HEALTH SERVICES UTILIZATION

Availability of and access to quality health care services directly affects all aspects of women's health. For women who have poor health status, disabilities, poverty, lack of insurance, and limited access to a range of health services, preventive treatment and rehabilitation can be critical in preventing disease and improving quality of life.

This section presents data on women's health services utilization, including data on women's insurance coverage, usual source of care, satisfaction with care, and use of various services, such as preventive care, HIV testing, hospitalization, and mental health services. A new addition to this section describes the use of alternative and complementary medicine among women.

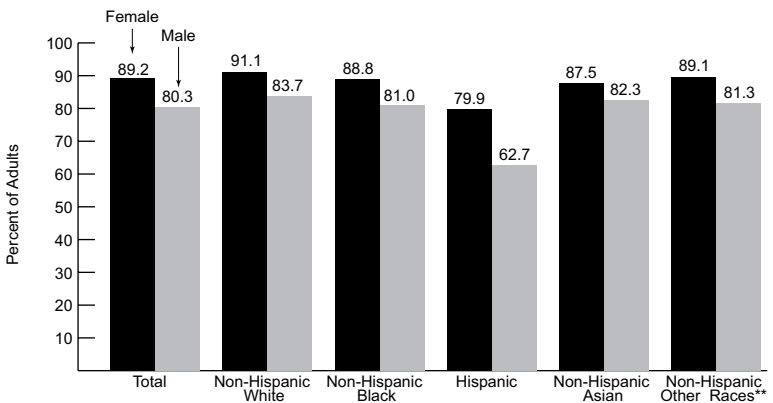
USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency department, or not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3] In 2007, 89.2 percent of women reported having a usual source of care. Within every racial and ethnic group, women were more likely than men to have a usual source of care. Non-Hispanic White women were most likely to report a usual source of care (91.1 percent), followed by non-Hispanic women of other races not specified (89.1 percent) and non-Hispanic Black women (88.8 percent). Among both women and men, Hispanics were least likely to report a usual source of care (79.9 and 62.7 percent, respectively).

In 2007, the percentage of women with a usual source of care varied by geographic region and poverty level. Among women with household incomes of 200 percent or more of the poverty level, there was little variation in having a usual source of care by geographic region. Among women with lower incomes, however, having a usual source of care varied noticeably by geographic region. Among women with incomes of less than 200 percent of poverty, those in the South and West were least likely to have a usual source of care (77.0 and 81.7 percent, respectively), while those in the Northeast were most likely to have a usual source of care (90.8 percent).

Adults Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity and Sex, 2007*

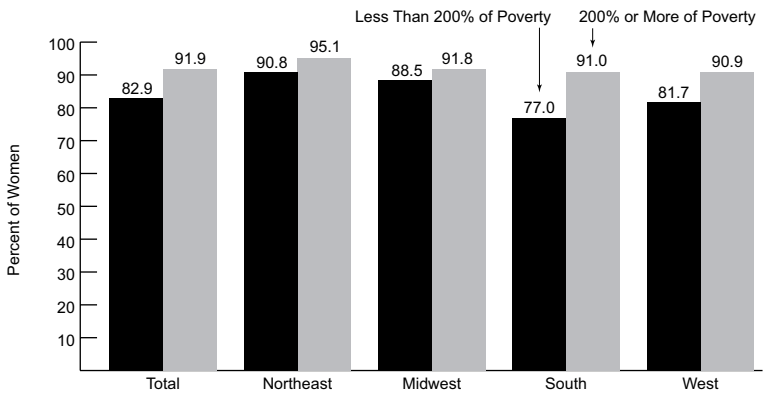
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Rates reported are not age-adjusted. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.

Women Aged 18 and Older with a Usual Source of Care, by Geographic Region and Poverty Status,* 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Poverty level, defined by the U.S. Census Bureau, was $21,027 for a family of four in 2007. Rates reported are not age-adjusted.

