

# Women's Health USA 2002



Maternal and Child Health Bureau



<b>PREFACE</b> .....	<b>5</b>	<b><i>Protective and Risk Factors</i></b>		<b>III. HEALTH SERVICES</b>	
<b>INTRODUCTION</b> .....	<b>6</b>	Physical Activity .....	32	<b>UTILIZATION</b> .....	<b>60</b>
<b>I. POPULATION</b>		Obesity .....	34	Health Insurance Coverage .....	61
<b>CHARACTERISTICS</b> .....	<b>10</b>	Nutrition .....	35	Usual Source of Care .....	62
U.S. Population .....	11	Cigarette Smoking .....	36	Preventive Care .....	64
U.S. Population Growth .....	12	Alcohol Misuse .....	37	Dental Care .....	66
U.S. Female Population by Race and		Illicit Drug Use .....	38	Hospitalizations .....	68
Ethnicity .....	13	Non-Medical Use of Prescription Drugs	39	Mental Health Care Utilization .....	69
Educational Attainment .....	14	<b><i>Morbidity</i></b>		Nursing Home Care Utilization .....	70
Women in Rural Areas .....	16	Heart Disease .....	40	Health Care Expenditures .....	71
Poverty Status .....	17	Diabetes .....	41	References .....	72
Household Composition .....	18	Cancers .....	42	Contributors .....	76
Labor Force Participation .....	20	AIDS .....	44		
Women in Health Professions Schools	21	Hypertension .....	46		
Women as Caregivers .....	22	Mental Illness/Suicide .....	47		
Federal Program Participation .....	24	Injury .....	48		
<b>II. HEALTH STATUS</b> .....	<b>25</b>	Asthma .....	50		
Life Expectancy .....	26	Osteoporosis .....	51		
Leading Causes of Death .....	27	Lupus .....	52		
Women with Disabilities .....	28	<b><i>Reproductive Health</i></b>			
Self-Reported Health Status .....	30	Prenatal Care .....	53		
Violence and Abuse .....	31	Live Births .....	54		
		Unintended Pregnancies .....	56		
		Sexually Transmitted Diseases .....	57		
		HIV Testing .....	58		
		Maternal Mortality .....	59		



## PREFACE

"Healthy Women Build Healthy Communities" is the principle that guides the work of the Health Resources and Services Administration (HRSA) to improve women's health. As an agency in the United States Department of Health and Human Services, HRSA is charged with assuring access to quality health care through a network of community-based health centers, maternal and child health programs, and State, Territorial, and community HIV/AIDS programs. In addition, HRSA's mission includes supporting individuals pursuing health careers in medicine, nursing, and many other disciplines. HRSA fulfills these responsibilities by collecting and analyzing timely and topical information that identifies health priorities and trends that can be addressed through program interventions and capacity building.

HRSA's Maternal and Child Health Bureau (MCHB) and the Office of Women's Health are pleased to present *Women's Health USA 2002*, the first annual report on the health status of America's women. This first edition of the *Women's Health USA* data book brings together key facts and figures to profile the health of women throughout the nation. The data book was developed by HRSA to provide readers with easy-to-use statistical information. A collection of current and historical data on some of the most pressing health challenges facing women,

their families, and their communities is included in this publication. *Women's Health USA 2002* is intended to be a concise reference for policy-makers and program managers at the Federal, State, and local levels to identify and clarify issues affecting the health of women.

*Women's Health USA* is modeled after *Child Health USA*, now in its twelfth edition. This latter statistical summary has become a useful tool for family advocates, policy makers, and organizations to track key indicators of child and adolescent health. With the introduction of *Women's Health USA*, HRSA begins a new series of publications that promises to deliver current information in a user-friendly format. Together, the two publications should be considered companion documents.

*Child Health USA* and now *Women's Health USA* address common themes, including Population Characteristics, Health Status, and Health Services Utilization. The first section, Population Characteristics, presents statistics on factors that influence the well-being of women. The second section, Health Status, contains data on vital statistics, protective and risk factors, morbidity, and reproductive health. The third section, Health Services Utilization, contains data regarding health care financing and access to care.

In these 76 pages, readers will find a profile of women's health captured by a variety of data

sources. The data book brings together the latest available information from various agencies within the Federal Government including the U.S. Departments of Health and Human Services, Agriculture, and Justice. Every attempt has been made to use data collected in the past five years. This new resource may inspire users to search for comparable statistics at a State or local level to assess women's health in a particular jurisdiction, to identify trends, or to identify needs in their communities and plan appropriate interventions.

We hope you find *Women's Health USA* to be a useful resource. Please provide any feedback on this publication to the HRSA Information Center at 1-888-ASK-HRSA or <http://www.ask.hrsa.gov/> so that subsequent editions may better meet your data needs. We also refer you to the HRSA Women's Health website at <http://www.hrsa.gov/womenshealth>.

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Single copies of this publication are available at no cost from the HRSA Information Center, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182-2536, telephone: 703-442-9051 or 1-888-ASK-HRSA.

## INTRODUCTION

At the start of the new millennium, women comprised more than half of the United States (U.S.) population. Indeed, women outnumber men in every age cohort over 25 years. Because women's life expectancy is now at a record 79.5 years, a majority of the rapidly growing aging population, particularly among those 85 years and older, are women. Ensuring good health in these years requires partnerships between women and their families, clinicians, employers, and community organizations.

The U.S. population is increasingly diverse. Over the decade 1990 to 2000, the proportion of the female population represented by White non-Hispanic women declined from 76 to 71.2 percent, while the Hispanic population grew from 8.6 to 11.6 percent and Asian/Pacific Islanders grew from 2.8 to 3.9 percent of U.S. females. Other racial and ethnic groups changed only slightly or remained constant.

*Women's Health USA* illustrates many advances in women's educational attainment and employment. The year 2000 census shows that men achieve higher levels of education than women. Data from the Bureau of Labor Statistics indicate that more than 56 percent of White, Black, and Hispanic women aged 16 and older are employed. Still, disparities exist in

income between men and women, with women earning less than 75 cents for every dollar men earn.

Employment is a gateway for health insurance coverage. In 2000, nearly 87 percent of women had health insurance coverage and 13 percent of women lacked any health insurance coverage. Although women are more likely than men to have health insurance coverage, approximately one quarter of women aged 18-24 were without insurance in 2000.

Many women perform multiple roles—including caregiver to elderly relatives and young children—which affect their own health and economic stability. Data from The Commonwealth Fund's 1998 *Survey of Women's Health* indicate that 9 percent of women were caring for a sick or disabled relative, with 43 percent of these women providing more than 20 hours of care per week. Caregivers are more likely than non-caregivers to be in poor health.

Poverty continues to be a problem particularly affecting women in the U.S., with 11 percent of women living below the Federal poverty level. Single women with young children or who are elderly are most likely to live in poverty, with Black and Hispanic women of all ages having particularly high poverty rates.

Preventive health care can help to promote

good health throughout a woman's life span, and women are more likely than men to seek preventive care. In 1996, nearly a quarter (24 percent) of women's ambulatory care visits were for preventive services such as mammograms, Pap smears, and immunizations. Impressive gains have been made in closing the gap in the use of preventive services among women from all racial and ethnic groups, with Black women now having higher rates of Pap smears and comparable rates of mammography screenings as White women. Dental care is also an important component of preventive services. In 2000, the majority of women had visited a dentist in the last year. However, a substantial minority, approximately one-third, had not visited a dentist for a year or more.

While these important preventive health services can detect diseases in early stages, the influence of medical care on women's health status is limited. Healthy behaviors, like regular physical activity and healthy nutritional choices, are critical to a long and healthy life. Women are less likely to engage in light or moderate leisure time physical activity than men. They are also less likely to consume recommended servings of fruit and vegetables. The percentage of women who smoke—a behavior associated with numerous chronic illnesses—has

remained steady over the last several years at slightly more than 20 percent of the adult female population. Of particular concern is that adolescent girls report smoking cigarettes at slightly higher rates than boys (14.1 percent compared with 12.8 percent). Reducing the prevalence of smoking among women, particularly young women, is a public health priority. As prevention science continues to establish important relationships between lifestyle choices and chronic illnesses, education and activities that promote healthful behaviors become increasingly important.

Mental health is a critical component of a person's overall health. Though limited data are available to describe women's use of mental health care, it is apparent that depression significantly affects women. Women report a higher percentage of poor mental health days as compared to men and are more likely than men to be hospitalized for depression.

Substance abuse, which often occurs in people who suffer from mental illness, is also an important health concern among women. National survey data collected by the Substance Abuse and Mental Health Administration in 2000 found that more than a quarter of women 18-25 years old reported binge drinking in the past month and as many as 7.4 percent were found to drink heavily. This same survey also showed that

approximately 24 percent of women aged 18-25 and 19 percent of females aged 12-17 had used some type of illicit drug in the past year, most commonly marijuana. In addition, approximately 8 percent of females aged 12-25 reported using psychotherapeutic prescription drugs for non-medical reasons in the past year. Rates of drug abuse for all types of drugs show that misuse declines significantly among women after age 25.

Women report a higher number of chronic conditions and have higher rates of disability and activity limitations than men. A person's self report of health status provides an overall qualitative measure of health. A higher proportion of men than women rate their health as "excellent" or "very good." Among women, Hispanic and Black women are more likely than White women to report their health as "fair" or "poor."

As a part of the Department of Health and Human Services' Race and Health Initiative, six priority areas were identified for disparity reductions. These areas include: infant mortality, breast and cervical cancer screening and management, cardiovascular diseases, diabetes, HIV/AIDS, and child and adult immunizations. More women are seeking prenatal care in the first trimester and both infant and maternal mortality rates are decreasing. Despite the record low levels in both of these measures, a gap continues to grow between Black and White women. Black

women are at four times higher risk for pregnancy-related death than White women. Reasons for this disparity are complex, and may include access to care and stress in pregnancy.

For most major causes of death—heart disease, cancer, and stroke—women die at lower rates than men. However, heart disease remains the number one killer of women. More women are diagnosed each year with breast cancer than any other type of cancer, although lung cancer kills more women. Of the cancer deaths in 2001, it is estimated by the National Cancer Institute that 67,300 females died of lung and bronchus cancers, compared with 40,200 deaths from breast cancer. Black women have the highest lung cancer death rates, and White women have the highest breast cancer death rates.

Women are disproportionately affected by such conditions as diabetes, asthma, and osteoporosis. The prevalence of diabetes increases with age and is higher among people who are overweight or obese. Women are also more likely to suffer from asthma, with 9.1 percent of women compared to 5.1 percent of men being afflicted by this condition. Osteoporosis, often called the "silent disease" because it frequently goes undiagnosed, is especially common in women aged 65 and older.

Two other conditions that have recently come to the forefront of the women's health agenda

are HIV/AIDS and domestic violence. As of December 2000, a total of 130,104 cases of AIDS had been reported in adolescent and adult women in the U.S. This disease is most prevalent among women aged 25-44 years and among Black women. A national survey on violence in 1995-96 found that more than half of women reported being physically assaulted in their lifetime. American Indian and Alaska Native women were more likely to report being raped, physically assaulted, or stalked than women of other races and ethnicities.

As the number of older Americans grows, attention is also focused on the care of senior citizens. The rate of women aged 65 and older in nursing homes fell between 1973-74 and 1999, indicating that more women are living in the community, either independently or with relatives, in their older years. Women continue to make up the majority of nursing home residents.

As a result of these conditions and the utilization of the health care system, women have significant expenditures for health care. While most health care expense is paid by insurance, women bear about 20 percent of the costs out of pocket. The largest category of health care expenses for women in 1997 was inpatient services, followed by home health care costs.

Men and women alike will continue to benefit from advances in medical research and treat-

ment. Perhaps the most important message that we have gained from these advances is that our health and quality of life are shaped by both our own health behaviors and our geographic and economic access to necessary preventive, primary, and acute care. *Women's Health USA* will provide a mechanism for tracking our efforts to help shape a healthy future for all Americans.



## POPULATION CHARACTERISTICS

Population characteristics describe the diverse social, demographic, and economic features of women in the United States (U.S.). Representing slightly more than half of the Nation's population, women and girls number approximately 141 million.

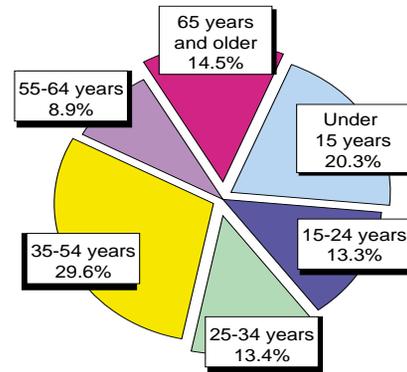
Analysis and comparison of data across gender, age, and race and ethnicity can be used to tailor the development and evaluation of programs and policies serving women's health.

The following section presents data on population characteristics that affect women's health. These indicators include age, population growth, race and ethnicity, educational attainment, residency in rural areas, poverty status, household composition, labor force participation, enrollment in health professions schools, caregiver status, and participation in Federal programs.



### U.S. Female Population, by Age, 2000

Source (I.1): U.S. Census Bureau



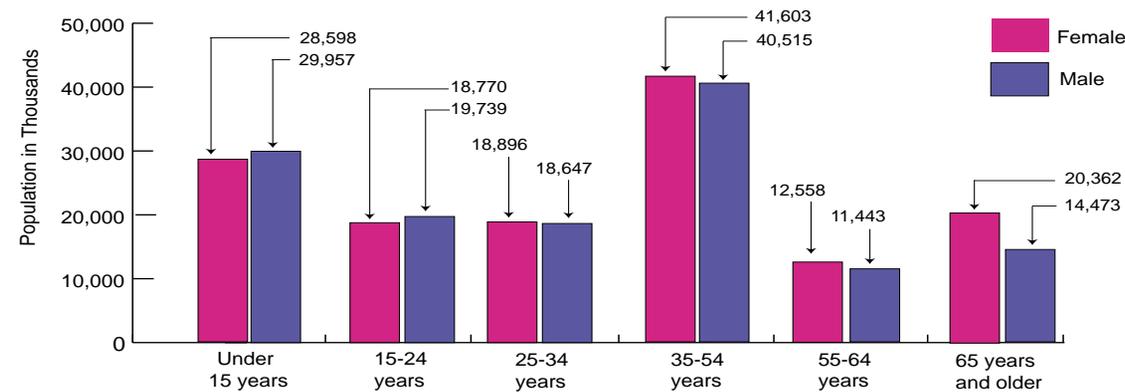
### U.S. POPULATION

In 2000, the U.S. population reached 276 million, with females representing 51 percent of the total population. Females under age 34 accounted for 47 percent of the female population, those aged 35-64 represented 38 percent, and females aged 65 and older accounted for nearly 15 percent.

The population of women and men was very similar for all age groups, with the exception of a significantly larger number of women in the older age group. Of people aged 65 and older, 58 percent were women.

### U.S. Population, by Age and Sex, 2000 (In Thousands)

Source (I.1): U.S. Census Bureau



## POPULATION CHARACTERISTICS

### U.S. POPULATION GROWTH

The U.S. population grew by 83 percent between 1950 and 2000. There was an 86.1 percent increase in the female population and an 80.1 percent increase in the male population over this time period. The total population is expected to grow another 47 percent by the year 2050.<sup>1</sup>

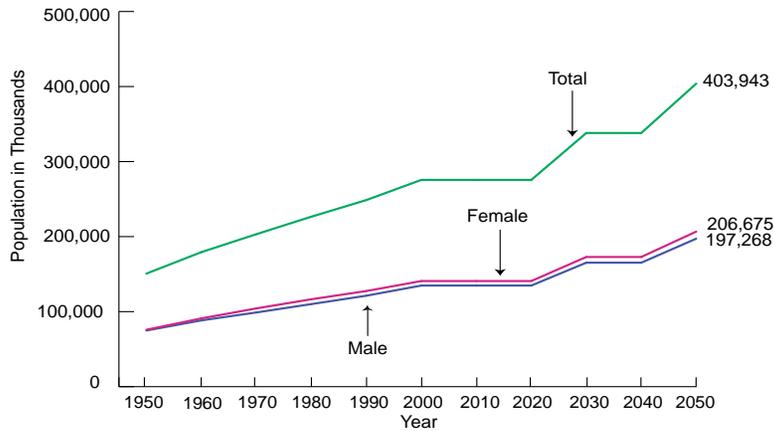
Since 1950, there has been a shift in the age distribution of females toward the older age cohorts, a trend that is expected to continue through 2050. In 1950, females under age 35 made up 57 percent of the female population; by

2050, it is projected that this proportion will decrease to 44 percent. Over the same period, the proportion of the female population that is aged 65 and older is expected to double from 9 percent in 1950 to 20 percent in 2050.

<sup>1</sup>Future population projections are derived from a base population by looking at births, deaths, migration, and demographic components.

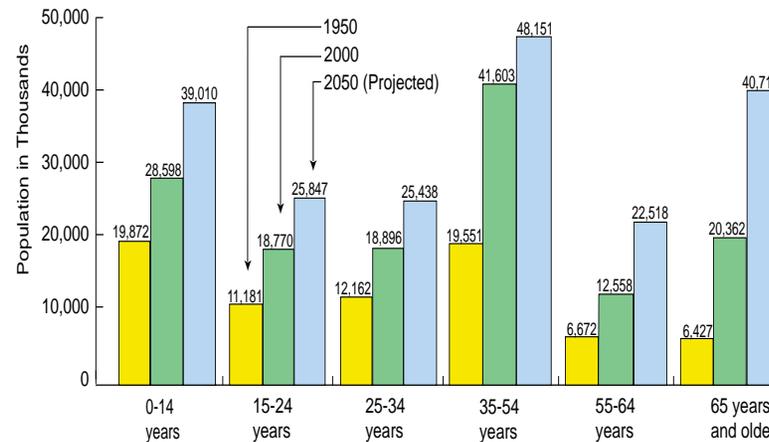
### Growth of U.S. Population Over Time, by Sex (In Thousands)

Source (I.1, I.2): U.S. Census Bureau



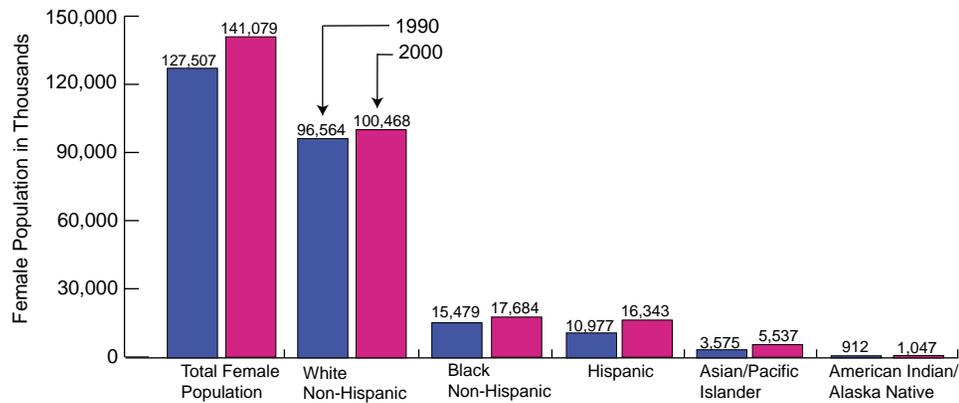
### Growth of Female Population Over Time, by Age (In Thousands)

Source (I.1, I.2): U.S. Census Bureau



### U.S. Female Population by Race and Hispanic Origin, 1990 and 2000 (In Thousands)

Source (I.3): U.S. Census Bureau

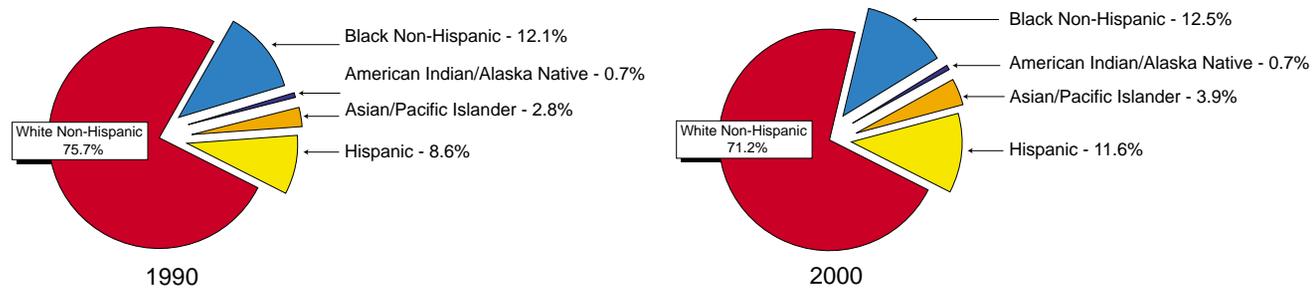


### U.S. FEMALE POPULATION BY RACE AND ETHNICITY

There has been a considerable increase in the racial and ethnic diversity of females in the U.S. in recent years. Over the last decade, while the number of White non-Hispanic females has increased, the proportion of the female population that they represent has decreased from 76 percent to 71 percent. At the same time, the proportion of females who are non-White has increased. The greatest growth has occurred in the Asian/Pacific Islander and Hispanic populations, whose numbers grew between 1990 and 2000 by approximately 55 percent and 50 percent, respectively.

