

## HEALTH SERVICES UTILIZATION

Availability of and access to quality health care services directly affects all aspects of women's health. Access to health care is critical to prevent the onset of disease, as well as to identify health issues early and prevent disease progression. Although health care is important for all women, it may be particularly important among women who have poor health status, chronic conditions, or disabilities. Appropriate utilization can be hampered by limited financial resources and lack of health insurance or comprehensive insurance, as well as language, transportation, and other barriers.

This section presents data on women's use of health services, including data on women's health insurance coverage, usual source of care, health care expenditures, and use of various services, such as preventive care, oral health care, and mental health services. New features within this section include data on contraceptive use and patient-centered care.

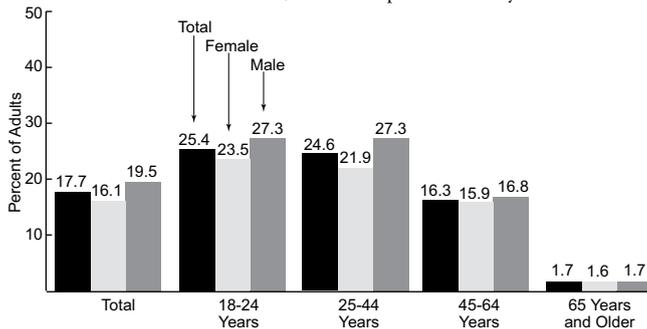


## HEALTH INSURANCE

People who are uninsured face substantial financial barriers to health care, which can result in delayed diagnoses and poor health outcomes, including premature death.<sup>1</sup> Overall, 15.7 percent or 48.6 million people in the United States lacked health insurance in 2011, a decline from 16.3 percent in 2010.<sup>2</sup> Adults aged 18 and older accounted for 86 percent of all uninsured individuals in 2011 and have higher rates of uninsurance than children due to more limited eligibility for public insurance (17.7 versus 9.4 percent, respectively; data for children not shown). In 2011, women were less likely than men to be uninsured (16.1 versus 19.5 percent, respectively). Women are more likely to be in poverty (see *Women and Poverty*) and to qualify

### Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2011

Source III.1: U.S. Census Bureau, Current Population Survey



for Medicaid insurance available to low-income individuals who are pregnant, children, parents, elderly, or disabled.<sup>1,3</sup> Younger adults were most likely to be uninsured—about one in four adults under age 45 lacked health insurance compared to 16.3 percent of those aged 45–64 years and only 1.7 percent of those aged 65 and older, most of whom are eligible for Medicare coverage.

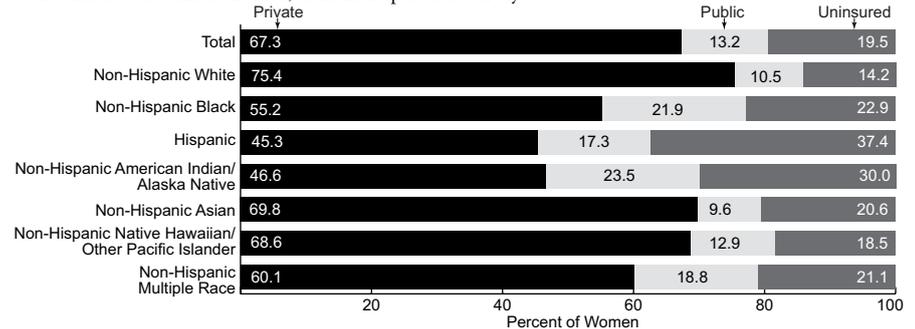
Among women aged 18–64 years in 2011, 67.3 percent had some form of private insurance, 13.2 percent had only public insurance, and 19.5 percent were uninsured. This distribution varied by race and ethnicity with non-Hispanic White women having the highest rates of any private insurance coverage (75.4 percent), compared to 55.2 percent of non-Hispanic Black women and less than half of non-Hispanic American Indian/

Alaska Native and Hispanic women (46.6 and 45.3 percent, respectively). Public coverage alone was most common among non-Hispanic Black and non-Hispanic American Indian/Alaska Native women (21.9 and 23.5 percent, respectively). The highest rates of uninsurance were among Hispanic women and non-Hispanic American Indian/Alaska Native women (37.4 and 30.0 percent, respectively).