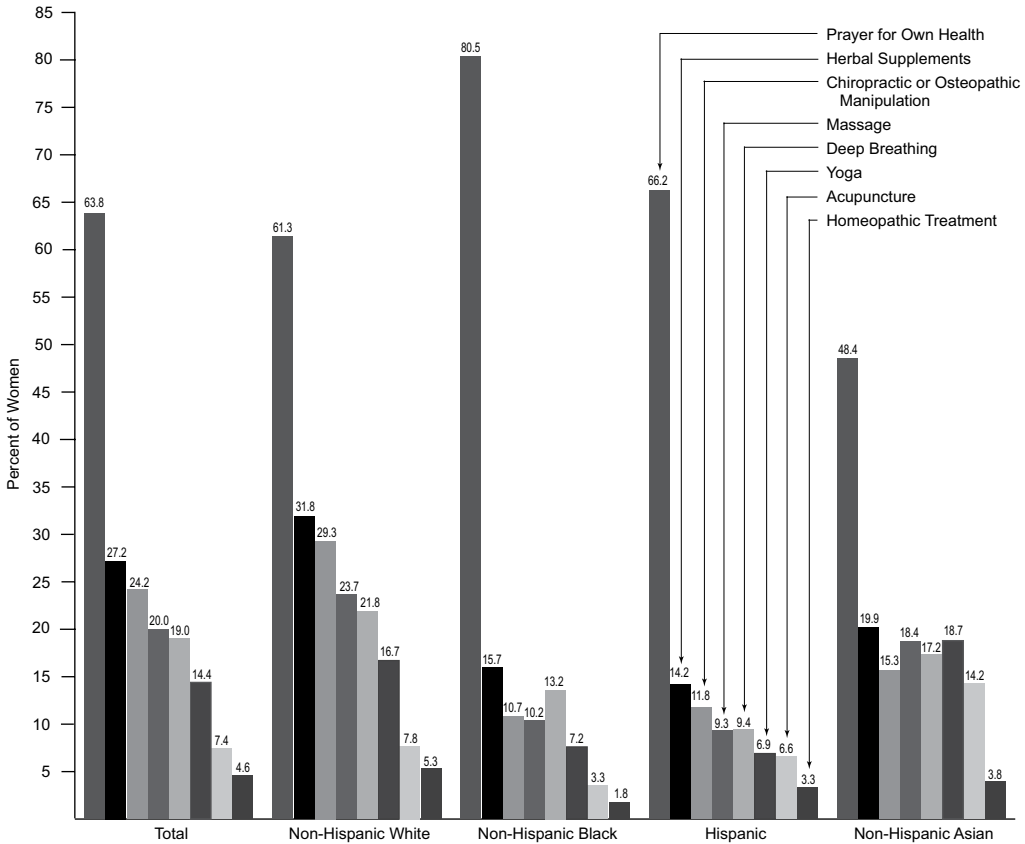
COMPLEMENTARY AND ALTERNATIVE MEDICINE

Complementary and alternative medicine (CAM) describes a wide range of health care practices, therapies, and products that are not considered to be part of conventional Western medicine. Complementary interventions are used together with conventional treatments, while alternative interventions are used in place of those treatments. Both can be used to improve health and well-being, to relieve symptoms associated with illness, and to relieve side effects from conventional treatments.

In 2007, 63.8 percent of women reported having ever prayed for their own health. The second most commonly reported CAM therapy was the use of herbal supplements (27.2 percent), followed by chiropractic or osteopathic manipulation (24.2 percent) and massage (20.0 percent). Use of CAM therapies varied by race and ethnicity: non-Hispanic Black women were more likely than women of other races to have ever prayed for their own health (80.5 percent), while non-Hispanic White women were the most likely to utilize massage (23.7 percent), deep breathing (21.8 percent), and homeopathic treatment (5.3 percent). Non-Hispanic Asian women were most likely to have used yoga (18.7 percent) and acupuncture (14.2 percent) as a complementary or alternative treatment.

Selected Complementary and Alternative Medicines Ever Used by Women Aged 18 and Older, by Race/Ethnicity* and Treatment Type, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



The sample of Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other and unspecified races was too small to produce reliable results. Data are not age-adjusted.

HEALTH INSURANCE

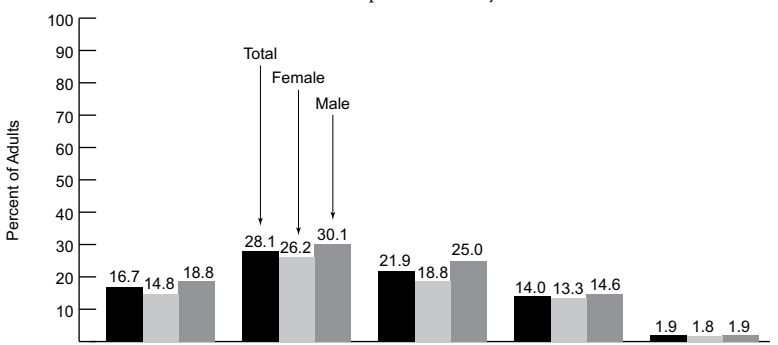
People who are uninsured are less likely than those with insurance to seek health care, which can result in poor health outcomes and higher health care costs. In 2007, 37.5 million adults (16.7 percent) were uninsured. Adults aged 18-64 accounted for 36.8 million of those uninsured, representing 19.6 percent of that population (data not shown).[4] The percentage of people who are uninsured varies considerably across a number of categories, including age, sex, race and ethnicity, income, and education.

Among adults in 2007, those aged 18–24 years were most likely to lack health insurance. Men were more likely than women to be uninsured in every age group. The highest rate of uninsurance occurred among 18- to 24-year-old men (30.1 percent), which was substantially higher than the percentage for women of the same age group (26.2 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest percentage of uninsured occurred among women and men aged 45–64 (13.3 and 14.6 percent, respectively); the sex disparity in this age group was less pronounced than in the younger age groups.

Among women aged 18–64 in 2007, 71.5 percent had private insurance, 15.0 percent had public insurance, and 17.6 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (78.9 percent), followed by Asian/Pacific Islander women (72.6 percent). American Indian/Alaska Native females had the highest rate of public insurance coverage (23.9 percent) followed closely by non-Hispanic Black women (23.3 percent). Hispanic females had the highest rate of uninsurance (36.6 percent), followed by American Indian/Alaska Native women (30.7 percent). [Respondents were able to report more than one type of coverage.]

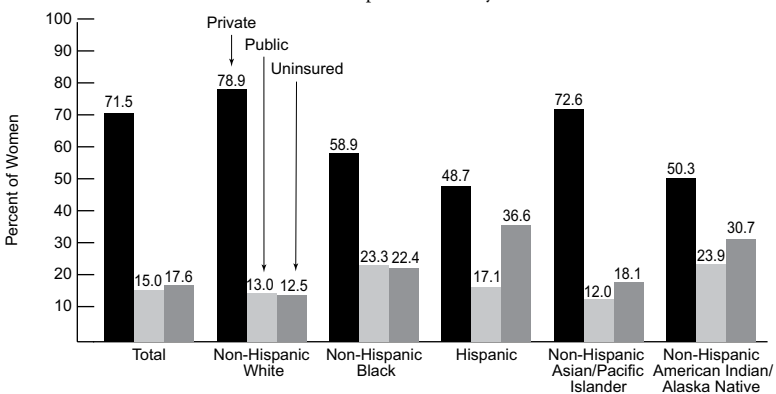
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2007

Source I.4: U.S. Census Bureau, Current Population Survey



Health Insurance Coverage of Women Aged 18–64, by Race/Ethnicity and Type of Coverage,* 2007

Source I.4: U.S. Census Bureau, Current Population Survey



Percentages may equal more than 100 because it was possible to report more than one type of coverage.

