

INTRODUCTION

In 2010, females represented 50.8 percent of the 308 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 56.9 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 and time. Non-Hispanic Whites accounted for 79.3 percent of women aged 65 years and older, but only 53.4 percent of those under 18 years of age. Between 2000 and 2010, the Hispanic and non-Hispanic Asian female population grew the most—increasing their proportion of the female population by about 30 percent. Hispanics grew from 12.1 to 15.9 percent of the female population and non-Hispanic Asians increased from 3.8 to 4.9 percent. By 2050, non-Hispanic White females are projected to no longer be the majority (46.1 percent) and about one-third of females will be Hispanic (29.9 percent).

America's growing diversity underscores the importance of examining and addressing racial and ethnic disparities in the social determinants of health, health status, and the use of health care services. In 2010, at least one in five non-Hispanic Black (25.5 percent), Hispanic (25.0 percent), non-Hispanic American Indian/Alaska Native women (25.0 percent), and non-His-

panic Native Hawaiian/Other Pacific Islander women (20.3 percent) were living in households with income below the poverty level compared to just 12.2 percent of non-Hispanic Asians and 10.4 percent of non-Hispanic Whites. Similarly, fair or poor health was reported by more than one in five Hispanic (29.5 percent), non-Hispanic American Indian/Alaska Native (26.0 percent), non-Hispanic Black (23.2 percent), and non-Hispanic Native Hawaiian/Other Pacific Islander women (20.8 percent), compared to about 13 percent of non-Hispanic White and non-Hispanic Asian women. Many minority women are disproportionately affected by several diseases and health conditions, including diabetes, high blood pressure, overweight and obesity, asthma, HIV/AIDS, and sexually transmitted infections. For instance, in 2010, rates of new HIV cases were highest among non-Hispanic Black, Hispanic, and non-Hispanic American Indian/Alaska Native females (41.7, 9.2, and 6.4 per 100,000 females, respectively), compared to just 2.1 cases per 100,000 non-Hispanic White females. Diabetes was nearly twice as common among non-Hispanic Black and Mexican American women (16.5 and 16.9 percent, respectively) than among non-Hispanic White women (8.9 percent). Similarly, obesity was considerably higher among non-Hispanic Black and Mexican American women (58.0 and 44.0 percent, respectively) than non-Hispanic

White women (33.1 percent).

Although Asian women tend to be healthier, some subgroups may face higher rates of diabetes, hepatitis infection, and certain types of cancer. For example, in 2006–2010, 12.4 percent of Asian Indian women reported having been diagnosed with diabetes compared to 4.7 percent of Chinese women. The receipt of recommended cervical cancer screening was substantially lower among Asian Indian, Chinese, and Other Asian (71.5, 71.6, and 70.2 percent, respectively) compared to Filipina (86.9 percent) and non-Hispanic White women (84.6 percent). Cultural differences in health-related beliefs may contribute to this disparity.

However, many conditions and health risks are more closely linked to education and family income than to race and ethnicity and 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 levels of education and income and may contribute to higher obesity levels among minority women. In 2008–2010, over half of college-educated women (57.3 percent) achieved recommended levels of physical activity compared to less than one-quarter of women without a high school diploma (24.4 percent). Fruit and vegetable consumption also increased with educational attainment. For instance, in 2009, about 40 percent of women with a col-

lege degree ate vegetables three times per day compared to 22.0 percent of those who hadn't finished high school.

Health care access also varies greatly by income and education. In 2008–2010, about 20 percent of women with incomes below 200 percent of the poverty level had forgone needed health care due to cost compared to 6.5 percent of women with incomes of 400 percent or more of poverty. Only 41.6 percent of women with less than a high school education had a dental visit in the past year compared to 80.9 percent of women with a college degree.

In addition to income and education, there are also geographic barriers to health care. For example, rural areas have fewer physicians and dentists per capita than urban areas, and may lack certain specialists altogether. In 2010, rural women were less likely than urban women to have had a past year dental visit (64.4 versus 77.9 percent, respectively). Compared to their urban counterparts, rural women were also more likely to smoke (20.5 versus 14.4 percent, respectively), to be physically inactive (29.2 versus 25.1 percent, respectively) and to be obese (30.4 versus 25.9 percent, respectively).

Women veterans are another population group that may face unique health problems due to possible exposure to combat-related stress and trauma. Although women veterans were more likely than civilian women to have had a past-

year preventive health visit in 2010 (76.2 versus 72.0 percent, respectively), they were more likely to report limitations in activity due to physical, mental, or emotional problems (29.3 versus 20.7 percent, respectively) and to report poor mental health on 14 or more days in the past month (18.1 versus 12.5 percent, respectively).

A variety of conditions increase with age and are more likely to affect older women, including activity limitations, arthritis, obesity, diabetes, high blood pressure, infecundity, maternal morbidity, osteoporosis, and Alzheimer's disease. For example, nearly three-quarters of women aged 65 and older had high blood pressure in 2009–2010 and 71.1 percent were overweight or obese. However, some health behaviors and indicators improve with age, such as mental health-related quality of life, the receipt of preventive check-ups, and positive health behaviors prior to pregnancy. For instance, among recent mothers aged 40 and older, only 12.4 percent reported smoking and 15.3 percent reported binge drinking in the 3 months prior to pregnancy, compared to 34.2 and 25.5 percent, respectively, among mothers aged 20–24 years. Older mothers were more likely to have taken daily preconception multivitamins, which dramatically reduce the risk of neural tube defects, and to have intended or planned their pregnancy.

Since women live an average of about 5 years longer than men, they are more likely to have

certain age-related conditions like Alzheimer's disease. Regardless of age, however, women are also more likely to have activity limitations, asthma, arthritis, osteoporosis, and depression. For example, 9.0 percent of women had osteoporosis in 2007–2010, compared to 1.3 percent of men. Women also experience more physically and mentally unhealthy days than men. In 2010, women reported an average of 3.9 days of poor physical health, compared to 3.3 days per month for men. Similarly, women reported an average of 4.1 mentally unhealthy days, while men reported an average of 3.0 days per month. Men, nonetheless, bear a greater burden of certain health conditions, such as HIV/AIDS, heart disease, and substance use disorders, and were less likely than women to have received a preventive check-up or dental visit in the past year.

Women's Health USA 2012 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 population health determinants, health behaviors, health status, and health care utilization practices of women throughout the United States.