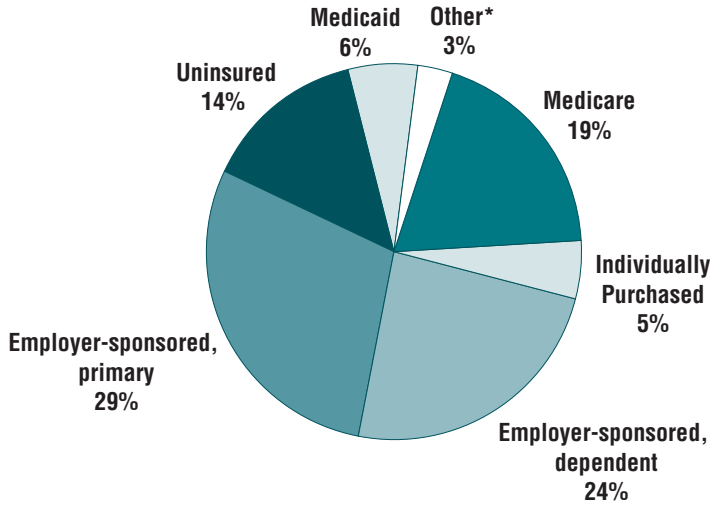
CHAPTER 3: WOMEN AND HEALTH INSURANCE COVERAGE

Although several factors determine whether and how women use health care services, the importance of health coverage as a critical resource in promoting access cannot be overstated. Most women have some form of either public or private insurance coverage, although there is great variation between different forms of coverage in terms of benefits covered, costs, and access to services. Many women, however, do not have insurance. Studies have consistently shown the adverse consequences of being uninsured, including lower receipt of preventive services, delays in seeking treatment for acute illnesses, higher use of emergency room services, higher rates of bankruptcy, and even higher rates of mortality. In fact, the Institute of Medicine estimates that 18,000 deaths per year could be averted if everyone had health insurance.[4]

This section presents women's health insurance and the different coverage patterns among subgroups of women, particularly women of different economic levels and racial/ethnic groups, and looks at which women are at greatest risk for being uninsured. Because nearly all women age 65 and older have Medicare, this section on health coverage focuses on non-elderly women ages 18 to 64.

Exhibit 3a

Health Insurance Coverage of Women, Ages 18 and Older



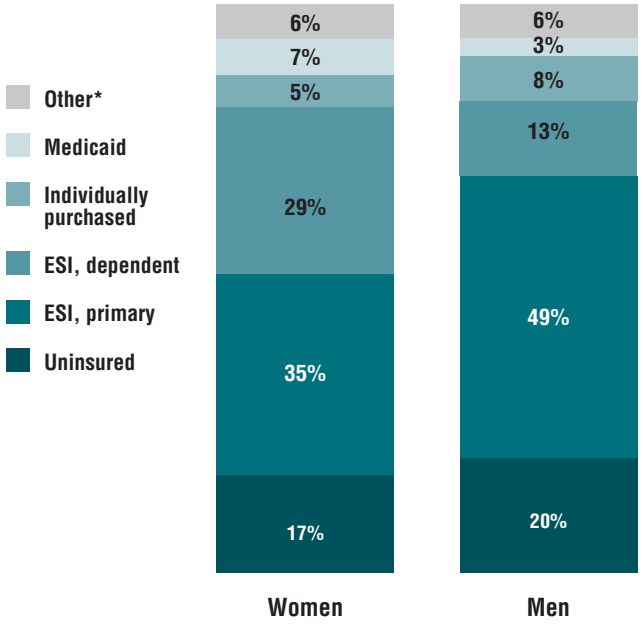
*Other includes CHAMPUS, TRICARE, and unknown insurance.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Most adult women ages 18 and older have some form of either private or public health insurance. The private sector covers most women, typically through employer-sponsored insurance, which covers half (53%) of all adult women. A small share of women (5%) purchase private insurance on their own. In the public sector, Medicare, the federal health coverage program for seniors, covers one in five women—nearly all women 65 and older and a small share of younger women with permanent disabilities. Medicaid, the public program for the poor assists 6% of adult women, mostly all low-income. A small share of women (3%) is covered by some other form of public insurance, such as military coverage through CHAMPUS or TRICARE. Despite the wide array of private and public programs that make up health coverage in the U.S., 14% of all adult women 18 and older are uninsured.

Because Medicare covers nearly all women and men 65 and older, non-elderly adults are more likely to be uninsured and the rest of this section focuses on the under 65 population.

Exhibit 3b

Health Insurance Coverage of Women and Men, Ages 18 to 64



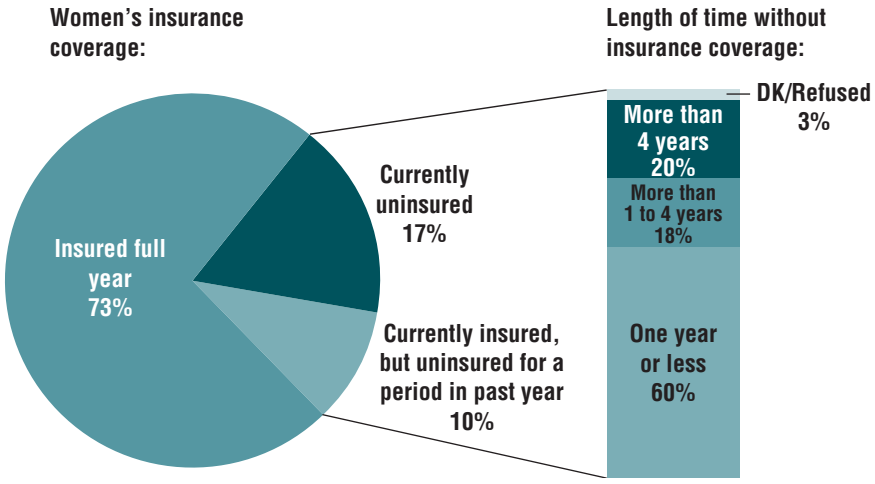
Note: ESI = employer-sponsored insurance.
*Other includes Medicare, CHAMPUS, TRICARE, and unknown insurance.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

There are some key differences in coverage patterns between women and men. Job-based coverage is the primary source of coverage for non-elderly women, with 64 percent covered either through their own employment (35%) or as a dependent through family coverage (29%). While the rates of employer-sponsored insurance (ESI) are similar for men, they are much more likely to have coverage through their own employment (49%), rather than as a dependent (13%). Women are therefore more susceptible to losing coverage when premium costs rise or when employers reduce their contributions for family coverage. Dependent coverage also makes them more vulnerable when they become divorced or widowed.

Medicaid (7%) serves as a vital safety net for low-income women who do not have access to or cannot afford employer-sponsored or individually purchased coverage. Women are more likely than men to qualify for Medicaid because they are disproportionately poorer and thus more likely to meet the program's strict income thresholds as well as categorical eligibility criteria (typically limited to women who are pregnant, mothers, disabled or seniors). Many women on Medicaid do not have access to employer-sponsored insurance and would otherwise be uninsured.

Exhibit 3c

Duration of Lack of Health Insurance Coverage, Women Ages 18 to 64



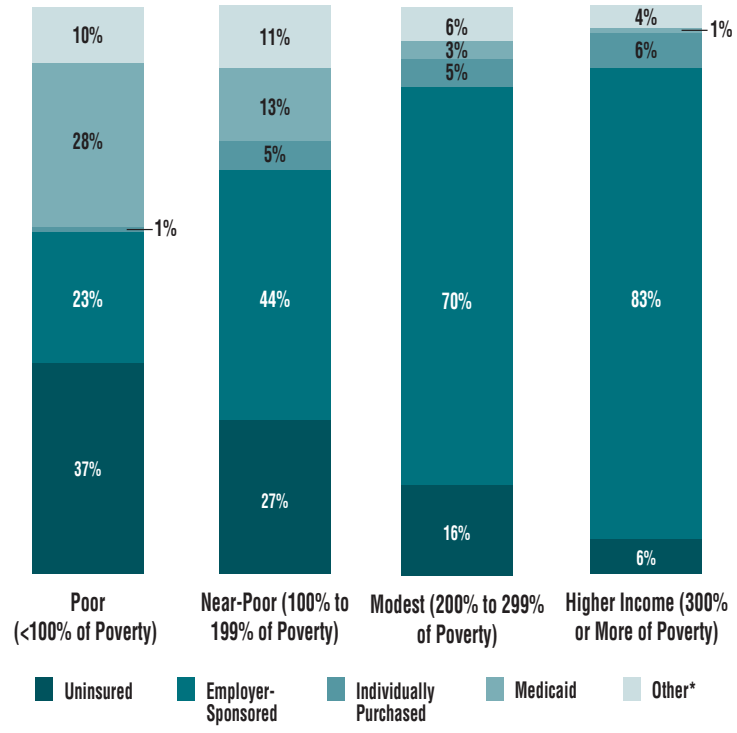
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Even among women with insurance, coverage is not always stable. One in 10 women who were covered at the time of the survey were uninsured at some earlier point during the year. Thus, 27% of women were uninsured for some period of time in the past year.

Among the group of women who had a spell of uninsurance during the year, the majority (60%) lacked coverage for a period of one year or less. Gaps in coverage can place women at risk for some of the same problems faced by the chronically uninsured, including delays in treatment and in obtaining preventive care. One in five uninsured women lacked coverage for four or more years.

Exhibit 3d

Health Insurance Coverage, by Poverty Level, Women Ages 18 to 64



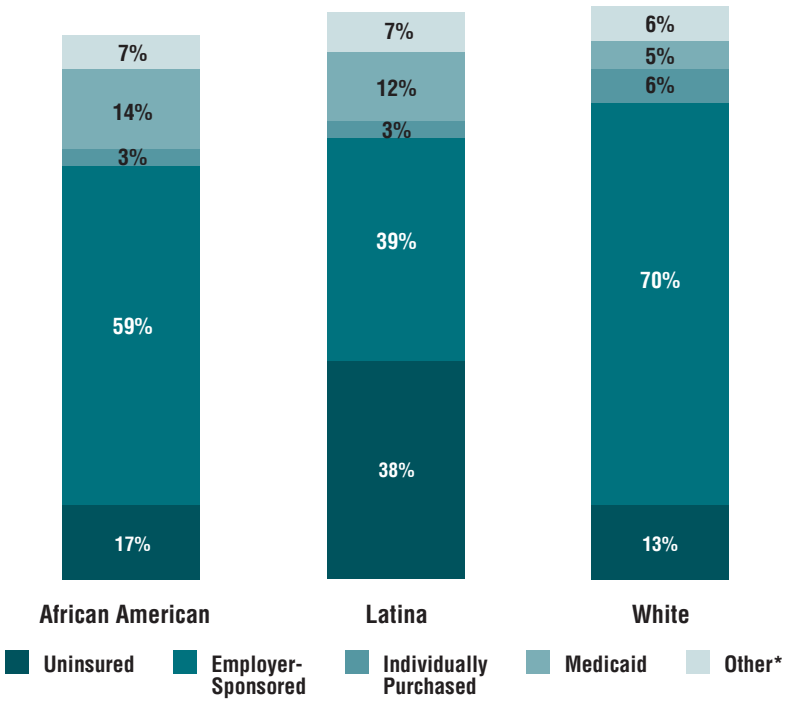
Note: 100% of the federal poverty threshold was $14,776 for a family of three in 2004.
* Other includes Medicare, CHAMPUS, TRICARE, and unknown insurance.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Women with the lowest incomes, who often have the poorest health status, are the most likely to be uninsured. More than one-third (37%) of poor women (family incomes below the federal poverty threshold) and 27% of near-poor women (100 to 199% of poverty) are uninsured. Lack of coverage also affects women with modest incomes; 16% of women at 200% to 299% of poverty lack coverage. The contrast in uninsured rates by family income is striking; the uninsured rate for poor women is six times higher than for women with family incomes at or over 300% of poverty.

Part of this disparity is due to differences in insurance options among women and the resultant disparities in employer-sponsored coverage. Higher-income women (family incomes at or over 300% of poverty) are 3.5 times as likely to have employment-based coverage as poor women (83% vs. 23%). Medicaid prevents this income-related gap in coverage from being even wider by providing coverage to women with limited incomes, but it covers just under one-third of poor women and a much smaller proportion of near-poor women, still leaving many women with limited resources uninsured. Lack of health insurance compounds the great financial strains that low-income women face in many aspects of their daily lives.

Exhibit 3e

Health Insurance Coverage, by Race/Ethnicity, Women Ages 18 to 64



* Other includes Medicare, CHAMPUS, TRICARE and unknown coverage.
Data source: *2004 Kaiser Women's Health Survey*, Kaiser Family Foundation.

Latinas (38%) have the highest rate of uninsurance of all groups of women examined by this survey—three times the uninsured rate of white (13%) women. They also have much lower employer-sponsored coverage rates with only 39% covered by this source, compared to 70% of white women. African American (59%) women also have lower employer-sponsored coverage rates and higher rates of Medicaid coverage than white women. Women of color are more likely to work in low-wage jobs and have disproportionately lower incomes. Low-wage workers are less likely to be offered coverage by their employers[5] and even when they are offered coverage, it is more difficult for them to afford the cost of premiums.

Exhibit 3f

Uninsured Rate by Selected Characteristics, Women Ages 18 to 64

Characteristic:	Percent Uninsured	Characteristic:	Percent Uninsured
Total	17%		
Age Group		Employment Status	
18 to 24 years	22%	Full-time	10%
25 to 34 years	21%	Part-time	21%
35 to 44 years	19%	Self-employed	26%
45 to 54 years	13%	Not employed	25%
55 to 64 years	13%		
Marital Status		Health Status	
Married	13%	Excellent/very good/good	16%
Living with partner	35%	Fair/poor	22%
Never married	19%		
Divorced, separated, widowed	20%		
Parental Status			
Child under 18 in household	18%		
No child under 18 in household	16%		

Data source: *2004 Kaiser Women's Health Survey*, Kaiser Family Foundation.