MEDICARE AND MEDICAID

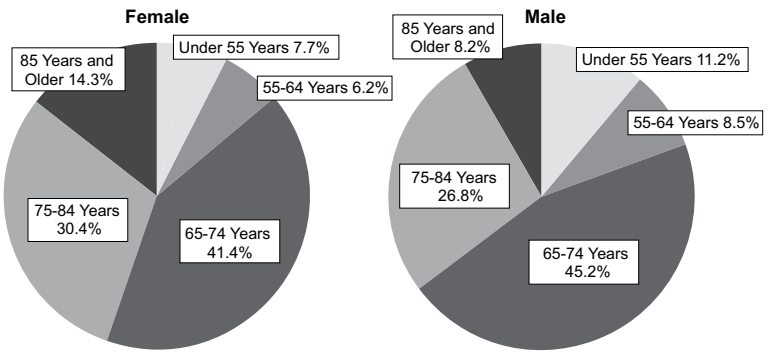
Medicare is the Nation's health insurance program for people aged 65 years and older, some people under age 65 with disabilities, and those with end-stage renal disease (permanent kidney failure). Medicare has four components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician services, outpatient services, and durable medical equipment; Part C (Medicare Advantage Plans) allows beneficiaries to purchase additional insurance coverage through private insurers; and Part D allows coverage for prescription drugs through private insurers.

In 2007, 60.2 percent of Medicare's 44.3 million enrollees were female. Among both women and men, those in older age groups accounted for a greater proportion of overall enrollment; however, men were more likely to have greater representation than women in the younger age groups. For instance, 8.5 percent of male enrollees were aged 55–64 years, compared to 6.2 percent of female enrollees. Similarly, adults aged 65–74 years accounted for 45.2 percent of male enrollees, compared to 41.4 percent of female enrollees. In contrast, adults aged 75 years and older accounted for 44.7 percent of female enrollees, compared to 35.0 percent of male enrollees.

Medicaid, jointly funded by Federal and State governments, provides coverage for low-income people and people with disabilities. In 2006, Medicaid covered 59.4 million people including children; the aged, blind, and disabled; and adults who are eligible for cash assistance programs. Adults aged 19 and older accounted for nearly half of Medicaid enrollees (29.4 million), and women accounted for 69.4 percent of adult enrollees. Women accounted for a greater proportion of adult Medicaid enrollees than men in every age group, most noticeably among 21- to 44-year-olds and those aged 85 years and older (74.3 and 80.4 percent, respectively).

Medicare Enrollees,* by Sex and Age, 2007

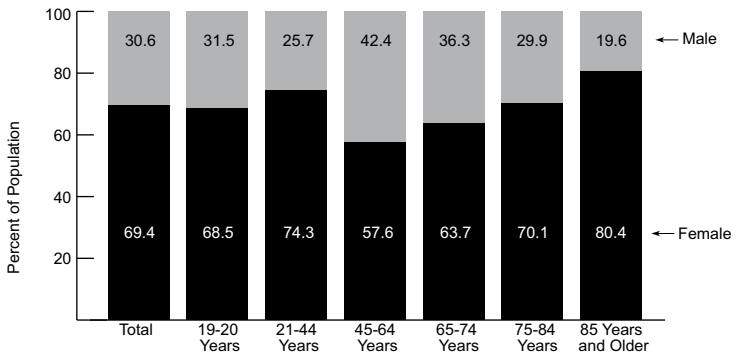
Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2007.

Adult Medicaid Enrollees Aged 19 and Older, by Age and Sex, 2007

Source III.1: Centers for Medicare and Medicaid Services



PREVENTIVE CARE

Preventive health care, including counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2006, females of all ages made 533 million physician office visits. Of these visits, 21.5 percent were for preventive care, including prenatal care, health screening, and insurance examinations (data not shown).[5]

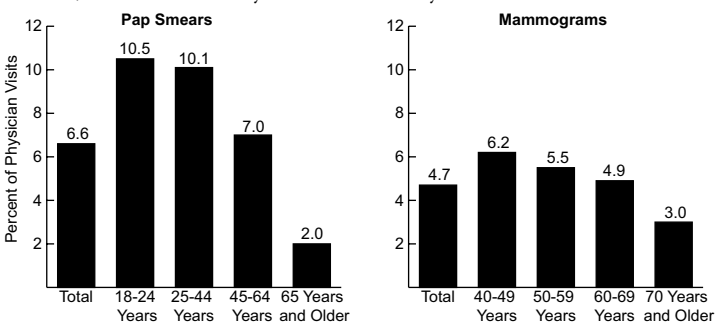
Routine Pap smears, which detect the early signs of cervical cancer, are recommended at least every 3 years beginning within 3 years of initiation of sexual activity, or by age 21.[6] In 2006, 6.6 percent of physician office visits made by women aged 18 and older included a Pap smear. This rate was higher among younger women and decreased with age, most likely due to higher rates of physician office visits among older women for non-preventive care. Among women aged 18–24 years, 10.5 percent of physician visits included a Pap smear, compared to 7.0 percent of visits made by women aged 45–64 years and 2.0 percent of visits among those aged 65 years and older.

Among women aged 40 and older, 4.7 percent of physician visits included a mammogram, which is recommended every 1–2 years to screen for breast cancer among this age group.[6] The rate of office visits including a mammogram was highest among the younger age groups. Among women aged 40–49 years, 6.2 percent of visits included a mammogram, compared to 3.0 percent of visits made by women aged 70 years and older.

High cholesterol is a risk factor for heart disease. The Healthy People 2010 goal is to increase the percentage of adults aged 20 and over who receive a cholesterol screening at least every 5 years to 80 percent.[7] In 2005–2006, 72.1 percent of women aged 20 years and older had received a cholesterol test within the previous 5 years. Non-Hispanic White and non-Hispanic Black women were more likely to have had the test (75.7 and 71.3 percent, respectively), compared to Hispanic women and non-Hispanic women of other races (53.5 and 64.7 percent, respectively).