Of the nearly 13 million women aged 18–64 who rely on publicly-funded insurance, over two-thirds are covered by Medicaid alone, while 13.1 percent are covered by Medicare alone, and 10.3 percent have dual coverage. Another 9.4 percent rely on some other form of public coverage, including insurance from the military (data not shown).

### Health Insurance Coverage of Women Aged 18–64, by Race/Ethnicity and Health Insurance Coverage,\* 2011

Source III.1: U.S. Census Bureau, Current Population Survey



\*Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans. Estimates may not add to 100 due to rounding.

## BARRIERS TO CARE AND UNMET NEED FOR CARE

Barriers to receiving needed health care can include cost, language or knowledge barriers, and structural or logistical factors, such as long waiting times and not having transportation.<sup>4</sup> Barriers to care contribute to socioeconomic, racial/ethnic, and geographic differences in health care utilization and health status.

In 2011, 11.4 percent or 26.4 million adults reported that they delayed getting medical care in the past year due to various logistical or structural factors, such as not being able to get an appointment soon enough and inconvenient office hours (data not shown). Women were more likely than men to report having delayed care due to logistical barriers in the past year (13.5

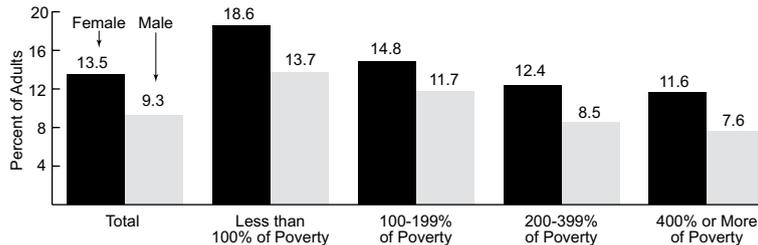
versus 9.3 percent, respectively). For both men and women, those with lower household incomes were more likely to report having delayed care as a result of logistical factors. For example, nearly 1 in 5 women (18.6 percent) living in households with income below 100 percent of poverty reported having delayed care, compared to about 12 percent of women in households with incomes of 200 percent or more of poverty. Hispanic and non-Hispanic American Indian/Alaskan Native women were more likely than non-Hispanic White, non-Hispanic Black, and non-Hispanic Asian women to report having delayed care due to logistical barriers (17.9 and 23.7 percent versus 12.4, 14.0, and 12.4 percent, respectively; data not shown).

Women were also slightly more likely than

men to have forgone needed health care due to cost (8.7 versus 7.4 percent, respectively). For both women and men, the proportion who did not get needed care due to cost varied by insurance status. Among women, more than 1 in 4 (28.2 percent) of those without health insurance experienced an unmet need for health care due to cost compared to 3.9 percent of women with private insurance and 8.8 percent with public insurance. The Affordable Care Act helps to remove financial barriers to care by expanding Medicaid eligibility for more low-income people, establishing health insurance marketplaces where many individuals and small businesses will qualify for financial assistance with health insurance, and requiring private plans to cover preventive services without copays.<sup>5</sup>

### Adults Aged 18 and Older Who Delayed Care Due to Logistical Barriers\* in Past Year, by Poverty Level\*\* and Sex, 2011

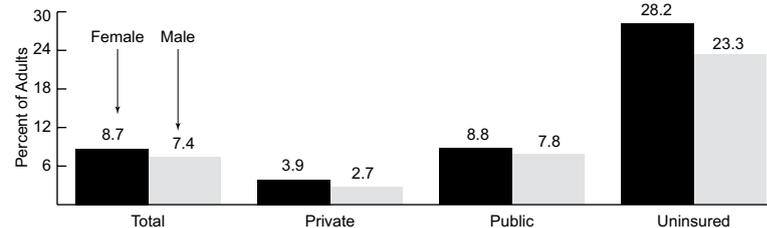
Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*Reported that they delayed getting medical care in the past year due to any of five reasons: couldn't get through on phone, couldn't get appointment soon enough, office room wait too long, inconvenient office hours, no transportation; all estimates are age-adjusted. \*\*Poverty level, defined by the U.S. Census Bureau, was \$23,021 for a family of four in 2011.