Women who are young, single, working part-time or unemployed are at the highest risk for being uninsured. This is largely due to their lower incomes and lack of access to employment-based coverage.

Full-time employment status, however, is no guarantee of coverage as one in 10 women who work full-time are uninsured. Access to and affordability of coverage is also a problem for a sizable share of women in poor health, with over one in five (22%) reporting that they are uninsured. These women are disproportionately low-income and may have difficulty working because of their health problems. They also may not be able to afford or qualify for non-group insurance because of their health status.

Exhibit 3g

Characteristics of Women Ages 18 to 64, by Insurance Status

	Employer-sponsored	Individually purchased	Medicaid	Uninsured
Age Group				
18 to 24 years	11%	14%	25%	17%
25 to 34 years	21%	13%	26%	26%
35 to 44 years	26%	18%	22%	27%
45 to 54 years	26%	28%	11%	17%
55 to 64 years	15%	27%	16%	12%
Race/Ethnicity				
African American	12%	7%	23%	13%
Latina	8%	8%	21%	29%
White	75%	76%	44%	54%
Other*	5%	9%	12%	5%
Poverty Level				
Less than 200% of poverty	19%	24%	87%	64%
200% of poverty and higher	81%	76%	13%	36%
Education				
Less than high school	6%	10%	34%	29%
High school	31%	18%	37%	37%
Post high school	30%	35%	21%	25%
College graduate	34%	37%	9%	10%
Parental Status				
Parent	45%	31%	66%	50%
Non-parent	55%	69%	34%	50%
Employment				
Full-time	60%	21%	23%	28%
Part-time	13%	26%	14%	18%
Self-employed	4%	18%	3%	8%
Not employed	23%	35%	60%	46%
Health Status				
Excellent/very good/good	88%	88%	66%	78%
Fair/poor	12%	12%	34%	22%

Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.

* Other includes Asian, Pacific Islander, American Indian, Alaska Native, people of multiple races, and those who identified themselves as "other."

Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

The profiles of women that are covered by different types of insurance are very different from each other. Not surprisingly, women with employer-sponsored insurance have higher incomes, higher education levels and are more likely to work full-time than women with any other forms of coverage.

Women on Medicaid are the poorest; nearly nine in 10 (87%) are low-income, compared to 19% of women with employer-sponsored coverage. They are also the youngest and most likely to have dependent children. Medicaid also is serving the least healthy population, with fully one-third (34%) reporting fair or poor health status, compared to only 12% of women with private coverage.

Uninsured women are also poorer than women who are privately insured. Nearly two-thirds (64%) are low-income and thus have very limited resources to cover medical needs. Uninsured women are also disproportionately younger than privately insured women. The majority are in the younger age groups where there is a high need for reproductive health care. A significant portion is over 45, an age group that experiences onset of many chronic conditions and relies on medical care heavily. Half of uninsured women have dependent children and notably, half (54%) are employed. Many uninsured women also have partners who are employed full-time or part-time, yet they still do not have access to insurance.

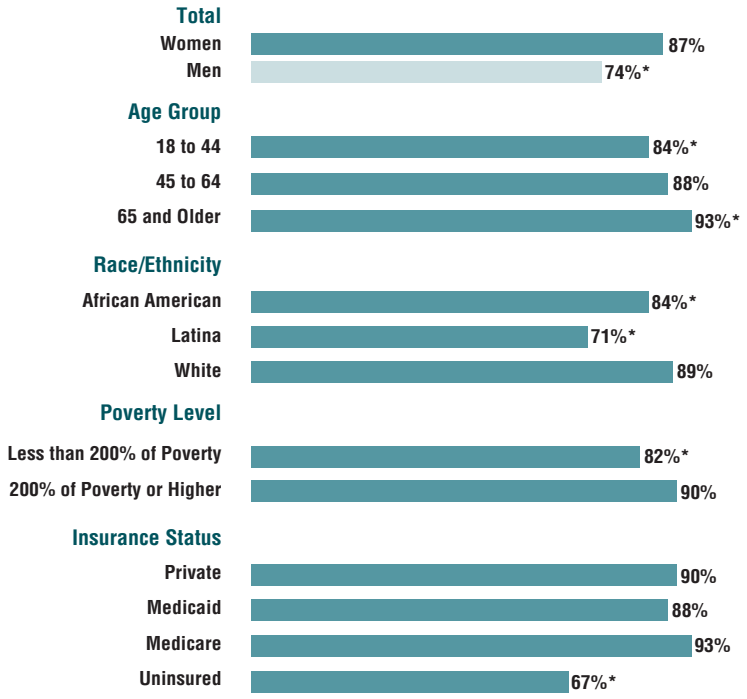
CHAPTER 4: WOMEN'S ACCESS TO HEALTH CARE

Women have a different relationship to the health care system than men. Women are more likely to use health care services because of their health status, higher incidence of chronic health problems, and lifetime need for reproductive and related services.[6] There are also considerable differences in how different groups of women use the health care system that are driven by economic factors, age, and health status and health needs. Many women experience a range of barriers to care that are logistical and economic in nature. These include lack of coverage or coverage that is not comprehensive, out-of-pocket charges, restrictions on physician choice, and lack of time due to competing family and work responsibilities. Such barriers can impede access to timely and necessary preventive, diagnostic, and treatment services.

Chapter 4 discusses women's access to care and utilization of services, specifically their visits to various providers, utilization of screening services, reasons for delaying care, access to physicians, and use of prescription drugs.

Exhibit 4a

Provider Visit in Past Year, by Selected Characteristics, Women Ages 18 and Older



*Significantly different from reference group (Women, 45 to 64, White, 200% of poverty or higher, Private), p <.05.
Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

The vast majority of women (87%) have had at least one visit to a health care provider in the past year, a higher rate than that of men (74%). While there is no specific guidance on how often one should go to the doctor, a visit to a health care provider in the past year is an indication of some level of access to the health care system.

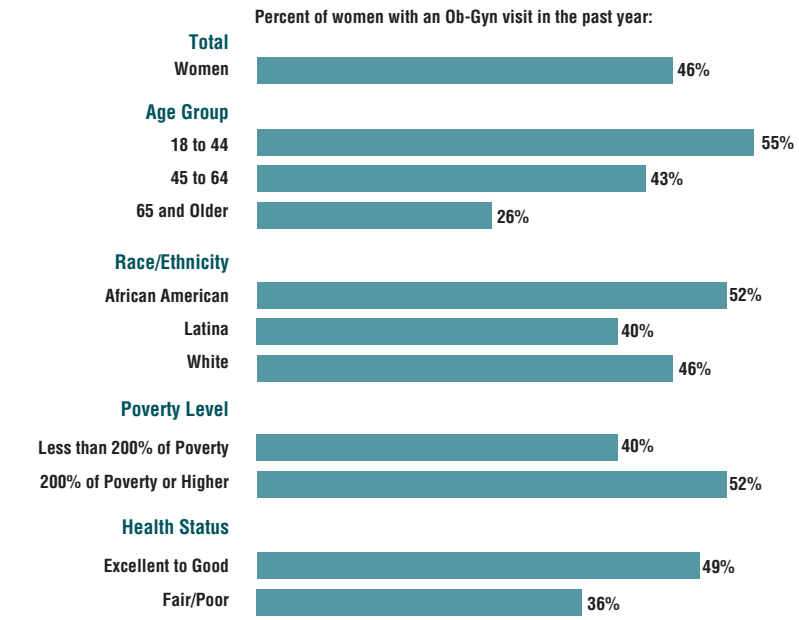
As women age, they are more likely to have a health problem and are therefore more likely to have a medical visit—with nearly all older women (93%) reporting a visit in the past year.

Latinas, who as a population are younger and more likely to be uninsured, are less likely to have had a provider visit compared to white and African American women. Despite their poorer health status, low-income women have lower rates of a provider visit than higher-income women. This could also be due to insurance coverage and general problems with health care affordability and availability.

The importance of coverage in influencing use of health care services is also evident—uninsured women are the least likely to have had a provider visit in the past year (67%) compared to women who are insured—regardless of the type of coverage.

Exhibit 4b

Gynecological Care, by Selected Characteristics, Women Ages 18 and Older



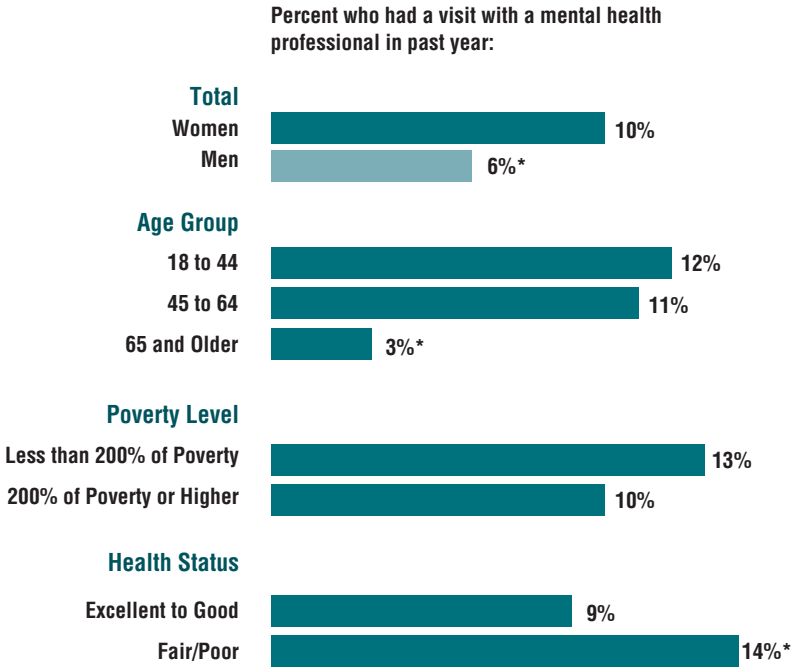
200% of the federal poverty threshold was $29,552 for a family of three in 2004.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

About one-half of women have seen an Ob-Gyn in the past year. Reproductive care is an important component of care for women. Not surprisingly, younger women are more likely to have had an Ob-Gyn visit, reflecting the fact that they are in their peak reproductive years and have greater need for obstetric care and family planning.

Despite greater health needs, low-income women and women in poor health are less likely to have had an Ob-Gyn visit in the past year than women who are higher income or in better health.

Exhibit 4c

Mental Health Care, by Selected Characteristics, Women Ages 18 and Older



Note: Includes visits to psychiatrist, therapist, counselor, and other mental health providers.
200% of the federal poverty threshold was $29,552 for a family of three in 2004.
*Significantly different from reference group (Women, 45 to 64, 200% of poverty or higher, Excellent to good), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Only one in 10 women report a visit with a mental health professional, such as a psychologist or psychiatrist, in the past year. Mental health care is often overlooked as a women's health care issue. These low use rates could be related to the considerable stigma that still surrounds mental health, lack of proper screening and identification, and poor coverage by insurance—both private and Medicare.[7]

Only a very small fraction (3%) of senior women have had a visit with a mental health professional in the past year. While older women have lower rates of depression and anxiety, it is not clear whether their lower use of mental health services reflects unmet need for mental health care, or whether they are more likely to receive counseling and guidance from other sources, such as social services agencies or clergy.

Women in fair or poor health, who may be struggling with a broad range of health issues, are more likely to have seen a mental health provider (14%) than women in better health (9%).

Exhibit 4d

Screening Tests, by Age Group and Insurance Status, Women Ages 18 and Older

Percent of women reporting they received screening test in past two years:

		Age Group			Insurance Status			
Screening Test	**All**	**18 to 44**	**45 to 64**	**65+**	**Private**	**Medicaid**	**Medicare**	**Uninsured**
Physical/clinical breast exam	75%	72%*	80%	74%*	81%	73%*	74%*	51%*
Mammogram (ages 40 and older)	70%	~	73%	74%	74%	~	73%	40%*
Pap smear	73%	78%*	73%	56%*	80%	84%	59%*	59%*
Colon cancer (ages 50 and older)	38%	N/A	35%	43%*	36%	~	44%*	~
Blood pressure	89%	85%*	92%	97%*	92%	88%	95%	72%*
Blood cholesterol	62%	49%*	74%	76%	63%	57%	77%*	38%*
Osteoporosis (ages 45 and older)	37%	N/A	35%	41%	38%	~	41%	15%*

* Significantly different from reference group (45 to 64, Private), p <.05.
N/A - Were not asked question.
~ Sample size too small for reliable estimate.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Screening rates for women still fall short of some recommended guidelines and public health goals. The early detection of disease through screening paves the way for prevention and early treatment of more costly and damaging conditions.

For breast and cervical cancer screenings, the rates are generally higher than for other screening tests. However, many women still do not get mammograms at recommended intervals—every one to two years for women 40 and older.[8] Around three-quarters of women have had a clinical breast examination, a mammogram, and a pap smear in the past two years. The large exception within this group is among uninsured women whose rates are considerably lower.

Among women ages 50 and older, only 38% have been screened in the past two years for colon cancer, with screening rates increasing with age, going from 35% of women ages 50 to 64, to 43% of women 65 and older.

Cardiovascular problems are leading causes of mortality and morbidity among women. While the vast majority of women (89%) have had a blood pressure check within the past two years, only six in 10 women (62%) have had a blood cholesterol screening test in the past two years. Screening rates are lowest among women ages 18 to 44.

Among women ages 45 and older, very few women have been screened for osteoporosis within the past two years —35% of women ages 45 to 64 and 41% of women 65 and older.