### Distribution\* of U.S. Female Population, by Race and Hispanic Origin, 1990 and 2000

Source (I.3): U.S. Census Bureau



\*Percentages may not add to 100% due to rounding.

## POPULATION CHARACTERISTICS

### EDUCATIONAL ATTAINMENT

Census data from 2000 indicate that men achieve higher levels of education than women. While slightly more women aged 25 and older have a high school diploma or an associate degree, a larger proportion of males have obtained a bachelor's or master's degree or above. The percentage of males with bachelor's degrees or above was slightly higher in 2000 than that of females. However, as women now outnumber men among college students, this educational gap is expected to narrow.

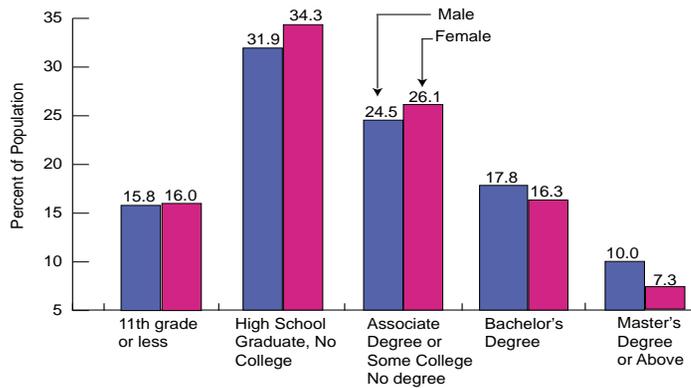
In 2000, 16 percent of adults aged 25 and older had not completed a high school education; however, 30 percent of both women and men in this group were aged 65 and older, a group less likely than younger cohorts to have pursued higher education.

Asian/Pacific Islander women were significantly more likely than women of other races to achieve higher levels of education. Approximately 41 percent of Asian/Pacific Islander women had a bachelor's degree or above in 2000, followed by 25.5 percent of non-Hispanic White women, and 17 percent of non-

Hispanic Black women. Forty-three percent of Hispanic women had an eleventh grade education or less.

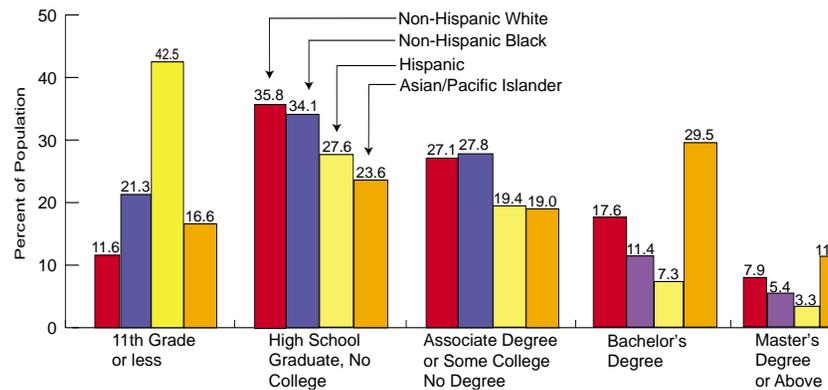
#### Educational Attainment for Population 25 Years and Older, All Races, by Sex, 2000

Source (I.4): U.S. Census Bureau



#### Educational Attainment for Women 25 Years and Older, by Race and Hispanic Origin, 2000

Source (I.4): U.S. Census Bureau





## POPULATION CHARACTERISTICS

### WOMEN IN RURAL AREAS

In 1996, 52 million people, or 20 percent of the U.S. population, lived in a nonmetropolitan or rural area. The rural population differs in important ways from more urbanized populations. Demographically, rural populations are older than metropolitan populations, with a greater proportion of the population made up of persons aged 65 years and older. These and other factors, including a more limited supply of health care providers and increased distances from health care resources, contribute to special health concerns among rural populations.

The highest percentages of both males and females living in rural areas were represented

by children aged 14 years and younger and adults aged 45-64. Males in rural areas outnumbered females through age 44, but there were more women than men over age 44, especially among persons aged 65 and older. Furthermore, the population of older women is expected to grow substantially in the coming years; between 1996 and 2020, the number of women aged 65 and older is projected to increase by 55 percent in nonmetropolitan areas.

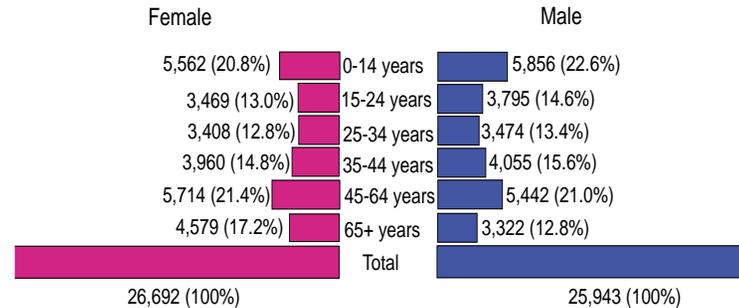
On a variety of measures, rural populations are in poorer health, or at higher risk for poor health due to health behaviors, than more urbanized populations. Adults living in rural areas are more likely to smoke than those living

in urban areas. In 1997-98, 27 percent of women living in nonmetropolitan areas smoked as compared to 20 percent of women in metropolitan areas.<sup>1</sup> In addition, people in rural areas are more likely to be limited in their activities by a chronic health condition than people in urban areas, with women in rural areas more likely than their male counterparts to have limited activity levels due to chronic conditions.

<sup>1</sup>Eberhardt, MS, Ingram, DD, Makuc, DM et al. *Urban and Rural Health Chartbook. Health, United States, 2001. Hyattsville, Maryland: National Center for Health Statistics. 2001.*

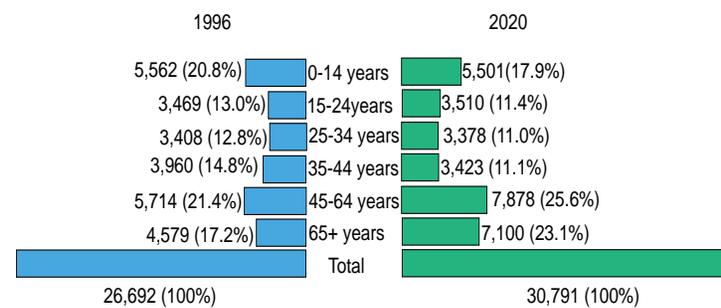
#### Non-Metro Population by Gender and Age, 1996 (Number in Thousands and Percent of Population)

Source (I.5): Woods & Poole Economics, Inc. using U.S. Census Bureau Files



#### Projected Growth in Non-Metro Female Population, 1996-2020 (Number in Thousands and Percent of Population)

Source (I.5): Woods & Poole Economics, Inc. using U.S. Census Bureau Files



## POVERTY STATUS

In 2000, 11.9 million women and 7.6 million men aged 18 and older were living with incomes below the Federal poverty level.<sup>1</sup> Women aged 18-24 were most likely to be poor, with a poverty rate of 17.2 percent. The percentage of females under the Federal poverty level continually decreased between the ages of 25 and 64, reaching a low of 8.4 percent for women aged 45-64. The poverty rate for women 65-74 was 10 percent and 14 percent among women aged 75 and older. This pattern of younger and older women with

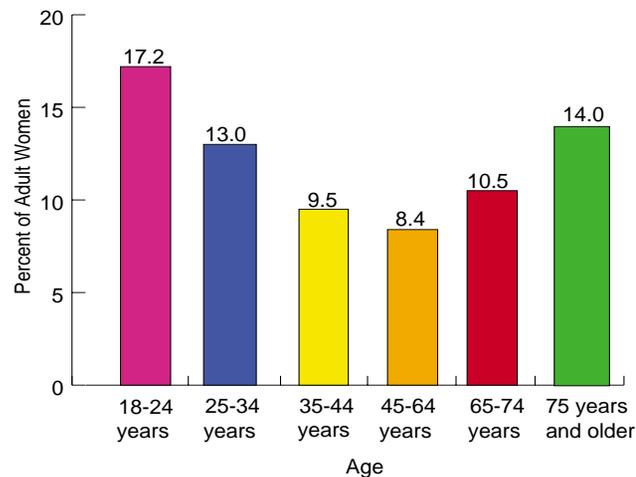
the higher poverty rates was consistent across racial and ethnic groups.

Among adult women, Black and Hispanic women had the highest percentage living below the poverty level (21.4 and 20.1 percent, respectively). This is more than twice the proportion of White (9.6 percent) and Asian/Pacific Islander women (10.1 percent) living in poverty.

<sup>1</sup>The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family and every individual in it is considered to be poor.

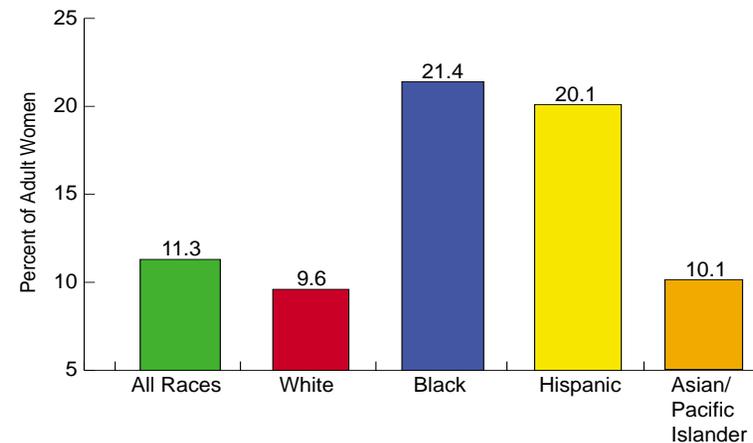
### Adult Women Living Below the Poverty Level, by Age, 2000

Source (I.6): U.S. Bureau of the Census



### Adult Women Living Below the Poverty Level, by Race and Hispanic Origin, 2000

Source (I.6): U.S. Bureau of the Census



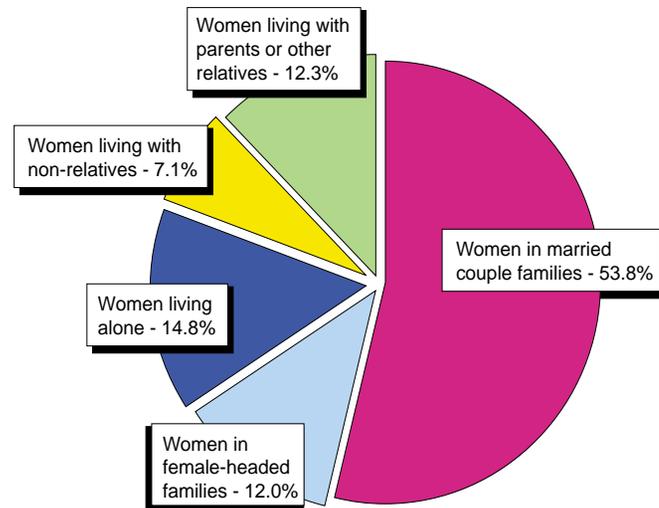
## HOUSEHOLD COMPOSITION

In 2000, 78 percent of adult women lived with relatives, including a spouse, their children, and parents. Over half of all women lived in a married-couple family, and another 12 percent lived with their children but not with a spouse. Slightly more than one-fifth of women lived alone or with an unrelated individual. Married couples made up a smaller portion of family households in 2000 than in 1970.<sup>1</sup>

<sup>1</sup>Fields, J. and Casper, L.M. *America's Families and Living Arrangements: Population Characteristics, 2000*. U.S. Census Bureau, June 2001.

## Adult Women by Household Composition, 2000

Source (I.7): U.S. Census Bureau





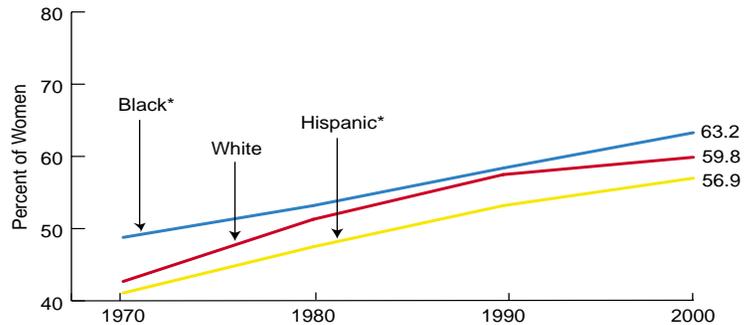
## LABOR FORCE PARTICIPATION

U.S. Department of Labor statistics show that the proportion of U.S. women in the labor force grew significantly between 1970 and 2000, a trend which was seen across racial and ethnic groups. The greatest increase (40 percent) was observed among White women since 1970. Over the past three decades, Black women have consistently had the highest percentage of women in the labor force, and Hispanic women have been the least represented.

Many working women are mothers. In 2000, 65 percent of mothers of children under the age of six and 79 percent of mothers of children between the ages of six and 17 were in the labor force.

### Women Aged 16 Years and Older in the Labor Force, 1970-2000

Source (I.8): U.S. Department of Labor



\*Data for Black women starts at 1972 and at 1973 for Hispanic women.

As the number of women in the labor force has grown, so has their representation in various occupational sectors. In 1983, 40.9 percent of workers in managerial and professional specialty fields were women; by 2000, half were women. Women have greatly increased their numbers in government positions as well; for every two jobs that have been added for men in the government, five have been added for women. In the past 35 years, women's jobs have doubled in every industry with the exception of manufacturing.<sup>1</sup>

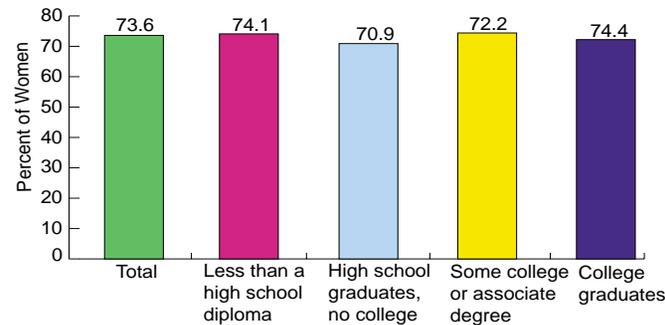
Although women may be making strides in terms of equal employment with men, they are still not paid equally. In 2000, women aged 25 years and older earned 73.6 cents for every dollar that men earned, a figure only slightly less

that the 74.4 cents that college-educated women earned as compared to men with the same education. High school graduates with no college had the biggest discrepancy, with females earning 70.9 percent of males' wages.

<sup>1</sup>Women's Jobs 1964-1999: More Than 30 Years of Progress. U.S. Department of Labor.

### Women's Earnings as a Percent of Men's Earnings for Full-Time Wage and Salary Workers, by Educational Attainment, 2000

Source (I.9): U.S. Department of Labor



## WOMEN IN HEALTH PROFESSIONS SCHOOLS

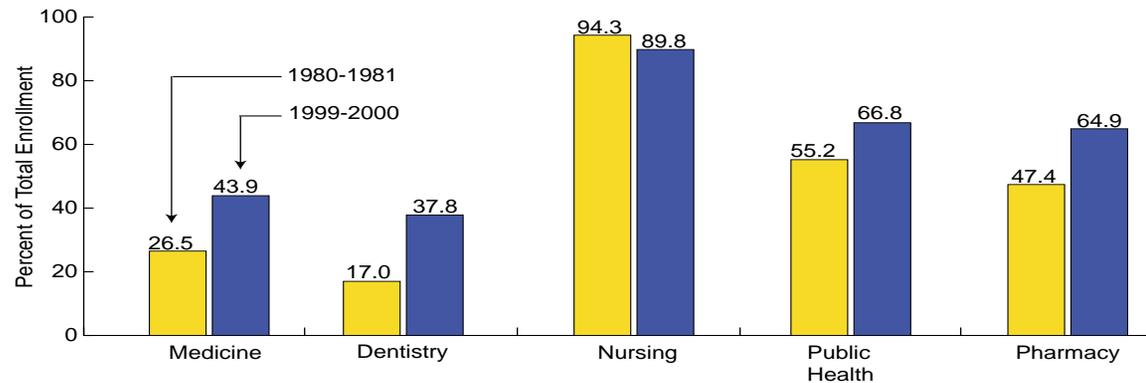
Like many other occupational fields, the health professions have long been characterized by gender disparities. Males have generally dominated medical, dental, and pharmaceutical schools, while women have made up the majority of nursing and public health students. This disparity lessened between the early 1980s and late 1990s. For example, dental schools saw a 122 percent increase in female enrollment as a proportion of total enrollment, from 17.0 per-

cent in 1980-81 to 37.8 percent in 1999-2000. The proportion of medical students who were women also increased dramatically over this time period. In 1980-81, females made up slightly more than one quarter of medical students; by 1999-2000, this proportion had increased to 43 percent, a 66 percent increase over this time period. Women also made up a larger portion of students in schools of public health and pharmacy in 1999-2000 than in the early 1980s.

As women have increased their representation in health professions schools that have traditionally been dominated by men, their concentration has decreased somewhat in nursing, a field that has been and continues to be made up almost entirely of women. While the numbers of students enrolled in nursing schools increased over the past two decades, the proportion of nursing students who were women declined from 94.3 percent in 1980-81 to 89.8 percent in 1999-2000, reflecting men's increasing role in the nursing profession.

### Enrollment of Women in Schools for Selected Health Occupations, 1980-1981 and 1999-2000

Source (I.2, I.10): Professional Associations



## POPULATION CHARACTERISTICS

### WOMEN AS CAREGIVERS

Women play a significant role in society as caregivers for family members. In 1998, 9 percent of women were caring for a sick or disabled relative. Of these women, 43 percent provided more than 20 hours of care per week. While women of all incomes fulfill caregiving roles, there is a greater caregiving burden on lower income women. In 1998, 52 percent of women caregivers with annual family incomes of \$35,000 or less spent 20 hours or more providing care each week. Only 29 percent of women with family incomes higher than \$35,000 devoted as much time to these activities. Lower income women were also substantially more like-

ly to live with a relative for whom they were providing care.

Twenty-four percent of women who were providing informal caregiving were assisted by additional paid care. Almost twice as many women with annual incomes greater than \$35,000 had additional paid help as compared to women with lower incomes.

Grandparents also play an important role in caregiving. In 2000, there were more than 2.4 million grandparents responsible for the care of their grandchildren,<sup>1</sup> 62 percent of whom were grandmothers. Studies have shown that grandparents raising grandchildren are more likely than their counterparts without this responsibil-

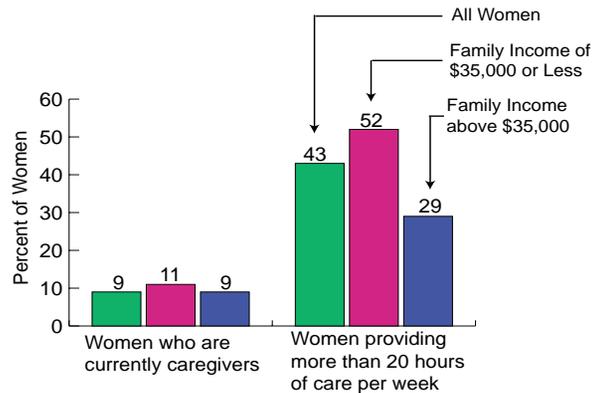
ity to be in poor health. They are more likely to have multiple chronic health problems and to be clinically depressed than grandparents who are not the primary caretakers of their grandchildren.<sup>2</sup>

<sup>1</sup>A grandparent is responsible for their grandchild if they are financially responsible for food, shelter, clothing, and day care for any or all grandchildren living in the household.

<sup>2</sup>Casper, Lynne, and Bryson, Kenneth. (1998). *Co-resident Grandparents and Their Grandchildren: Grandparent Maintained Families*. U.S. Bureau of the Census: Population Division.

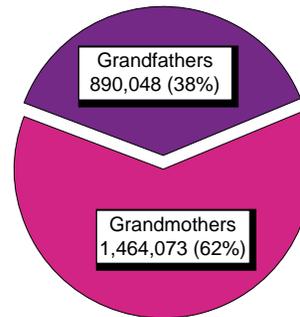
#### Women Caring for Sick or Disabled Family Member, 1998

Source (I.11): Commonwealth Fund



#### Grandparents Responsible for Own Grandchildren Under 18 Years of Age, 2000

Source (I.12): U.S. Bureau of the Census





## FEDERAL PROGRAM PARTICIPATION

Public assistance programs support low-income and disabled persons, especially women. In 1999, 71 percent of adult Food Stamp program participants were woman, 62 percent of adults receiving federally administered Supplemental Security Income (SSI) payments in 2000 were women, and 58 percent of adult Medicaid users in 1998 were females. The Supplemental Food Program for Women, Infants, and Children (WIC) also plays an important role in serving women by providing nutritional support during pregnancy, the postpartum

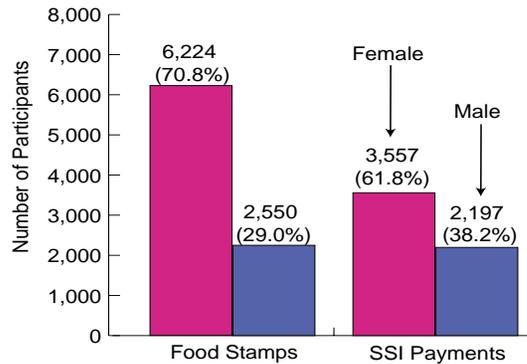
period, and while breastfeeding. In 1998, WIC served 1.8 million women, 147 percent more than in 1988.<sup>1</sup>

Females using public programs are largely dominated by young and middle-aged women. Seventy percent of females who received Food Stamps in 1999 were between the ages of 18 and 59. The majority of adult females receiving SSI payments in 2000 were also under age 65, although a significant proportion (41 percent) were elderly.

