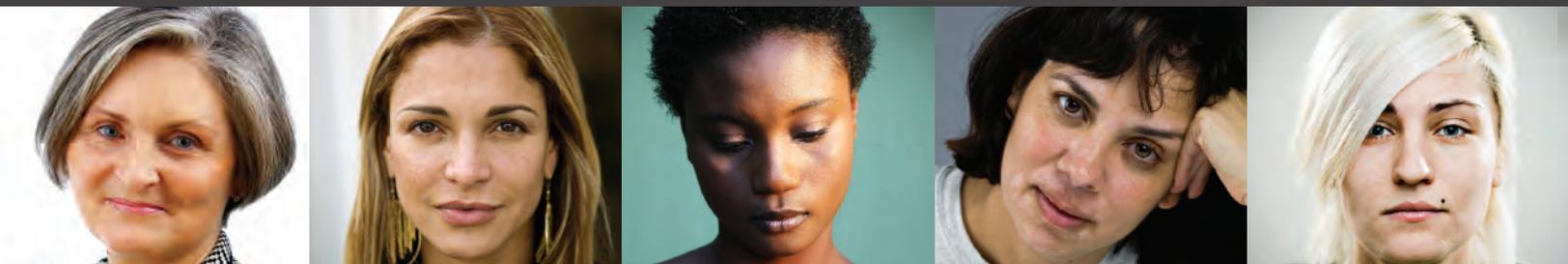




Women's Health Care Chartbook

Key Findings from the
Kaiser Women's Health Survey



MAY 2011



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INTRODUCTION

Health care has long been a priority issue for women, and women's health and access to care were central issues in the lead up to the passage of the new health reform law. Health care is a central element of women's lives, shaping their ability to care for themselves and their families, to be productive members of their communities, contribute to the work force, and to build a base of economic security. While the final health reform legislation encompassed a broad range of areas, several of the issues important to women – access to coverage, affordability, and quality of health care services – were key concerns from the outset.

The data in this chartbook describe how women are faring in the health care system, and will provide a useful baseline of understanding women's experiences as the health reform implementation moves forward. These data also highlight differences in experience between various sub groups of women, particularly those who are at risk for poor access to care, those who are low-income, and women of color.

The data presented in this *Women's Health Care Chartbook* are based on a nationally representative survey of 2,015 women ages 18 to 64 interviewed by telephone in the Spring and Summer of 2008. This survey builds on prior Kaiser Family Foundation surveys on women's health, conducted in 2001 and 2004, when the economy was much stronger. This survey was conducted in the early days of the recession in 2008, and economic conditions have become much worse since the data were collected.

This chartbook provides the latest data on major areas of women's health policy, including women's health status, insurance coverage, their interaction with the health care delivery system, use of preventive services, access to care, and work and family health issues. Across all of these areas, several key findings have emerged:

WOMEN'S HEALTH STATUS

While most women in the U.S. enjoy good health, one third report that they live with a chronic health problem and one in four report depression or anxiety. As women age, they are more likely to experience chronic health problems and report fair or poor health.

- Eight in 10 women between 18 and 64 report excellent, very good, or good health. However, a sizable minority—nearly one in five (18%)—are in fair or poor health, which is a good predictor of need for health care services. This proportion increases with age, to over one-quarter (29%) of women ages 50 to 64 reporting fair or poor health.
- More than one-third of women (35%), have a chronic condition that requires ongoing medical attention, such as diabetes or hypertension. Even among younger women, approximately one in 10 women of reproductive age (18 to 44 years) say they have been diagnosed with arthritis (9%), hypertension (11%), or high cholesterol (9%), and by the time women reach their middle years (45 to 64 years), these rates triple to 39%, 36%, and 34% respectively.

Women of color and low-income women are more likely to report health problems than higher income or white women.

- Poor women (33%) are three times as likely as women in the highest income group (11%) to rate their overall health as fair or poor. African American women have higher rates of several chronic conditions, compared to White and Latina women, including arthritis, hypertension, and heart disease.

A sizable minority of women report experiencing high levels of stress attributable to economic, health, or work related concerns. One in four women have struggled with depression or anxiety in the past five years.