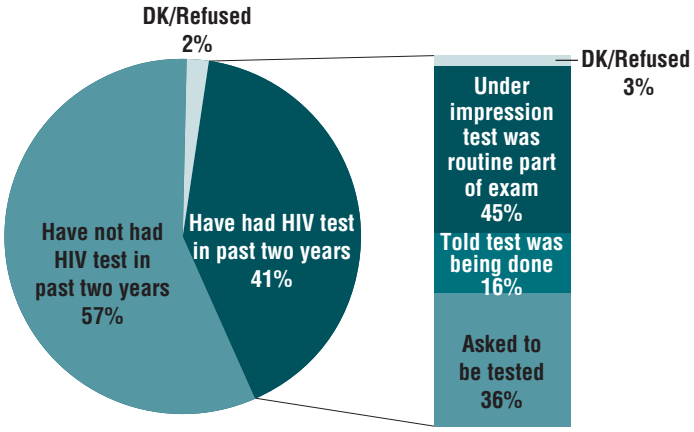
Across the board, uninsured women are consistently less likely than women with coverage to be screened.

Exhibit 4e

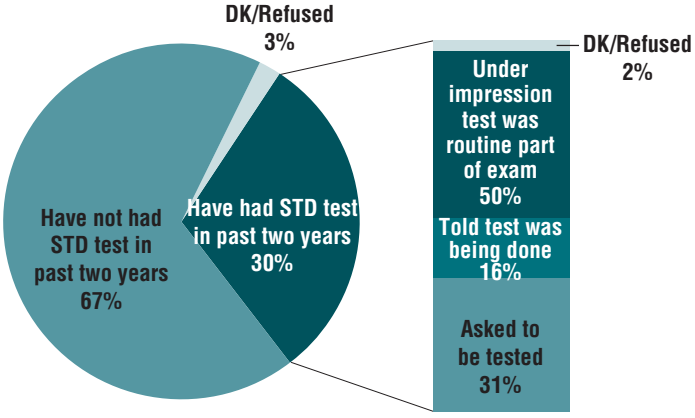
HIV and STD Testing, Women Ages 18 to 44

Percent who received test in past two years:

HIV Testing



STD Testing



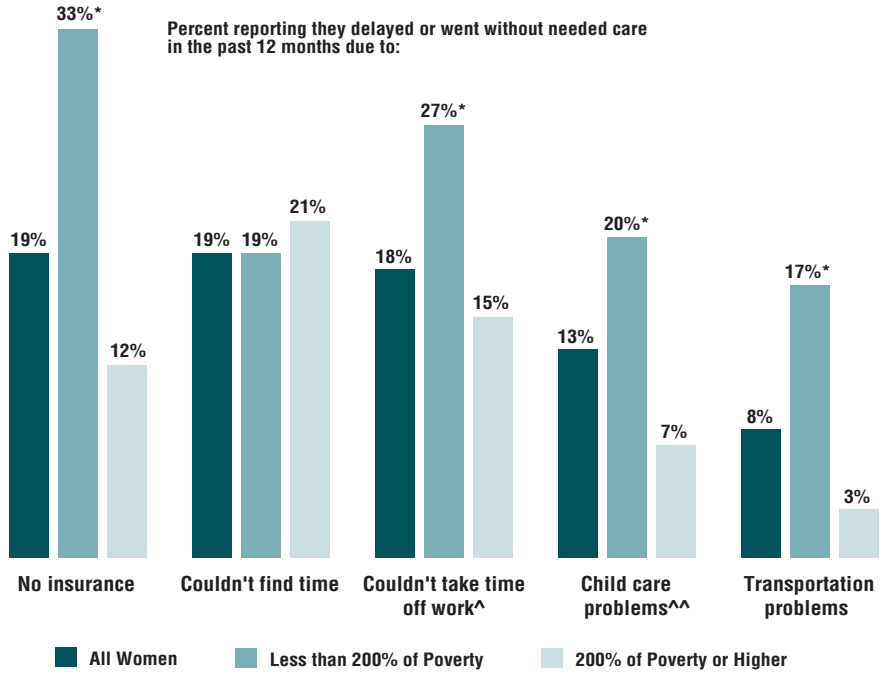
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Testing rates for HIV and sexually transmitted diseases (STDs) are still low for women of reproductive age. Among women ages 18 to 44, 41% report they have been tested for HIV and 30% report they have been tested for other STDs within the past two years.

Some women, however, may think they were tested for these health conditions when they were not. Among those who report being tested for HIV, approximately one-half say they were told the test was being done or asked to be tested. However, nearly one-half (45%) are under the impression that the test is a routine part of their examination. The HIV test, in fact, is not conducted routinely and requires patient consent before testing. Similarly, among women who report being tested for other STDs, about one-half base this information on their impression that tests are a routine part of the examination.

Exhibit 4f

Reasons for Delaying or Going Without Care, by Poverty Level, Women Ages 18 and Older



Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
*Significantly different from 200% of poverty or higher, p <.05.
^Among women who are employed. ^^ Among women with children younger than 18 years living in household.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

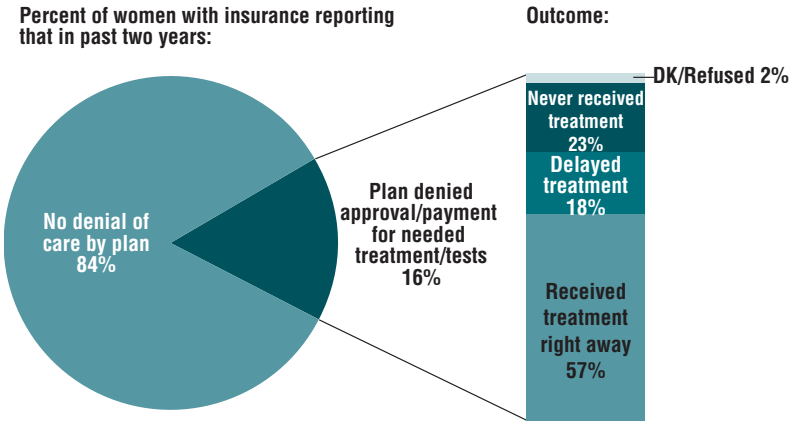
A sizable minority of women experience barriers to care that result in delays and forgoing care. While logistical barriers to care can affect all women, those with low incomes are disproportionately affected. One-third of low-income women indicate that lack of insurance affects their access to care, 2.5 times the rate of women with higher incomes.

Lack of time is a universal barrier for many women, with one in five saying that they delayed or went without care because they couldn't find the time, regardless of income.

Women's other responsibilities, such as their jobs and child care also compete with their own health care. Problems obtaining transportation and child care are also a barrier, particularly for many low-income women.

Exhibit 4g

Denial of Care by Insurance Plan, Women Ages 18 and Older

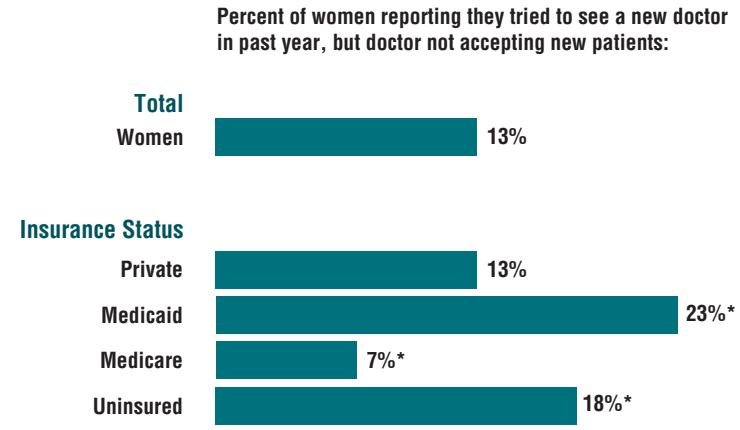


Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Almost one in six insured women (16%) report being denied approval or payment by their health plan for a health care service. Having coverage improves affordability of health care services, but it does not guarantee access to care or coverage for services. While most women eventually obtained care, 18% who were denied approval or payment delayed care and one-quarter (23%) never received the care.

Exhibit 4h

Access to New Doctors, by Insurance Status, Women Ages 18 and Older



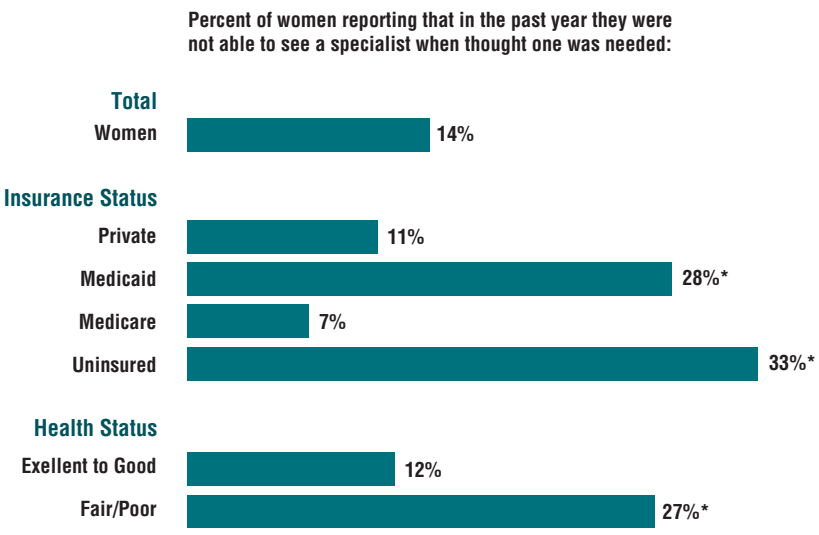
*Significantly different from private, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Thirteen percent of women report they had tried to see a new doctor in the past year, but that the doctor was not taking new patients. Getting an appointment with a new doctor is often difficult, particularly in a timely way.

Provider availability particularly affects women with Medicaid, nearly one-quarter (23%) of whom report a problem getting an appointment with a new doctor. There have been longstanding problems with physician participation in Medicaid because of low provider payment rates, and it is often hard for women to find a doctor willing to accept Medicaid as payment. Getting an appointment with a new doctor is also a problem for 18% of uninsured women. Women with Medicare are the least likely to report problems finding a new doctor, likely due to nearly universal acceptance of Medicare by physicians.

Exhibit 4i

Access to Specialists, by Selected Characteristics, Women Ages 18 and Older



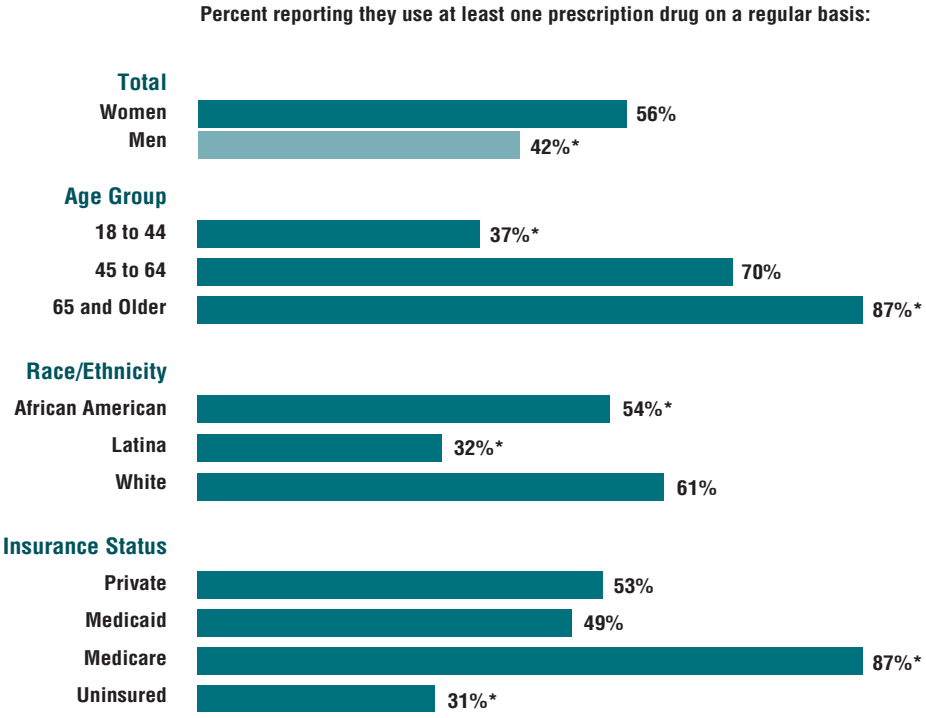
*Significantly different from reference group (Private, Excellent to good), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Fourteen percent of women report that in the past year they were not able to see a specialist when they thought one was needed. This may be driven in large part by provider supply, specialty type, insurance status, and health plan policies. Access to specialists is an important aspect of women's care.

Uninsured women and those on Medicaid are three to four times more likely than women with private coverage or Medicare to encounter this problem. Over one-quarter of women in fair or poor health (27%) were not able to see a specialist when needed, twice the rate for women in better health (12%).

Exhibit 4j

Use of Prescription Drugs, by Selected Characteristics, Women Ages 18 and Older



*Significantly different from reference group (Women, 45 to 64, White, Private), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Nearly six in 10 women (56%) take at least one prescription medication on a regular basis, a rate higher than that of men (42%). The difference in use rates by gender may be accounted for by women's higher rates of chronic conditions that require ongoing treatment (see Exhibit 2a), and their use of oral contraceptives and hormone replacement therapy.

Nearly four in 10 women ages 18 to 44 (37%) take prescription medicines on a regular basis. This rate rises to 70% of women ages 45 to 64 and almost nine in 10 older women (87%).

A wide range of factors in addition to health status contribute to women's use of prescription drugs. These factors include access to care, insurance coverage, health care experiences, cultural beliefs around medical care, and physician practice patterns. There are major differences in the use of prescription medicines by race/ethnicity; 32% of Latinas, 54% of African American women, and 61% of white women take prescription medicines on a regular basis.