<sup>1</sup>U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis Nutrition and Evaluation, National Survey of WIC Participants, 2001 Final Report.

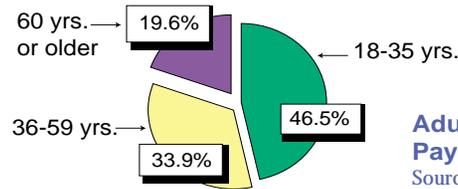
### Adult Food Stamp Participants, 1999, and Adults Receiving Federally Administered SSI Payments, 2000, by Sex

Source (I.13): U.S. Department of Agriculture  
Source (I.14): SSI Annual Statistical Report



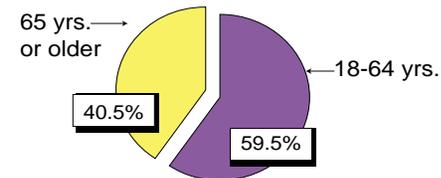
### Adult Female Food Stamp Participants, by Age, 1999

Source (I.13): U.S. Department of Agriculture



### Adult Females Receiving SSI Payments, by Age, December 2000

Source (I.14): SSI Annual Statistical Report





## HEALTH STATUS

The systematic assessment of women's health status enables health professionals and policy makers to determine the impact of past and current health interventions and the need for new programs. Trends in health status help to identify new issues as they emerge.

In the following section, health status indicators are presented related to mortality, protective and risk factors, morbidity, and reproductive health. The data are displayed by gender, age, race and ethnicity, where available.

**LIFE EXPECTANCY**

The past 50 years have seen an increase in life expectancy for both males and females. Between 1950 and 2000, life expectancy increased on average by eight years for males and females. The most significant increase in life expectancy was among Black females, whose average life expectancy increased 12.3 years over this time period.

Across racial groups, women live longer than men. National Vital Statistics data show

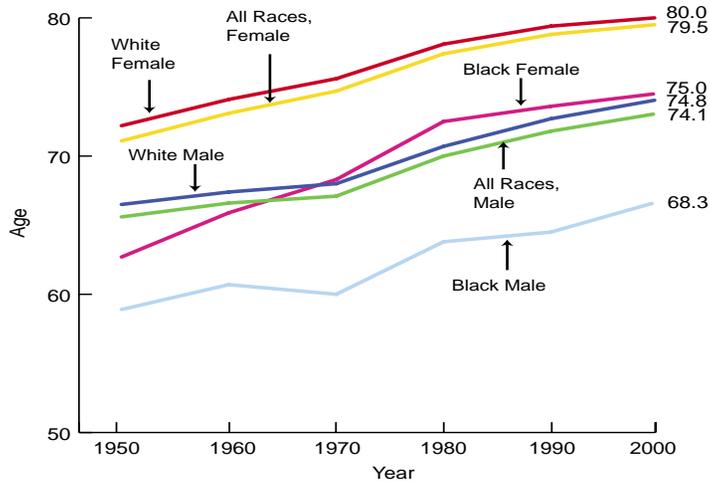
that, in 2000, White females on average lived five years longer than Black females. These trends have been consistent over time.

In addition to life expectancy, years of potential life lost is another important measure of a population's health. This measure takes into account the years of life lost by persons who died before reaching a full life expectancy of 75 years. Significant differences in years of potential life lost exist among women of different races and ethnicities. In 1998, Black

women had more than 10,000 years of potential life lost due to all causes, double the number of White females and more than three times the number of Asian or Pacific Islander females. American Indian and Alaska Native women had the second highest years of potential life lost at more than 7,200 years lost in 1998. These disparities reflect the younger ages at which these women died.

**Life Expectancy At Birth, by Sex and Race, 1950-2000**

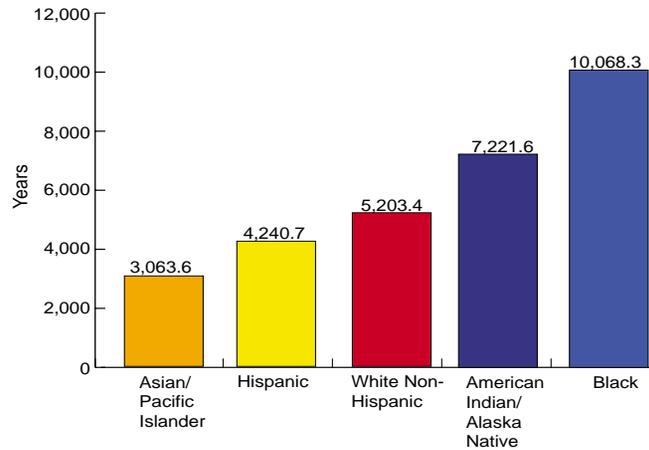
Source (II.1, II.2): National Vital Statistics System



Note: Life expectancy calculations are not available for other racial or ethnic groups.

**Years of Potential Life Lost Before Age 75 for Women for All Causes, by Race and Hispanic Origin, 1998 (Age-adjusted)**

Source (II.1): National Vital Statistics System



Note: Rates are age adjusted to the 2000 U.S. standard million population.

## LEADING CAUSES OF DEATH

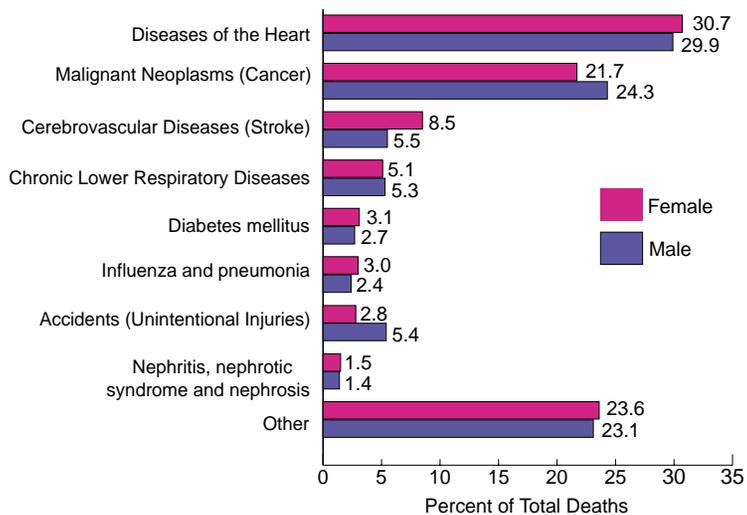
There were 1.2 million female deaths in 1999. Diseases of the heart, malignant neoplasms (cancer), and cerebrovascular diseases (stroke) were the three leading causes of death for both males and females. A larger proportion of females than males died in 1999 of stroke, diabetes, and influenza, while nearly twice as many males as females died due to accidents (unintentional injuries).

For the three leading causes of death among females, there is significant variability in the death rates by race and ethnicity. In 1999, non-Hispanic White women were nearly four times more likely to die from heart disease as Asian/Pacific Islander women. Cancer deaths were nearly four times greater among White women than Hispanic women. For both cancer and stroke, similar racial/ethnic patterns were observed, with non-Hispanic White females having the highest rate, followed by

non-Hispanic Black, Asian Pacific Islander, American Indian, and Hispanic females, respectively.

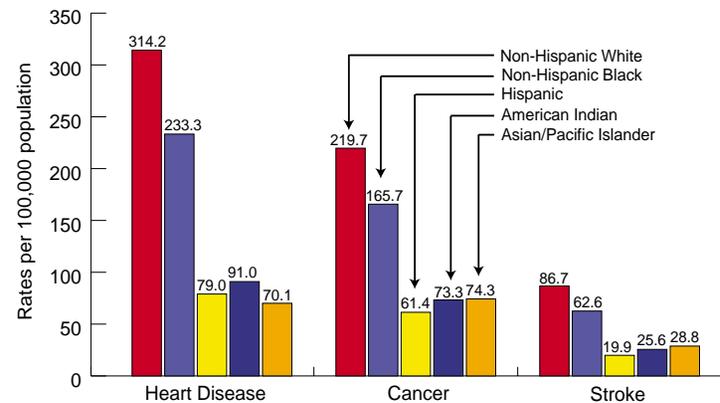
### Leading Causes of Death, by Sex, 1999

Source (II.3): National Vital Statistics System



### Death Rates\* for Selected Leading Causes of Death for Females, by Race and Hispanic Origin, 1999

Source (II.3): National Vital Statistics System



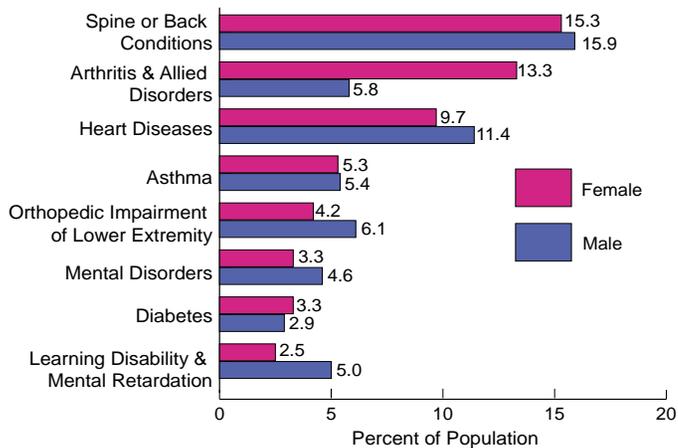
\*Death rates reported here are crude rates, meaning that they are not adjusted for the different age distributions of these populations.

## WOMEN WITH DISABILITIES

Women have a higher rate of disability than men and report a higher number of conditions that limit their activity. In 1997, 20.7 percent of women had a disability as compared to 18.6 percent of men. The types of disabling conditions experienced by women and men also differ. While back disorders were the most prevalent disability reported among both genders in 1992, twice as many women than men were disabled by arthritis, making it the second leading cause of disability among women.

### Major Activity-Limiting Conditions, 1992, by Sex

Source (II.4a): National Health Interview Survey



Women's higher rates of disability as compared to men are observed across racial and ethnic groups. Among women in 1997, White non-Hispanic and Black women had the highest rates of disability; with more than one-fifth of each group experiencing a disability. Fifteen percent of Hispanic women were disabled, while Asian/Pacific Islander females had the lowest disability rate at 13.9 percent.

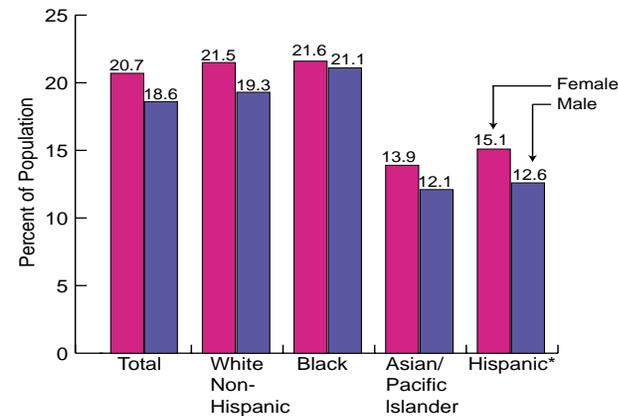
The prevalence of disability in the U.S. and around the world has stimulated efforts to develop more uniform definitions of disability. In 2001, the World Health Organization

approved the International Classification of Functioning, Disability and Health (ICF) as a unifying framework for classifying the consequences of disease, an approach first created in 1980.<sup>1</sup> These efforts emphasize the importance of functional status as a critical component of overall health.

<sup>1</sup>*Classification of Diseases and Functioning and Disability. National Center for Health Statistics. [www.cdc.gov/nchs/about/otheract/icd9/icdhome.htm](http://www.cdc.gov/nchs/about/otheract/icd9/icdhome.htm)*

### Percent of Persons (All Ages) with Disability, by Sex and by Race and Hispanic Origin, 1997

Source (II.4b): Survey of Income and Program Participation



\*Hispanics may be of any race



## SELF-REPORTED HEALTH STATUS

In 2000, more than two-thirds of women and men reported being in excellent or very good health. For both men and women, the percent reporting their health as excellent or very good declined significantly with age. While 67 percent of females between the ages of 18 and 64 reported their health as excellent or very good, only 36.9 percent of females aged 65 and over did so.

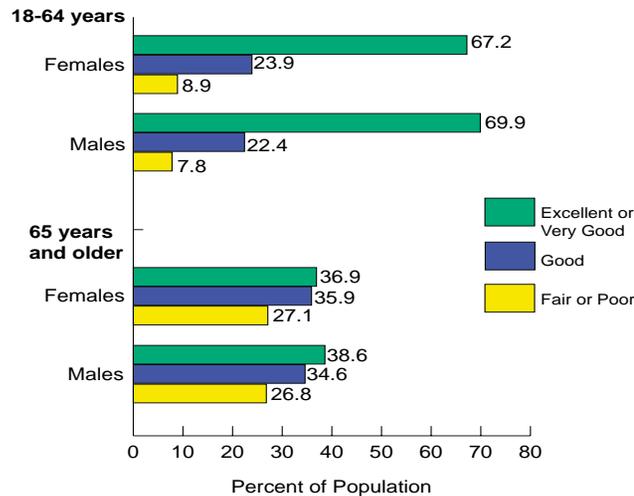
While more than half of Black and Hispanic women reported being in excellent or very good health, a greater proportion (67 percent) of White females rated their health as excellent or very good. Black women were most likely to report being in fair or poor health. Women of other races were the most likely to report being in excellent or very good health (66 percent) and the least likely to report being in fair or poor health (9.6 percent).

Educational levels are also associated with health status. In 2000, 67 percent of women

with 12 or more years of education perceived their health status to be excellent or very good compared to 40 percent of women with less than 12 years of education.

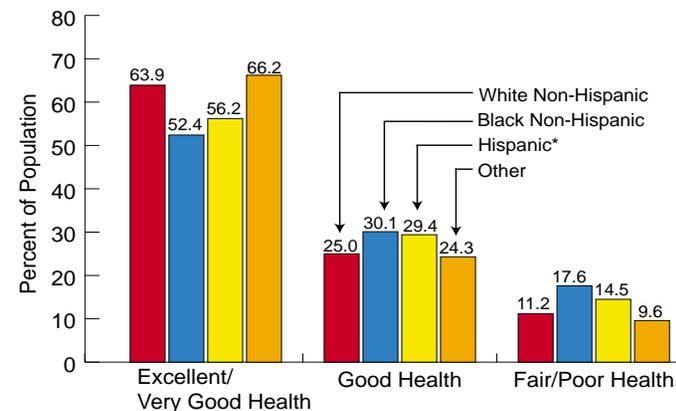
### Self-Reported Health Status, by Sex and Age, 2000

Source (II.5): National Health Interview Survey



### Women's Self-Reported Health Status, by Race and Hispanic Origin, 2000

Source (II.5): National Health Interview Survey



\*Hispanics may be of any race.

## VIOLENCE AND ABUSE

Violence is a widespread public health threat in the U.S. Data from the National Violence Against Women Survey, conducted by the U.S. Department of Justice and the Centers for Disease Control and Prevention in 1995-96, found that a significant proportion of U.S. women are victims of violence. In 1995-96, 18 percent of women reported having been raped, 52 percent reported having been physically assaulted, and 8 percent reported having been stalked in their lifetimes. Among women of different racial/ethnic groups, American Indian/Alaska Native women were most likely

to have been raped, physically assaulted, and stalked, with women of mixed race reporting the second highest levels of violence.

The National Violence Against Women Survey also explored violence experienced by minors. Nine percent of surveyed women and 1.9 percent of surveyed men said they were raped before age 18. Women physically assaulted or raped as children were twice as likely to report experiencing the same crime as adults than women who were not victimized as children.

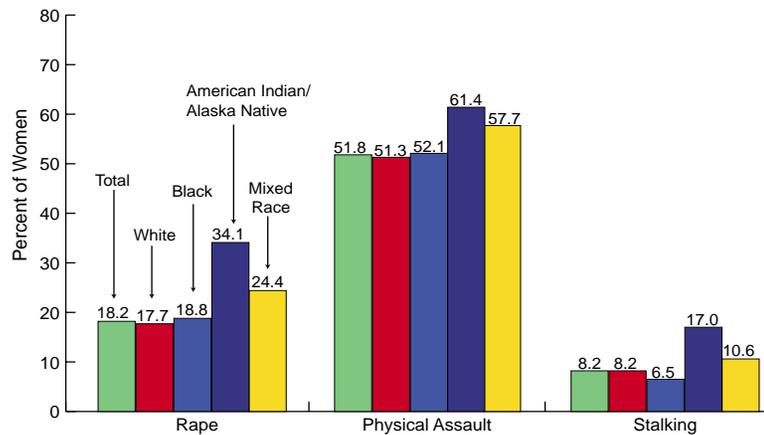
Data from the National Crime Victimization Survey conducted by the U.S.

Department of Justice in 2000 found that women were most likely to experience a violent crime perpetrated by a friend or acquaintance, and men were most likely to be the victim of a crime committed by a stranger. However, female victims were seven times more likely than men to report being the victim of a crime where the offender was an intimate partner. Females were also more likely to be victims of homicide committed by intimate partners than were men.<sup>1</sup>

<sup>1</sup>Centers for Disease Control and Prevention. *Surveillance for Homicide Among Intimate Partners—United States, 1981-1998. MMWR, Vol.50, No. SS03:1.*

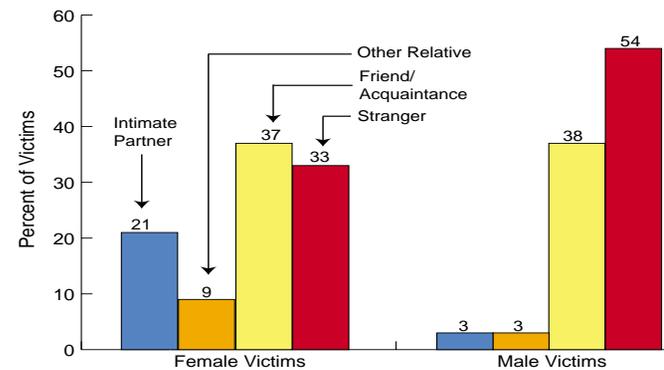
### Women Victimized in Lifetime, by Race of Victim, 1995-1996

Source (II.6): U.S. Department of Justice and the Centers for Disease Control and Prevention



### Persons Experiencing a Violent Crime,\* by Victim-Offender Relationship and Victim Gender, 2000

Source (II.7): U.S. Department of Justice



\*Violent crime includes rape or sexual assault, robbery, aggravated assault, and simple assault.

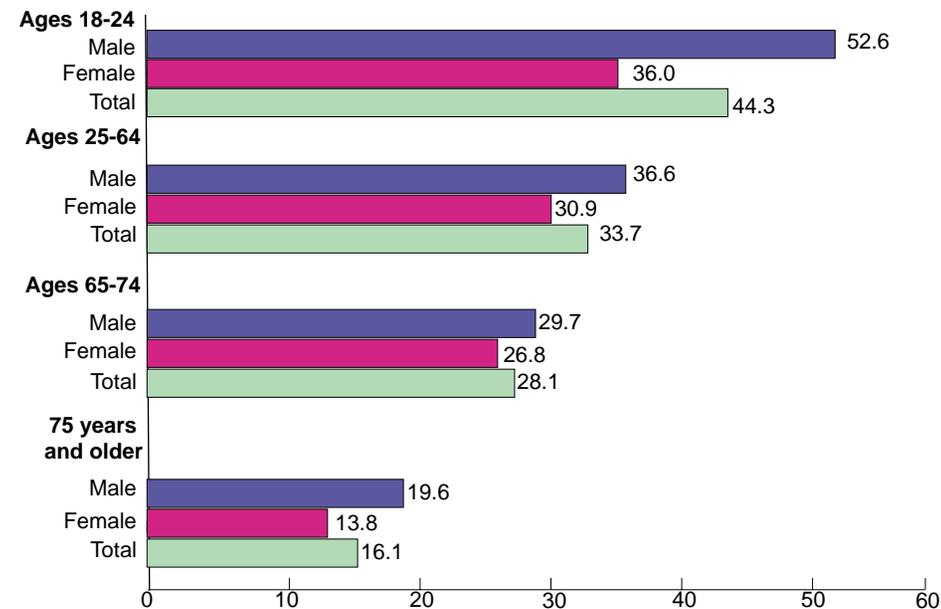
## PHYSICAL ACTIVITY

Health professionals recommend regular participation in physical activity to improve wellness and reduce risk of disease. Physical inactivity is a significant problem among American adults, contributing to a host of health risk factors and health conditions including obesity, hypertension, heart disease, diabetes, and cancer.