- Many women feel heavy stress from a range of health, economic, and family issues, including health problems of their family members, financial concerns, and career challenges. Approximately a quarter of women report feeling high levels of stress from career (23%) and financial concerns (26%). However, these pressures are even worse for women in poorer health, who are two to three times as likely to experience heavy stress from these issues when compared to women in more favorable health status.
- Mental health is an often overlooked but critical aspect of women's health care. One out of every four women (26%) report they have been diagnosed with depression or anxiety in the past five years. Lower-income women, in particular, are more likely (34%) to experience depression/anxiety compared to women with higher incomes (23%).

HEALTH COVERAGE

Most adult women have some form of either private or public health insurance, but nearly one quarter are either currently uninsured or were uninsured for part of the prior year.

- Employer-sponsored insurance is the leading form of coverage for women, covering 61% of women either through their own job or as a dependent. Six percent of women purchase individual insurance policies, 10% are covered through Medicaid, the health program for low-income individuals, and another 6% have either Medicare or some other form of coverage, such as military benefits. Despite this patchwork of insurance types, 17% of women ages 18 to 64 are uninsured.
- Lower-income women and women of color are at greater risk for being uninsured, as are women who are single, young, and in fair or poor health. These groups of women tend to have lower rates of employer-sponsored coverage and are also more reliant on the Medicaid program than their counterparts.
- In addition to the 17% of women currently without insurance, another 7% of women report being uninsured earlier in the year.

The share of women who are uninsured for extended periods of time is growing.

- Many uninsured women are remaining without coverage for longer periods of time. In 2008, more than a quarter (27%) of uninsured women had been without coverage for at least four years, compared to 20% of uninsured women in 2004, when the economy was stronger.

INTERACTIONS WITH THE HEALTH CARE DELIVERY SYSTEM

A sizable minority of women report problems with access to primary and specialty care and have concerns about the quality of care they receive. These problems are greatest for, but not limited to, uninsured women.

- Most women (83%) report that they have a provider they see on a regular basis. This increases with age, from 77% of women ages 18 to 44 to 90% of women 45 to 64.
- However, some groups of women have a less stable relationship with the health care system and lack a usual source of care. Only two-thirds of Latinas (67%) have a regular provider, much lower than White (86%) and African American (84%) women. Uninsured women are particularly at a disadvantage, with less than half (47%) having this vital link to the health care system.

Many women have two or more regular providers, typically a primary care provider and an Ob-Gyn.

- For most women with a regular provider, the specialty of their regular provider is family medicine or internal medicine. About one in 10 women say their regular health provider is a nurse practitioner or a physician's assistant. Over four in 10 women (44%), report that they have two or more regular providers.
- Two thirds of women reported that they had had at least one Ob-Gyn visit in the past year, more common among younger women in their reproductive years.

Many low-income and uninsured women have not had a recent health care visit.

- A provider visit in the past year is often considered another indicator of access to the health care system. Again, uninsured women are the least likely to have had a provider visit in the past year (67%), compared to women with either private (90%) or public insurance (Medicaid (89%) and Medicare (96%).
- Latina women (80%) are significantly less likely to report a medical visit in the past year compared to African American (88%) and White (87%) women.

Access to specialty care is a problem for many women, but particularly for those who are uninsured or in fair or poor health. Access to specialty care is also worsening over time.

- Many women require care from medical specialists and are not able to gain access to these providers. There are large differences by insurance and health status. While 12% of women with private insurance state that they were not able to see a specialist when needed, the problem is far worse for women on Medicaid (30%) and those without insurance (43%).

- Compared to women in favorable health (15%), women in poorer health (42%) are almost three times as likely to report they couldn't get access to specialty medical care they thought they needed, possibly exacerbating existing health problems.
- Over time, access to specialists has worsened for women, with one-fifth (21%) of women reporting they could not see a specialist by 2008, compared to 16% just four years earlier.

Quality of care is a concern for one in four women.

- Concerns about quality were particularly common among women in fair or poor health (42%) compared to 22% of women in better health.
- A sizable minority of low-income (32%) or uninsured (39%) reported quality concerns as well as those on Medicaid (28%) and Medicare (30%). Women of color also are more likely to express concerns about quality of care than White women.

While there has been a rapid proliferation of health information through the internet, health providers are still the leading source of health information for women.

- Over four in ten women (44%) report turning to their provider first when seeking information on a health issue.
- While health care providers are the leading source of information for women of all ages, there are generational differences, with many younger women also seeking information online and from family and friends, with older women more likely to seek information from providers first.