Women with Medicare, who are mainly older, are the most likely to take prescription medicines and uninsured women the least likely.

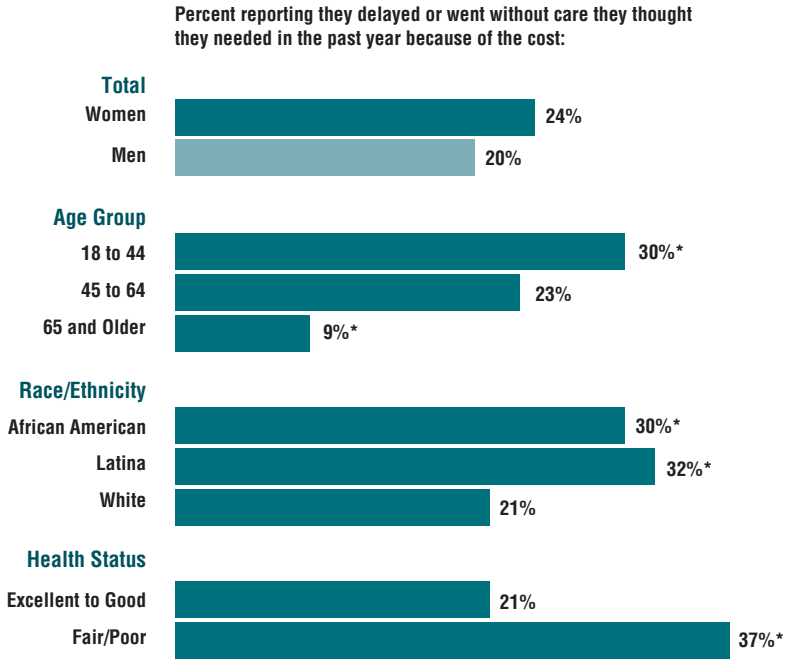
CHAPTER 5: WOMEN AND HEALTH CARE COSTS

One of the nation's greatest public policy challenges is addressing health care costs, which have been rising at double-digit rates for several years. Patients, providers, and employers are all affected by the growth in costs and have been searching for ways to slow the rate of growth. While several factors–technology, prescription drugs, the aging of the population-have been posited as contributing to rising health care costs, strategies for controlling costs have not been particularly effective. There is also some evidence that costs are increasingly being shifted to consumers in the forms of premiums, deductibles, and co-pays.[9] These out-of-pocket costs hit women hard because of their lower incomes, and potentially hinder their access to care.

This section looks at the impact of costs on women's access to care, the barriers women face because of the costs of prescription drugs in particular, some of the strategies and tradeoffs women employ to cope with drug costs, and how much women spend out-of-pocket on prescription medicines.

Exhibit 5a

Delayed or Went Without Care Because of Cost, by Selected Characteristics, Women Ages 18 and Older



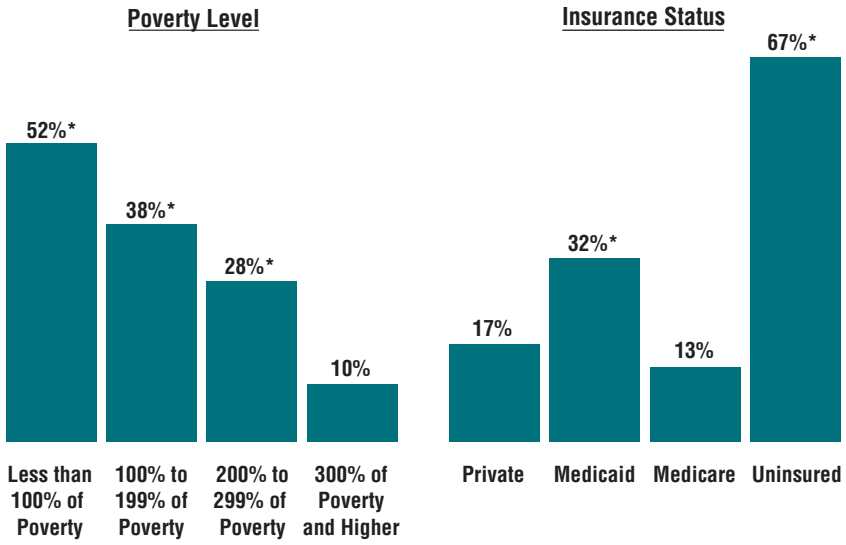
*Significantly different from reference group (45 to 64, White, excellent to good), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

A sizable minority of women cannot afford needed health care. One-quarter of women (24%) delayed or went without care in the past year because of the cost of that care, slightly higher but not statistically different than men (20%). Younger and midlife women are more likely to have delayed/forgone care than women 65 and older (30%, 23%, and 9%, respectively). This could be related to the fact that seniors have nearly universal coverage through Medicare.

Women of color are at higher risk for delaying or missing care because of costs. Approximately one in three African American women (30%) and Latinas (32%) report delayed/forgone care due to costs, compared to one in five white women (21%). Also of concern is the high proportion of women whose health is fair or poor who reported access problems due to costs (37%). Both women of color and women in poorer health are more likely to be on the lower ends of the income scale, affecting their ability to pay for out-of-pocket expenses.

Exhibit 5b

Delayed or Went Without Care Because of Cost, by Poverty and Insurance Status, Women Ages 18 and Older



Note: 100% of the federal poverty threshold was $14,776 for a family of three in 2004.
*Significantly different from reference group (300% of poverty and higher, Private), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Women with the fewest resources—lower incomes and lack of insurance—have the greatest difficulty affording health care. There are stark disparities between low-income and upper-income women as well as between the uninsured and women with health insurance in ability to pay for needed care. One-half of poor women (52%) and 38% who are near-poor (100 to 199% of poverty) report they delayed or did not get needed health care because of the cost. Costs were also a concern for modest-income women, with 28% reporting a cost barrier to care. Two-thirds of uninsured women (67%) report delayed/forgone care due to costs, compared to 17% of women with private coverage and 13% of women with Medicare. Women on Medicaid, who tend to have very low incomes, delay care at twice the rate of privately insured women, but still less than uninsured women.

Exhibit 5c

Prescription Drug Costs, by Selected Characteristics, Women Ages 18 and Older

	Total		Age Group			Race/Ethnicity			Poverty Level	
Percent of women reporting that in the past year they:	Women	Men	18 to 44	45 to 64	65 and older	African American	Latina	White	Less than 200% of poverty	200% of poverty and higher
Did not fill prescription medicine due to cost	20%	14%*	23%	20%	11%*	23%	24%*	18%	32%*	15%
Skipped or took smaller doses of prescription medicines to make them last longer	14%	11%	15%	17%	7%*	16%	15%	14%	23%*	11%
Spent less on basic needs for family to have enough money for prescription medicines	8%	5%*	8%	9%	8%	13%*	16%*	6%	16%*	4%

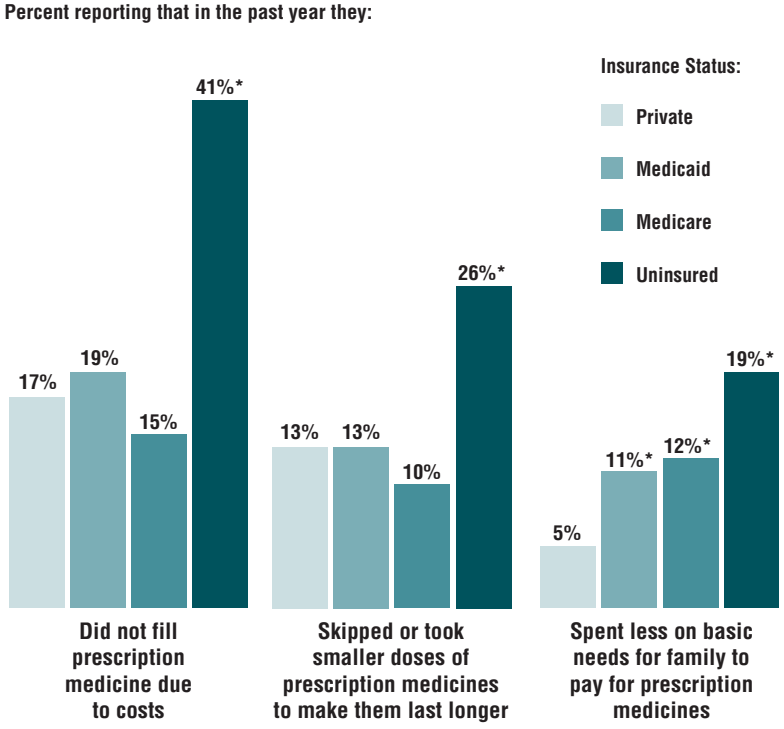
Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
*Significantly different from reference group (Women, 45 to 64, White, 200% of poverty and higher), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

A significant share of women, even those with insurance coverage, cannot afford to buy prescription drugs. One in five women (20%) report there was a time in the past year when they did not fill a prescription medicine because of the cost, a rate higher than for men (14%). Fourteen percent of women manage prescription drug costs by skipping or taking smaller doses of medicines to make them last longer. Non-elderly women (under age 65) are more likely to not fill a prescription or skip/reduce doses due to costs than women 65 and older. Latinas are also more likely than white women to not fill a prescription because of the costs. These cost barriers are particularly problematic for low-income women. Because of costs, one-third (32%) of low-income women report they did not fill a prescription and nearly one-quarter (23%) say the skipped or took smaller doses to make them last longer.

Women also face other tradeoffs because of the cost of prescription medicines. Nearly one in 10 women (8%) report that they spent less on basic needs for the family to have enough money to pay for prescription medicines, a rate slightly higher than men (5%). Women of color and low-income women are more likely to be faced with this financial tradeoff than their counterparts.

Exhibit 5d

Prescription Drug Costs, by Insurance Status, Women Ages 18 and Older



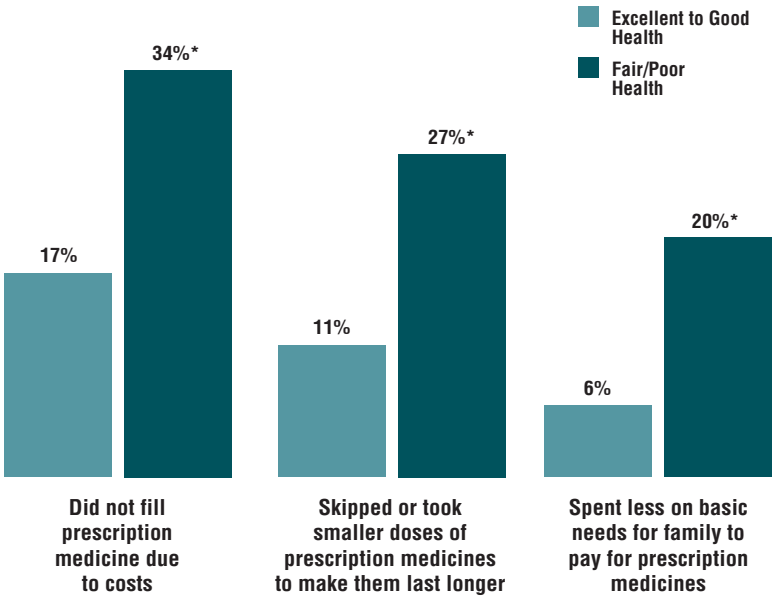
*Significantly different from Private, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

By all measures, uninsured women face the most severe cost barriers to prescription medicines. Four in 10 uninsured women report they did not fill a prescription due to costs, and 26% skipped or took smaller doses to make medicines last longer. One in five report they spent less on basic family needs to pay for their medicines. Although insurance coverage makes an important difference for women, it does not eliminate the cost barrier. Many women with insurance face obstacles due to prescription drug costs, highlighting the need to consider drug affordability for all women, not just those who are uninsured or on Medicare, which has received widespread public attention.

Exhibit 5e

Prescription Drug Costs, by Health Status, Women Ages 18 and Older

Percent reporting that in the past year they:



*Significantly different from Excellent to good, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

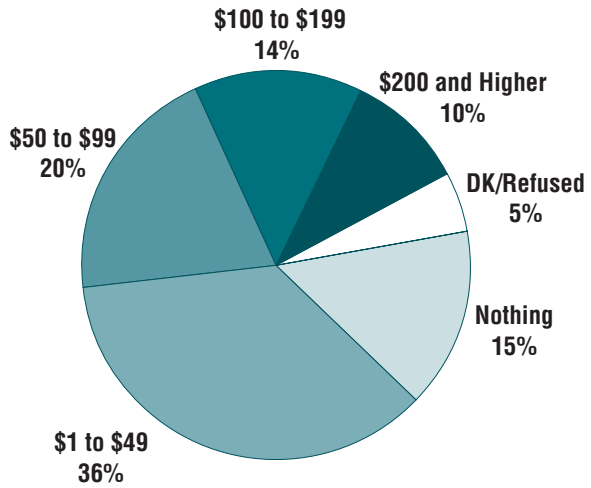
Women in poorer health, the vast majority of whom take a prescription medicine regularly (80%), experience greater challenges affording the costs of their medicines. This disparity is particularly alarming since gaps in prescription drug use among women in poorer health may jeopardize their already fragile health.

One-third of women in fair or poor health (34%) report they did not fill a prescription medicine due to costs, twice the rate of women in better health. Nearly three in 10 (27%) say they skipped or took smaller doses to make the medicine last longer and one in five (20%) spent less on basic needs for their families to pay for prescription medicines.