The National Health Interview Survey (NHIS) examines the percentage of U.S. adults who engage in regular leisure-time physical activity. Preliminary data from early 2001 show that 36 percent of females aged 18-24 reported exercising regularly, with the proportion continually decreasing with advancing age. Among persons 18-64 years and 75 years and older, males were more likely than women to participate in regular exercise. The difference in the percentages of women and men aged 65-74 years who exercise regularly was not statistically significant

### Adults Aged 18 Years and Older Who Engaged In Regular Leisure-Time Physical Activity,\* by Sex and Age, January - June 2001

Source (II.8): National Health Interview Survey



\*Note: Engaging in leisure-time physical activities includes a report of light-moderate physical activities for 30 minutes, 5 times per week as well as a report of vigorous physical activities for 20 minutes, 3 times per week. This measure reflects the new definition being used for the physical activity leading health indicator in Healthy People 2010.



## OBESITY

Obesity is rising in the U.S. An expert panel convened by the National Institutes of Health defines obesity as a Body Mass Index (BMI) of 30 kg/m<sup>2</sup> or greater, a measure which takes both height and weight into account. Using this measure, over one-fifth of the U.S. population aged 20 years and older was obese in 2000. The prevalence of obesity among U.S. adults increased from 19.4 percent in 1997 to 21.8 percent in 2000, a 12 percent increase.

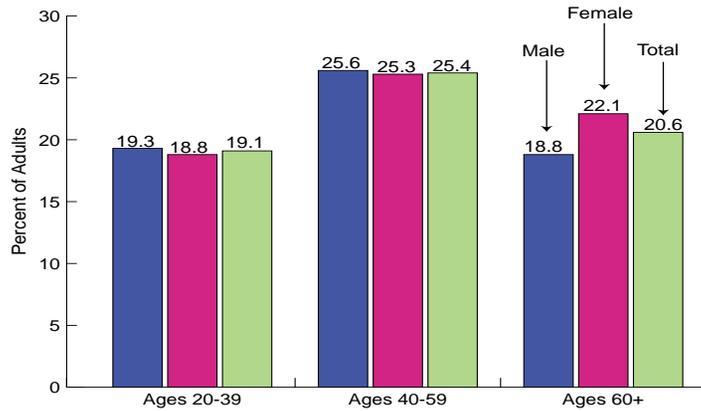
Among U.S. adult females in 2000, the prevalence of obesity was highest among those

aged 40-59, one quarter of whom were obese, followed by women 60 years and older, with women aged 20-39 the age group least likely to report being obese. These age differentials were also consistent for both sexes. Over a quarter of women and men aged 40-59 were estimated to be obese in 2000, compared to 20.6 percent of persons aged 60 and older and 19.1 percent of persons 20-39 years old. However, while males and females had roughly the same likelihood of being obese in the 20-39 and 40-59 age groups, a greater proportion of women aged 60 and older were obese.

The disproportionate prevalence of obesity among minorities has also been a significant challenge for women's health in the U.S. In 2000, the National Health Interview Survey showed the highest prevalence of obesity in Black women at a rate of 35.8 percent; Black women were nearly twice as likely as White women to be obese. One quarter of Hispanic women were obese. In all populations, obesity is linked to chronic conditions such as high blood pressure, heart disease, diabetes, and stroke.

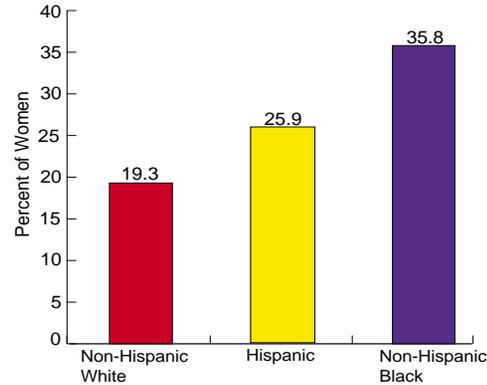
### Self-Reported Prevalence of Obesity Among Adults Aged 20 Years and Older, by Age and Sex, 2000

Source (II.9): National Health Interview Survey



### Self-Reported Prevalence of Obesity Among Women Aged 20 Years and Older, by Race and Hispanic Origin, 2000 (Age-Adjusted)

Source (II.9): National Health Interview Survey



\*Age-sex-race/ethnicity adjusted to the 1990 U.S. population.

## NUTRITION

The U.S. Department of Agriculture's (USDA) Food Guide Pyramid provides dietary guidelines for individuals aged two years and older on daily nutritional intake and reducing excessive fat consumption. The Food Guide Pyramid recommends at least 2-4 servings of fruit and 3-5 servings of vegetables daily, with more servings for very active individuals. Vegetables and fruit are low in fat and supply vitamins, minerals, fiber, and complex carbohy-

drates that help prevent high blood pressure, heart disease, certain cancers, stroke, and diabetes.

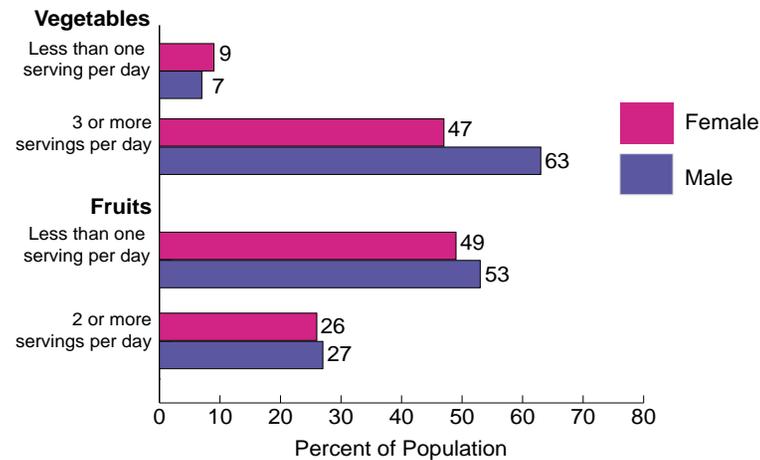
Data from the USDA indicate that the majority of American women in 1996 did not consume the Food Guide Pyramid's daily recommended servings of fruits and vegetables. In that year, 9 percent of U.S. adult women aged 20 years and older ate less than one serving of vegetables per day, and the USDA estimates that only 47 percent of women con-

sumed the minimum daily requirement of at least three vegetable servings per day. In addition, only 26 percent of adult women ate the minimum recommended intake of two fruit servings per day, with nearly half of U.S. women receiving less than one serving of fruit daily.

U.S. adult women fared slightly worse than men in meeting these fruit and vegetable dietary guidelines. In 1996, men were more likely than women to consume three servings of vegetables per day and about equally as likely to consume two servings of fruit per day. Males were also slightly less likely than females to consume less than one serving of vegetables per day. However, a greater percentage of U.S. adult men were found to eat less than one serving of fruit per day than adult women.

### Individuals Aged 20 Years and Older Consuming Specified Numbers of Vegetable and Fruit Servings Per Day, by Sex and Age, 2-day Average, 1996

Source (II.10): USDA Continuing Survey of Food Intakes by Individuals



## CIGARETTE SMOKING

The percentage of women who smoke, a behavior associated with numerous chronic illnesses, has remained steady over the last several years at slightly more than 20 percent of women aged 18 and older.<sup>1</sup> Results of the Substance Abuse and Mental Health Services Administration's 2000 National Household Survey on Drug Abuse (NHSDA) found that, for a broader age group of females aged 12 and older, one quarter of women reported smoking cigarettes in the month prior to the survey. Women aged 18 years and older were less likely than men to have smoked in the prior month.

Among adolescents aged 12-17, however, slightly more females than males reported smoking in the past month (14.1 percent versus 12.8 percent). For both sexes combined, cigarette smoking was most prevalent among young adults aged 18-25 and decreased with increasing age to approximately 10 percent for individuals aged 65 and older.

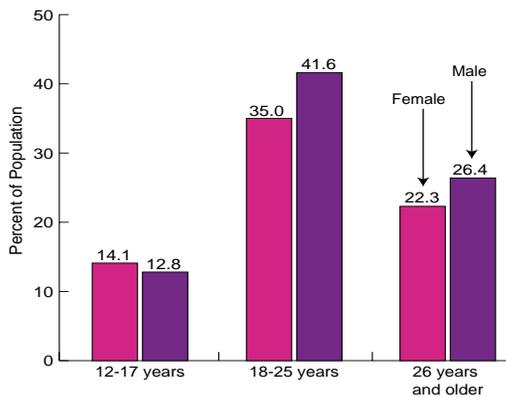
The NHSDA data also showed that White women were more likely to smoke than Black women in 1999/2000. Among females who were not pregnant, nearly 34 percent of White females aged 15-44 smoked cigarettes in 2000 compared to approximately 24 percent of Black women. Although the prevalence of smoking

was lower in both White and Black pregnant women as compared to their non-pregnant counterparts, White women were twice as likely to smoke during pregnancy than Black women. The NHSDA survey found a slight decrease in recent years in the proportion of pregnant women who reported cigarette smoking in the past month, from 19.9 percent in 1996/1997 to 18.6 percent in 1999/2000. Maternal smoking during pregnancy is associated with ectopic pregnancies and miscarriages, newborn low birth weight, and infant mortality.

<sup>1</sup> National Center for Health Statistics (2001). *Health, United States*. Hyattsville, Maryland: DHHS (Table 60).

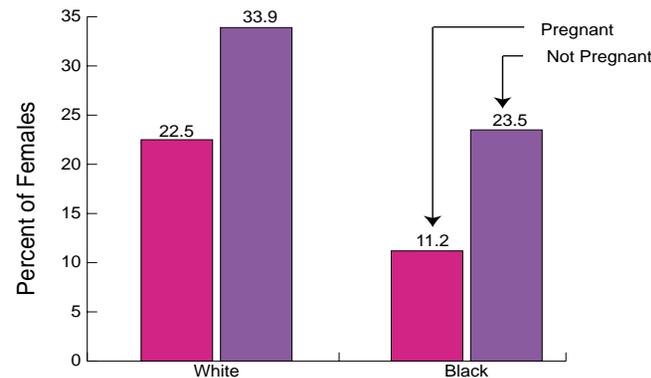
### Persons Reporting Past Month Use of Cigarettes, by Age and Sex, 2000

Source (II.11): National Household Survey on Drug Abuse, SAMHSA



### Females Aged 15-44 Years Reporting Past Month Use of Cigarettes, by Race and Pregnancy Status, 1999/2000

Source (II.11): National Household Survey on Drug Abuse, SAMHSA



## ALCOHOL MISUSE

According to the National Household Survey on Drug Abuse (NHSDA), alcohol misuse in the U.S. is quite common among persons of all ages. In 2000, 13.5 percent of females and 28.3 percent of males aged 12 and older reported binge drinking in the past month, defined as five or more drinks on the same occasion at least once in the month prior to the survey. This same survey found that nearly 3 percent of females and 9 percent of males 12 years and older reported drinking heavily in the past month, defined as having five or more drinks on

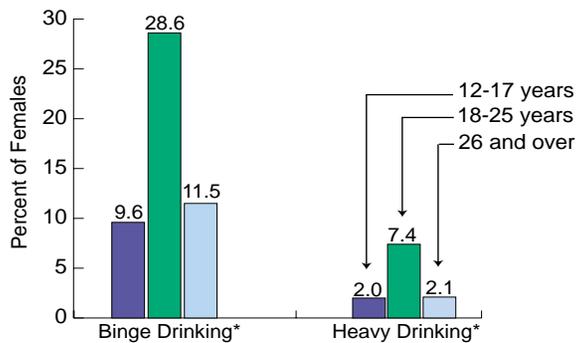
the same occasion on five or more days within the month prior to the survey.

Overall, alcohol misuse appears higher among college-aged women than among their younger and older counterparts. More than a quarter of women 18-25 years old in 2000 reported binge drinking in the past month, and as many as 7.4 percent of women aged 18-25 were found to drink heavily. This compares to approximately 10 percent of female teenagers and females 26 years and over who reported binge drinking. For all levels of alcohol consumption, use declined significantly after age 25.

Among women aged 15-44 who were not pregnant, White women were more likely be binge drinkers (22.1 percent) compared to Hispanic (16.1 percent) and Black (15.6 percent) women. However, Black pregnant women were four times as likely as Hispanic pregnant women to binge drink, while White pregnant women were nearly three times as likely to binge drink as Hispanic pregnant women. Drinking alcohol during pregnancy contributes to Fetal Alcohol Syndrome (FAS), infant low birth weight, and developmental delays in children.

### Females Reporting Past Month Binge Drinking and Heavy Drinking, 2000

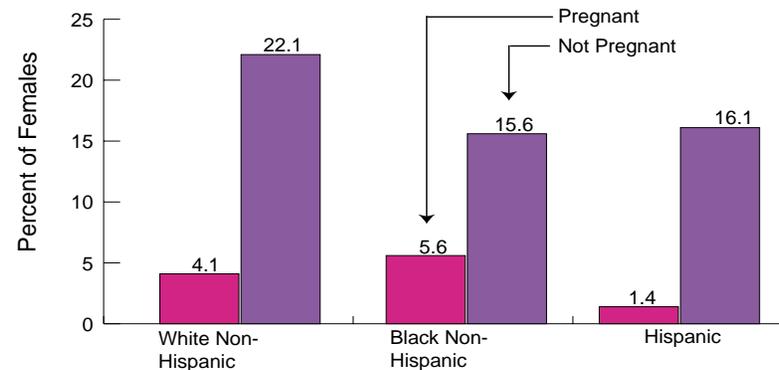
Source (II.11): National Household Survey on Drug Abuse, SAMHSA



\*Binge drinking is defined as five or more drinks on the same occasion at least once in the 30 days prior to survey. Heavy drinking is defined as having 5 or more drinks on the same occasion on 5 or more days within the past 30 days. All heavy alcohol drinkers are also binge drinkers.

### Females Aged 15-44 Years Reporting Past Month Binge\* Alcohol Use, by Race and Pregnancy Status, 1999/2000

Source (II.11): National Household Survey on Drug Abuse, SAMHSA



\*Binge alcohol use is defined as five or more drinks on the same occasion at least once in the 30 days prior to the survey

## ILLICIT DRUG USE

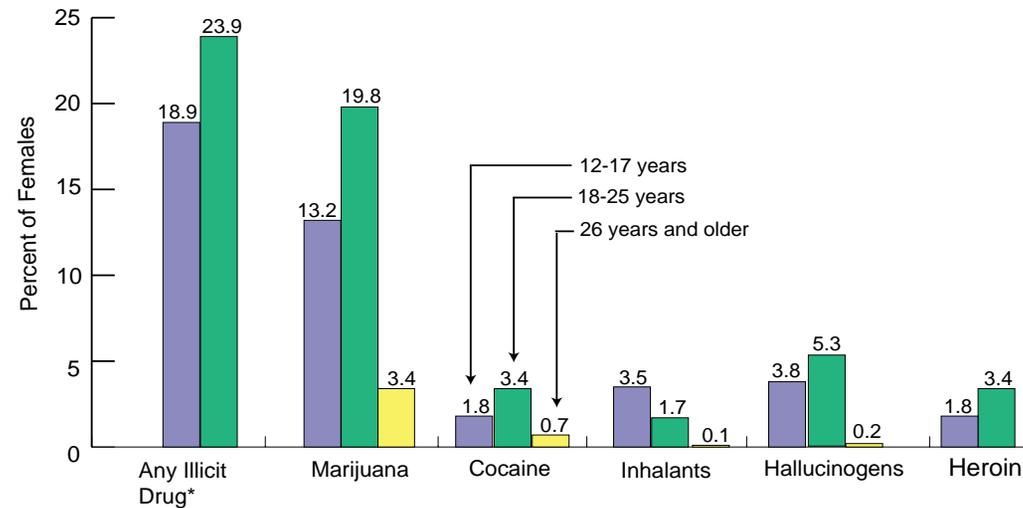
Results from the 2000 National Household Survey on Drug Abuse (NHSDA) indicated that approximately 24 percent of women aged 18-25 and 19 percent of females aged 12-17 had used some type of illicit drug within the past year. Marijuana was reported as the leading illicit drug used by women of all ages. Nearly one-fifth of women aged 18-25, 13 percent of females aged 12-17, and 3 percent of women 26 and older reported using marijuana in the past year. The 18-25 age group was also more likely to use cocaine, hallucinogens, and heroin. Women 18-25 years were twice as likely as males aged 12-17 and nearly five times as likely as women 26 and older to use cocaine. In addition, about 5 percent of women aged 18-25 used hallucinogens in the past year compared to 3.8 percent and 0.2 percent of females aged 12-17 and 26 and older, respectively. Women 18-25 years old were also twice as likely to use heroin as females 12-17 years old.

Inhalants were the only illicit drugs reported most frequently among females aged 12-17; this age group was twice as likely as women aged 18-25 and 35 times more likely than women 26 and older to use inhalants. With the

exception of inhalant drugs, the proportion of women who used illicit drugs increased from the teen years to the mid-twenties and then decreased among women aged 26 years and older.

### Females Reporting Past Year Use of Illicit Drugs, by Age and Drug Type, 2000

Source (II.11): National Household Survey on Drug Abuse, SAMHSA



\*Data for use of heroin and any illicit drug not available for 26 years and older age category.

## NON-MEDICAL USE OF PRESCRIPTION DRUGS

While it is widely acknowledged that abuse of illicit drugs is a national concern, misuse of prescription drugs is also a significant health problem in the United States. Psychotherapeutic drugs in particular are misused. A psychotherapeutic drug is a substance that alters the mood and includes prescription-type stimulants, sedatives, tranquilizers, and pain relievers. Misuse of prescription drugs is a particular concern among women, who are nearly 50 percent more likely than men to be prescribed an abusable prescription drug, especially narcotics and anti-anxiety

drugs.<sup>1</sup> Because of their potential risk for misuse and addiction, most psychotherapeutic drugs are classified as controlled substances by the Food and Drug Administration.

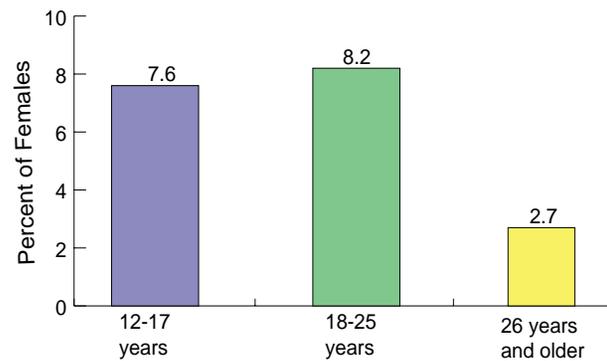
Data from the National Household Survey on Drug Abuse indicate that 14.5 percent of the U.S. population aged 12 years and older in 2000 had ever used at least one psychotherapeutic drug for non-medical reasons. Overall, the rates of prescription drug misuse were similar for women and men; among persons aged 12-17, however, females were more likely than males to misuse psychotherapeutic drugs. Adolescent and young adult women were about three times more

likely to use psychotherapeutic drugs for non-medical purposes than women 26 years and older. In 2000, roughly 8 percent of females aged 12-17 and 18-25 reported using psychotherapeutic prescription drugs for non-medical reasons in the past year, compared to approximately 3 percent of women 26 years and older. Among the various types of psychotherapeutic drugs reported, prescription pain relievers were most commonly misused, followed by tranquilizers, stimulants, and sedatives.