PREVENTION AND SCREENING

Despite growing attention to the important role of early intervention and healthy behaviors in health promotion and disease prevention, use of preventive counseling and screening services still fall far below recommended levels.

- Two-thirds of women (67%) say they have discussed diet, exercise, and nutrition with a doctor or nurse during the past three years.
- Fewer than half of all women report having had recent conversations about other health behaviors, such as calcium intake (44%), smoking (35%), and alcohol use (25%).
- Compared to women with insurance, uninsured women consistently report lower rates of screening tests for many conditions, including breast cancer, cervical cancer, high blood pressure, and high cholesterol.
- There seems to be growing attention to underlying causes of chronic diseases, such as diet, exercise, and high cholesterol. Almost half (49%) of women said they had talked with a provider about diet and exercise in the past year, compared to just 39% in 2004. Over six in ten (63%) women reported having a recent cholesterol test in 2008, up from 56% in 2001.

Counseling and screening services that address women's sexual health are infrequent, especially considering the negative impact of sexually transmitted diseases, unintended pregnancy and violence on women's health and well being.

- Only 38% of women ages 18 to 44 say that they have talked with a provider about their sexual history in the past three years. Discussion of more specific topics, such as STDs (28%), HIV/AIDS (29%) and domestic or dating violence (15%) are even less frequent in the clinical setting.
- Thirty percent of women ages 18 to 49 report that they have been tested for an STD in the past two years, but 35% of these women were erroneously under the impression that STD testing was a routine part of a clinical exam.
- The story is similar for HIV testing, but there is greater uncertainty. Thirty-six percent of women 18 to 49 reported having an HIV test in the past two years, but more than half (54%) assumed it was a routine part of an exam, which is not typically the case.
- One of the newest preventive technologies is the development of vaccines against HPV, the virus responsible for most cases of cervical cancer. Most women had heard of the relatively new vaccine, however most report (62%) that they learned about it from advertisements such as television commercials, not from a medical provider (20%).

ACCESS AND AFFORDABILITY

Health care costs pose a barrier to health care and prescription drugs for many women.

- One-quarter of non-elderly women (24%) went without or delayed needed care because they could not afford the costs. Costs were more frequently reported to be a problem for women without insurance (55%) and those living below the poverty line (46%).
- Insured women also face cost related barriers to care. One in seven women with private coverage (14%) and almost one-third of women with Medicaid (31%) stated that they postponed or went without needed services in the past year because they could not afford it.
- Half of all women use at least one prescription drug (51%) on a regular basis. The rate is higher for women ages 45 to 64 (63%) compared to younger women ages 18 to 44 (42%). The number of prescriptions also rises with age, with nearly a quarter of women ages 45 to 64 (23%) taking at least six medications regularly, compared to just 4% of younger women in their reproductive years.
- Many women cannot afford to fill their prescriptions. They either do not fill prescriptions (23%) or resort to skipping doses and splitting pills (18%). These problems do not just affect uninsured women, but are also reported by a significant share of women with private health coverage who may have difficulty affording copays for drugs.

Barriers to health care intersect with many other facets of women's lives.

- Increasing shares of women are dealing with health care cost pressures by making tradeoffs with other expenses. Between 2004 and 2008, the share of women reporting they had to spend less on other basic needs to pay for health care doubled from 8% to 16%. The dual pressures of increasing health care costs and the recession have likely strained many women and affected their ability to make ends meet and pay for care.
- Women also delay care for reasons besides costs. Transportation problems (8%), lack of child care (13%), and limited time off from work (18%) force many women to postpone or go without care, and these problems are more common among women who are low-income.

WORK, FAMILY, AND CAREGIVING

Women are the primary managers of their children's care and for mothers who also work, this responsibility has consequences for their work and economic wellbeing.

- More than eight in 10 mothers/guardians say they take on chief responsibility for choosing their children's doctors (85%), taking them to appointments (84%), and ensuring they receive follow-up care (79%).
- As the primary coordinators of health care for their children, many working mothers (48%) must take time off when their children get sick. However, on top of shouldering primary responsibility for caring for sick children, about half (47%) of women who don't have child care alternatives lose pay when they stay home to care for a sick child.
- Balancing work and family can be an ongoing challenge for many women, but it can be particularly difficult for lower-income women who have fewer workplace benefits. Less than half of low-income women have paid sick leave (45%), compared to 69% of higher income women. Less than half also have disability insurance (42%) or a retirement plan (44%).