### Adults Aged 18 and Older with Unmet Need for Health Care\* Due to Cost, by Health Insurance Coverage\*\* and Sex, 2011

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*Reported that they needed but did not get medical care because they could not afford it; excludes dental care; all estimates are age-adjusted. \*\*Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

### USUAL SOURCE OF CARE

In 2009–2011, 86.8 percent of women and 77.7 percent of men reported having a usual source of care, defined as a place where one usually goes when sick, such as a physician's office or health center but not an emergency department. Having a usual source of care has been shown to improve care quality and the receipt of preventive services.<sup>6</sup>

Health insurance coverage greatly increases the likelihood of having a usual source of care. Over 90 percent of women with private or public insurance coverage had a usual source of care, compared to only 56.2 percent of uninsured

women. Having both a usual source of care and health insurance coverage has been found to significantly reduce problems obtaining needed medical care and delaying or forgoing needed care.<sup>7</sup>

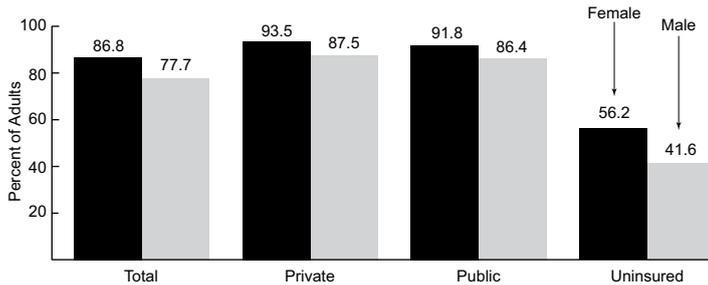
Access to a usual source of care varies by race and ethnicity. For example, non-Hispanic White women were most likely to report a usual source of care (89.3 percent), while Hispanic women were least likely to do so (78.6 percent). Hispanic women are also least likely to have health insurance (see *Health Insurance*). Among women with private or public insurance, the proportion reporting a usual source of care was

about 90 percent or higher for all racial and ethnic groups (data not shown).

Having a usual source of care also varies by age and is more common among older adults, who are most likely to have health insurance (see *Health Insurance*). For example, nearly all women aged 65 years and older (96.9 percent) had a usual source of care, compared to 78.6 percent of women aged 18–34 years. However, the likelihood of having a usual source of care increased with age even among those with private insurance: from 88.4 percent of women aged 18–34 years to 97.8 percent of those aged 65 years and older (data not shown).

### Usual Source of Care\* Among Adults Aged 18 and Older, by Health Insurance Coverage\*\* and Sex, 2009–2011

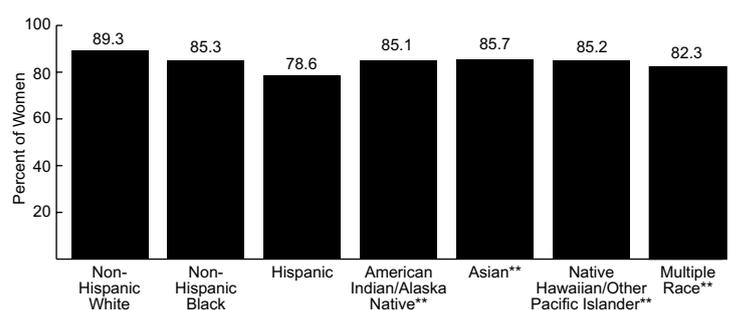
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*Defined as having a place where one usually receives care when sick, excluding emergency departments; all estimates are age-adjusted. \*\*Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

### Usual Source of Care\* Among Women Aged 18 and Older, by Race/Ethnicity, 2009–2011

Source III.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*Defined as having a place where one usually receives care when sick, excluding emergency departments; all estimates are age-adjusted. \*\*May include Hispanics.

## PREVENTIVE CARE

Preventive health care can help prevent or minimize the effects of many serious health conditions. The U.S. Preventive Services Task Force (USPSTF) recommends specific screening tests, counseling, immunizations, and preventive medications for a variety of diseases and conditions.<sup>8</sup> For example, annual blood pressure screening is recommended for adults aged 18 and older and annual cholesterol screenings are recommended for adults aged 20 and older with other cardiovascular risk factors. High blood pressure and cholesterol are risk factors for heart disease and stroke that can be lowered with identification and treatment. In 2011, 86.1 percent of women aged 18 and older had a blood pressure screening and 63.3 percent of women aged 20 and older

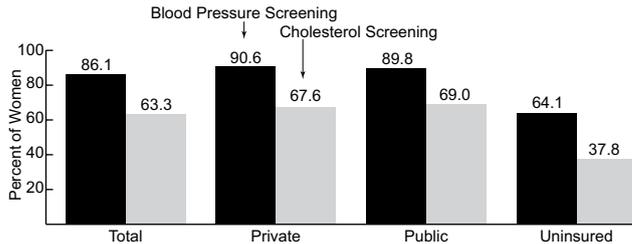
received a cholesterol screening in the past year. Receipt of screening was much lower among women without health insurance. For example, only 64.1 percent of uninsured women had their blood pressure checked in the past year compared to about 90 percent of insured women.