Physician Office Visits Involving Pap Smears* and Mammograms,** by Selected Age Group, 2006†

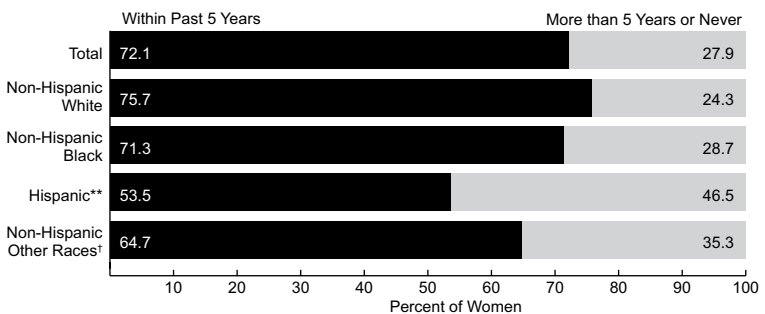
Source II.10: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Among women aged 18 and older. **Among women aged 40 and older. †Results should be interpreted with caution; older women visit physician's offices more frequently for non-preventive care.

Receipt of Cholesterol Screening Among Women Aged 20 and Older, by Race/Ethnicity, 2005–2006*

Source I.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Estimates are not age-adjusted. **Estimates for Hispanics should be interpreted with caution; they may not be representative of the entire Hispanic population.†Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of other races.

VACCINATION

Vaccination prevents the spread of infectious diseases. Vaccination for influenza is recommended for young children 6 months through 18 years of age, adults aged 50 years and older, pregnant women or women who will be pregnant during flu season, persons with certain chronic medical conditions, persons in long-term care facilities, and health care workers and other persons in close contact with those at high risk.[8] In 2007, 44.8 percent of women aged 55–64 years and 66.3 percent of women aged 65 years and older reported receiving a flu vaccine in the past year; this varied, however, by race and ethnicity. Non-Hispanic White women were more likely than women of other races and ethnicities to have received the flu vaccine: 47.0 percent of 55- to 64-year-olds and 68.4 percent of those aged 65 years and older did so. Fewer than 57 percent of non-Hispanic Black and Hispanic women aged 65 years and older received the flu vaccine.

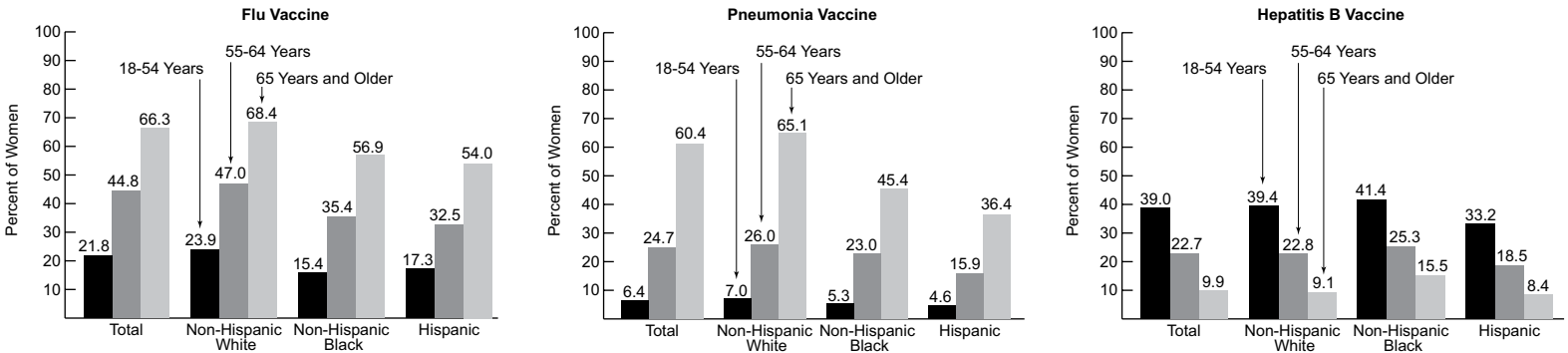
Pneumonia (pneumococcal) vaccine is recommended for adults aged 65 years and older and for people with certain health conditions. In 2007, 60.4 percent of women aged 65 and older reported ever receiving the vaccine. In this age group, 65.1 percent of non-Hispanic White women had ever received the pneumonia vaccine, compared to 45.4 percent of non-Hispanic Black women and 36.4 percent of Hispanic women.

Hepatitis B vaccine is recommended to reduce the spread of hepatitis B, which may result in cirrhosis of the liver, liver cancer, liver failure, and even death.[9] Hepatitis B vaccination also varied by race and ethnicity, as well as age. Younger women were most likely to have received at least one of the three recommended doses, and non-Hispanic White and non-Hispanic Black women in every age group were more likely than Hispanic women to have received the vaccine.

Genital human papillomavirus (HPV) can cause cervical cancer and other diseases in women. In 2006, the HPV vaccine was recommended for adolescent females and young women aged 9–26 years.[10] In 2006–2007, 10 percent of women aged 18–26 had been vaccinated for HPV (data not shown).[11]

Receipt of Selected Vaccinations* Among Women Aged 18 and Older, by Race/Ethnicity** and Selected Age Group, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Having received the flu vaccine in the past 12 months; having ever received the pneumonia vaccine; and having ever received at least one dose of the three-dose hepatitis B vaccine. **Sample of Asian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of all other and unspecified races was too small to produce reliable results. Totals include all races/ethnicities.