Women play a central role in providing care for chronically ill or disabled family members.

- Over one in 10 women (12%), cares for a sick or aging relative, often an ill parent. These women must also contend with a host of their own health challenges. One in five are uninsured, half (51%) have a chronic health condition of their own, and 28% rate their health as fair or poor.
- About one in five (19%) caregivers provides full-time assistance to family members (more than 40 hours per week), the equivalent of a full-time job. Providing this care strains the finances of one in five (21%) caregivers as well creates high levels of stress for one third of this group.

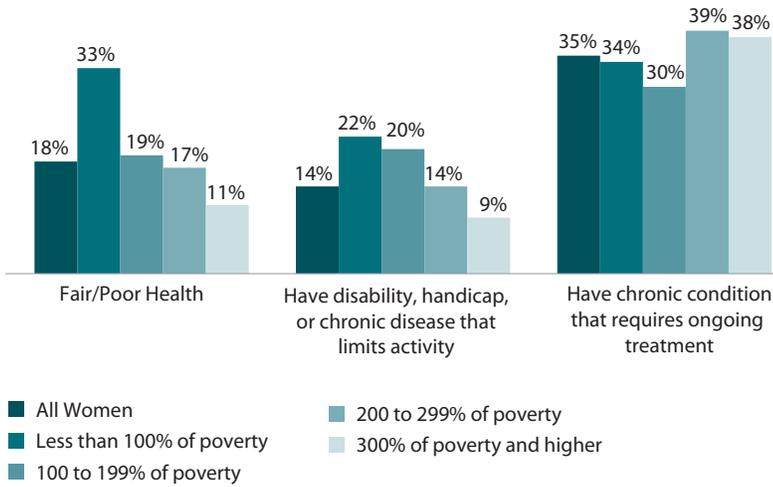


CHAPTER 1:
Profile of Women's Health

EXHIBIT 1a

Health Status Indicators by Poverty Level

Percentage of women ages 18 to 64 reporting:



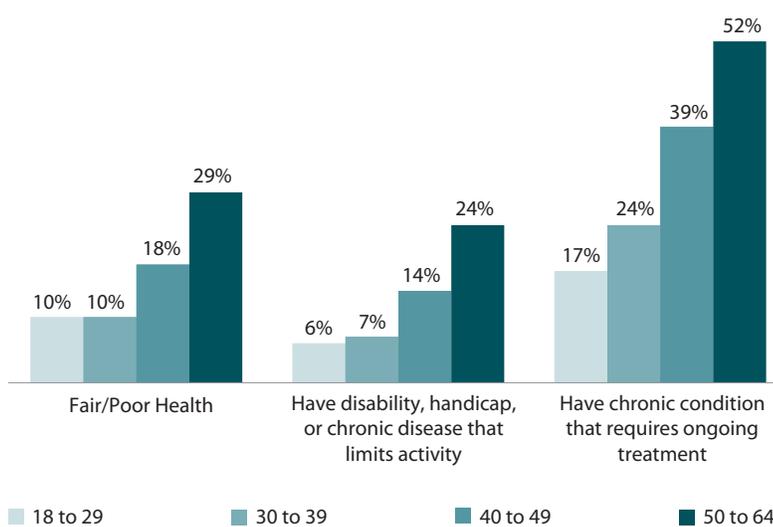
A large body of research has documented the relationship of low-income to poorer health. Women with incomes less than 100% of the federal poverty threshold are three times as likely (33% vs. 11%) to assess their health status as fair or poor than their higher income counterparts (300% of the poverty level or greater). Similarly, the rate of disabling conditions is over twice as high among poor women. Approximately, one third of women of all incomes reported they had a chronic condition that requires ongoing treatment. The similarity in the rates could be attributable to lack of access to care, resulting in lower rates of identification of chronic health problems among poorer women.