To protect against certain strains of the Human Papillomavirus (HPV) that cause cervical cancer, anal cancer, and genital warts, vaccination is now universally recommended for girls and boys aged 11–12 years with catch-up vaccination for females aged 13–26 years and males aged 13–21 years who have not been previously vaccinated.<sup>9</sup> Pneumococcal vaccination protects against a bacterial infection that may cause pneumonia or other life-threatening illnesses and is recommended for young children, adults

aged 65 years and older, and persons with certain health conditions.<sup>9</sup> In 2011, only 30.4 percent of women aged 18–26 years had received at least one dose of HPV vaccine and 64.5 percent of women aged 65 and older had received pneumococcal vaccination. Hispanic and non-Hispanic Asian women had lower HPV vaccination rates compared to women of other racial/ethnic groups. Along with non-Hispanic Black women, Hispanic and non-Hispanic Asian women also had lower rates of pneumococcal vaccination. The Affordable Care Act improves access to preventive care by expanding health insurance and requiring new private plans to cover USPSTF-recommended preventive services and additional services for women, such as well-woman visits, without copays.<sup>5</sup>

### Receipt of Selected Screenings in Past Year Among Women,\* by Health Insurance Coverage,\*\* 2011

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey

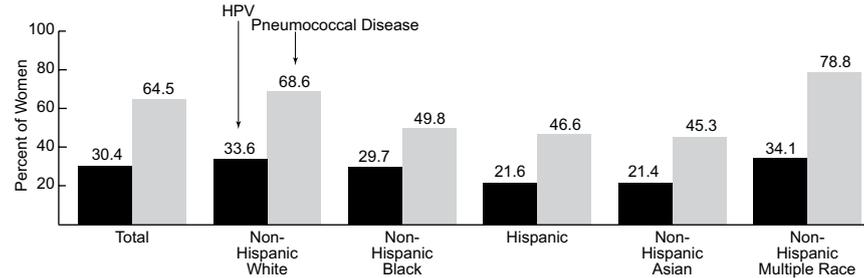


\*Aged 18 or over for blood pressure screen and aged 20 or older for cholesterol screen; reported to have been checked by a health professional; all estimates are age-adjusted.

\*\*Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

### Receipt of Selected Vaccinations Among Women,\* by Race/Ethnicity,\*\* 2011

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*Reported having ever received the HPV vaccine among women aged 18–26 years and having ever received the pneumonia vaccine among women aged 65 years and older. \*\*The sample of American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

### CONTRACEPTIVE USE

Family planning is considered to be among the top 10 public health achievements of the past century, enabling women to achieve desired birth spacing and family size, and resulting in improved health of infants, children, and women.<sup>10</sup> Yet, half of all pregnancies and one-third of all births in the United States are estimated to be unintended at the time of conception with wide disparities by race and ethnicity and other demographic characteristics.<sup>11</sup> Unintended pregnancies that lead to births are associated with both short- and long-term negative outcomes for both mother and child, including delayed prenatal care, maternal depression, increased risk for intimate partner violence, and poor developmental and educational outcomes for children.<sup>12</sup>

In 2006–2010, there were 43 million women

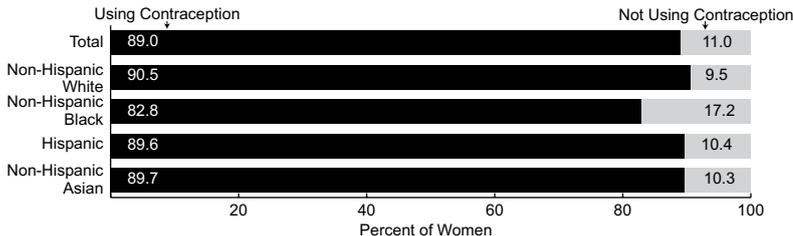
at risk of unintended pregnancy—who were either currently using contraception or having intercourse and not sterile (for noncontraceptive reasons), pregnant, postpartum, or trying to get pregnant—of whom 89.0 percent reported using contraception while the remaining 11.0 percent did not. Non-Hispanic Black women were more likely than women of other races and ethnicities to not use contraception while at risk of unintended pregnancy (17.2 percent). Younger and never-married women were also more likely than their older or married counterparts to not use contraception while at risk of unintended pregnancy (data not shown).