*1 National Institute on Drug Abuse Research Report Series. Prescription Drugs: Abuse and Addiction.  
<http://www.nida.nih.gov/ResearchReports/Prescription/prescription5.html>*

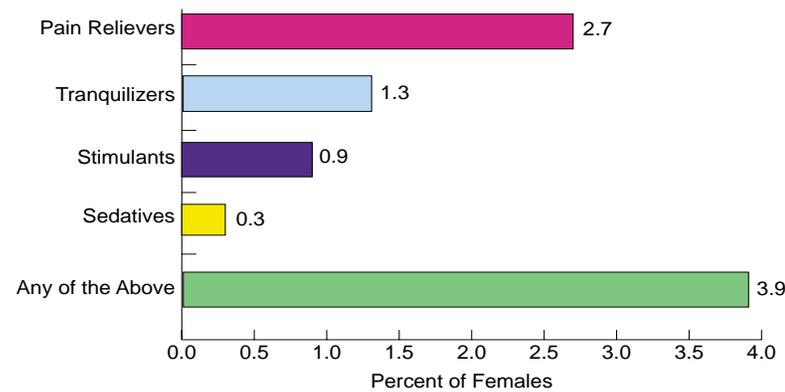
### Females Reporting Past Year Non-Medical Use of Any Psychotherapeutic Prescription Drug, by Age, 2000

Source (II.11): National Household Survey on Drug Abuse, SAMHSA



### Females Reporting Past Year Non-Medical Use of Psychotherapeutic Prescription Drugs, by Drug Type, 2000

Source (II.11): National Household Survey on Drug Abuse, SAMHSA



## HEART DISEASE

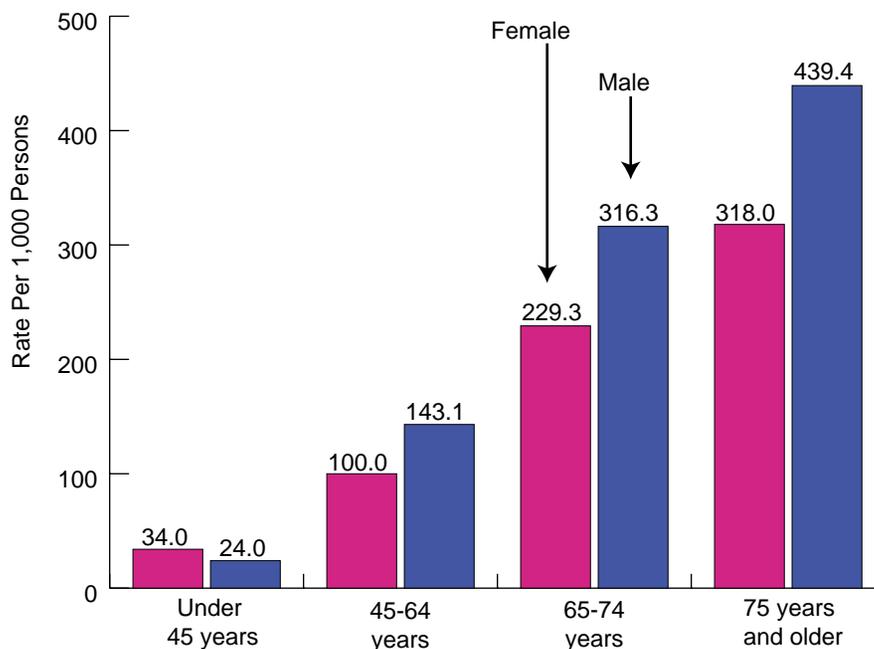
Heart disease is the leading cause of death for both males and females in the U.S. and a chronic condition that affects millions of American adults. According to the National Health Interview Survey (NHIS), the prevalence of heart disease in both men and women climbs significantly with increasing age. In 1995, the rate of heart disease was approximately three times higher among women aged 45-64 than among those under 45, and nearly seven times higher in women aged 65-74 than among those under 45. For women 75 years and older, the disease rate reached 318.0 per 1,000 persons in 1995, or nine times higher than the rate in women under 45 years.

The NHIS data show differences in heart disease prevalence between younger and older women and men. Among U.S. adults under 45 years, women had higher rates of heart disease than men in 1995. However, this trend reversed in middle-aged and older adults when heart disease was more prevalent among men.

High blood pressure, obesity, and smoking are significant risk factors for developing heart disease. Health professionals recommend modifying behaviors such as smoking, diet, and exercise to prevent onset or further progression of the disease.

### Rate of Heart Disease, by Age and Sex, 1995

Source (II.12): National Health Interview Survey



## DIABETES

Diabetes is a chronic condition and a leading cause of death and disability in the United States. Complications from diabetes include loss of vision, kidney failure, heart disease, limb amputations, and nerve damage, conditions which can both shorten the life span and diminish the quality of life.

Among both men and women, the prevalence of diabetes increases with age. The rate of diabetes is nearly seven times higher in

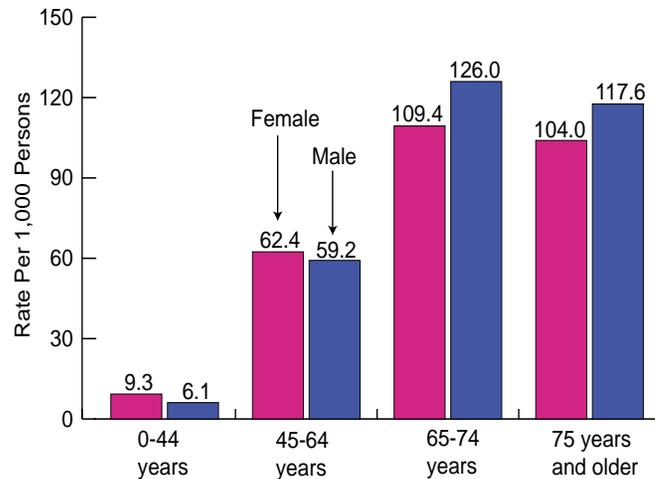
women aged 45-64 than females under 45 years, and more than ten times higher in women over 65 years than females under 45 years. Among persons aged 64 and younger the prevalence of diabetes is slightly higher among U.S. females than males. However, this trend is reversed in persons aged 65 and older, where men exhibit higher rates of the disease. Furthermore, the number of new cases of diabetes appears to be significantly greater in middle-aged men than in middle-aged women.

In 1996, women aged 45-64 were diagnosed with diabetes at a rate of 4.86 per 1,000 population, compared to a rate of 7.29 for men of the same age.

Black women have a significantly higher prevalence of diabetes than White women. In 1996, the rate in Black women was nearly double that of the rate in White women and 1.5 times the average for all women.

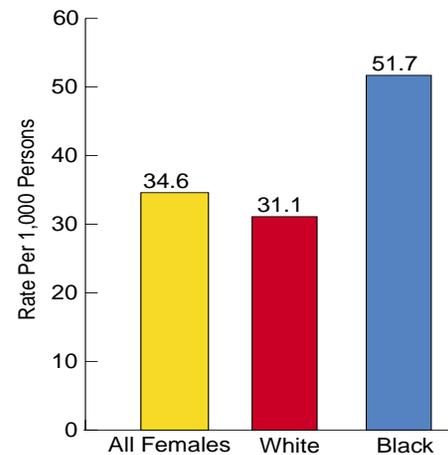
### Prevalence of Diabetes, by Age and Sex, 1996

Source (II.13): National Health Interview Survey



### Prevalence of Diagnosed Diabetes Among Females (All Ages), by Race, 1996

Source (II.13): National Health Interview Survey



## CANCERS

In 2001, approximately 267,300 women died of cancer in the U.S. Representing a quarter of all female cancer deaths, lung/bronchus cancer was the leading cause of cancer mortality, followed by breast cancer (15 percent) and cancer of the colon and rectum (11 percent). The lung cancer and colorectal death rates for women (41.5 and 18.2 per 100,000 population, respectively) were considerably lower than for men (79.9 and 25.4 per 100,000 population, respectively).

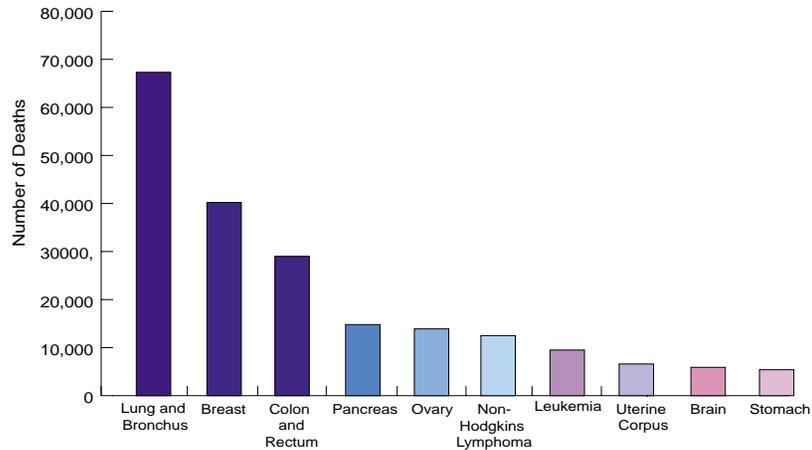
Cancer rates are tracked by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program, which obtains data from 11 population-based registries and three supplemental registries covering approximately 14 percent of the U.S. population. According to SEER data from 1992-1998, the rate of new cases of lung/bronchus cancer decreased slightly in females from 42 cases per 100,000 population in 1992 to 41.2 in 1998. In 1998, Black and White women displayed the highest incidence rates of lung/bronchus cancer

(46.7 and 42.8, respectively), with incidence rates that were at least twice those of Asian/Pacific Islander and Hispanic women. American Indian/Alaska Native women had the lowest cancer incidence rates; however, cancer remains the second leading cause of death among American Indian/Alaska Native women.<sup>1</sup> Although the rate of new lung cancer cases in U.S. women has declined, it is still the leading cause of cancer death among females.

<sup>1</sup>National Vital Statistics Report, Vol. 49, No. 11, October 12, 2001.

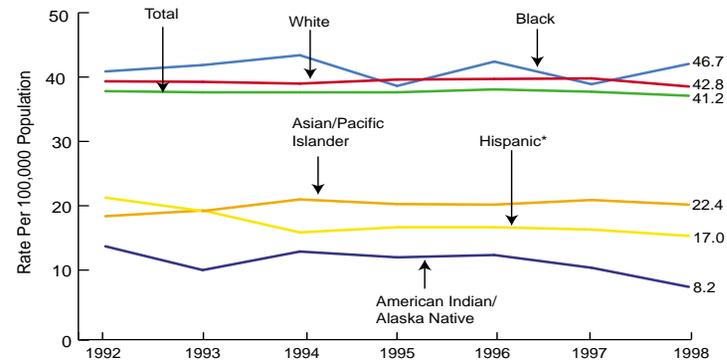
### Leading Causes of Cancer Deaths for Females, by Site, 2001

Source (II.14): American Cancer Society/National Cancer Institute



### Incidence Rates for Females with Cancer of the Lung and Bronchus by Race and Hispanic Origin, 1992-1998 (Age-Adjusted)

Source (II.15): National Cancer Institute



Note: Age adjusted to the 1970 U.S. population

\*Hispanic is not mutually exclusive from Whites, Blacks, Asian/Pacific Islanders, and American Indians/Alaska Natives

## CANCERS (Cont'd)

From 1992 to 1998, the incidence rate of breast cancer among American women increased over 6 percent, from 111.2 per 100,000 population in 1992 to 118.1 in 1998. In 1998, White women had the highest incidence rates of breast cancer (119.9), followed by Black women (99.7). Breast cancer incidence rates increased from 1992 to 1998 among White and Asian/Pacific Islander women.

The colon cancer rate for females overall remained relatively stable, with only a slight (1.6 percent) decrease in incidence rates among U.S.

women between 1992 and 1998. In 1998, Black women displayed the highest incidence rates of colorectal cancer, followed by White and then Asian/Pacific Islander women. American Indian/Alaska Native women had a major decrease in the incidence of colon/rectum cancer, while other groups had smaller decreases.

Although death rates from colorectal and lung/brochus cancers are higher than breast cancer death rates, breast cancer is more common among U.S. women. The rate of new cases of breast cancer in 1998 was three times higher than the incidence rates of lung/bronchus and

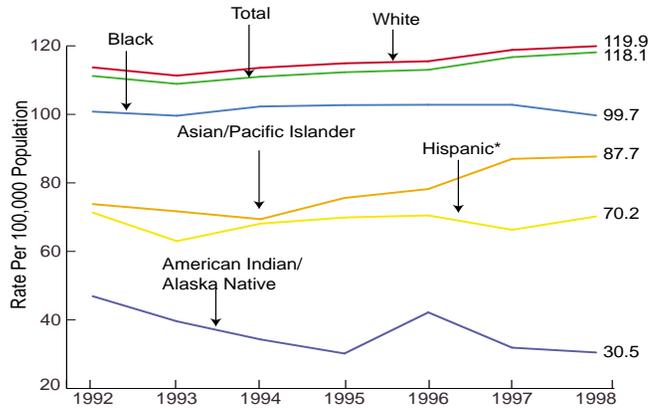
colon/rectum cancers.

Smoking is a significant contributor to lung cancer risk, as well as other types of cancers. To reduce the risk of cancer, health professionals recommend quitting smoking, exercising regularly, and eating healthfully. Mammograms are recommended for women aged 40 years and older to screen for breast cancer and, for persons aged 50 and older, fecal occult blood testing and sigmoidoscopy are recommended to screen for colorectal cancer.<sup>1</sup>

<sup>1</sup>U.S. Preventive Services Task Force, 1996.  
<http://www.ahrq.gov/dinic/prevenix.htm>

**Incidence Rates for Females with Breast Cancer, by Race and Hispanic Origin, 1992-1998 (Age-Adjusted)**

Source (II.15): National Cancer Institute

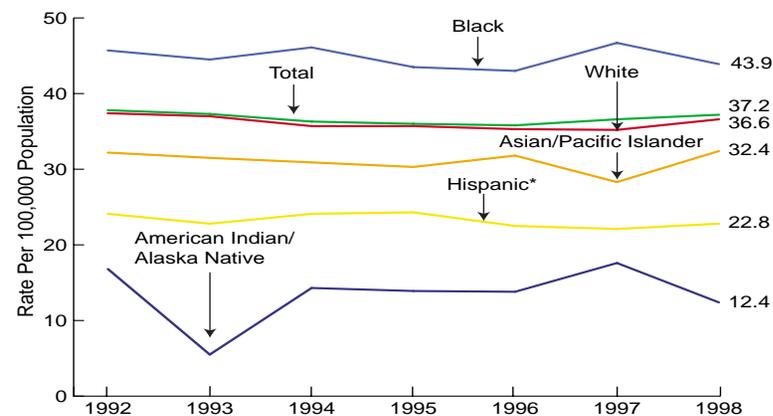


Note: Age adjusted to the 1970 U.S. population

\*Hispanic is not mutually exclusive from Whites, Blacks, Asian/Pacific Islanders, and American Indians/Alaska Natives

**Incidence Rates for Females with Cancer of the Colon and Rectum, by Race and Hispanic Origin, 1992-1998 (Age-Adjusted)**

Source (II.15): National Cancer Institute



Note: Age adjusted to the 1970 U.S. population

\*Hispanic is not mutually exclusive from Whites, Blacks, Asian/Pacific Islanders, and American Indians/Alaska Natives

## ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

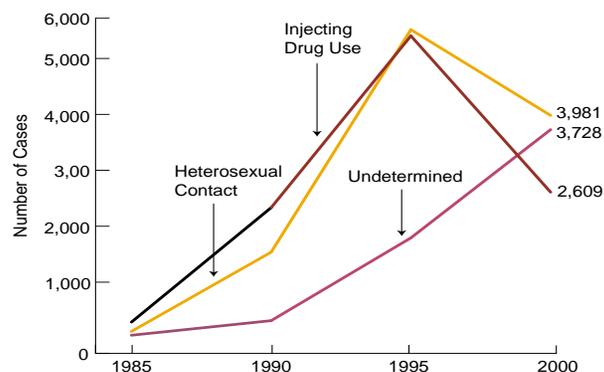
Although Acquired Immunodeficiency Syndrome (AIDS) was primarily diagnosed in men in the early 1980s, by the 1990s the disease had become prevalent in women. In 1993, the Centers for Disease Control and Prevention expanded the definition of an AIDS case to include persons with severe immunosuppression, pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer.<sup>1</sup> This had the effect of greatly increasing the number of reported AIDS cases among women.

In 2000, there were 10,459 AIDS cases among U.S. females aged 13 years and older attributed to three major exposure categories: heterosexual contact, injecting drug use, and undetermined modes of transmission. The plurality (38 percent) of these women were exposed through heterosexual contact. However, between 1995 and 2000, the number of AIDS cases from heterosexual exposure in females dropped by 28 percent, from 5,515 AIDS cases in 1995 to 3,981 cases in 2000. AIDS cases attributable to injection drug use in women also declined by 52 percent over this period, from 5,404 to 2,609 cases.

AIDS cases due to heterosexual contact and injecting drug use were highest among Black women in 2000 (2,449 and 1,468 cases, respectively), representing 62 percent of all AIDS cases in women attributable to heterosexual contact and 56 percent of AIDS cases among women attributable to injecting drug use.

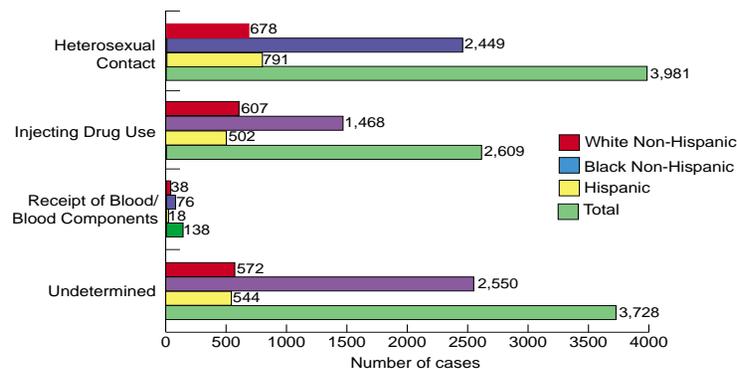
<sup>1</sup>Centers for Disease Control and Prevention, 1993. *Impact of the Expanded AIDS Surveillance Case Definition on AIDS Case Reporting — United States, First Quarter, 1993. MMWR, April 30, 1993. 42(16): 308-310.*

**Female AIDS Cases, by Selected Exposure Categories\* for Persons Aged 13 Years of Age and Over at Diagnosis, United States, Selected Years 1985-2000**  
Source (II.1): Centers for Disease Control and Prevention



\*Changes in reporting procedures in 1993 led to an increase in the number of cases reported without information about the exposure category.

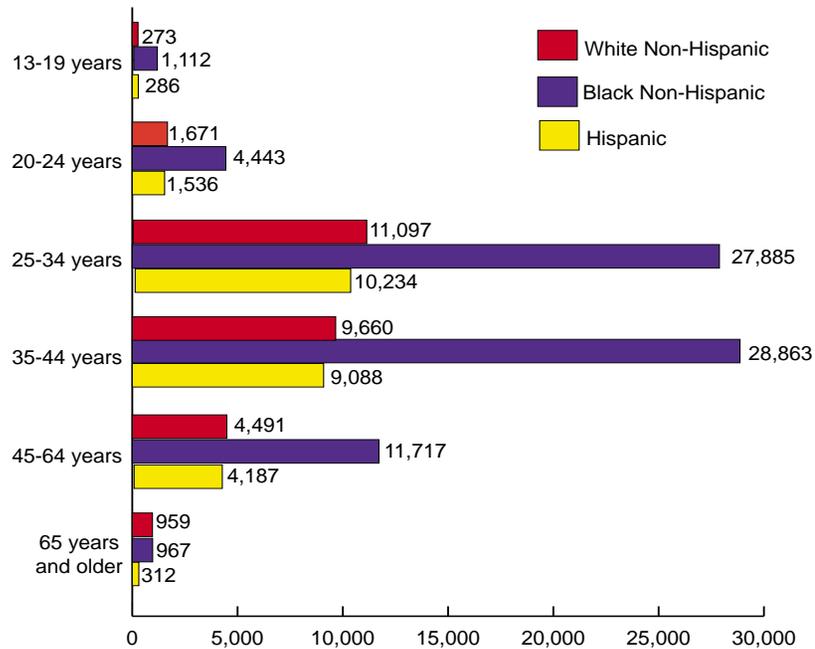
**Female Adult/Adolescent AIDS Cases, by Selected Exposure Categories\* and Race and Hispanic Origin, 2000**  
Source (II.16): Centers for Disease Control and Prevention



\*Number for Asian Pacific Islanders and American Indian/Alaska Natives is too small to illustrate on graph  
\*Each reported case of AIDS is assigned to one exposure category, even if more than one risk factor is present, according to the probability of acquiring the infection from each risk behavior.

### Female AIDS Cases, by Age at Diagnosis and Race and Hispanic Origin, Reported through December 2000

Source (II.16): Centers for Disease Control and Prevention



### AIDS (Cont'd)

As of December 2000, a total of 130,104 cases of AIDS had been reported in adolescent and adult women in the U.S. The majority of reported AIDS cases among adolescent and adult women were among women aged 25-44 years. In all age categories, the largest number of reported AIDS cases was among Black women.

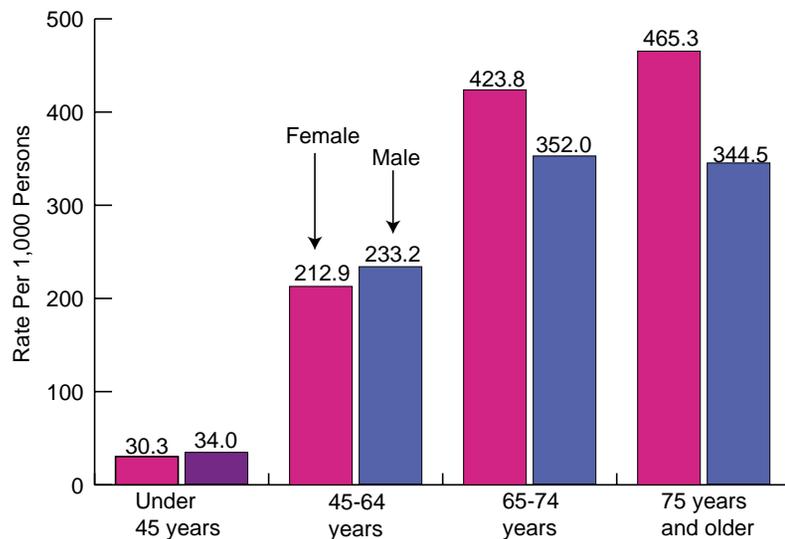
## HYPERTENSION

Hypertension (high blood pressure) is a significant risk factor for heart disease and stroke. National survey data from 1995 indicated that males aged 64 and younger had slightly higher rates of hypertension than their female counterparts. However, hypertension was far more prevalent among older females than males. This pattern contrasts with that seen for other major conditions such as heart disease and diabetes, which are more prevalent among younger females than males but less prevalent in females among older populations.