Note: The federal poverty threshold was \$17,600 for a family of three in 2008.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

EXHIBIT 1b

Health Status Indicators, by Age Group

Percentage of women ages 18 to 64 reporting:



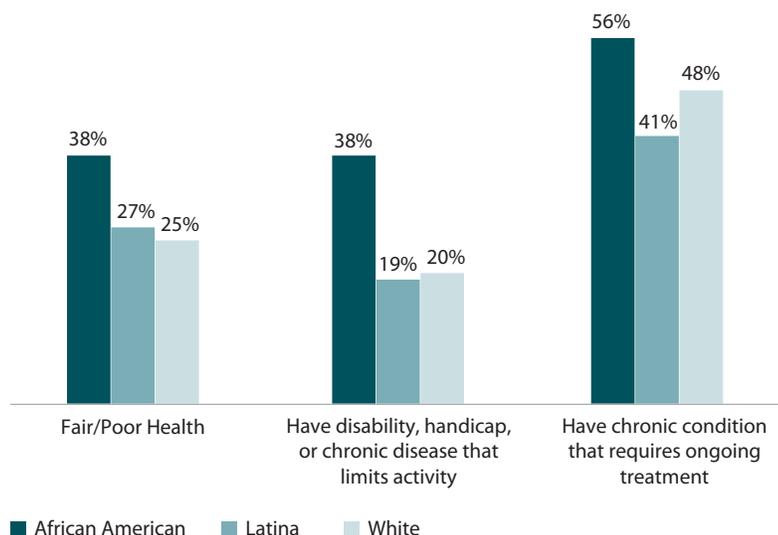
While most adult women in the U.S. report their health status as excellent, very good, or good, almost one-fifth (18%) of women report their overall health status as just fair or poor. This proportion increases with age, rising from 10% among women 18 to 29 and reaching 29% of women age 50 to 64. Rates of disability and chronic conditions also rise as women get older. Overall, 14% of women have a disability or condition that limits their daily activities, but the rate quadruples from 6% to 24% between women in their early reproductive years and women in their later mid-life years, respectively. Similarly, the presence of chronic conditions that require ongoing medical care such as diabetes or arthritis, increases from 17% among young women (18 to 29) to over half (52%) of women age 50 to 64.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

EXHIBIT 1c

Health Status Indicators, by Race/Ethnicity

Percentage of women ages 45 to 64 reporting:



Note: Among women ages 45 to 64.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Race and ethnicity have long been associated with differences in health status, with women of color typically experiencing a greater rate of health problems. These differences become more notable as women reach middle age. Among women ages 45 to 64, African American women are more likely to report fair/poor health status, having a limiting disability, and having a chronic disease than women who are white or Latina.

EXHIBIT 1d

Chronic Health Conditions, by Selected Characteristics

Condition (diagnosed by physician in past 5 years)	ALL WOMEN	BY AGE GROUP		POVERTY LEVEL		RACE/ETHNICITY		
		18-44	45-64	Less than 200% of poverty	200% of poverty or higher	African American	Latina	White
Arthritis	22%	9%	39%*	24%	20%	54%*	36%	37%
Asthma/Other respiratory	15%	14%	17%	20%*	13%	24%	16%	17%
Diabetes	9%	5%	14%*	11%	8%	23%*	19%	11%
Heart Disease	5%	2%	9%*	7%*	4%	10%	8%	9%
High Cholesterol	20%	9%	34%*	20%	20%	32%	29%	34%
Hypertension	22%	11%	36%*	25%	21%	53%*	32%	33%
Obesity	16%	12%	21%*	20%*	15%	29%	18%	21%
Thyroid	11%	8%	16%*	8%*	13%	11%	13%	17%

Note: Among women ages 18 to 64.

*Significantly different from reference group (18 to 44, 200% of poverty or higher, White), $p < .05$

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Women are at risk for a wide range of chronic conditions. Overall, the most frequently reported in women include arthritis (22%), hypertension (22%), and high cholesterol (20%). Other conditions such as obesity, asthma, and diabetes are less prevalent, but have gained more attention in recent years because of their growing rates and the toll they take, particularly on certain populations.