Among women aged 15–44 years who were using contraception, the most commonly used methods were female or male sterilization (36.6 percent), the pill (27.5 percent), and condoms

(16.4 percent), followed by other hormonal methods such as implants, patches, and rings (7.2 percent) and intrauterine devices (IUDs; 5.6 percent). Effectiveness rates based on typical use, including incorrect or inconsistent use, are highest for sterilization, IUDs, the pill, and other hormonal methods, and fall below 90 percent for condoms, sponges, withdrawal, and periodic abstinence.<sup>13</sup> Variation in contraceptive use and method may help to explain demographic patterns of unintended pregnancy. The Affordable Care Act ensures women have access to a full range of recommended preventive services by expanding insurance coverage and requiring most private health plans to provide FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling without copays.<sup>14</sup>

#### Contraceptive Use Among Women Aged 15–44 Years at Risk of Unintended Pregnancy,\* by Race/Ethnicity,\*\* 2006–2010

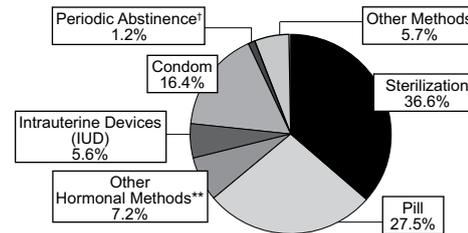
Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



\*At risk of unintended pregnancy is defined as either currently using contraception or having had intercourse in the last 3 months among those who were not currently pregnant, postpartum, trying to get pregnant, or sterile for noncontraceptive reasons. \*\*The sample of American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

#### Contraceptive Method Used Among Women Aged 15–44 Years Using Contraception, 2006–2010\*

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Family Growth



\*Women who used more than one form of contraception are classified according to the most effective form listed; estimates may not total to 100 due to rounding. \*\*Includes hormonal implants, patches, injectables, and rings. \*Includes calendar rhythm, natural family planning (NFP), cervical mucus test, and temperature rhythm.

## MENTAL HEALTH CARE UTILIZATION

In 2009–2011, 31 million, or 13.6 percent of adults in the United States reported receiving mental health treatment in the past year for a mental, behavioral, or emotional disorder other than a substance use disorder (data not shown). Women were more likely than men to receive treatment or counseling (17.5 versus 9.4 percent), which is consistent with the higher prevalence of mental illness (excluding substance use disorder) among women (see *Mental Illness*).

Utilization of mental health services was highest among non-Hispanic White and multiracial

women with more than one in five reporting past-year treatment or counseling (21.8 and 21.5 percent, respectively). Non-Hispanic Asian women were least likely to have reported receiving past year mental health treatment or counseling (5.3 percent).

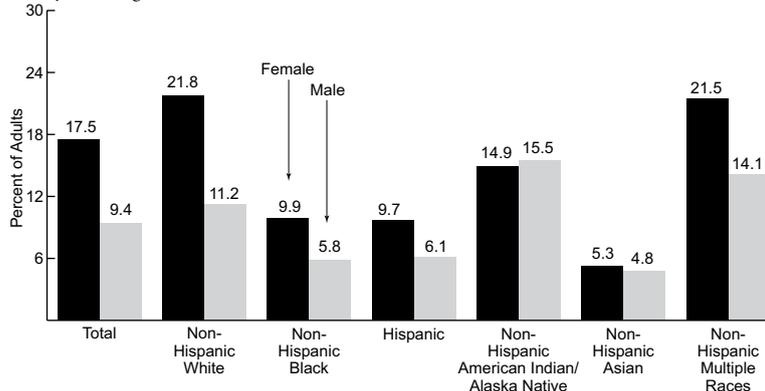
In 2009–2011, 17.7 million women aged 18 years and older reported using prescription medication for treatment of a mental or emotional condition, representing 14.9 percent of women, which is almost twice the proportion of men (7.8 percent). Women were also nearly twice as likely as men to report receiving outpatient mental health treatment (8.6 versus 4.7 percent, respec-

tively). Less than 1 percent of men and women received inpatient treatment during this period (data not shown).