Exhibit 5f

Out-Of-Pocket Expenditures on Prescription Drugs, Women Ages 18 and Older

Percent reporting level of expenditures on prescription medicines in past month:



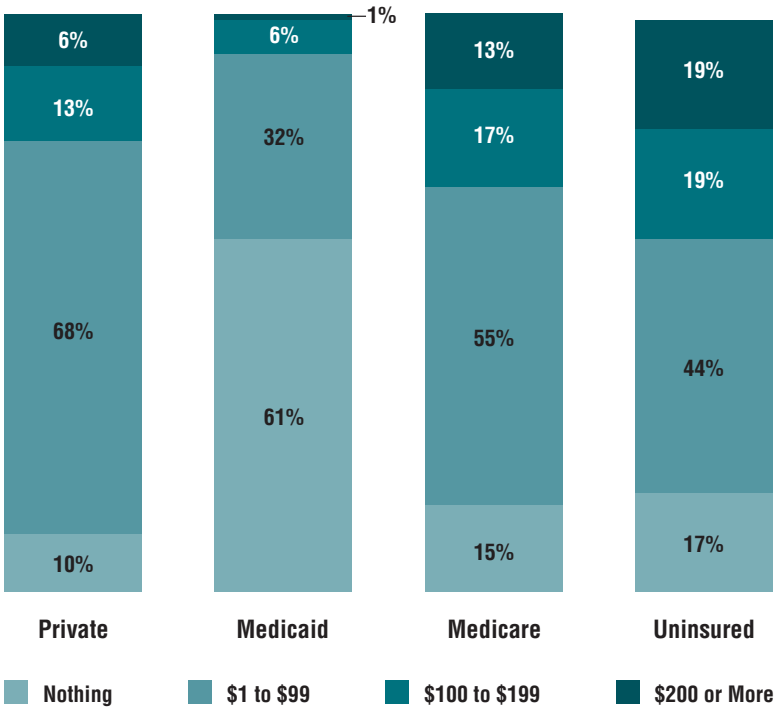
Note: Includes women who take at least one prescription medicine on a regular basis.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Most (80%) women who use prescription medicines regularly pay for some portion of the costs out-of-pocket. While 15% of women report they paid no out-of-pocket costs for their medicines in the past month, over one-third (36%) say they paid up to $50 and an additional 20% paid from $50 to $99 of their own money. However, one in four women (24%) face significant out-of-pocket expenses for prescription medicines, paying $100 or more in the past month, including 10% who paid at least $200 in the past month for their medicines.

Exhibit 5g

Out-Of-Pocket Expenditures on Prescription Medicines, by Insurance Status, Women Ages 18 and Older

Percent reporting level of expenditures on prescription medicines in past month:



Note: Among women who take at least one prescription medicine on a regular basis.
Only includes women who were able to respond to question. Excludes those who did not know expenditure level or refused to answer question: Private (2%), Medicaid (<1%), Medicare (13%), Uninsured (1%).
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Uninsured women have the highest out-of-pocket expenses for prescription medicines. Nearly four in 10 uninsured women (38%) say they spent $100 or more in the past month, including 19% that spent $200 or more. Given that most uninsured women are disproportionately low-income, these costs place a great strain on their already very tight budgets. However, women with insurance are not immune to the costs of prescription medicines either. Three in 10 women with Medicare coverage and nearly one in five (19%) privately-insured women spend $100 or more monthly on their medicines. The lowest out-of-pocket expenses are among women with Medicaid. Six in 10 (61%) report no spending for their medicines, a much higher proportion than women in the other insurance categories. This is because Medicaid policy only permits nominal or no cost-sharing for drugs, affording many poor women protection against the out-of-pocket costs of prescription drugs.

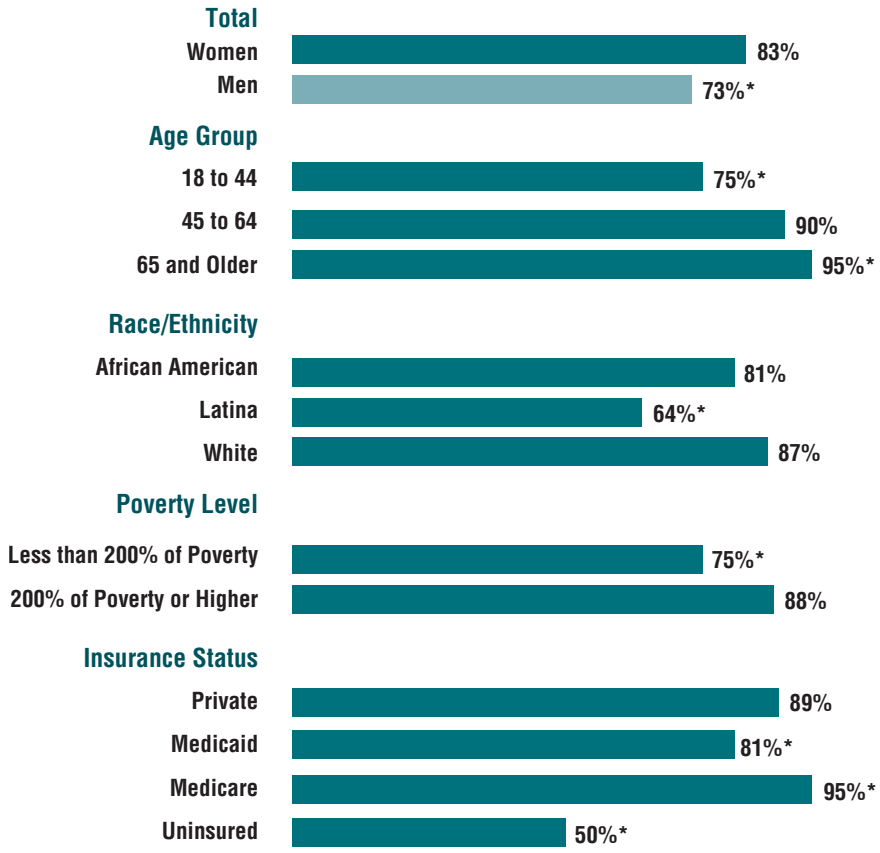
CHAPTER 6: WOMEN AND THEIR HEALTH CARE PROVIDERS

Relationships with their providers remain at the nucleus of women's health care. There is a large body of research that shows that having an ongoing relationship with a provider helps in tracking and monitoring a woman's overall health, aids in coordination of care, improves attention to preventive services, fosters adherence to treatment and medication, and provides patients with a source of contact in the health care system.[10] Women rely on doctors for health care information–53% reported they would turn to a health care provider when seeking medical information.

Chapter 6 covers the nature of women's relationships with health care providers, including how many women have a regular provider, provider specialties, and changing patterns of care over the course of women's lives. This section also looks at women's interactions with providers, such as counseling on preventive medicine and women's satisfaction with their health care.

Exhibit 6a

Women With a Regular Health Care Provider, by Selected Characteristics, Ages 18 and Older



*Significantly different from reference groups (Women, 45 to 64, White, 200% of poverty and higher, Private), p <.05.
Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Most women have a regular health care provider, but there are some striking disparities within groups of women by age, race/ethnicity, poverty, and insurance status. A regular provider has been documented to help maintain a consistent relationship with the health care system and has been shown to foster use of preventive services and promote access to care.[11] Women are more likely to have a regular provider (83%), than men (73%).

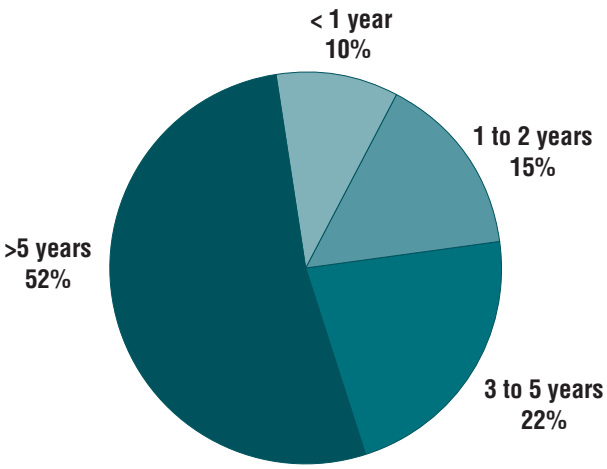
As women age, they are more likely to have a provider they see on a regular basis. Nearly all older women report they have a regular provider, compared to three-quarters of women ages 18 to 44 and 90% of midlife women. Only two-thirds of Latinas have this important connection to the health system, a considerably lower rate than African American (81%) and white women (87%). Low-income women are also less likely to have a regular provider.

Not surprisingly, insurance status is an important factor related to women's access to a regular provider. Only half of uninsured women have this connection compared to 89% of women with private coverage. And while women on Medicaid are more likely to have a regular provider than uninsured women, they still lag behind privately-insured women and those with Medicare, a group consisting primarily of older women.

Exhibit 6b

Length of Time with Health Care Provider, Women Ages 18 and Older

Among women reporting they have a regular provider:



Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Most women have long-standing relationships with their providers. Half of women have been going to their provider for five or more years. Another 22% have been going to their doctor for three to five years and one-quarter have seen their regular provider for a relatively short period (two years or less)

There are many reasons women change providers including dissatisfaction, change in their health plan, and moving to a new location. Because many women have multiple providers and have had short relationships with these doctors they are at higher risk for having fragmented care.

Exhibit 6c

Type of Provider, by Age Group, Women Ages 18 and Older

Percent of women with a regular provider whose provider practices in the following specialty:

Type of Provider	All Women	18 to 44	45 to 64	65 and Older
Primary Care Practitioner				
Family Practitioner	61%	63%	61%	57%
Internist	18%	10%*	24%	25%
Physician Assistant	2%	2%	3%	2%
Nurse Practitioner	2%	3%	2%	1%
Obstetrician-Gynecologist	9%	17%*	4%	1%*
Other Specialist	4%	3%	5%	8%
DK/Refused	3%	2%	2%	7%*
Have an Additional Regular Provider	47%	45%*	51%	47%

*Significantly different from 45 to 64, p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

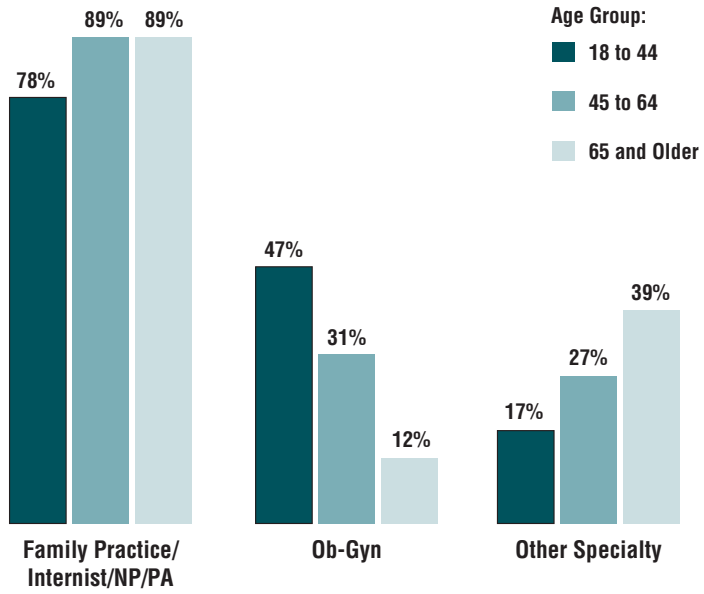
For most women, their routine health care provider is a family practitioner (61%) or internist (18%). Only 9% identify their routine provider as an Obstetrician-Gynecologist (Ob-Gyn), 4% note other specialists besides an Ob-Gyn, and 4% say they rely on nurse practitioners or physician assistants for their routine care.

Women's health care has often been characterized as fragmented because of the division between reproductive health and other health needs, sometimes requiring the use of multiple providers with different specialties. Among women with a regular provider, 47% have at least one other provider they see routinely, in contrast to 30% of men.

Exhibit 6d

Specialty of Providers, by Age Group, Women Ages 18 and Older

Specialty of Regular Providers:



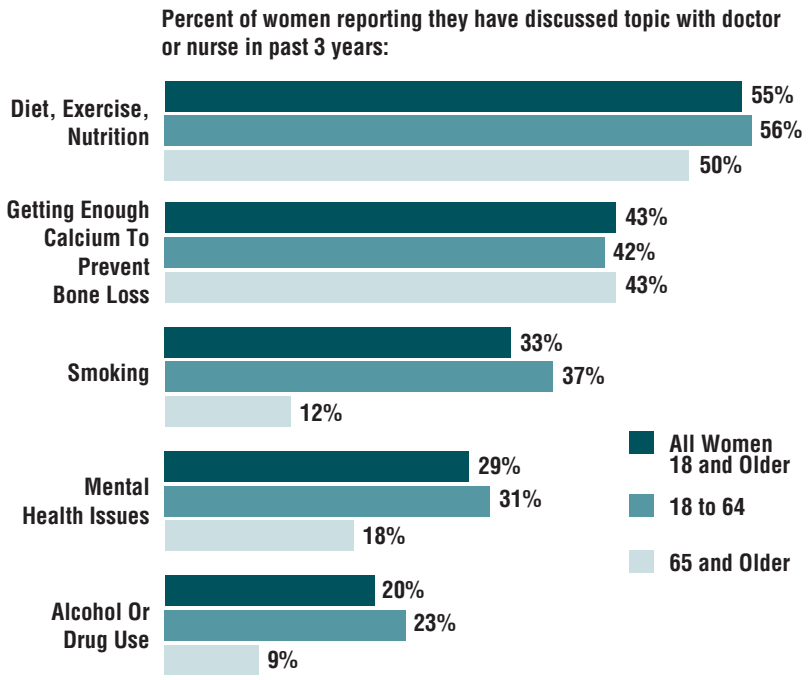
Note: Among women with at least one regular provider.
NP = nurse practitioner, PA = physician assistant, Ob-Gyn = Obstetrician/gynecologist
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Even though women of all ages are most likely to see a family practitioner/internist as at least one of their regular providers, there are clear age-group differences in the specialties of other providers.