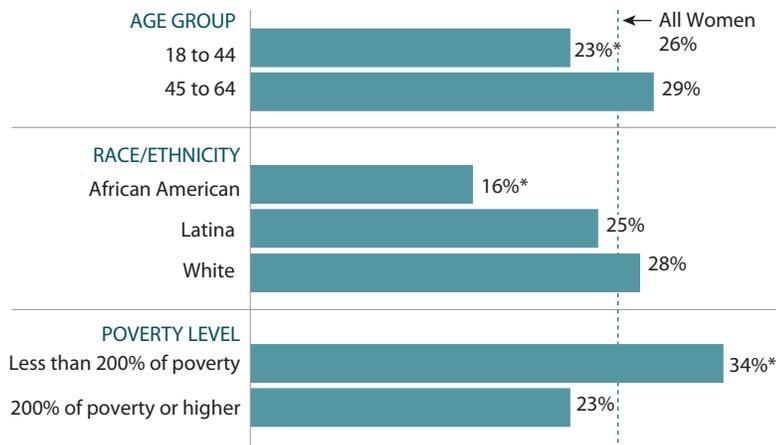
In general, the prevalence of most chronic conditions increases with age among women, often doubling or tripling between the reproductive and mid-life years. Low-income women have higher rates of asthma, obesity, and heart disease than higher-income women, but women with lower incomes report lower rates of thyroid conditions than higher-income women. This could be an artifact of testing related to poorer access to care for this population.

While African American women report higher rates of almost all chronic conditions than Latina and white women, the starkest differences are reported for arthritis, hypertension, and diabetes, with rates 1.5 to 2 times as high among African Americans.

EXHIBIT 1e

Depression and Anxiety, by Selected Characteristics

Percentage of women ages 18 to 64 reporting they have been diagnosed with depression or anxiety in past five years by physician:



Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

*Significantly different from reference group (45 to 64, White, 200% of poverty or higher), p < .05.

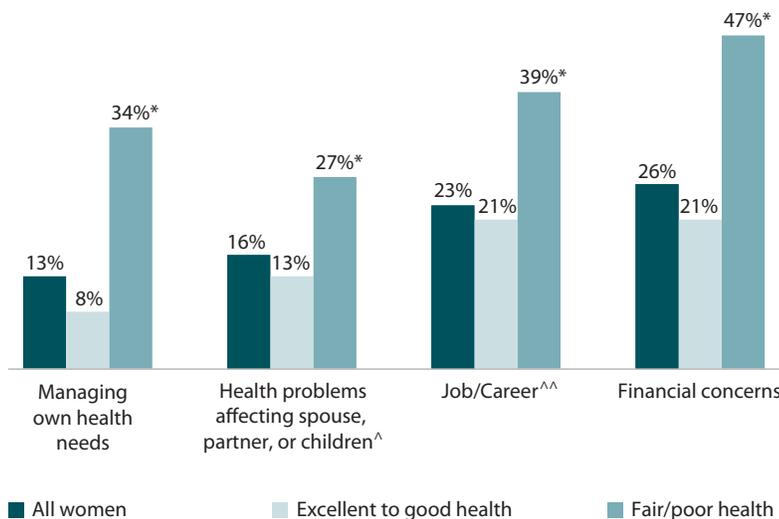
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Depression and anxiety are mental health conditions that affect approximately a quarter (26%) of all women ages 18 to 64. The prevalence increases with age, rising from 23% of women of reproductive age to 29% of mid-life women. White and Latina women report higher rates of diagnosed anxiety and depression than African American women. Approximately one-third (34%) of low-income women have been diagnosed with anxiety or depression in the past five years, compared to 23% of women with higher incomes.

EXHIBIT 1f

Sources of Stress, by Health Status

Percentage of women ages 18 to 64 reporting they feel a lot of stress from:



*Significantly different from excellent to good, p < .05.

[^]Among women who are married, living with a partner, or have a child under 18 in the household.

^{^^}Among women who are employed.

Response scale: a lot, some, not much, no stress at all.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Women experience stress from many different sources, including those generating from economic and health care problems. Over one in 10 women report that their own health needs (13%) and those of a family member (16%) cause them a lot of stress. About one in four women report feeling a lot of stress from their job/career (23%) and economic concerns (26%).

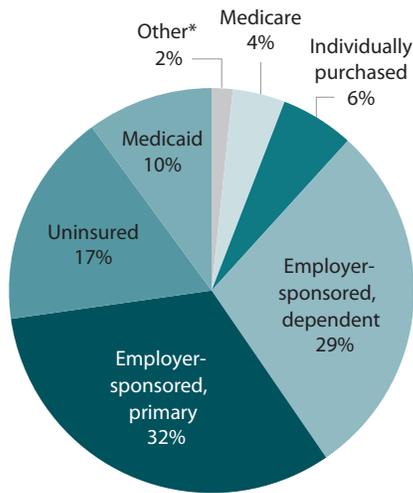
Women who are poorer health are more likely to report experiencing high levels of stress resulting from health, work, and financial concerns than women with better health. For example, four times as many women in fair or poor health (34%) report that managing their own health needs causes them a lot of stress compared to women in excellent to good health (8%). Nearly half (47%) of women reporting fair or poor health say that finances cause a lot of stress, as do 21% of women in excellent to good health.