HEALTH CARE EXPENDITURES

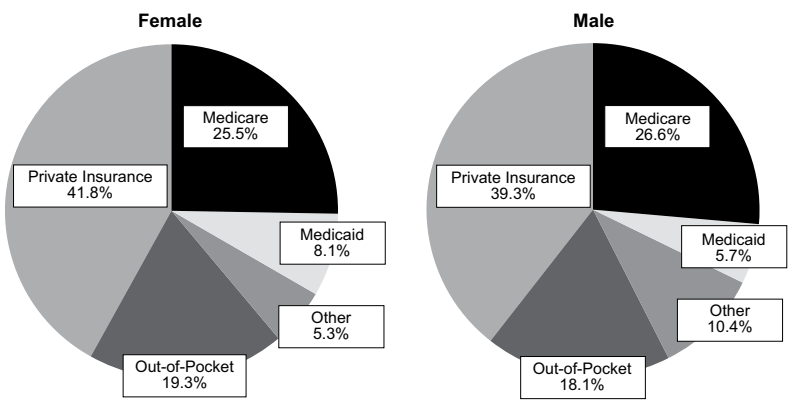
In 2006, the majority of health care expenses of both women and men were covered by public or private health insurance. Among women, one-third of expenses were covered by either Medicare or Medicaid, while 41.8 percent of expenses were covered by private insurance. Although the percentage of expenditures paid through private insurance was similar for both sexes, health care costs of women were more likely than those of men to be paid by Medicaid (8.1 versus 5.7 percent, respectively).

In 2006, 90.5 percent of women had at least one health care expenditure, compared to 77.9 percent of men (data not shown). Among those who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was higher for women ($5,219) than for men ($4,546). However, men's average expenditures exceeded women's for hospital inpatient services ($17,531 versus $13,104, respectively), hospital outpatient services ($2,369 versus $1,871), and home health services ($5,450 versus $5,286). Women's expenditures exceeded men's in the categories of office-based medical services ($1,426 versus $1,253, respectively) and dental services ($622 versus $595). Despite women's mean health care expenses by category generally being lower than men's, the overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, more women had hospital inpatient services than men, which contributes to a higher mean expenditure overall.

Overall per capita health care expenditures have increased substantially in the past decade for both men and women. In 2006, the annual mean health care expenses for both men and women were nearly 59 percent higher than in 1999 (data not shown).

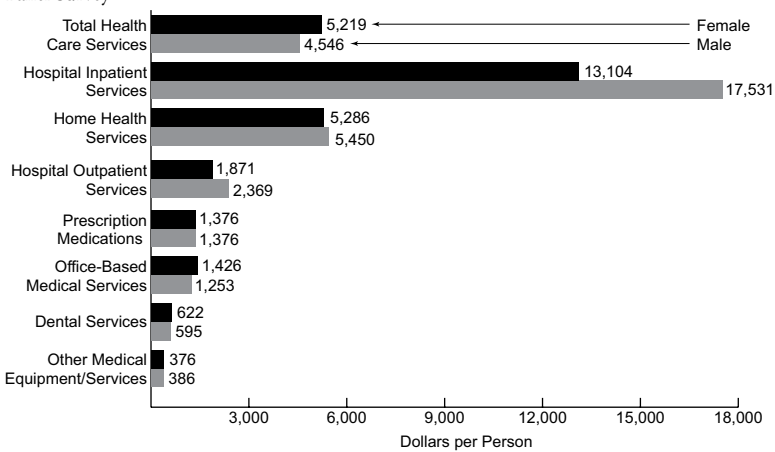
Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment, 2006

Source III.2: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2006

Source III.2: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



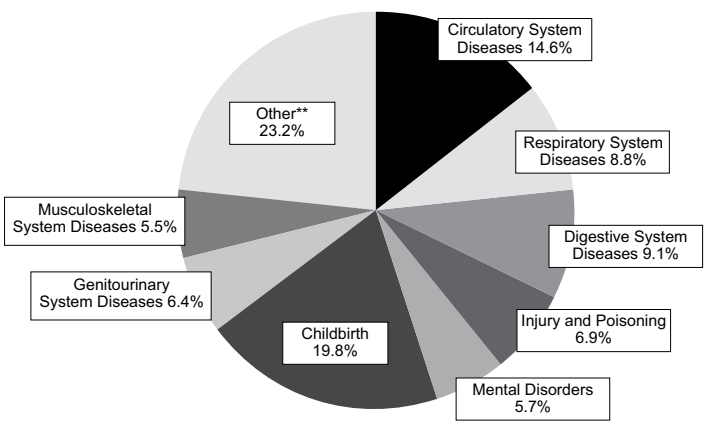
HOSPITALIZATIONS

Females represented 59.9 percent of the 34.9 million short-stay hospital discharges in 2006. Nearly 20 percent of hospital stays for all females were due to childbirth, while 14.6 percent were due to diseases of the circulatory system. Other common reasons for hospitalization included diseases of the respiratory, digestive, and genitourinary systems; injury and poisoning; and mental disorders. Overall, females had a higher hospital discharge rate than males in 2006 (1,375.3 versus 954.9 per 10,000 population; data not shown).

The types of procedures conducted during short hospital stays also vary by sex. Overall procedure rates were 1,811.5 procedures per 10,000 females (this includes 466.4 obstetrical procedures per 10,000 females) and 1,261.5 procedures per 10,000 males. Several of the procedures more common among females included operations on the digestive system (207.0 per 10,000 females versus 166.0 per 10,000 males) and operations on the genital organs, including hysterectomy for women (129.0 versus 17.1 per 10,000, respectively). Males had a higher rate than females for operations on the cardiovascular system (280.9 versus 205.6 per 10,000, respectively). Among females, the highest rate of procedures for discharges from short-stay hospitals was obstetrical procedures (466.4 per 10,000).