Among women in their reproductive years, half (47%) of those with a regular provider identify an Ob-Gyn as one of their routine doctors. This proportion drops steadily as women age, falling to one in three women ages 45 to 64 and just 12% of women 65 and older. Over the course of their lives, as they face more chronic illnesses and the need for specialty care grows, women's use of other specialists, such as cardiologists, orthopedists, and endocrinologists increases. Four in 10 women 65 and older (39%) see a provider in a specialty other than Ob-Gyn on a regular basis.

Exhibit 6e

Provider Counseling About Health Behaviors, by Age Group, Women Ages 18 and Older

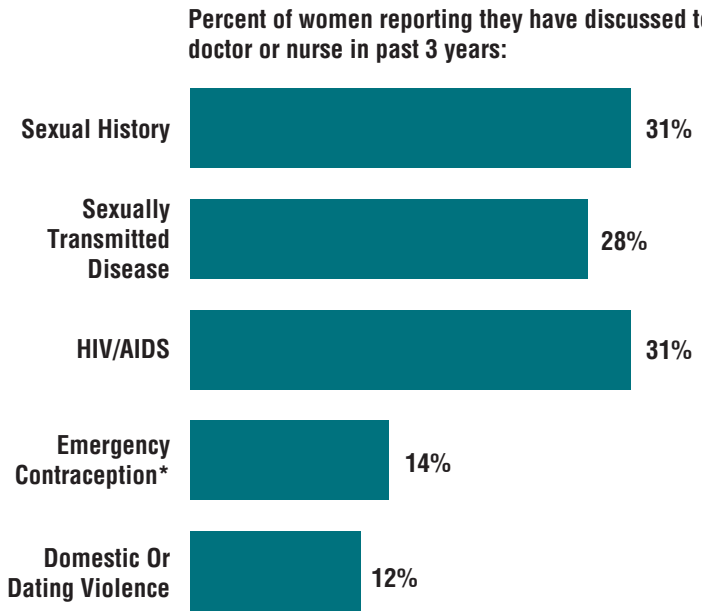


Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Provider information and counseling on health risks remains an important tool to promote health, but its reach is limited. Over half of women (53%) cite health care providers as their primary source of health information, much higher than the Internet (15%), friends and family (16%), and books (7%). However, many women report they have not discussed specific health risks with a health care provider within the past three years. The most frequently mentioned general health counseling was discussion of diet, exercise, and nutrition, with over one-half of women (55%) saying that their doctor asked about these health habits. Next in decreasing frequency are the discussion of calcium to prevent bone loss (43%), smoking (33%), mental health issues, such as anxiety and depression (29%), and alcohol and drug use (20%). Rates of counseling about several of these health issues decline with age, with older women less likely to have discussions with their physicians about these health issues.

Exhibit 6f

Provider Counseling About Sexual Health, Women Ages 18 to 44

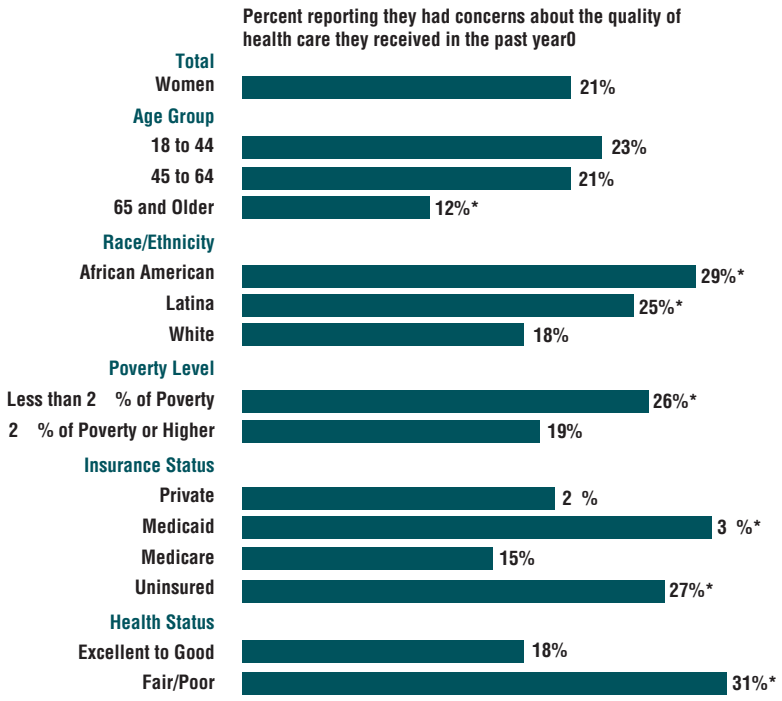


*Percent reporting they have ever discussed emergency contraception with a doctor or nurse.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Counseling on sexual health topics is also infrequent even among women in their reproductive years. Prevention and treatment of STDs remains a major public health challenge. However, fewer than one in three women ages 18 to 44 report that they had discussed their sexual history (31%), sexually transmitted diseases (28%), or HIV/AIDS (31%) with a health care provider in the past three years. While women of color, particularly African Americans, are at higher risk for HIV/AIDS, less than half of African American women (41%) and Latinas (44%) of reproductive age have discussed the topic with a provider in the past three years. Counseling on other topics, such as domestic violence is even more limited, with only one in 10 women (12%) having spoken to a provider about it and only 14% having ever discussed emergency contraception with a provider.

Exhibit 6g

Concerns About Quality of Care, by Selected Characteristics, Women Ages 18 and Older



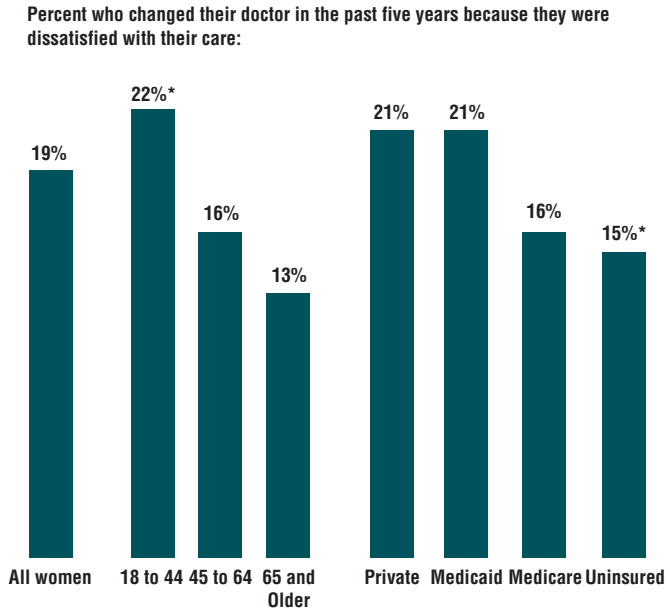
Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
*Significantly different from reference group (45 to 64, White, 200% of poverty or higher, Private, Excellent to good).
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

The quality of their own health care concerns a sizable minority of women. In recent years, there has been growing attention to quality of health care and medical errors. Overall, one in five women (21%) have concerns about the quality of the health care they received in the past year. Quality concerns are expressed more frequently by younger and midlife than older women (23% and 21% vs. 12%). In addition, one-quarter of Latinas and three in 10 African American women have quality concerns, rates higher than for white women (18%).

While Medicaid is an important program for poor women, one in three women on this program express concerns with the quality of care they received, a rate higher than privately-insured women and those on Medicare, but similar to those who are uninsured. Another group with concerns about quality are women in fair or poor health, who typically have had many encounters with the health care system. One in three (31%) women in fair or poor health express concerns with quality compared to 18% of women in more favorable health.

Exhibit 6h

Changed Doctors because of Dissatisfaction with Care, by Age Group and Insurance Status, Women Ages 18 and Older



*Significantly different from reference group (45 to 64 and Private), p <.05.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

One in five women (19%) changed their doctors within the past five years because of dissatisfaction with care. Younger women (ages 18 to 44) are more likely to change doctors for this reason than older women (65 and older) (22% vs. 13%). Privately-insured women are also more likely to do so than the uninsured (21% vs. 15%), perhaps because the latter are less likely to have a regular provider or the resources to change doctors when dissatisfied.

While concern about quality and dissatisfaction was an issue for a sizable minority of women, paradoxically, most women do not report problems communicating with their doctors. Among women who have gone to the doctor in the past year, only a small percent (5%) report that the doctor didn't take adequate time to answer all questions. Latinas (10%) are more likely than white women (4%) to report their questions were not fully answered (data not shown). Only a small share of women (4%) also say they didn't understand or remember some portion of the information given during a medical appointment (data not shown).

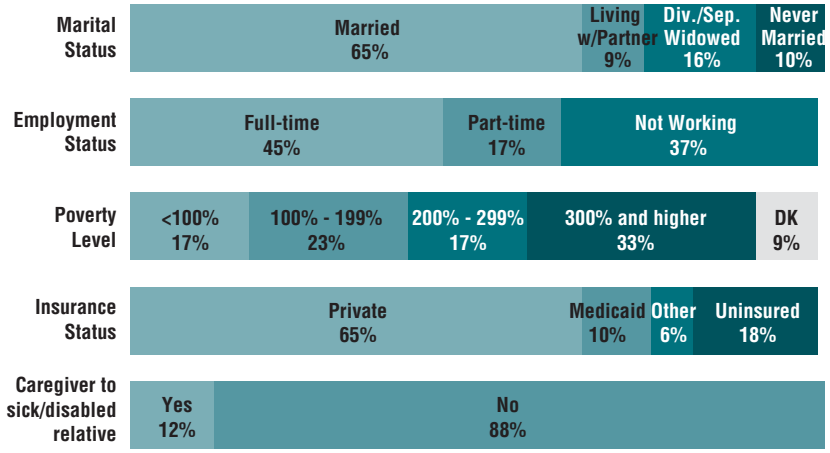
CHAPTER 7: WOMEN AND FAMILY HEALTH

Women's health is intimately connected to their roles as mothers, partners, and daughters. Women are often the main providers for their children's health and well-being, and are usually their children's critical link to the health care system. Many women also help manage their partners' health needs, and over one in 10 women are taking care of an aging or chronically sick relative, often a parent. Although women assume the bulk of family health responsibilities, the influence of these added duties on their health and well-being is often not delineated or recognized. However, these responsibilities are just a portion of the myriad of financial, family, and other obligations that women must balance to meet their families' needs. And many women undertake these tasks in the face of difficult circumstances, including their own health problems, limited financial resources, and while raising children and working. For many of these women, balancing family health needs with other commitments is a heightened challenge.

This chapter discusses the roles that women play in their families' health care, including the decisions they make on behalf of their children, the impact their multiple roles have on their own stress, and their roles as caregivers to ill or aging relatives.

Exhibit 7a

Profile of Mothers and Guardians of Dependent Children, Women Ages 18 and Older

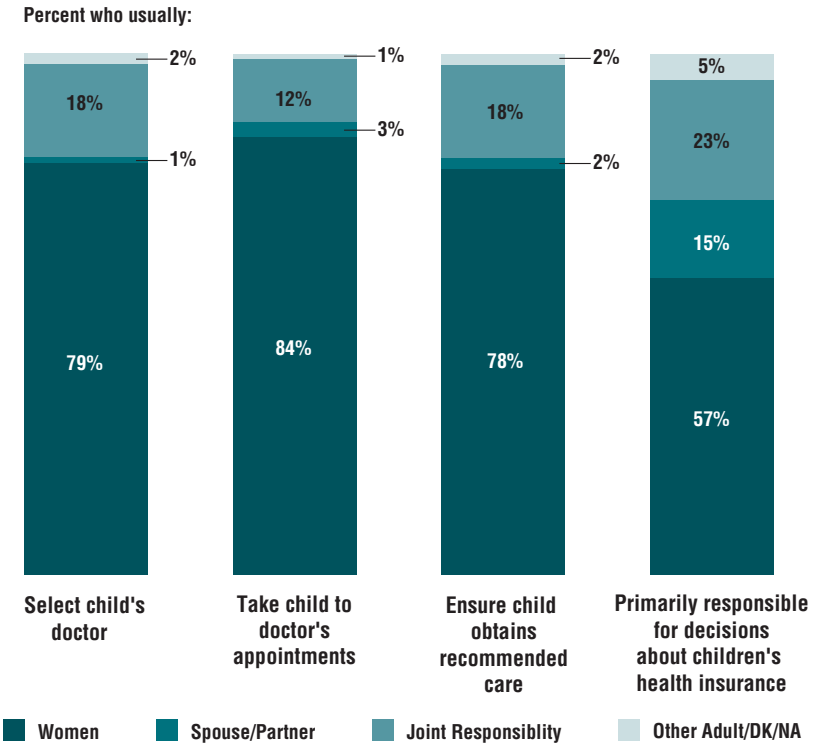


Note: Mothers/guardians refers to women with children under 18 in the household.
100% of the federal poverty threshold was $14,766 for a family of three in 2004.
Other includes Medicare, CHAMPUS, TRICARE, and unknown insurance.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

As mothers, women are the primary caretakers of their children's needs, including their health. Nearly four in 10 adult women (38%) have dependent children (under age18) at home. Women with children often face challenging time constraints and must balance multiple obligations. One in four (26%) women with children are single parents and slightly over six in 10 work outside the house. Four in 10 have limited resources, with family incomes below 200% of poverty. Many mothers are also contending with their own health problems—18% are uninsured, one-quarter have a chronic health condition, and 12% are in fair or poor health status (data not shown). In addition to their regular childrearing responsibilities, over one in 10 mothers are also caregivers for a chronically sick or disabled family member.