In 2009–2011, mental health services were needed, but not received in the previous year, by 5.0 percent of adults. Women were twice as likely as men to report an unmet need for mental health treatment or counseling in the past year (6.7 versus 3.3 percent, respectively; data not shown). Among women, cost was the most commonly reported reason for not receiving needed services (45.4 percent), followed by the belief that the problem could be handled without treatment (25.0 percent).

### Past-Year Mental Health Treatment/Counseling\* Among Adults Aged 18 and Older, by Race/Ethnicity and Sex,\*\* 2009–2011

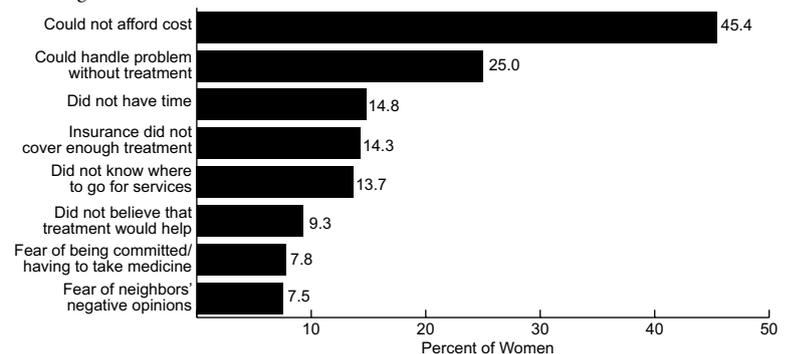
Source II.3: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



\*Excludes treatment for alcohol or drug use; all estimates are age-adjusted. \*\*The sample of non-Hispanic Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

### Reasons for Not Receiving Mental Health Treatment/Counseling\* Among Women Aged 18 and Older with an Unmet Need for Mental Health Services, 2009–2011

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



\*Defined as a perceived need for mental health treatment/counseling that was not received; all estimates are age-adjusted.

## ORAL HEALTH CARE UTILIZATION

Regular dental care is essential to promote oral health and to prevent and treat tooth decay and infection. Untreated dental disease can produce significant pain and disability, and can result in tooth loss. In addition to daily brushing and flossing, the American Dental Association recommends regular dental exams and cleanings.<sup>15</sup> In 2011, women were somewhat more likely to have a past-year dental visit than men (64.6 and 57.8 percent, respectively). Among both men and women, those with greater household incomes were more likely to have had a dental visit. For example, 82.3 percent of

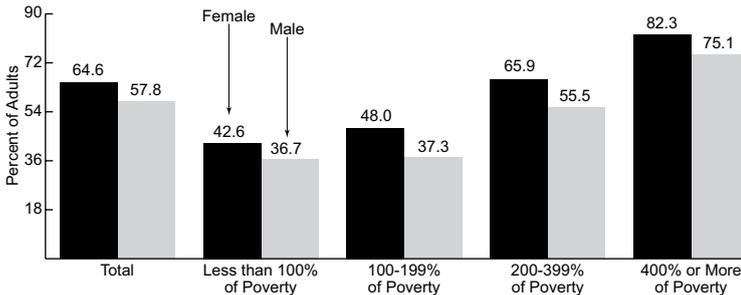
women with household incomes of 400 percent or more of poverty had a past year dental visit, compared to 42.6 percent of women with incomes less than 100 percent of poverty.

Cost is a significant barrier to appropriate utilization of dental care. In 2011, only 20.4 percent of adults had private insurance coverage that included dental care (data not shown). Medicaid and Medicare generally do not cover dental care and even private plans with dental coverage contain limited benefits with high cost-sharing.<sup>16</sup> In 2011, 16.4 percent of women reported that they did not obtain needed dental care in the past year because they could not afford it; this was slightly higher than the per-

centage of men who reported an unmet need for dental care due to cost (13.0 percent). The likelihood of not getting dental care due to cost varies significantly by health insurance coverage. For example, only 7.0 percent of women with private insurance that included dental benefits reported that they did not obtain needed dental care in the past year due to costs, which nearly doubles to 13.7 percent of women with private insurance that did not include dental benefits. However, the likelihood of not getting needed dental care because of cost was considerably higher for women with public insurance (22.7 percent) and highest for women without any insurance (36.3 percent).