CHAPTER 2:
Health Coverage

EXHIBIT 2a

Women’s Health Insurance Coverage



Note: Among women ages 18 to 64.

*Other includes CHAMPUS, TRICARE, and unknown insurance.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women’s Health Survey*, 2008.

More than 80% of women between the ages of 18 and 64 have some form of health insurance. The majority (61%) are covered through employer-sponsored health insurance. A small share of women (6%) purchase their own private insurance through individual policies. The public sector covers many women: Medicaid, the public program for the poor, assists 10%, Medicare covers 4% of women under 65 with disabilities, and a small share of women (2%) is covered under other government health care, such as military-sponsored insurance through CHAMPUS and TRICARE. Despite the array of private and public health coverage options available, 17% of women ages 18 to 64 do not have health insurance.

Covering the uninsured is a central element of the new health reform law and almost all individuals will be required to have coverage by 2014. Medicaid eligibility will be expanded to assist very low-income women, new private insurance market exchanges and subsidies will be available to assist those with modest or moderate incomes. In addition, a number of insurance reforms will be implemented that will prohibit insurers from turning down applicants based on health status. These changes will alter the profile of women’s health coverage in years to come.

EXHIBIT 2b

Characteristics of Women, by Type of Insurance

	Employer-sponsored	Individually purchased	Medicaid	Uninsured
AGE				
18 to 24 years	9%	19%	21%	23%
25 to 34 years	20%	9%	30%	24%
35 to 44 years	25%	27%	20%	21%
45 to 54 years	25%	19%	21%	21%
55 to 64 years	18%	26%	9%	10%
EDUCATION				
Less than high school	3%	2%	33%	29%
High school	27%	31%	36%	35%
Post-high school	30%	32%	23%	27%
College graduate and higher	39%	35%	6%	8%
EMPLOYMENT				
Full-time	60%	48%	13%	25%
Part-time	14%	18%	16%	15%
Retired	6%	11%	6%	3%
Not employed	17%	18%	55%	51%
Other*	6%	5%	9%	6%
HEALTH STATUS				
Excellent/very good/good	86%	92%	69%	75%
Fair/poor	13%	8%	30%	21%

Notes: Among women ages 18 to 64. Column totals may not add to 100% due to rounding.

*Other includes student, don't know, refused.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

The profiles of women covered by different types of insurance reflect the different avenues that individuals obtain coverage in the U.S. Not surprisingly, a higher share of women with employer-sponsored insurance have higher education levels and work full-time, compared to women with other forms of coverage.

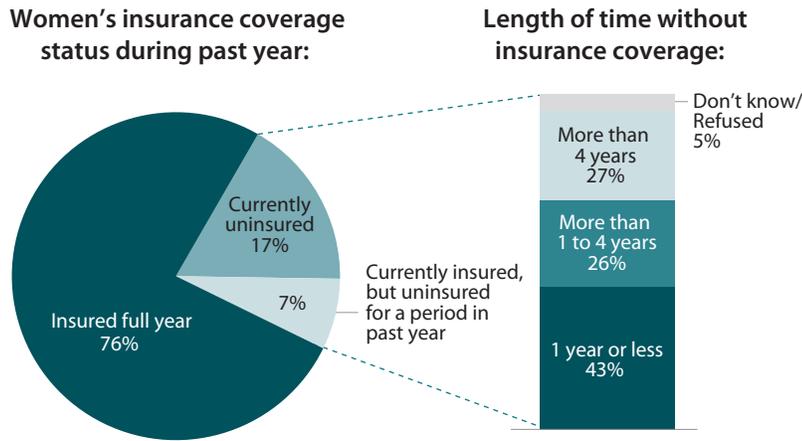
On average, women who purchase individual insurance policies are similar to women with employer-sponsored insurance in that they have higher income and education levels than women with public coverage or those without insurance. Nearly half (48%) of women who purchase individual insurance also work full-time, yet for a variety of reasons, they must purchase their own insurance, often because they are not offered insurance by their employer or their spouses, particularly if they work for a small business. Because women in poor health often do not qualify for coverage in the individual insurance market, those who do purchase individual policies are notably more likely to be in better health, even than those who get insurance through their employers.