Exhibit 7b

Mothers' Family Health Care Roles*, Women Ages 18 and Older

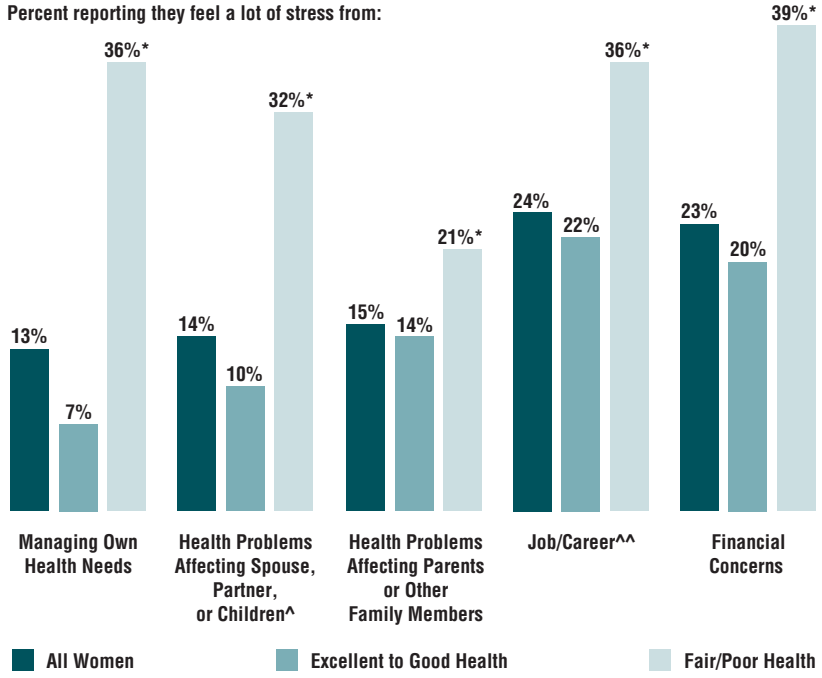


*Refers to women with children under 18 in the household.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Women's roles in family health are central, as they are the primary coordinators of health care for their children. The vast majority, approximately 80%, of mothers shoulder main responsibility in the family for selecting their children's doctor, taking them to doctor's appointments, and arranging for their children's follow-up care. Decisions about children's health insurance coverage are more likely to be a joint responsibility with a spouse, yet still a majority of women (57%) assume the primary role in this area.

Exhibit 7c

Causes of Stress, by Health Status, Women Ages 18 and Older



*Significantly different from excellent to good, p <.05.

^Among women who are married, living with a partner, or have a child under 18 in the household.

^^ Among women who are employed.

Response scale: a lot, some, not much, no stress at all.

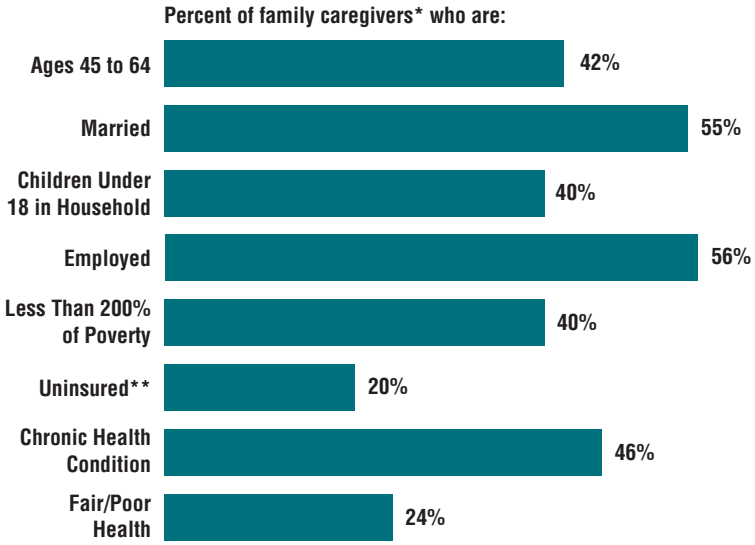
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Women face multiple sources of stress, particularly economic problems and to a lesser though significant extent, health care issues. Over one in 10 women report that their own health needs and those of a family member caused them a lot of stress. A greater proportion of women than men report managing their own health needs (13% and 9% respectively) and those of their parents (15% and 11% respectively) as very stressful. Job-related stress and financial concerns are similar between men and women, with each of these areas causing a significant amount of stress (data not shown for men).

Women in fair or poor health clearly experience higher levels of stress than women in better health. Particularly of note is the high proportion of women in fair or poor health who report that managing their own health needs or the health needs of a spouse or child causes a lot of stress, three to five times the rate of women in better health. Job and financial stress are also higher for women in fair or poor health, affecting nearly four in 10 women.

Exhibit 7d

Profile of Family Caregivers, Women Ages 18 and Older



*Caregivers are those caring for a chronically ill, aging, or disabled relative.

** Among caregivers ages 18 to 64.

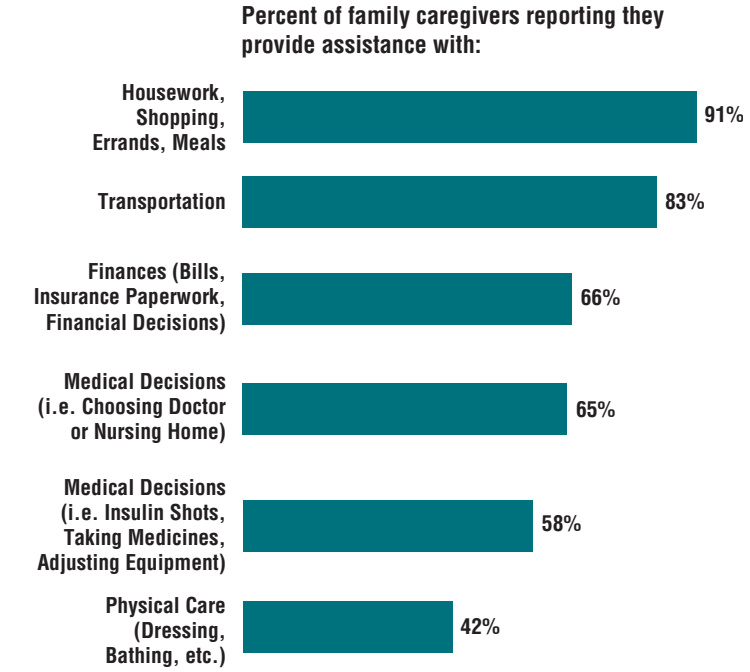
Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.

Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

In addition to their regular family obligations, 12% of women care for a family member who is chronically ill, disabled, or elderly, compared to 8% of men. Nearly one-half of these women are caring for a parent or parent-in-law (47%), 18% for a spouse, 12% for a child, and the remainder (22%) for other relatives (data not shown). These caregivers often have multiple roles and responsibilities and often face economic and health challenges of their own. Many are low-income and have chronic health problems. Caregivers cross the age spectrum: 41% are 18 to 44, 42% are 45 to 64, and 16% are 65 and older. Four in 10 caregivers have children under age 18 and nearly six in 10 are employed outside the home (56%). A significant portion (40%) are in families with household incomes below 200% of poverty, compared to 29% of non-caregivers. And, many caregivers are also dealing with their own serious health problems. Almost one-half have a chronic health condition and one-quarter report their health as fair or poor.

Exhibit 7e

Caregiver Roles, Women Ages 18 and Older

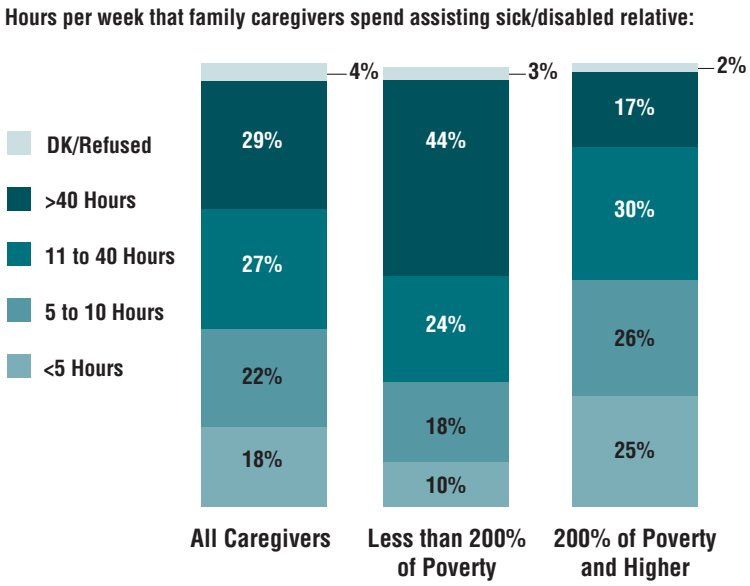


Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Caregivers provide assistance across a wide range of daily activities. Nearly all provide assistance with housework, shopping, and errands. Transportation is the next most common caregiving activity, with eight in 10 women providing this care to a family member. Two-thirds of caregivers assist with financial issues (e.g., dealing with bills, insurance, and paperwork) and participate in medical decisions for their relative. Six in 10 provide medically-related care, such as help with medications, injections, and equipment. And, four in 10 provide assistance with physical care activities, such as dressing and bathing. Many informal caregivers do not receive formal training in these tasks and must learn how to perform them to keep up with their relative's health needs.

Exhibit 7f

Caregiver Time Commitment, by Poverty Level, Women Ages 18 and Older

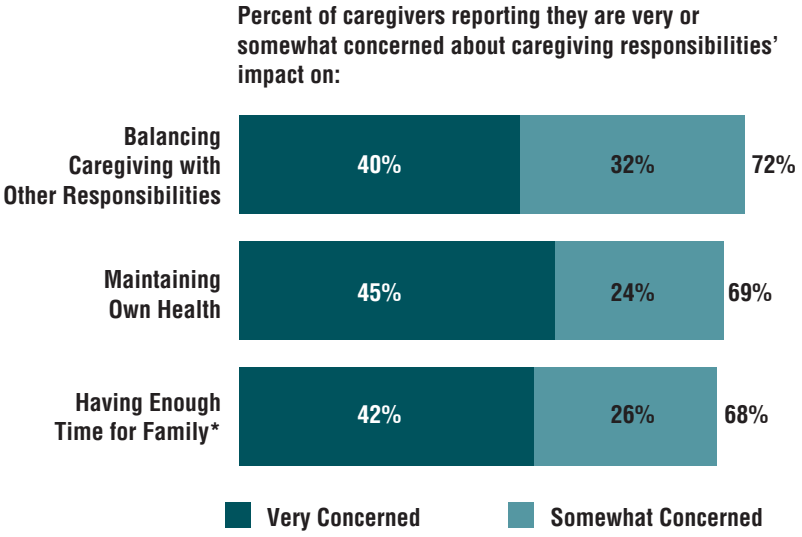


Note: 200% of the federal poverty threshold was $29,552 for a family of three in 2004.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

A sizable share of caregivers spend the equivalent time as a full-time job caring for their sick family member. The weekly time involved in caregiving ranges from fewer than 5 hours per week (18%) to more than 40 hours (29%). Low-income caregivers spend more time in caregiving for their family members than women with incomes of 200% of poverty and higher, who have more resources to pay for professional care. Forty-four percent of low-income caregivers assist 40 hours or more compared to 17% of caregivers with family incomes over 200% of poverty. Family caregivers are not generally paid for their time, and for those who do it on a full-time basis, their ability to earn income through outside work is compromised, which may be particularly hard on low-income women.

Exhibit 7g

Caregiver Concerns, Women Ages 18 and Older



*Among those who are married, living with a partner, or have children under 18 in the household.
Response scale: very, somewhat, not very, not concerned at all.
Data source: *2004 Kaiser Women's Health Survey,* Kaiser Family Foundation.

Their multiple roles and commitments take a toll on family caregivers. Forty percent report that they are very concerned with being able to balance caregiving with other responsibilities and an additional 32% are somewhat concerned. Maintaining one's own health was also an issue for many caregivers (45% very concerned), many of whom have chronic health problems. Many of these women are also stretched for time. Forty-two percent are very concerned with having enough time for family members because of caregiving responsibilities.

CHAPTER 8: CHANGES BETWEEN 2001 AND 2004

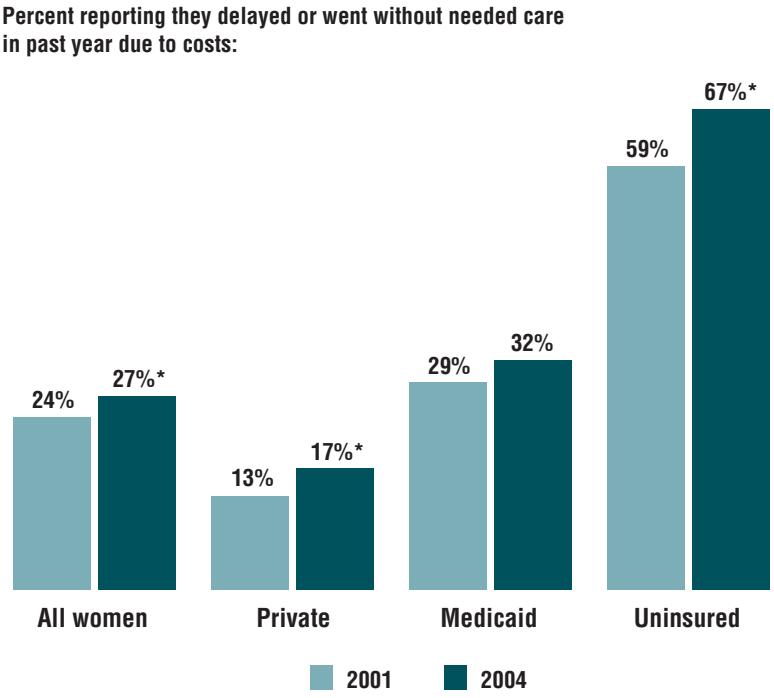
The Kaiser Women's Health Survey was initially conducted in 2001 and then expanded and repeated in 2004. During this period, the health sector did not experience any dramatic changes other than a continuing rise in the rate of health care costs. It is therefore not surprising that there were relatively few changes in women's health coverage and access to care between the 2001 and 2004 surveys. Of the changes that were observed, most were small with shifts of 5% or less. While modest, some are notable in that they may be suggestive of trends–both positive and negative–in the health status and access to care experienced by women. Since the 2004 survey was broadened to include women 65 and older, this section presents comparisons only for women ages 18 to 64.