Similar to the trends found in heart disease and diabetes, however, the rate of hypertension for both women and men increased from younger to older ages. In women, the rate of hypertension was seven times higher in persons aged 45-64 than among those under 45, and approximately 15 times higher in women 65 and older than those under 45 years.

### Hypertension, by Age and Sex, 1995

Source (II.17): National Health Interview Survey



## MENTAL ILLNESS/SUICIDE

Depression and anxiety disorders disproportionately affect women. According to the 1998 Behavioral Risk Factor Surveillance Survey (BRFSS), females were more likely than males to report poor mental health status in the month prior to the survey. Twelve percent of females reported having between three and seven poor mental health days as compared to 9 percent of men. Five percent of women reported being in poor mental health for the entire month.

In addition to the depression that women may experience at other times in their lives, about 10 percent of women experience post-

partum depression after having a baby.<sup>1</sup> As described by the American College of Obstetricians and Gynecologists, in contrast to more transient "baby blues" experienced by 70-80 percent of new mothers, women with postpartum depression have more long-lasting and intense feelings of sadness, anxiety, or despair and may have trouble coping with their daily tasks. Without treatment, postpartum depression may persist and worsen and, in some cases, may develop into more severe mental illness.

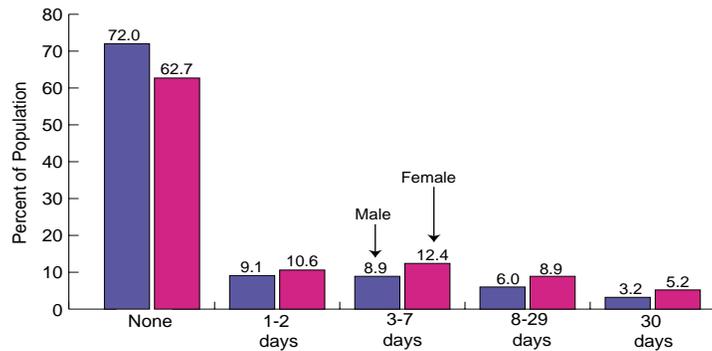
Suicide in women is also a serious concern. In 1998, females had an overall age-adjusted suicide rate of 4.3 per 100,000 females. American Indian/Alaska Native and White

non-Hispanic women had especially high rates of suicide at 5.3 and 5.0 per 100,000 females, respectively, as compared to 3.6 for Asian/Pacific Islander, 2.0 for Hispanic, and 1.8 for Black females. Female suicide rates peak for women aged 45-64 at 7.0 deaths per 100,000 females. Female suicide rates in 1998 were significantly lower than male suicide rates overall and at every age. The 1998 overall age-adjusted male suicide rate was 19.2 per 100,000 males, with the rate peaking at 57.8 per 100,000 males for men 85 years and older.

*1 American College of Obstetricians and Gynecologists. Postpartum depression. <http://www.medem.com/> (search on "postpartum depression")*

### Number of Days Mental Health was Not Good During Past 30 Days, 1998

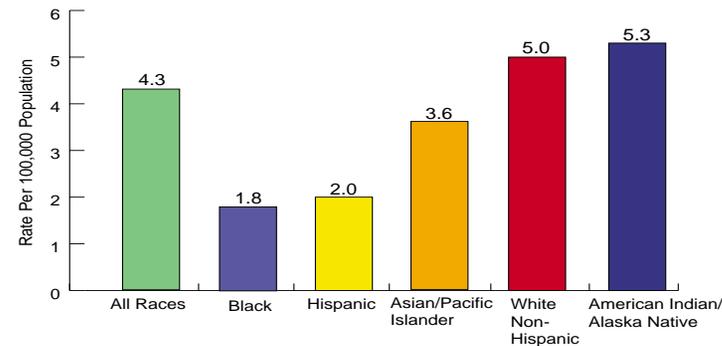
Source (II.18): Behavioral Risk Factor Surveillance System



Note: These data represent the median of percentages reported by the 50 states, the District of Columbia, and Puerto Rico.

### Suicide Death Rates for Females Aged 15 Years and Older, by Race, 1998 (Age-Adjusted)\*

Source (II.1): National Vital Statistics System



\*Age-adjusted rates calculated using the year 2000 standard population.

## INJURY

Injuries, many of which are preventable, are a significant source of health care costs. In 1999, there were 37.6 million visits to emergency departments (ED) due to injuries. Overall, females accounted for approximately 46 percent of injury-related ED visits in 1999 and males accounted for 54 percent. Among females with injury-related ED visits, the greatest proportion, approximately 15 percent, were among women aged 25-44.

In 1999, the overall number of injury-related visits to EDs per 100 persons per year was 13.8, with a rate of 12.3 for females and 15.4 for males. For persons aged 44 and younger, males had a higher rate of injury-related ED visits per year than females, with the gender disparity particularly large for persons aged 15-24 years. However, these gender differences essentially disappeared for persons aged 45 and older. Among females, the rate of injuries resulting in a visit to an emergency department was highest for women aged 75 years and older,

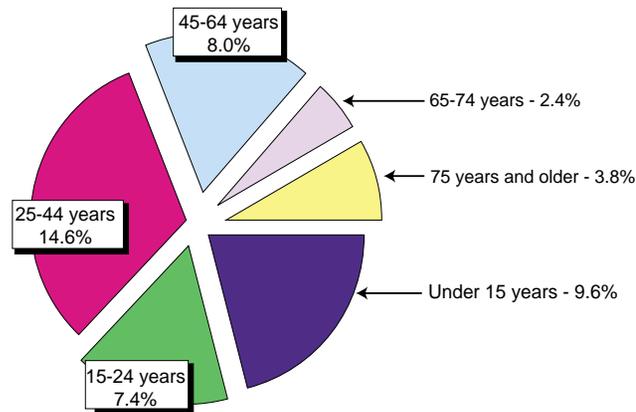
with the second highest rate among females aged 15-24 years.

Falls are a leading cause of injury in women, especially among women aged 65 and older. Other injuries commonly resulting in a visit to an emergency department result from being struck by or against a person or object, car crashes, overexertion, and cuts.<sup>1</sup>

<sup>1</sup>Warner M, Barnes PM, and Fingerhut LA. Injury and poisoning episodes and conditions. National Health Interview Survey, 1997. Vital Health Stat 10(202), 2000.

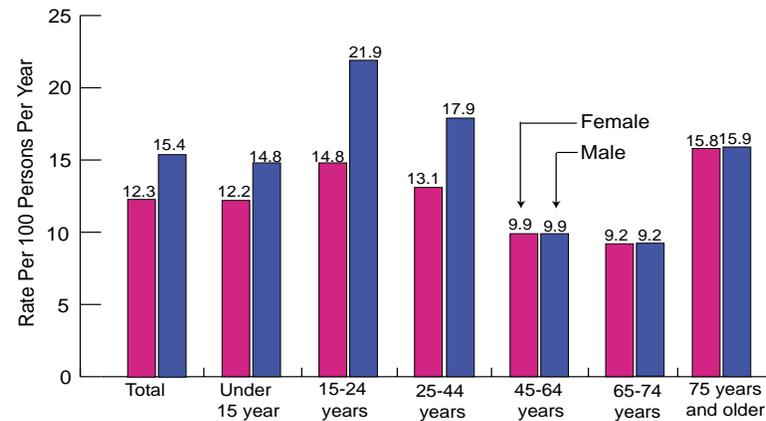
### Distribution of Injury-Related Emergency Department Visits for Females, by Age, 1999

Source (II.19): National Ambulatory Medical Care Survey



### Rate of Injury-Related Visits to Emergency Departments, by Sex and Age, 1999

Source (II.19): National Ambulatory Medical Care Survey





## ASTHMA

Asthma is a chronic inflammatory disorder of the airways producing episodes of wheezing, chest tightness, shortness of breath, and coughing. Episodes are triggered by allergens, tobacco smoke and other irritants, exercise, and infections of the respiratory tract. The number of asthma sufferers increased by 75 percent between 1980 and 1993-94<sup>1</sup> and, by 1996, it was the third most common chronic condition in the U.S.<sup>2</sup> With effective management, however, persons with asthma can enjoy normal activities.

While 7.2 percent of U.S. adults had asthma in 2000, women had higher rates than men, 9.1 percent compared to 5.1 percent respectively.<sup>3</sup> This higher prevalence appeared to be concentrated among middle-aged adults. In 1999, more than twice as many women as men aged 45-64 had asthma, though the rates were more comparable among men and women in younger and older age groups. In addition to higher prevalence, women were more likely than men to use health care for asthma, including hospitalizations and emergency room visits, and they were also more likely to die from asthma.<sup>1</sup> Higher prevalence, morbidity, and mortality among women may be associated with hormones, obesity, or other characteristics,

although it is unclear whether this variation is due to a real difference in prevalence, reporting, or other factors.<sup>3</sup>

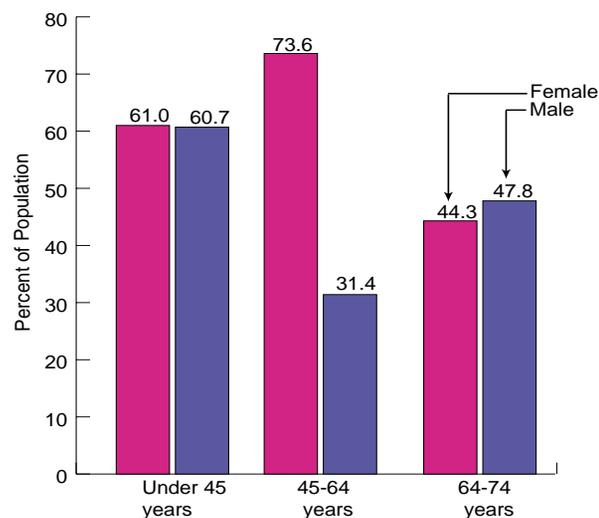
<sup>1</sup>National Health, Lung, and Blood Institute Data Fact Sheet. *Asthma Statistics*. National Institutes of Health, January 1999.

<sup>2</sup>Druss BG, Marcus SC, Olsson M, Tanielian T, Elinson L, PinCUS HA. *Comparing The National Economic Burden Of Five Chronic Conditions*. Health Affairs, November/December, 233-241, 2001.

<sup>3</sup>Centers for Disease Control and Prevention. *Self-reported asthma prevalence among adults—United States, 2000*. JAMA, 286(13): 1571-1572, 2001.

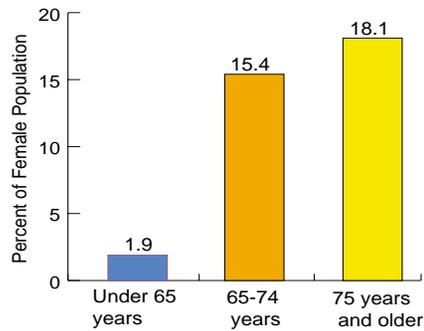
### Persons Diagnosed with Asthma, by Age and Sex, 1999

Source (II.20): National Health Interview Survey



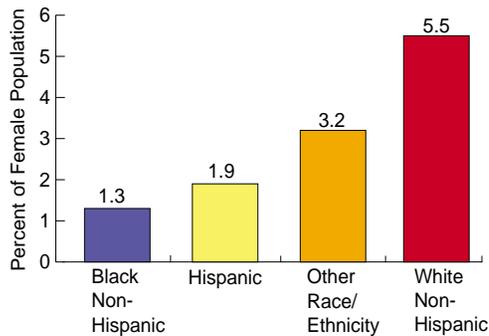
### Females Diagnosed with Osteoporosis, by Age, 1999

Source (II.20): National Health Interview Survey



### Females Diagnosed with Osteoporosis, by Race and Ethnicity, 1999

Source (II.20): National Health Interview Survey



## OSTEOPOROSIS

Osteoporosis is characterized by progressive loss of bone density and thinning of bone tissue, leading to vulnerability to bone fractures. The condition can result from disease, dietary or hormonal deficiency, or advanced age.<sup>1</sup> Ten million Americans have osteoporosis and another 18 million are at risk due to low bone density. Osteoporosis is responsible for more than 1.5 million fractures annually, including hip fractures, vertebral and rib fractures, wrist fractures, and fractures at other sites.<sup>2</sup>

National data from 1999 indicate that nearly 90 percent of those with osteoporosis were women and most of these women were aged 65 and older. Fewer than 2 percent of women under 65 had ever been told they have osteoporosis compared to 15.4 percent of women aged 65-74 years and 18.1 percent of women aged 75 and older. The condition was approximately twice as common among non-Hispanic White women (5.5 percent) than the average rate for non-Hispanic Black women (1.3 percent), Hispanic women (1.9 percent), and women of other race and ethnicity (3.2 percent).

Immutable risk factors for osteoporosis include female gender, older age, small or thin body size, Caucasian and Asian ethnicity, and

family history of fractures. Modifiable risk factors include a diet low in calcium and vitamin D, use of certain medications, an inactive lifestyle or extended bed rest, cigarette smoking, and excessive alcohol consumption.<sup>3</sup>

Because it can be asymptomatic and difficult to diagnose in the absence of bone fracture, osteoporosis is often called "the silent disease." The only way to determine bone density and fracture risk for osteoporosis is through a bone mineral density test.

The condition may be prevented and treated through a diet rich in calcium and vitamin D, exercise, elimination of smoking or excessive alcohol intake, and medication such as estrogen therapy.<sup>3</sup>

<sup>1</sup>MEDLINEplus Medical Encyclopedia: Osteoporosis. [Http://medlineplus.nlm.nih.gov/medlineplus/ency/imagepage/17285.htm](http://medlineplus.nlm.nih.gov/medlineplus/ency/imagepage/17285.htm)

<sup>2</sup>National Osteoporosis Foundation, Disease Statistics, <http://www.nof.org/osteoporosis/stats.htm>

<sup>3</sup>Osteoporosis and Related Bone Diseases National Resource Center. Osteoporosis Overview. National Institutes of Health, October 2000. <http://www/osteo.org/osten.html>.

## LUPUS

Systemic lupus erythematosus (SLE) is an autoimmune disease in which the body harms its own healthy cells and tissues. SLE ranges in severity from mild to severe and can affect various parts of the body, especially the skin, joints, blood, and kidneys. It is characterized by flares of activity and periods of improvement or remission. Diagnosis of lupus is complicated by vague, nonspecific symptoms that can be confused with other conditions and the absence of a definitive diagnostic test. However, the most common symptoms include extreme fatigue, swollen joints, unexplained fever, skin rashes, and kidney problems.

An estimated 500,000 to 1.5 million Americans have lupus and 16,000 develop lupus each year.<sup>1</sup> Lupus is three times more common in African American women than in Caucasian women and is also more common in women of Hispanic, Asian, and Native American descent.<sup>2</sup> More than 85 percent of lupus patients are women.<sup>3</sup>

The exact cause of lupus is unknown, but heredity, environment and hormonal changes may be involved. While there is no cure for lupus, it can be treated with appropriate drugs and many people with the condition lead active, healthy lives.

<sup>1</sup>Lahita RG. *Causes, Symptoms, Testing, and Treatment. Lupus Foundation of America.* <http://www.lupus.org/info/general.html>

<sup>2</sup>National Institute of Arthritis and Musculoskeletal and Skin Diseases, National Institutes of Health. *Handout on Health: Systemic Lupus Erythematosus.*

<http://niaus.nih.gov/hi/topics/lupus/slehandout/index.htm>

<sup>3</sup>American College of Rheumatology. *Systemic Lupus Erythematosus, 2000.* <http://www.rheumatology.org/patients/factsheet/sle.html>.



## PRENATAL CARE

The proportion of women beginning prenatal care in the first trimester of pregnancy remained stable at 83.2 percent in 2000, the same proportion as in 1999. This figure has risen 9 percent since 1989, when 75.5 percent of women received early prenatal care.

Though the majority of women received early prenatal care, racial disparities persist. In 2000, 89 percent of White women and 84 percent of Asian or Pacific Islander women received early prenatal care compared to 74

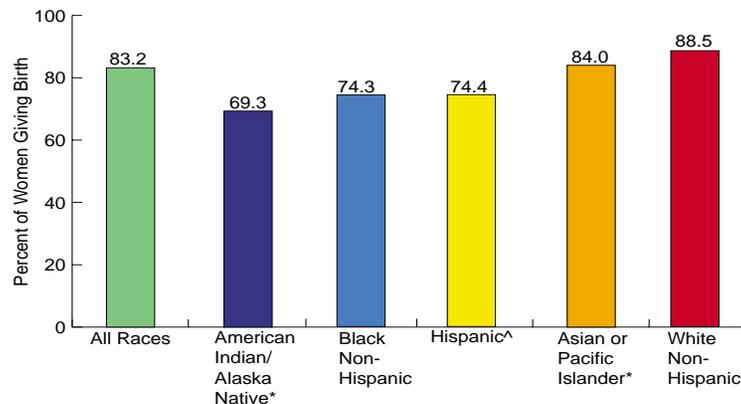
percent of Black and Hispanic women and 69 percent of American Indian/Alaska Native women. The proportion of Black, Hispanic, and American Indian/Alaska Native women receiving early prenatal care increased by 20-24 percent between 1990 and 2000. Women under the age of 20 are much less likely to receive early prenatal care than older women.

The percentage of women beginning prenatal care in the third trimester or going without prenatal care dropped from 6.4 percent in 1989 to 3.9 percent in 2000. Black, Hispanic,

and American Indian/Alaska Native women were almost three times as likely to receive late or no prenatal care as White women in 2000.

### Mothers Beginning Prenatal Care in the First Trimester, by Race and Ethnicity, 2000

Source (II.21): National Vital Statistics System

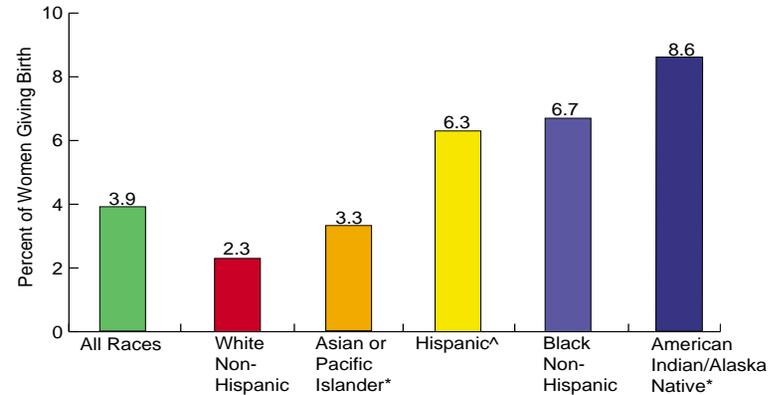


^Includes persons of any race

\*Includes persons of Hispanic origin

### Mothers Receiving Late<sup>1</sup> or No Prenatal Care by Race and Ethnicity, 2000

Source (II.21): National Vital Statistics System



^Includes persons of any race

\*Includes persons of Hispanic origin

<sup>1</sup>Late prenatal care is defined as care beginning in the third trimester.

## LIVE BIRTHS

The total birth rate in the U.S. in 2000 was 14.7 births per 1,000 population, a 1 percent increase from the record low rate reported in 1999. Not surprisingly, younger women had a higher birth rate than older women. However, birth rates for women in their twenties and early thirties were relatively stable with only small increases over the past 20 years, while the birth rates for women

aged 35 and older made substantial increases, matching highs reported 30 or more years ago.

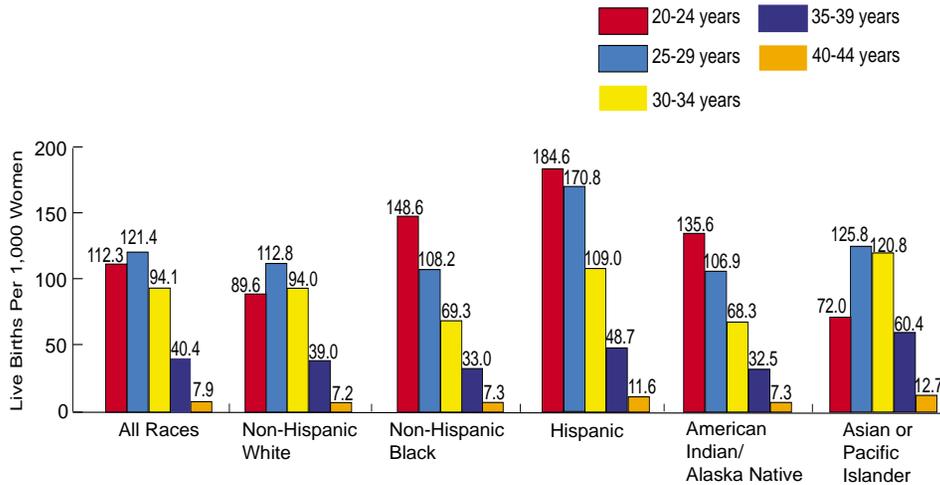
Childbearing peaked among White and Asian or Pacific Islander women in 2000 at 25-29 years, compared to 20-24 years among Hispanic, Black, and American Indian women. Fertility rates for Asian or Pacific Islander women remained high as these women entered their thirties.