Discharges from Non-Federal, Short-Stay Hospitals Among Females of All Ages,* by Diagnosis, 2006

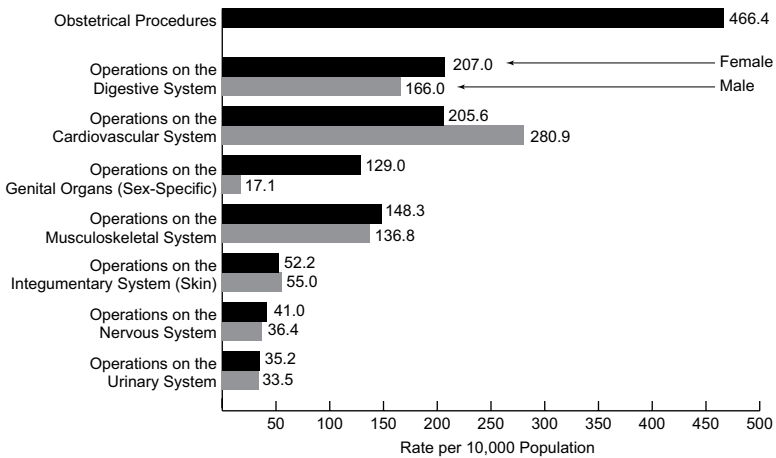
Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants. **Includes all other diagnoses, including neoplasms; infectious and parasitic diseases; endrocrine, nutritional, and metabolic diseases; skin and subcutaneous tissue diseases; nervous system and sense organ diseases; and diseases of the blood and blood-forming organs.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Procedure Category, All Ages,* 2006

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

HIV TESTING

People aware of and receiving appropriate care for positive HIV serostatus may be able to live longer and healthier lives because of newly available, effective treatments. It is recommended that people who meet any of the following criteria be tested at least annually for HIV: those who have injected drugs or steroids, or shared drug use equipment (such as needles); have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have had unprotected sex with anyone who meets any of these criteria.[12] In addition, the CDC recommends that all pregnant women be tested for HIV during their pregnancy. In 2006, CDC guidelines recommended that all health care providers include HIV testing as part of their patients' routine health care.

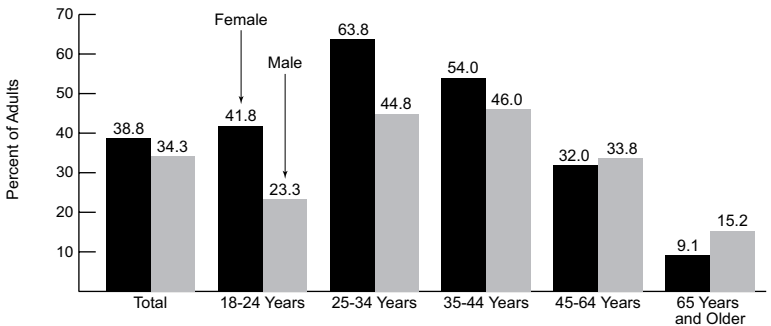
In 2007, nearly 37 percent of adults in the United States had ever been tested for HIV. Overall, women were slightly more likely than men to have been tested (38.8 versus 34.3 percent, respectively). Within younger age groups (18–44 years), women were more likely to have been tested than men, while men were more likely to have been tested at older ages (45 years and older).

Among women in 2007, non-Hispanic Blacks were most likely to have ever been tested (55.5 percent), while non-Hispanic White women were least likely (33.9 percent).

Of women who had not been tested, 78.0 percent reported that they had not been tested because they thought it was unlikely they had been exposed and 19.9 percent reported that there was no particular reason they had not done so (data not shown).

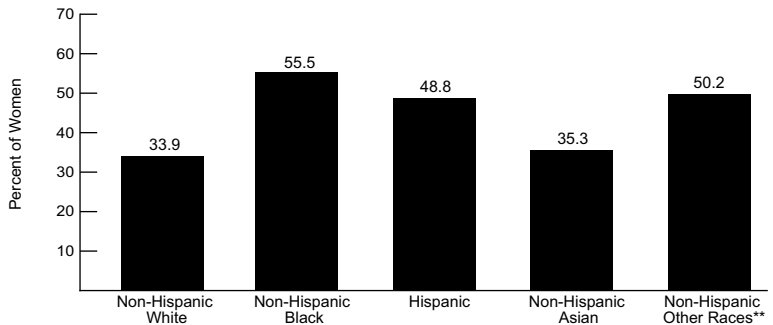
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2007

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity, 2007*

Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Rates reported are not age-adjusted. **Includes Native Hawaiian/Pacific Islanders, American Indian/Alaska Natives, persons of other races, persons of more than one race, and persons of unspecified race.*

MENTAL HEALTH CARE UTILIZATION

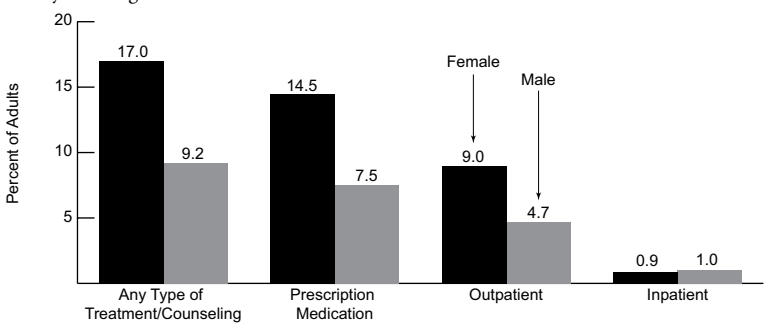
In 2007, more than 29 million adults in the United States reported receiving mental health treatment in the past year. Women represented two-thirds of users of mental health services, including inpatient and outpatient care and prescription medications. Nearly 17 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.5 percent of women aged 18 and older, almost twice the rate among men (7.5 percent). Outpatient treatment was reported by 9.0 percent of women, and inpatient treatment was reported by 0.9 percent of women.

In 2007, mental health services were needed, but not received, by an estimated 11 million adults in the United States. Nearly 7 percent of women and 3.1 percent of men reported an unmet need for mental health treatment or counseling in the past year. Cost or lack of adequate insurance coverage was the most commonly reported reason for not receiving needed services, reported by 50.7 percent of women and 47.5 percent of men with unmet mental health treatment needs. The next most commonly reported reasons among women were feeling that they could handle their problems without treatment (29.5 percent) and fear of stigma, including concerns about confidentiality or the opinions of others, or the potential effect on employment (21.5 percent). Not knowing where to go for services prevented 13.6 percent of women from receiving needed treatment.

