INTRODUCTION

In 2009, females represented 50.7 percent of the 307 million people residing in the United States. In most age groups, women accounted for approximately half of the population, with the exception of people aged 65 years and older; within this age group, women represented 57.5 percent of the population. The growing diversity of the U.S. population is reflected in the racial and ethnic distribution of women across age groups. Non-Hispanic Black and Hispanic women accounted for 8.9 and 6.9 percent of the female population aged 65 years and older, but they represented 13.8 and 22.4 percent of females under 18 years of age, respectively. Non-Hispanic Whites accounted for 79.7 percent of women aged 65 years and older, but only 55.0 percent of those under 18 years of age. Hispanic women now account for a greater proportion of the female population than they did in 2000, when they made up 17.0 percent of the population under age 18 and only 4.9 percent of those 65 years and older.

America’s growing diversity underscores the importance of examining and addressing racial and ethnic disparities in health status and the use of health care services. In 2007–2009, 58.1 percent of non-Hispanic White women reported themselves to be in excellent or very good health, compared to only 40 percent or less of Hispanic, non-Hispanic American Indian/Alaska Native, and non-Hispanic Black women. Minority women are disproportionately affected by a number of diseases and health conditions, including HIV/AIDS, sexually transmitted infections, diabetes, and asthma. For instance, in 2009, rates of new HIV cases were highest among non-Hispanic Black, non-Hispanic multiple race, Non-Hispanic Native Hawaiian/Pacific Islander, and Hispanic females (47.8, 13.4, 13.3, and 11.9 per 100,000 females, respectively), compared to just 2.4 cases per 100,000 non-Hispanic White females.

Hypertension, or high blood pressure, was
also more prevalent among non-Hispanic Black women than women of other races. In 2005–2008, 39.4 percent of non-Hispanic Black women were found to have high blood pressure, compared to 31.3 percent of non-Hispanic White, 16.3 percent of Mexican American, and 19.9 percent of other Hispanic women.

Diabetes is a chronic condition and a leading cause of death and disability in the United States, and is especially prevalent among minority and older adults. In 2007–2009, 14.0 percent of non-Hispanic American Indian/Alaska Native women and 11.9 percent of non-Hispanic Native Hawaiian/Other Pacific Islander women reported having been diagnosed with diabetes compared to 6.4 percent of non-Hispanic White women. Hispanic and non-Hispanic Black women also have higher rates of diabetes.

As indigenous populations that share similar histories of disenfranchisement, American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders have some health disparities in common related to substance abuse and chronic conditions, like diabetes. However, American Indian/Alaska Native women have especially high rates of injury, while Native Hawaiian/Other Pacific Islanders have higher cancer incidence and mortality.

In addition to race and ethnicity, income and education are important factors that contribute to women’s health and access to health care. Regardless of family structure, women are more likely than men to live in poverty. In 2009, poverty rates were highest among women who were heads of their households with no spouse present (27.1 percent). Poverty rates were also high among non-Hispanic American Indian/Alaska Native, non-Hispanic Black, and Hispanic women (25.5, 24.3, and 23.8 percent, respectively). Women in these racial and ethnic groups were also more likely to be heads of households than their non-Hispanic White, non-Hispanic Asian, and non-Hispanic Native Hawaiian/Pacific Islander counterparts.

Many conditions and health risks are more closely linked to education and family income than to race and ethnicity and differences in poverty tend to explain a large portion of racial and ethnic health differences. For example, healthy choices for diet and exercise may not be as accessible to those with lower incomes and may contribute to higher obesity levels among minority women. In 2005–2008, 40.0 percent of women with household incomes less than 100 percent of poverty were obese, compared to 31.1 percent of women with incomes of 300 percent or more of poverty.

Sleep disorders, such as insomnia and sleep apnea, were also more common among women with lower household incomes. In 2005–2008, 10.5 percent of women with household incomes below 100 percent of poverty had been diagnosed with a sleep disorder, compared to 5.5 percent of women with incomes of 300 percent or more of poverty. Oral health status and receipt of oral health care among women also varied dramatically with household income. In 2005–2008, women with household incomes below poverty were 3 times more likely to have untreated dental decay than women living in households with incomes of 300 percent or more of poverty (30.3 versus 10.3 percent, respectively). Less than half of women with incomes below 100 percent of poverty had received a dental visit in the past year (43.2 percent), compared to 77.7 percent of women with household incomes of 400 percent or more of poverty.

In addition to race and ethnicity and income, disparities in health status and behaviors, as well as health care access, are also observed by sexual orientation. In 2006–2008, only 37.4 percent of lesbian women received a Pap smear in the past year compared to over 60 percent of heterosexual and bisexual women. Bisexual women were also less likely than heterosexual women to have health insurance or report excellent or very good health status. Both lesbian and bisexual women reported high rates of smoking and binge drinking.
Although women can expect to live 5 years longer than men on average, women experience more physically and mentally unhealthy days than men. In 2007–2009, women reported an average of 4.0 days per month that their physical health was not good and 3.9 days per month that their mental health was not good, compared to an average of 3.2 physically unhealthy and 2.9 mentally unhealthy days per month reported among men. Due to their longer life expectancy, women are more likely than men to have certain age-related conditions like Alzheimer’s disease. Regardless of age, however, women are more likely to have asthma, arthritis, osteoporosis, and activity limitations. For example, 9.2 percent of women had asthma in 2007–2009, compared to 5.5 percent of men.

Men, nonetheless, bear a disproportionate burden of other health conditions, such as HIV/AIDS, high blood pressure, and coronary heart disease. In 2008, for instance, the rate of newly reported HIV cases among adolescent and adult males was more than 3 times the rate among females (32.7 versus 9.8 per 100,000, respectively). Despite the greater risk, however, a smaller proportion of men had ever been tested for HIV than women (36.1 versus 41.0 percent, respectively). In addition, men were more likely than women to lack health insurance and less likely to have received a preventive check-up in the past year.

Many diseases and health conditions, including some of those mentioned above, can be avoided or minimized through good nutrition, regular physical activity, and preventive health care. In 2009, 65.8 percent of women aged 65 years and older reported receiving a flu vaccine; however, this percentage ranged from about 50 percent of non-Hispanic Black and Hispanic women to 69.0 percent of non-Hispanic White women.

Regular physical activity and a healthy diet have numerous health benefits, such as helping to prevent obesity and chronic conditions like diabetes, heart disease, and certain types of cancer. In 2007–2009, only 14.7 percent of women participated in at least 2.5 hours of moderate intensity physical activity per week or 1.25 hours of vigorous intensity activity per week in addition to muscle-strengthening activities on 2 or more days per week. The majority of women (83.1 percent) also exceeded the recommended daily maximum intake of sodium—a contributor to high blood pressure, cardiovascular, and kidney disease.

Not smoking or quitting smoking is another important component to disease prevention and health promotion. Smoking during pregnancy is particularly harmful for both mother and infant. Women with lower incomes and less education are more likely to smoke and less likely to quit, both overall and during pregnancy. Past month smoking rates are also highest among non-Hispanic American Indian/Alaska Native women (41.8 percent) and lowest among non-Hispanic Asian women (8.3 percent).

Women’s Health USA 2011 is an important tool for emphasizing the importance of preventive care, counseling, and education, and for illustrating disparities in the health status of women from all age groups and racial and ethnic backgrounds. Health problems can only be remedied if they are recognized. This data book provides information on a range of indicators that can help us track the health behaviors, risk factors, and health care utilization practices of women and men throughout the United States.