During the three-year period between the surveys, the impact of the aging population is evident through some of the findings on the health status of women. Between 2001 and 2004, prevalence of certain chronic conditions rose in the non-elderly population. Among the statistically significant changes were the rise in diabetes from 5% to 8% of non-elderly women; anxiety/depression from 21% to 24%; and obesity from 11% to 13%. There was also a slight rise in the share of women who are heavy users of physician care. In 2001, 13% of the women with at least one provider visit in the previous year had more than 10 visits; by 2004, this number had risen to 17% of women.

There are also signs that out-of-pocket expenses for care and obtaining preventive services may be difficult for a growing share of women. The rate of reported blood pressure checks dropped from 90% to 88% among non-elderly women, and there were also declines in mammogram and Pap smear rates. While the changes are modest, they do warrant further attention and research. There are many factors that affect the use of health care services and while there appears to be erosion in preventive service use even among women with insurance, they still fare considerably better than their uninsured counterparts.

Exhibit 8a

Changes in Affordability as a Barrier to Care, by Insurance Status, 2001 and 2004, Women Ages 18 to 64



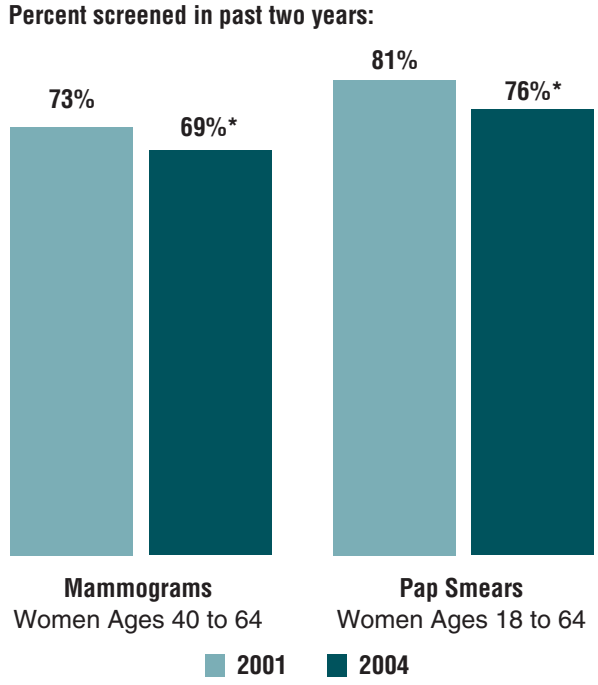
*Significantly different from 2001, p <.05.

Data source: *2001 and 2004 Kaiser Women's Health Surveys*, Kaiser Family Foundation.

In 2001, problems with affordability forced 24% of non-elderly women to delay or forgo needed health care. By 2004, this number had risen to 27%. This problem was particularly aggravated for uninsured women, 59% of whom reported that they delayed or went without care because of costs in 2001 and 67% who reported the same problem in 2004. This pattern was also evident, but to a lesser extent, among insured women where the share of women with private coverage (employer-sponsored or individually-purchased) who delayed or did not get needed care rose from 13% in 2001 to 17% in 2004.

Exhibit 8b

Changes in Mammography and Pap Smear Rates, 2001 and 2004



*Significantly different from 2001, p <.05.

Data source: *2001 and 2004 Kaiser Women's Health Surveys*, Kaiser Family Foundation.

Cancer screening rates for mammograms and pap smears fell between 2001 and 2004. Mammography rates for women 40 to 64 dropped from 73% in 2001 to 69% in 2004. Pap smear rates also fell from 81% to 76% for women ages 18 to 64 between 2001 and 2004. These trends also affected women with private coverage, with screening rates falling for mammograms and Pap smears, as well as clinical breast exams and blood pressure checks (data not shown). These changes could possibly be explained by a number of factors. There has been considerable media attention that has raised new questions about the accuracy of mammography in detecting early stage breast cancer. Furthermore, the guidance on mammography for women ages 40 to 49 is also ambiguous, with major breast cancer organizations and researchers in disagreement over the recommendations for this age group of women. While there is less disagreement about Pap smears, there have been some recent changes in recommendations, which are now based on risk and presence of other health conditions, rather than uniform guidelines based on age. While this is meant to improve the targeting of screenings and reduce unnecessary testing, this could be creating some confusion among women and providers.

CONCLUSION

The findings of the 2004 Kaiser Women's Health Survey speak to both the strengths and weaknesses of the health system in meeting women's health needs. Most women are in good health, have insurance coverage, and access to health care services. However, a substantial minority of women cannot gain access to health care services because they are either uninsured or unable to keep up with the increasing costs of heath services. In other cases, their poor health makes managing their treatment and addressing basic needs a difficult balancing act. For increasing shares of women, barriers to care attributable to cost are a growing problem.

Certain cross cutting issues emerge from the key findings of the survey:

Women's health needs and health care utilization patterns change and evolve as they age. Over the course of women's lives, their use of the health care system reflects their changing health needs, shifting from a focus on reproductive health in their younger years to an emergence of more chronic illnesses in the middle years, to higher rates of disability and physical limitations during the senior years. This is evidenced by more doctor visits among seniors, increased use of medications as women age, and shift in provider specialties from ob-gyn to other specialties. Chronic illness is not just a problem for older women though. Nearly one-quarter of reproductive age women have a chronic condition that requires ongoing treatment, and one in 10 contend with hypertension, high cholesterol, or asthma or other respiratory conditions. Similarly, the emergence of chronic conditions such as arthritis, hypertension, and diabetes in the middle years highlights the importance of reaching women early with prevention and counseling. Identifying, preventing or managing these conditions in the middle years may translate to a better quality of life in women's senior years.

Health coverage—public or private—matters for women. Disparities persist in access to care between uninsured women and those with coverage, be it private, Medicaid, or Medicare. Women without insurance consistently report lower use of preventive services, more difficulty paying for care and medicines, and greater barriers to obtaining services. For many women, particularly those who are poor or disabled, Medicaid serves as a lifeline to the health care system, improving their access to health services and making care affordable. Were it not for Medicaid, most of these vulnerable women would be uninsured. But increasingly, the state and federal funders of Medicaid are finding themselves unable to keep up with the program's increasing costs. The findings with regard to Medicare show that for senior women, a level of affordability, access, and satisfaction has been achieved that compares to or exceeds private insurance for the non-elderly population. However, there will be greater stress on the Medicare program as it assists increasing numbers of seniors and the costs of the program continue to rise. And while employer-sponsored insurance was once considered the "gold standard" of coverage, there is evidence of cracks and great strain on the private system as well. With women's central role in the health care system as patients, mothers, caretakers, and family decision makers, they will have much at stake in future health care policy debates on health coverage.

Health care costs increasingly pose a barrier to health care for many women. Over one-quarter of women say they delay or just don't get medical care they think they need because they cannot afford it, a larger share than in 2001. Many women also state they cannot afford prescription drugs. Women of all ages say they do not fill prescriptions or have resorted to skipping doses and splitting medicines. These problems do not just affect uninsured or elderly women, but are also increasingly reported by some younger women with private health coverage. The burdens of higher premium costs, larger co-payments and increased cost-sharing combined with rapid growth in the cost of prescription drugs fall increasingly hard on women because of their higher use of health care services and their disproportionately lower incomes. As costs are increasingly shifted to workers and their families and as premium costs become more difficult for employers to bear, costs will increasingly be cited as a barrier to care—for those with and without insurance. Stemming the growth in health care costs is a priority issue for women's health.

Women who are sick face more obstacles in obtaining health care. The challenges faced by women in poor health are notable. One-fifth of women in fair or poor health, for whom getting care may be a matter of urgency, are uninsured, and many with coverage also say they cannot afford needed services and medicines. Women in poorer health also report more concerns about the quality of their health care, a troubling sign given that they have and need more contact with the health system. Compared to women in good to excellent health, they are twice as likely to report they couldn't get access to specialty medical care, and are more likely to report that they delayed care, didn't fill a prescription, or took smaller doses of a medication to make it last longer. Some must also make difficult trade offs, with one in five saying that they spent less on basic needs for their families to pay for medicine. This analysis reveals that the health care system is falling short for many groups of women, particularly those who are already sick. For many of these women, obtaining the full range of services they need to improve or maintain their health is a formidable challenge at best and for many simply not achievable.

Certain groups of women—those who are low-income, uninsured or members of racial or ethnic minorities—are at higher risk for falling through the cracks in the health care system. This study finds that access to health care is more likely to be a challenge for women who lack economic resources or who are members of racial or ethnic minority groups. Low-income women and women of color are more likely to report poor health and experience certain chronic health problems, yet they are also more likely to confront obstacles to receiving timely care. Although many women experience financial barriers to care such as affordability and lack of insurance, a sizable share also have trouble getting care because of logistical problems with transportation, childcare, or just finding free time. This highlights the importance of considering the complexity of women's lives in developing strategies to improve women's health and well-being. However, additional measures, including assistance with transportation, language and cultural training for providers, and patient education are needed to assure that the health needs of women at the greatest risk are met.

Doctor-patient counseling about health risks and health promoting behaviors is lagging. In recent years, there has been growing attention to the important role of early intervention and healthy behaviors in health promotion and disease prevention. The U.S. Preventive Services Task Force recommends that health care providers counsel patients on a broad range of issues,[12] and the majority of women say they rely on providers for health care information, still far exceeding the advice of friends and family or the Internet. However, prevention counseling does not yet appear to be an integrated component of medical care. Most women have not had recent conversations with their providers about smoking or alcohol use, calcium and bone health, not to mention the more sensitive sexual health topics that have a critical bearing on their reproductive health. Health providers, on the other hand, are facing unprecedented constraints on their time, which leaves them little opportunity to provide the face-to-face counseling about health behaviors and risks. As it is increasingly becoming accepted that women can do much to prevent illness and manage their own health, it will be even more important to assure that counseling and education are part of the health care experience—whether it is done by a physician or integrated in some other way as part of the health care visit.

Screening rates for mammograms, Pap smears, and blood pressure have fallen slightly. Screening tests are an essential tool for early detection and prevention of many diseases. With early detection, many conditions can be treated and the severity and treatment costs minimized. This survey finds that screening rates for mammography, pap tests, and blood pressure tests fell slightly between 2001 and 2004. Guidelines and recommendations for certain screening tests (mammograms, clinical breast exams, and pap tests) have been challenged or altered in recent years. In many cases the recommended periodicity of these tests is based on individual health history and risks, with the goal of reducing unnecessary care and assuring that those at greatest risk are screened with the appropriate frequency. The convergence of changes in recommendations with a plethora of news stories and articles questioning the validity and accuracy of some screening services, may have resulted in patient and provider confusion regarding which recommendations to follow. While an overall reduction in the rates of mammography and pap smears does not necessarily signal a problem in the health system, it is worthy of further monitoring and research.

Women are the health care leaders for their families. Women's health responsibilities are not limited to addressing their own health needs. Women take charge of the vast majority of health care decisions and responsibilities for their children, including selecting their doctor and making sure they receive needed primary and follow-up care. On top of their everyday family obligations, over one in 10 women care for a sick or aging relative, with a sizable share spending at least 40 hours per week as a caregiver. Meeting these multiple obligations is demanding and leaves many women concerned about meeting all their family and work commitments as well as managing their own health. Social supports, workplace flexibility, and assistance with long-term care are all issues of paramount importance in maintaining women's health and well-being.

These themes also draw attention to the weakness of the health care network for many women. Many show signs of a tenuous connection to the health care system, such as delaying or going without care because of cost, forgoing or splitting medicines, and high stress levels from balancing multiple responsibilities. Women who are poor, sick, uninsured, or a racial/ethnic minority are particularly at risk for experiencing barriers throughout the health system. For many of these women, health care problems further exacerbate other challenges.

Access to health care is a linchpin for women's economic and health security and family well-being. As policymakers, providers, patients, advocates, and researchers develop strategies to strengthen the health care system, it is critical that they recognize women's central role in the system and how much is at stake for women as a consequence of their decisions.

ENDNOTES

1. Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 2002.

2. The federal poverty threshold is based on household income and household size. In 2004, the poverty threshold (100% of poverty) was $14,776 for a family of three.

3. Marmot, M. "The Influence of Income on Health: Views on an Epidemiologist," *Health Affairs*, March/April 2002, 21:(2), 31-46.

4. Institute of Medicine, *Insuring America's Health: Principles and Recommendations*, January 2004.

5. Garrett, B. "Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001", Kaiser Family Foundation, 2004.

6. Salganicoff, A, et al. *Women's Health in the United States: Health Coverage and Access to Care*, Kaiser Family Foundation, May 2002.

7. Glied, S, Kofman, S. "Women and Mental Health: Issues for Health Reform", The Commonwealth Fund Commission on Women's Health, 1995.

8. U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 3rd edition, Periodic Updates, www.ahrq.gov/clinic/uspstfix.htm.

9. Kaiser/HRET, *Employer Health Benefits Survey*, 2004.

10. Starfield B. *Primary Care: Balancing Health Needs, Services and Technology*. New York: Oxford University Press, 1998.

11. Ibid.

12. U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 3rd edition, Periodic Updates, www.ahrq.gov/clinic/uspstfix.htm.

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The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 USA
Phone: 650.854.9400 Fax: 650.854.4800

Washington Office: 1330 G Street N.W., Washington, DC 20005 USA
Phone: 202.347.5270 Fax: 202.347.5274 www.kff.org