Among women, unmet need for treatment varied by race and ethnicity. Non-Hispanic women of multiple races were most likely to report an unmet need for treatment (13.9 percent), followed by non-Hispanic White and non-Hispanic American Indian/Alaska Native women (7.4 and 6.6 percent, respectively). Additionally, 5.9 percent of non-Hispanic Black women and 5.2 percent of Hispanic women had an unmet need for treatment. Non-Hispanic Asian/Pacific Islander women were least likely to report an unmet need for mental health treatment (3.2 percent; data not shown).

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Type and Sex, 2007

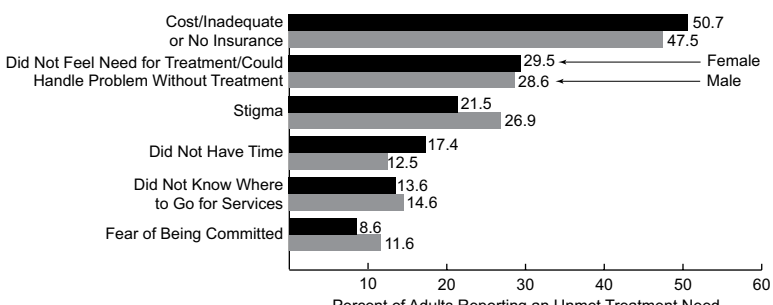
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use. Respondents could report more than one type of treatment.

Reasons for Unmet Mental Health Treatment* Needs Among Adults Aged 18 and Older, by Sex, 2007

Source III.4: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use. Respondents could report more than one reason.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, timeliness, and patient-centeredness of women's health services. Indicators used to monitor women's health care in managed care plans include screening for chlamydia, screening for cervical cancer, and receipt of mammograms.

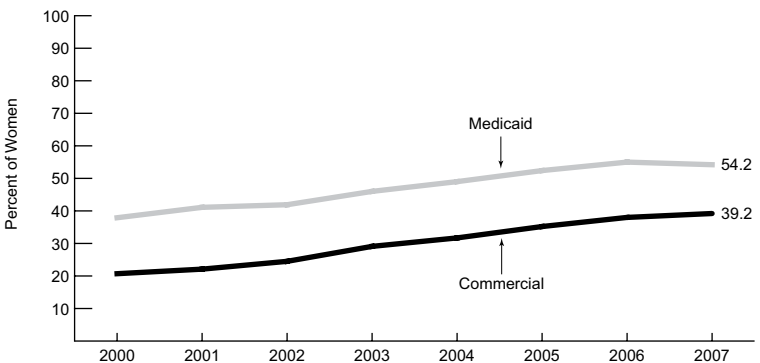
Despite a slight decline in chlamydia screenings for women aged 21–25 years enrolled in Medicaid from 2006 to 2007, females with Medicaid coverage were more likely to have received a chlamydia screening than those with private coverage (54.2 versus 39.2 percent, respectively). Since 2000, the percentage of sexually active females screened for chlamydia has increased by 89 percent among those in commercial plans and 43 percent among Medicaid participants.

In 2007, receipt of mammograms for women aged 40–69 years was approximately the same for women with private coverage and those covered through Medicare (69.1 and 67.3 percent, respectively). However, women enrolled in Medicaid were considerably less likely to have received a mammogram at least once during the previous 2 years (49.9 percent).

Cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Among women aged 21–64 years, cervical cancer screenings were received at least once during the previous 3 years by 81.7 percent of commercially-insured women and 64.7 percent of those covered by Medicaid.

HEDIS®* Chlamydia** Screening Among Women Aged 21–25 Years, by Payer, 2000–2007

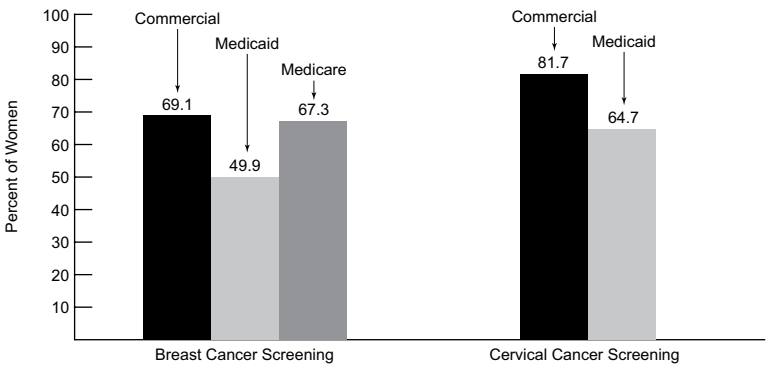
Source III.5: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active females who had at least one test for chlamydia in the past year.*

HEDIS®* Breast** and Cervical Cancer Screening,† by Payer, 2007

Source III.5: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 40–69 years who had at least one mammogram in the past 2 years. †The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years; Medicare data were not available.*

SATISFACTION WITH HEALTH CARE

Patients' utilization of health care is influenced by the quality of care; those who are not satisfied with their providers may be less likely to continue with treatment or seek further services.[13] Some aspects of patients' experience of care that may contribute to better outcomes are patients' perceptions of how well their doctors communicate with them and individuals' experiences with their health plans.

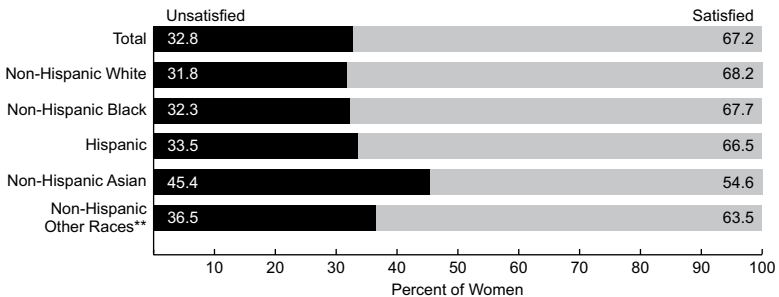
In 2007, 32.8 percent of women were not satisfied with their experiences related to their health plan's customer service, including receiving needed information or help and being treated with courtesy and respect. This varied by race and ethnicity. Non-Hispanic Asian women were most likely to be dissatisfied (45.4 percent), while non-Hispanic White women were least likely (31.8 percent). About one-third of non-Hispanic Black and Hispanic women were dissatisfied with their experiences related to their health plans.