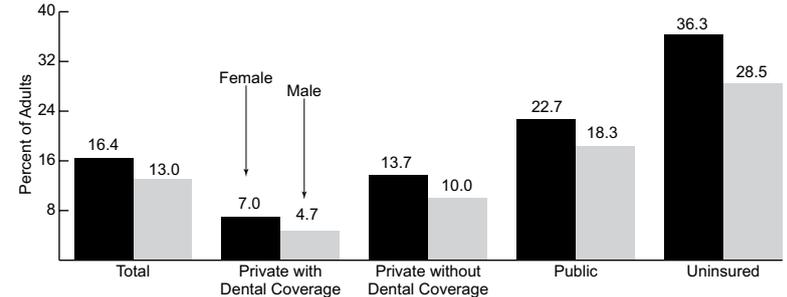
### Past-Year Dental Visit Among Adults Aged 18 and Older, by Poverty Level,\* 2011

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



### Unmet Need for Dental Care Due to Cost Among Adults Aged 18 and Older,\* by Health Insurance Coverage,\*\* 2011

Source II.20: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*Reported needing dental care in the past year, but not getting it because of costs; all estimates are age-adjusted. \*\*Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.

\*Poverty level, defined by the U.S. Census Bureau, was \$23,021 for a family of four in 2011; all estimates are age-adjusted.

## HEALTH CARE EXPENDITURES

In 2010, 89.4 percent of women had at least one health care expense, compared to 78.7 percent of men (data not shown). For both women and men, about 40 percent of expenses were paid by private insurance while about 35 percent were paid by Medicare or Medicaid, and slightly less than 15 percent were paid out of pocket.

In 2010, women paid an average of \$928 out-of-pocket for health care services compared to \$798 paid by men (data not shown). The proportion of health care expenses paid out-of-pocket by women varied by insurance coverage. Almost one-fifth (17.1 percent) of the expenses

reported by privately insured women younger than 65 were paid out-of-pocket, compared to 5.7 percent of expenses reported by publicly-insured women and nearly one-third (32.0 percent) of the expenses reported by uninsured women (data not shown).

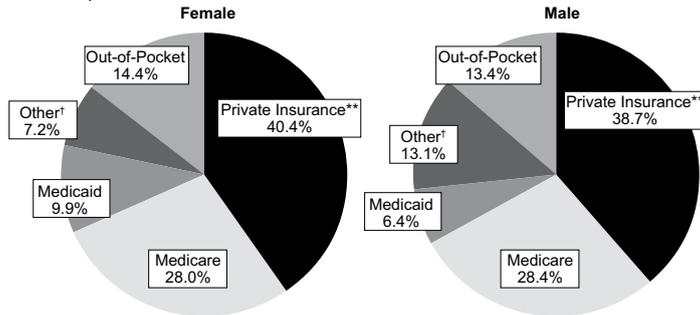
Among adults who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was slightly higher for women (\$6,066) than for men (\$5,547). However, men's average expenditures significantly exceeded women's for hospital inpatient services (\$22,118 versus \$15,792, respectively). Women's average expenditures significantly

exceeded men's only in the category of office-based medical services (\$1,645 versus \$1,455, respectively). The overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, 10.6 percent of women had hospital inpatient services, which includes childbirth delivery, compared to 6.5 percent of men.

The Affordable Care Act contains a number of provisions to reduce health care costs, for example by eliminating copayments for recommended preventive services in private plans and testing new payment systems for Medicare to improve quality and efficiency.<sup>17</sup>

### Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment\*, 2010

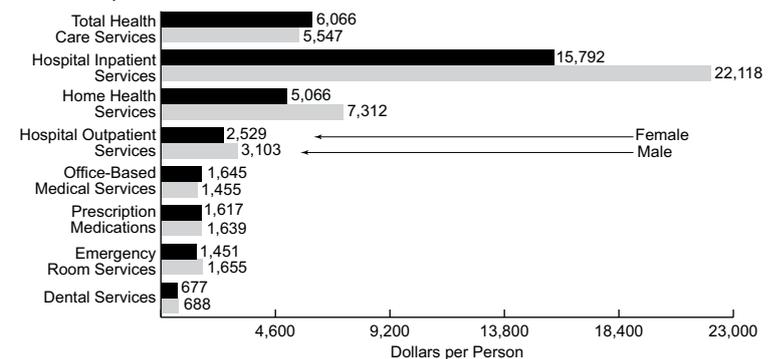
Source III.4: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



\*Percentages may not sum to 100 due to rounding. \*\*Includes Tricare (Armed-Forces-related coverage). †Includes other public programs, such as Department of Veterans Affairs, Indian Health Service, and community clinics, worker's compensation, as well as other unclassified sources.

### Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2010

Source III.4: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



## HEALTH CARE QUALITY

High quality health care can support effective disease prevention, detection, and treatment as well as opportunities to promote health and wellness. The quality of health care can be measured in many ways, including patient safety, receipt of evidence-based clinical services, care coordination, the timeliness of care and the extent to which patients feel that they are able to communicate with their doctors and engage in health care decision-making.<sup>18,19</sup>

In 2010, nearly one-sixth of women reported that they were only sometimes or never able to make an appointment for routine care and sick care as soon as they wanted (13.9 and 13.1 percent, respectively). This varied by race and eth-

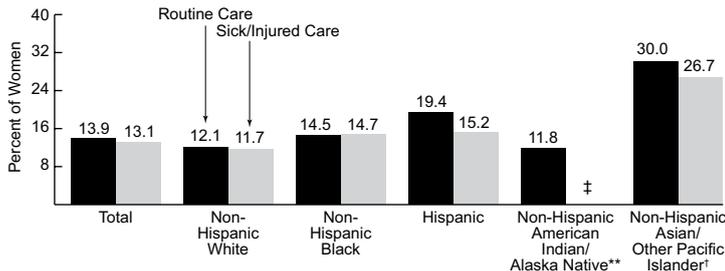
nicity. For example, non-Hispanic Asian/Pacific Islander and Hispanic women (30.0 and 19.4 percent, respectively) were more likely to report difficulty in making timely appointments for routine care than non-Hispanic Black (14.5 percent), non-Hispanic White (12.1 percent), or non-Hispanic American Indian/Alaska Native women (11.8 percent).

Patient centeredness refers to health care that is delivered in partnership with patients (and their families) and prioritizes informed patient engagement in health care decision-making.<sup>20</sup> In 2010, approximately three in five women who reported going to a doctor's office or clinic in the previous 12 months reported that their health care provider always listened carefully to them

(61.1 percent); a similar proportion reported that their provider always explained things clearly (60.9 percent). Nearly two-thirds (65.0 percent) reported that their provider showed respect for what they had to say, while only about half reported that their provider always spent enough time with them (50.4 percent). Among women younger than 65 years of age, privately insured women were more likely than publicly insured and uninsured women to report that their health care providers always engaged in each type of patient-provider communication. For example, 62.8 percent of privately insured women reported that their provider always explained things clearly compared to about 54 percent of publicly insured and uninsured women.

### Trouble Making Appointments\* for Routine and Sick/Injured Health Care Among Women Aged 18 and Older, by Race/Ethnicity, 2010

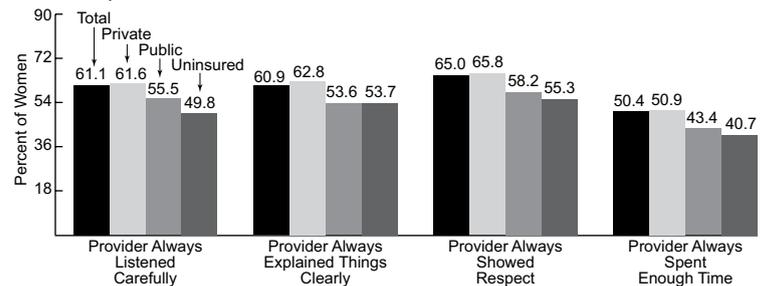
Source III.5: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



\*Sometimes or never able to get an appointment as soon as desired among women who reported making an appointment for routine health care in the past 12 months. \*\*Includes individuals of multiple races. <sup>1</sup>Separate estimates for Asians, Native Hawaiians, and Other Pacific Islanders were not available. <sup>†</sup>Estimate does not meet standards of reliability or precision.

### Patient Centeredness Experienced by Women Aged 18 and Older,\* by Health Insurance Coverage,\*\* 2010

Source III.5: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



\*Among women who reported going to a doctor's office or clinic in the past 12 months. \*\*Insurance type is presented for women under 65 years of age, consistent with the data source; totals include all women aged 18 and older. Private coverage includes persons with any private insurance, either alone or in combination with public coverage; public includes those covered only by government programs such as Medicaid, Medicare, military plans, and state-sponsored health plans.