Of the 4 million live births in 2000, 3.2 million were to White women. Though Hispanic and

Asian or Pacific Islander women had higher fertility rates, they had fewer births than White women, approximately 816,000 and 201,000, respectively. The number of live births made small but steady increases for each racial and ethnic group since 1970.

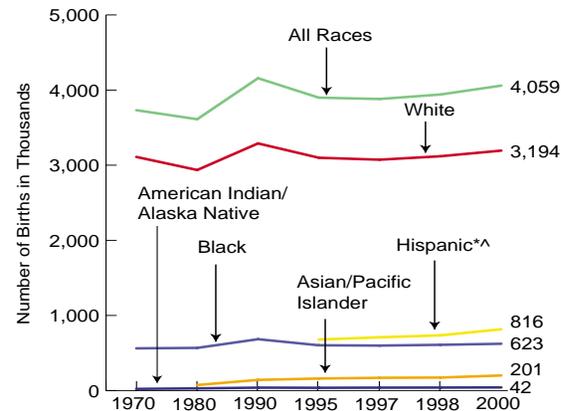
### Fertility Rates, by Age, Race and Hispanic Origin of Mother, 2000

Source (II.21): National Vital Statistics System



### Total Number of Live Births, by Race and Hispanic Origin, 1970-2000 (In Thousands)

Source (II.21): National Vital Statistics System



\*Due to changes in the number of states reporting on the Hispanic-origin item on the birth certificate prior to 1995, data before this time is not presented.

^Includes mothers of all races.



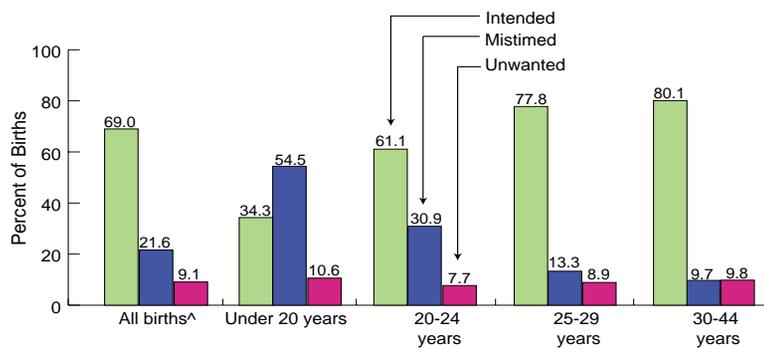
## UNINTENDED PREGNANCIES

Though the majority of births between 1990-1995 were intended, one in five was mistimed, occurring sooner than desired, while nearly one in ten was unwanted. Of all births to women aged 20 and younger, more than half (54.5 percent) were mistimed. Over three-quarters of women aged 25 and older had an intended birth.

Approximately 70 percent of births were intended among White and Hispanic women, compared to less than half (48.6 percent) of births among Black women. A greater proportion of births among Black women were mistimed or unwanted.

### Births in the Five Years Prior to the Interview to Women Aged 15-44 Years at Time of Interview, by Age and Wantedness Status at Conception, 1995

Source (II.22): National Survey of Family Growth

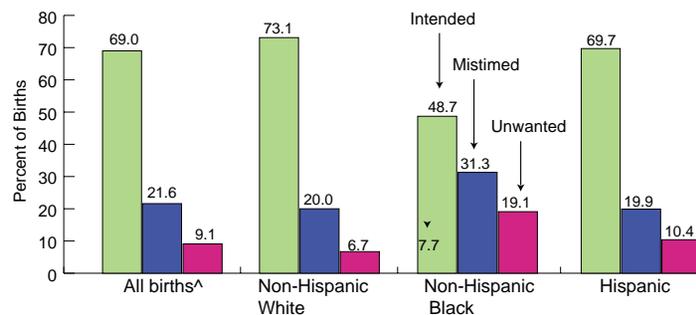


<sup>^</sup>Includes births to women of other race and origin groups not shown separately.

Note: Percents do not add to 100 because births with wantedness status reported as "don't know" are not shown separately.

### Births in the Five Years Prior to the Interview to Women Aged 15-44 Years at Time of Interview, by Race and Hispanic Origin and Wantedness Status at Conception, 1995

Source (II.22): National Survey of Family Growth



<sup>^</sup>Includes births to women of other race and origin groups not shown separately.

Note: Percents do not add to 100 because births with wantedness status reported as "don't know" are not shown separately.

## SEXUALLY TRANSMITTED DISEASES

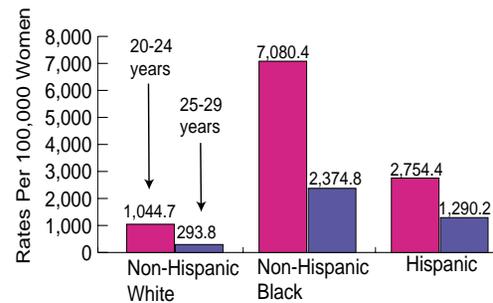
Rates of reportable sexually transmitted diseases (STDs) are particularly high among young women. In 1999, chlamydia was the most common infection, with 2,187 cases per 100,000 women aged 20-24, followed by gonorrhea, with 645 cases per 100,000 women aged 20-24. Women aged 20-24 had higher rates of chlamydia and gonorrhea than women aged 25-29. For all three reportable STDs, rates were much higher among Black women than among White and Hispanic women. While syphilis remained rela-

tively rare in 1999 among women in their twenties, infection rates for chlamydia and gonorrhea rose since 1996.

Although these conditions are treatable with antibiotics, STDs can have serious health consequences. Active infections can increase the likelihood of contracting HIV, and untreated STDs can lead to pelvic inflammatory disease, infertility, and adverse outcomes of pregnancy.

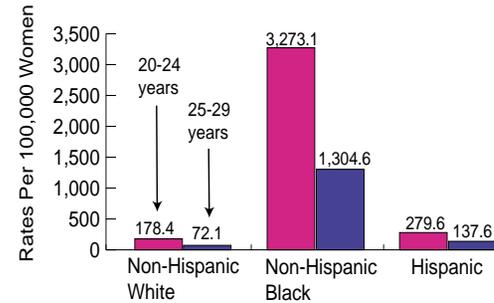
### Rates of Chlamydia Among Women, by Age and Race/Hispanic Origin, 1999

Source (II.23): Centers for Disease Control and Prevention



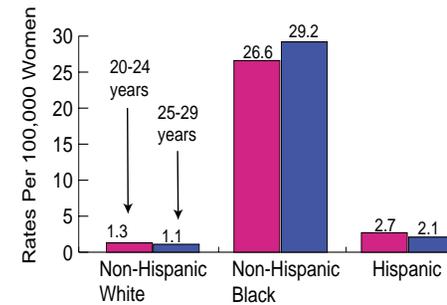
### Rates of Gonorrhea Among Women, by Age and Race/Hispanic Origin, 1999

Source (II.23): Centers for Disease Control and Prevention



### Rates of Primary and Secondary Syphilis Among Women, by Age and Race/Hispanic Origin, 1999

Source (II.23): Centers for Disease Control and Prevention,



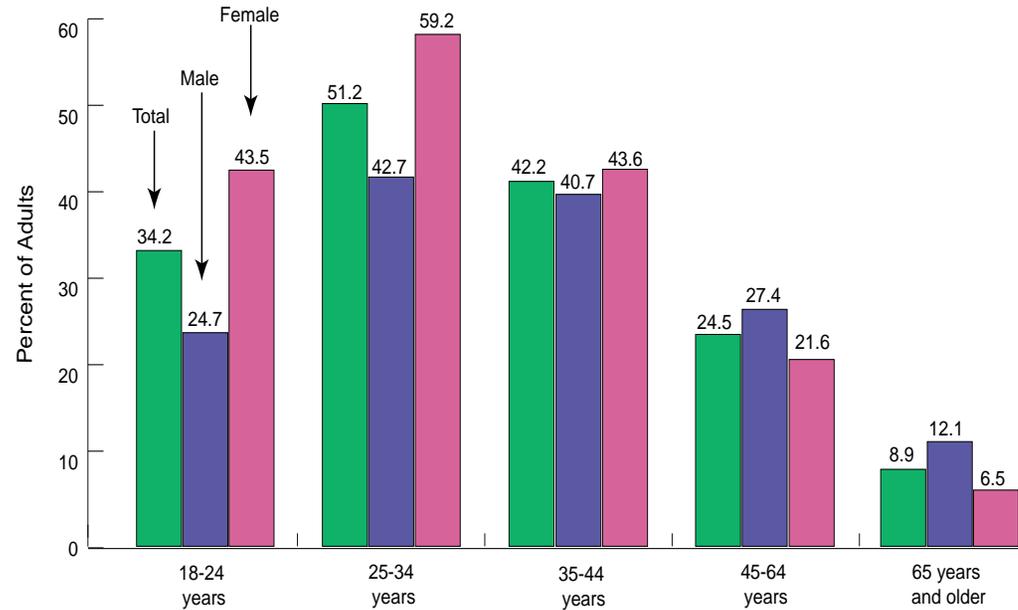
## HIV TESTING

The proportion of adults ever tested for HIV was fairly constant between 1997 and 2000, ranging between 30.2 percent and 32.3 percent. In 2000, young women were more likely to have been tested than older women. Approximately half of women under age 45 had been tested compared to 21.6 percent of women aged 45-64 and 6.5 percent of women aged 65 and older.

For adults aged 18-44, women were more likely than men to have ever been tested for HIV, but this trend was reversed for adults aged 45 and older, with men more likely than women to have ever been tested.

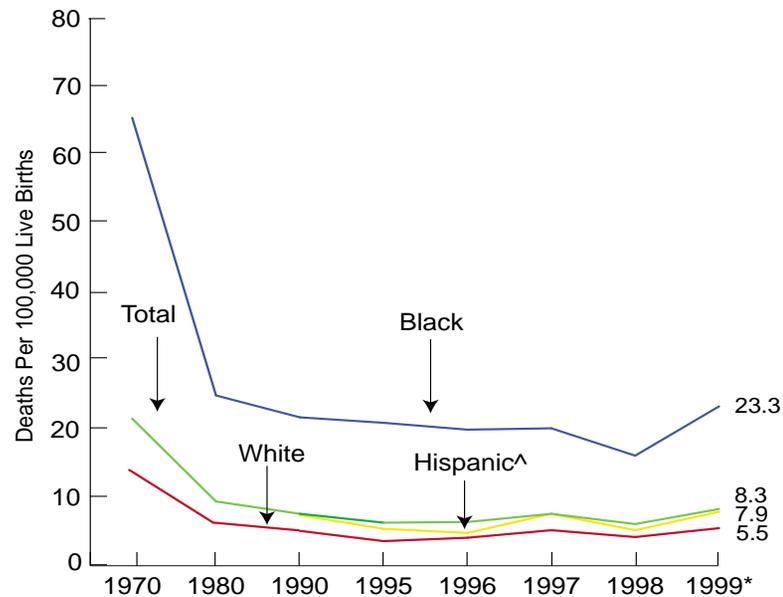
## Adults Aged 18 Years and Older Who Have Ever Been Tested for HIV, by Sex and Age, 2000

Source (II.24): National Health Interview Survey



## Age-Adjusted Maternal Mortality, by Race and Hispanic Origin, Selected Years 1970-1999

Source (II.1): National Vital Statistics System



Note: Rates are age adjusted to the 1970 distribution of live births by mother's age in the U.S.

\*Starting with 1999 data, changes have been made in the classification and coding of maternal deaths under ICD-10. The increase in the number of maternal deaths between 1998 and 1999 is due to changes associated with ICD-10.

<sup>^</sup>Data not available prior to 1990; excludes data from States lacking an Hispanic-origin item on their death and birth certificates.

## MATERNAL MORTALITY

During the past several decades, there was a dramatic decrease in maternal mortality. Between 1970 and 1980, maternal mortality decreased from 21.5 to 9.4 deaths per 100,000 live births, a 56 percent drop. However, from 1980-1998, the rate remained between 6 and 7 maternal deaths per 100,000 live births. In 1999, there were 391 maternal deaths related to complications of pregnancy, childbirth, and the postpartum period, a rate of 8.3 per 100,000 live births. Though an increase from the 1998 rate of 6.1, this difference is attributable to changes made in the classification and coding of maternal deaths starting with 1999 data.

In 1999, the maternal mortality rate for Black women (23.3 per 100,000 live births) was more than four times the rate for White women (5.5 per 100,000 live births) and three times the rate for Hispanic women (7.9 per 100,000 live births).

The risk of maternal death increases with age. In 1999, women aged 35 years and older had nearly three times the risk of death (23.0 per 100,000 live births) as women aged 25-29 (8.2 per 100,000 live births). Black women aged 35 years and older had the highest rate of maternal mortality of nearly 70 deaths per 100,000 live births.

## HEALTH SERVICES UTILIZATION

Availability and access to high quality health services directly affects the health of women, especially where need is confounded by poor health status, poverty, or lack of insurance. While nearly 87 percent of females of all ages were covered by some sort of health insurance during the year in 2000, 13 percent of females, or 18.5 million people, lacked a source of health insurance for the entire year. Lack of health insurance is likely to affect the receipt of timely and comprehensive care.

The following section presents data on women's health services utilization, including indicators on usual source of care, health care financing and expenditures, and use of preventive, dental, hospital, mental health, and nursing home services.



## HEALTH INSURANCE COVERAGE

People with health insurance are more likely to have a regular source of medical care and to use preventive care, while people without health insurance are more likely to have unmet medical needs and to use hospital emergency rooms for routine care.<sup>1</sup>

Nearly 80 percent of White women had private insurance coverage in 2000, compared to less

than half of Black and Hispanic women. More Black women and Hispanic women had public coverage, including Medicaid and Medicare, than White women. Of all racial and ethnic groups, Hispanic women were most likely to be uninsured.

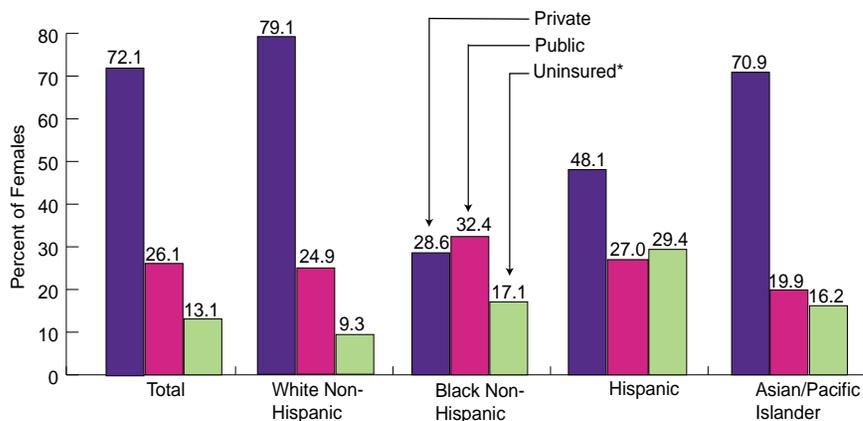
Among adults aged 18-44 years, women were less likely to be uninsured than men, with the greatest difference between men and women aged 21-24. This is likely to be attributable to the greater proportion of women of childbearing age

enrolled in Medicaid. Among persons aged 55-64 years, however, women were more likely than men to be uninsured.

<sup>1</sup>Bloom B, Simpson G, Cohen RA, Parsons PE. Access to health care. Part 2: Working-age adults. Vital and Health Statistics 10(197); 1997.

### Health Insurance Coverage of Females (All Ages), by Type of Coverage and Race and Hispanic Origin, 2000

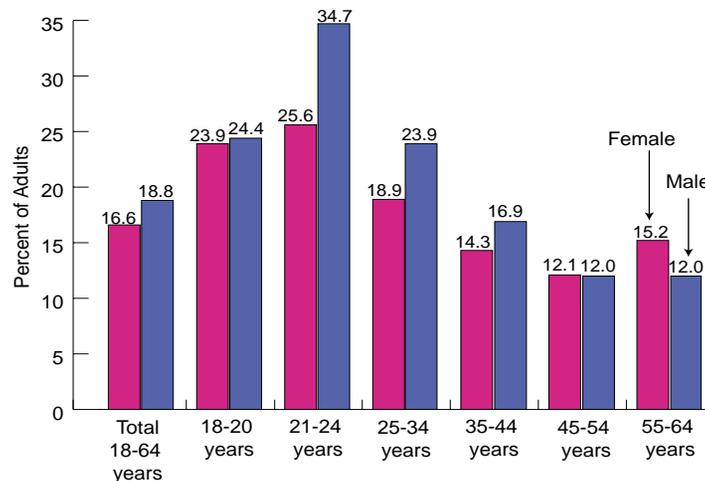
Source (III.1): U.S. Census Bureau



Note: Percents may add to more than 100 because people may have more than one source of coverage.  
\*Includes people without health insurance for the entire year.

### Adults Aged 18-64 Years Without Health Insurance, by Age and Sex, 2000

Source (III.2): Employee Benefit Research Institute using data from the Current Population Survey



## USUAL SOURCE OF CARE

A usual source of care has been positively associated with receipt of preventive care,<sup>1,2</sup> access to care,<sup>3</sup> continuity of care, decreased hospitalization, and lower health care costs.<sup>4</sup> In 2000, 90 percent of women reported having a source of care where they usually go for medical attention. Young women aged 18-29 were the least likely to have a usual source of care (84 percent). The proportion of women with a usual source of care increased with age, with nearly all (98 percent) of women aged 85 and older having a usual source of care.

Though most women across racial and ethnic groups had an office-based usual source of care, White women were more likely to have office-based care than non-White women in 2000. Black women were more likely to use a hospital outpatient department or emergency room for their usual care than Hispanic or White women or women of other races/ethnicities. One-fifth of Hispanic women and 15.3 percent of women of other races/ethnicities had no usual source of care.

<sup>1</sup>Ettner SL: The relationship between continuity of care and the health behaviors of patients: Does having a usual physician make a difference? *Medical Care* 37(6): 547-55, 1999.

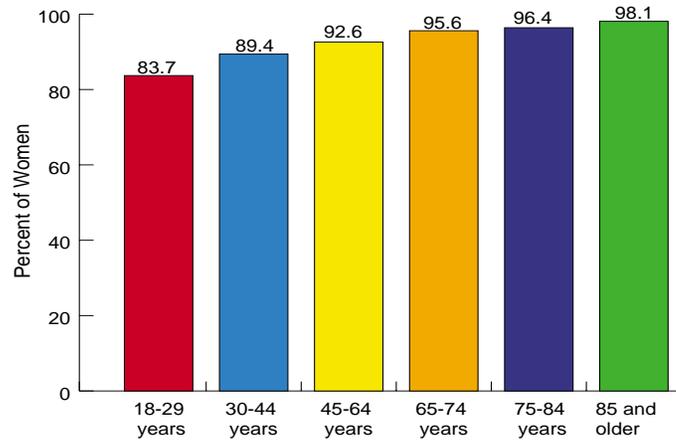
<sup>2</sup>Ettner SL: The timing of preventive services for women and children: The effect of having a usual source of care. *American Journal of Public Health* 86(12): 1748-54, 1996.

<sup>3</sup>Sox CM, Swartz K, Burstin HR, Brennan TA: Insurance or a regular physician: Which is the most powerful predictor of health care? *American Journal of Public Health* 88(3): 364-70, 1998.

<sup>4</sup>Weiss LJ, Blustein J: Faithful patients: The effect of long-term physician-patient relationships on the costs and use of health care by older Americans. *American Journal of Public Health* 86(12): 1742-7, 1996.

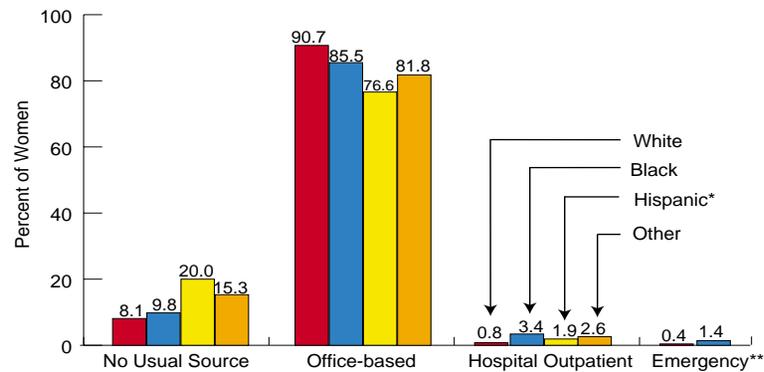
### Women with a Usual Source of Care, by Age, 2000

Source (III.3): National Health Interview Survey



### Women's Usual Source of Care, by Race and Hispanic Origin, 2000

Source (III.3): National Health Interview Survey



\*All Persons of Hispanic ethnicity are included in this group.

\*\* Data for Hispanic and other groups for this category are too small to be reliable and, therefore, are not reported.