Satisfaction with how well doctors communicate varies by education level; women with higher levels of education are more likely to be satisfied. In 2007, women who had at least a 4-year college degree were most likely to be satisfied with how well their doctors communicate (84.7 percent), followed closely by those completing at least some college (83.2 percent). In contrast, fewer than three-quarters of women with less than a high school diploma were satisfied with communications with their doctors.

More than 24 percent of women were not satisfied with their experiences in getting the care they needed when they needed it, including seeing specialists and getting necessary care, tests, or treatment. The percentage of women reporting dissatisfaction was greatest among non-Hispanic Asian women (32.4 percent). More than 29 percent of Hispanic women, 28.9 percent of non-Hispanic Black and 22.3 percent of non-Hispanic White women were also not satisfied with getting the care they needed (data not shown).

Women's Satisfaction with Experiences Related to Health Plans,* by Race/Ethnicity, 2007

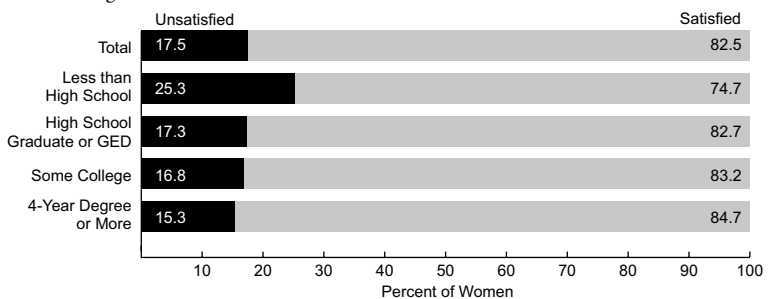
Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



*Based on questions related to respondents' experiences with their health plans in the past 6 months (Medicaid respondents) or 12 months (commercial health plan respondents). **Includes American Indian/Alaska Natives, persons of more than one race, and persons of other and unspecified races.

Women's Satisfaction with How Well Doctors Communicate,* by Level of Education, 2007

Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



*Based on questions related to respondents' experiences with their doctors in the past 6 months (Medicaid respondents) or 12 months (commercial health plan respondents).

ORGAN TRANSPLANTATION

Since 1988, there have been 447,518 organ transplants in the United States. More than 25,600 of those transplants occurred between January 1 and November 30, 2008. In 2008, nearly 13,000 people donated organs in the U.S. Overall distribution of organ donation by sex was nearly even (6,574 males and 6,357 females), though 60.3 percent of organs donated by living people were from females, and 59.4 percent of organs from deceased donors were from males.

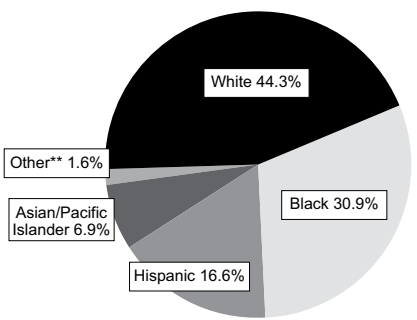
The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of February 13, 2009, there were 100,774 people awaiting a life-saving organ transplant. Females accounted for 41.6 percent of those patients but made up only 37.2 percent of those who received a transplant in 2008.[14] Among females waiting for an organ transplant, 44.3 percent were White, 30.9 percent were Black, and 16.6 percent were Hispanic. The kidney was the organ in highest demand, with 32,810 females awaiting this organ as of February 13, 2009.

The number of organs donated annually has increased significantly since 1988, from 5,909 to a total of 14,400 in 2007. In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. From 2003 to 2007, organ donation by deceased donors increased by an unprecedented 25.2 percent. One of the challenges of organ donation is obtaining consent from the donor's family or legal surrogate. Consent rates may vary due to religious beliefs, communication issues between health care providers and grieving families, perceived inequities in the allocation system, lack of knowledge of the wishes of the deceased, and lack of understanding concerning donation and funeral arrangements.[15]

The Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients are managed by HRSA's Healthcare Systems Bureau (HSB). Other HSB programs include: the National Marrow Donor Program, the National Vaccine Injury Compensation Program, and the C.W. Bill Young Cell Transplantation Program.

Females on Organ Waiting Lists,* by Race/Ethnicity, 2009

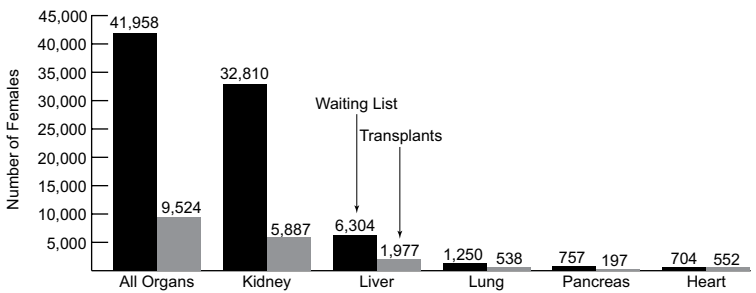
Source III.7: Organ Procurement and Transplantation Network



*As of February 13, 2009. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of unspecified race.

Females on Organ Waiting Lists,* 2009, and Female Transplant Recipients,** 2008, by Organ

Source III.7: Organ Procurement and Transplantation Network



*As of February 13, 2009. **Transplants occurring between January 1–November 30, 2008, as of February 13, 2009.