## PREVENTIVE CARE

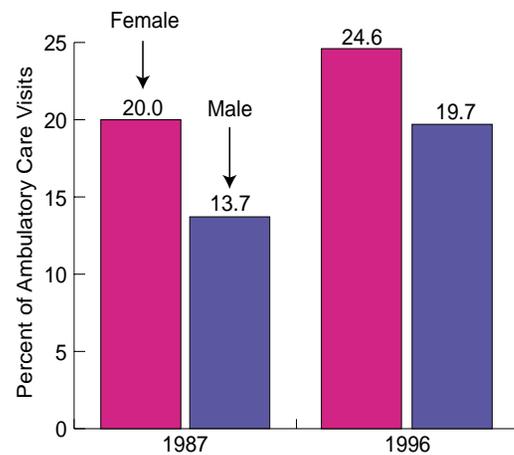
Prevention of health problems and promotion of optimal physical and emotional functioning are important outcomes of patients' interactions with the health care system. A greater proportion of women's visits to physicians were for preventive services compared to those of men in 1996 (24.6 percent versus 19.7 percent), though the proportion of services devoted to preventive care increased for both sexes since 1987.

Of the more than 458,000 visits to physicians or hospital outpatient departments made by women aged 15 years and older on average in 1997-98, approximately 94,000 visits, or nearly 21 percent, were made for preventive care or other non-illness reasons. A greater proportion of visits by women under age 45 were for the purpose of obtaining preventive care than for women aged 45 and older. Visits by older women were more likely to be dedicated to care of a chronic condition than were

visits by younger women. Use of preventive services did not differ between Black and White women.

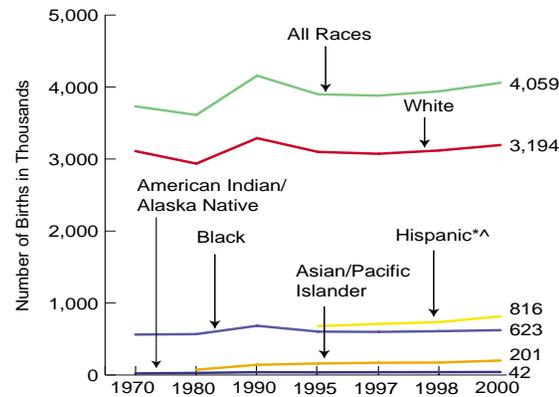
### Ambulatory Care Visits for Preventive Services, by Sex, 1987 and 1996

Source (III.4): Medical Expenditure Panel Survey



### Total Number of Live Births, by Race and Hispanic Origin, 1970-2000 (In Thousands)

Source (II.21): National Vital Statistics System



\*Due to changes in the number of states reporting on the Hispanic-origin item on the birth certificate prior to 1995, data before this time is not presented.

^Includes mothers of all races.

### PREVENTIVE CARE (Cont'd)

The U.S. Preventive Services Task Force recommends that women who are or have been sexually active have a Pap smear, a screening test for cervical cancer, at least once every three years. The Task Force also recommends that all women aged 40 and older have a screening mammogram every one to two years to detect breast cancer. In 1998, the majority of women

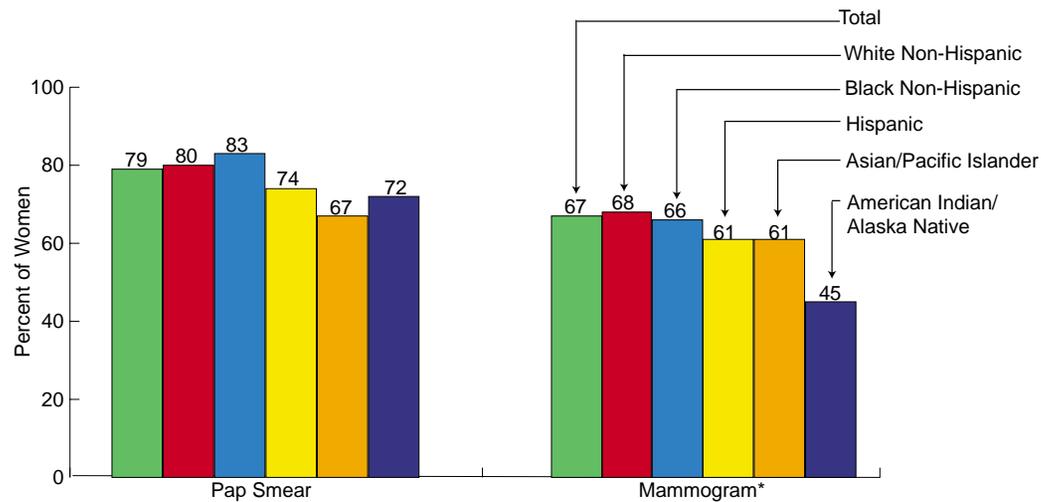
of all racial and ethnic groups had received a Pap smear within the past three years and a mammogram within the past two years. Black non-Hispanic women were the most likely (83 percent) and Asian/Pacific Islander women were the least likely (67 percent) to have reported receiving a Pap smear in the past three years. Among women aged 40 and over, White non-Hispanic women were most likely (68 percent)

to have had a mammogram in the past two years, while American Indian/Native Alaska women were the least likely (45 percent) to have received this preventive service.

Receipt of Pap smears and mammograms is also associated with income and education levels. In 1998, 73 percent of women aged 40 and older with middle or high incomes had received a mammogram, as compared to 54 percent of near poor women and 50 percent of poor women. Similar trends were seen for receipt of Pap smears, with 83 percent of women with middle or high incomes, 73 percent of near poor women, and 69 percent of poor women having had this test in the past three years. Women with at least some college were more likely to have received both mammograms and Pap smears than female high school graduates, followed by women with less than a high school education.

### Women's Self-Report of Receipt of Pap Smears (In the Past Three Years) and Mammograms (In Past Two Years), by Race and Hispanic Origin, 1998

Source (III.6): National Health Interview Survey



\*For women aged 40 and older.

## DENTAL CARE

While the majority (67.2 percent) of women visited a dentist during 2000, approximately one-third had not visited a dentist for a year or more. Hispanic and Black women (41.1 percent and 40.2 percent, respectively) were more likely than White women and women of other race/ethnicity (29.5 percent and 33.2 percent respectively) to have gone without dental care for a year or more. Less than 1 percent of

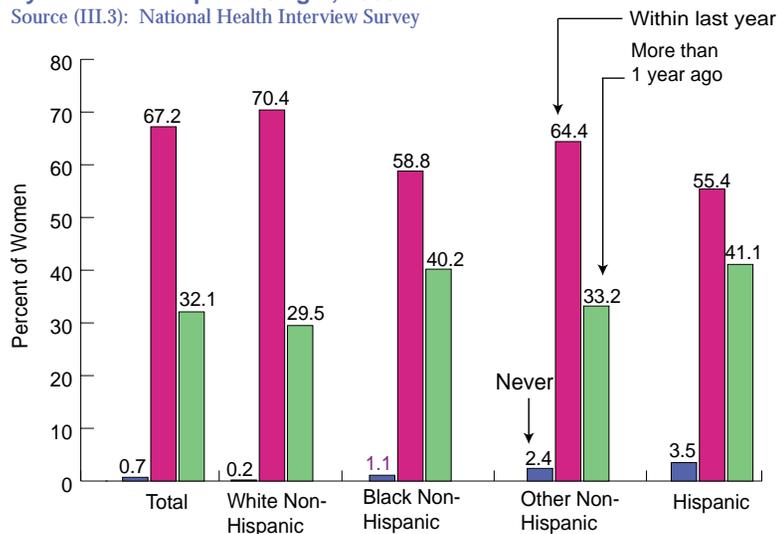
women had never seen or talked to a dentist, though Hispanic women were more likely than women of all other race and ethnic groups never to have seen a dentist.

Women with family incomes of at least \$20,000 were more likely to have seen or talked to a dentist in the last year (73.3 percent) than were women with lower family incomes (48.0 percent). Among lower-income women (less than \$20,000) 50.5 percent had gone a year or

more since they last saw a dentist, 48 percent saw a dentist in the last year, and 1.5 percent reported never having seen a dentist.

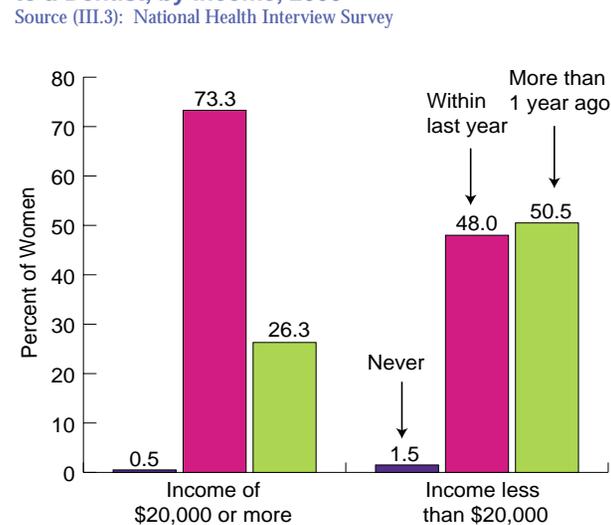
### Women's Report of Time Since Last Seen or Talked to a Dentist, by Race and Hispanic Origin, 2000

Source (III.3): National Health Interview Survey



### Women's Report of Time Since Last Seen or Talked to a Dentist, by Income, 2000

Source (III.3): National Health Interview Survey





## HOSPITALIZATIONS

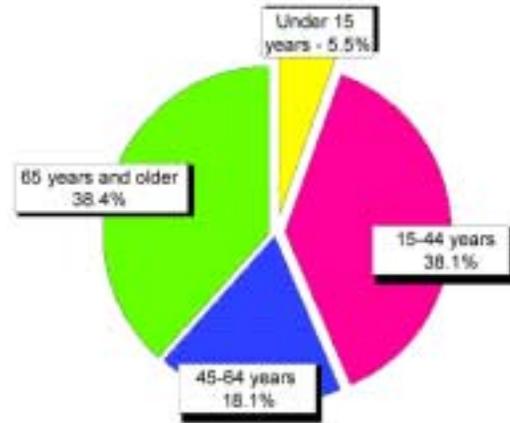
Women represented 60 percent of all hospital discharges in 1999. Most hospitalizations occurred among persons aged 15-44 and 65 years and older. The high percentage of hospitalizations for women aged 15-44 years corresponds to the high rate of childbirth during these ages; delivery is the most common hospital discharge diagnosis, representing 270.4 hospitalizations per 10,000 women in 1999.

Women were far more likely than men to be hospitalized for diseases of the genitourinary system, diseases of the digestive system, and cancer, and were somewhat more likely than men to be hospitalized for diseases of the respiratory system; diseases of the musculoskeletal system and connective tissue; endocrine, nutritional and metabolic diseases; and injuries and poisonings. Within these groupings, women were more fre-

quently hospitalized than men for conditions such as asthma, osteoarthritis, diabetes mellitus, fractures, and benign cancer. Though men were more likely to be hospitalized for diseases of the circulatory system, such as heart disease, women were more frequently hospitalized for congestive heart failure and stroke.

### Distribution of Discharges from Non-Federal Short-Stay Hospitals for Females, by Age, 1999

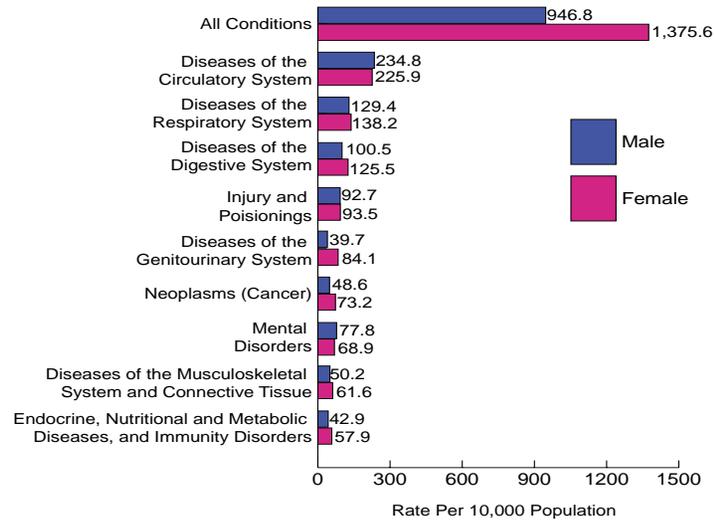
Source (III.7): National Hospital Discharge Survey



Note: Discharges of inpatients from non-Federal hospitals. Excludes newborn infants.

### Rate of Discharges from Non-Federal Short-Stay Hospitals, by Sex and First-Listed Diagnosis, 1999

Source (III.7): National Hospital Discharge Survey



## MENTAL HEALTH CARE UTILIZATION

As highlighted by the Surgeon General's report on mental health,<sup>1</sup> few adults who experience mental health disorders obtain care. Data from the early 1980s and early 1990s reveal that approximately 28 percent of the U.S. population has a diagnosable mental health or addictive disorder. Of these, however, fewer than one-third receive mental health services in a given year. Approximately 6 percent of the adult population use specialty mental health care, 5 percent use general medical and/or human services providers, and 3-4 percent receive services from other human service pro-

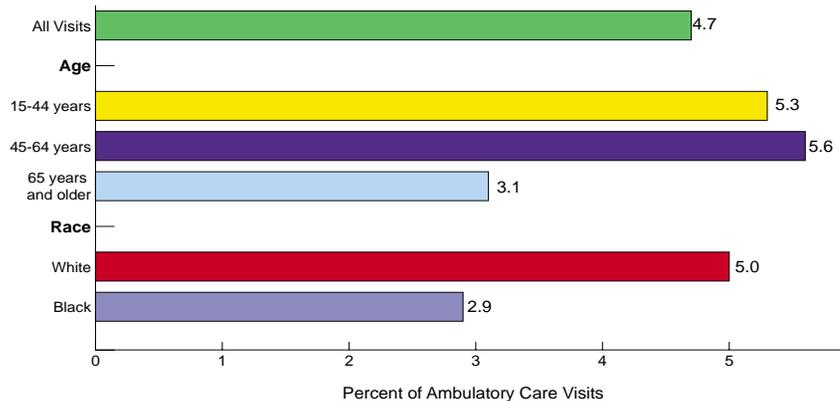
fessionals or self-help groups. African-Americans and Hispanics are far less likely to use mental health services than Whites. Limited data also reveal low rates of service use for Alaskan Natives and American Indians and Asian Americans and Pacific Islanders.<sup>2</sup>

Though limited data are available to describe women's use of mental health care, it is apparent that depression significantly affects women. Approximately 5 percent of women's ambulatory care visits on average in 1997-98 included mentions of drugs to treat depression. Mentions of antidepressants were more common for women under age 65 and nearly twice as common for White than Black women. In 1999, women were also more likely than men to

be hospitalized for depression, with 410,000 discharges for women as compared to 287,000 discharges for men in 1999. Hospital data are likely to understate the use of mental health services since many individuals affected by mental disorders may not use inpatient mental health care.

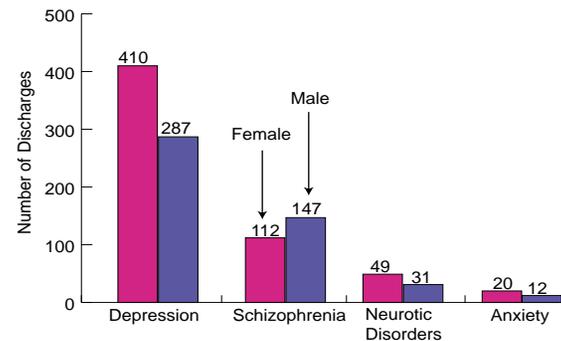
### Ambulatory Care Visits Mentioning Antidepressants for Women Aged 15 Years and Older, by Age and Race, Average Annual 1997-1998

Source (III.8): National Health Care Survey



### Number of First-Listed Diagnoses for Discharges, 1999 (In Thousands)

Source (III.7): National Hospital Discharge Survey



Note: Discharges of inpatients from non-Federal hospitals.

<sup>1</sup>U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

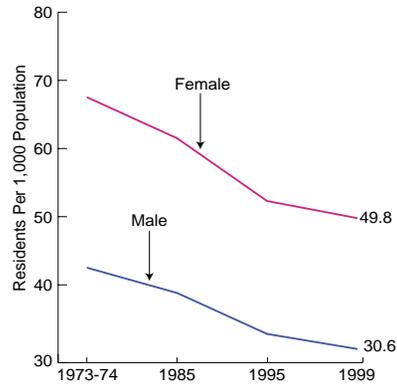
<sup>2</sup>U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999.

## NURSING HOME CARE UTILIZATION

Between 1973-74 and 1999, the proportion of persons aged 65 and older residing in nursing homes fell by 26 percent. Women residents consistently outnumbered men over this time period; in 1999, nearly 75 percent of nursing home residents were women.

Data from the National Nursing Home Survey show that, in 1999, approximately 40 percent of nursing home residents were women aged 85 and older. Nearly 21.1 percent of women aged 85 and older were in nursing homes, compared to 1.1 percent of women aged 65-74 years and 5.1 percent of women 75-84 years. While the number of women aged 65 and older in nursing homes increased between 1973-74 and 1999, the rate of women aged 65 and older in nursing homes fell, implying more elderly women living in the community.

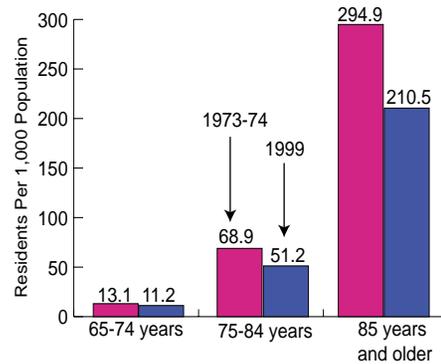
**Nursing Home Residents Aged 65 Years and Older, Age Adjusted, by Sex, for Selected Years 1973-74 to 1999**  
Source (III.9): National Nursing Home Survey



Note: Age adjusted to the year 2000 population standard

**Female Nursing Home Residents, by Age, 1973-74 and 1999**

Source (III.9): National Nursing Home Survey



## HEALTH CARE EXPENDITURES

While most health care expenses were paid by some type of private or public insurance in 1997, 20.1 percent of women's health care expenses were paid out of pocket. Women were slightly more likely than men to pay their health care expenses out-of-pocket, through private insurance, or through Medicaid. Women were slightly

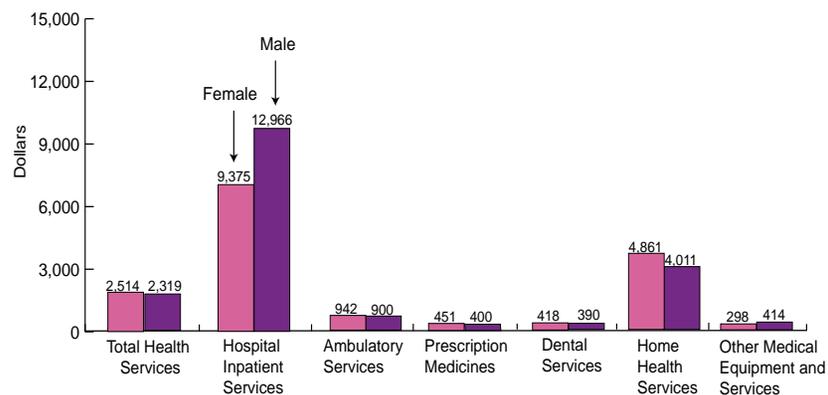
less likely than men to pay their expenses through Medicare, other public programs, and other sources.

Though the mean annual expense for health services was \$2,514 for women, the mean amount for hospital inpatient and home health services was much higher at \$9,375 and \$4,861, respectively. The mean annual expense for prescriptions, dental services, and other medical equip-

ment and services was under \$500 for each of these categories. Though men had a slightly lower mean annual expense for health services, they had a much higher mean amount than women for hospital inpatient services (\$12,966 for males as compared to \$9,375 for females) and lower expenses for outpatient care such as ambulatory services, prescriptions, dental care, and home health care.

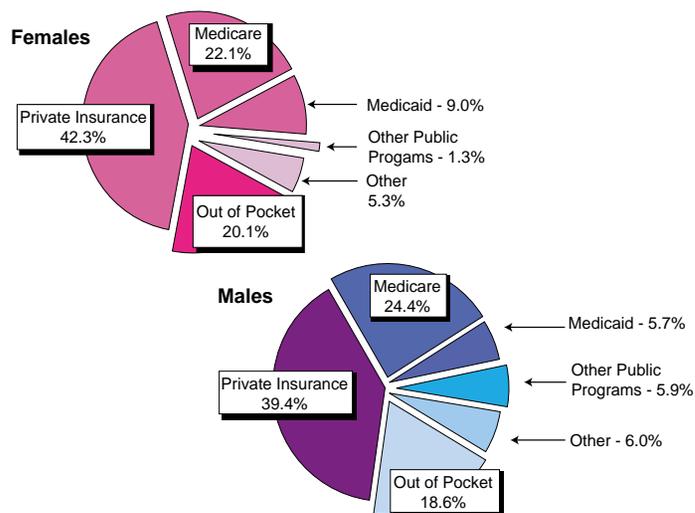
### Annual Mean Health Care Expenses for Persons With An Expense, by Sex and Category of Service, 1997

Source (III.10): Medical Expenditure Panel Survey



### Distribution of Total Health Care Expenses, by Source of Payment and Sex, 1997

Source (III.10): Medical Expenditure Panel Survey



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