Because of the way that Medicaid program eligibility is designed, women on Medicaid are the poorest group. However, this group of women are also most likely to be in poorer health, with 30% reporting health status as fair or poor, two to three times the rate of those with employer or individual insurance.

While employment is a major gateway to health insurance, it is not a guaranteed entrance. Approximately 40% of uninsured women work either full-time or part-time and many more likely have partners who are employed outside the home, yet they still do not have access to coverage because they cannot afford it or because they may not qualify because of health problems.

EXHIBIT 2c

Duration of Lack of Health Insurance Coverage



Note: Among women ages 18 to 64.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

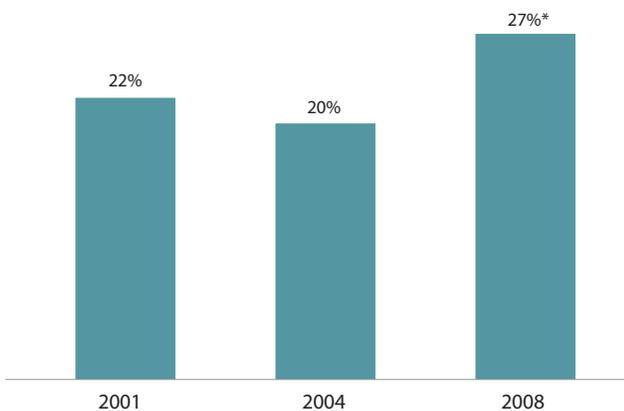
Even among women who have insurance, coverage is not always stable. In addition to the 17% of women currently uninsured, 7% of women who were insured at the time the survey was conducted were uninsured at some point during the prior year. One quarter (24%) of women ages 18 to 64 are currently without health insurance or have been uninsured at some point in the past year.

Though many of these women go without health insurance for a year or less, more than half (53%) were without health insurance for longer than a year; and 27% of women had long-term coverage gaps of more than four years. Gaps in coverage for longer periods of time can place women at risk for delays in treatment and lack of preventive care and ultimately affect health outcomes.

EXHIBIT 2d

Growth in Long-Term Uninsured

Percentage of uninsured women ages 18 to 64 reporting they were uninsured for at least four years:

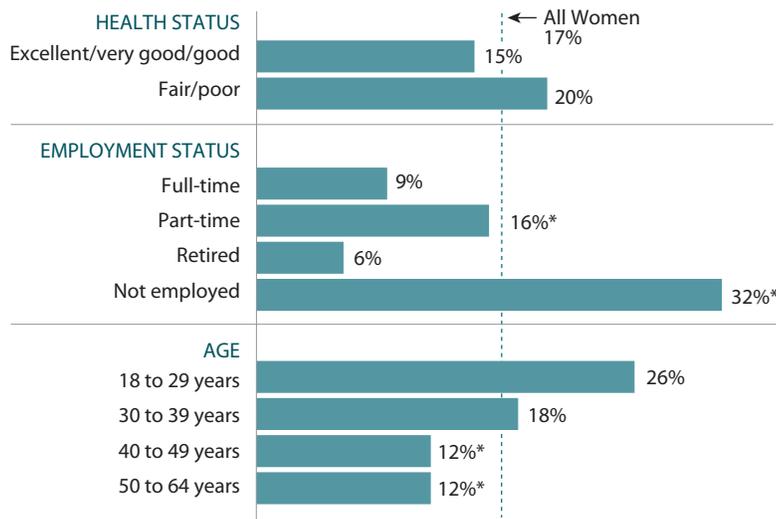


*Significantly different from 2004, $p < .05$.
 Source: Henry J. Kaiser Family Foundation, *2001, 2004, 2008 Kaiser Women's Health Surveys*.

The share of women who have been uninsured for longer periods of times has been rising. By 2008, 27% of uninsured women had been without coverage for at least four years. This is an increase from 20% in 2004. This could reflect changes in employment rates and the general downturn in the economy that occurred over this time.

EXHIBIT 2e

Uninsured Rate by Selected Characteristics



Note: Among women ages 18 to 64.

*Significantly different from reference groups (excellent to good, full-time employment, 18 to 29 years), p<.05.

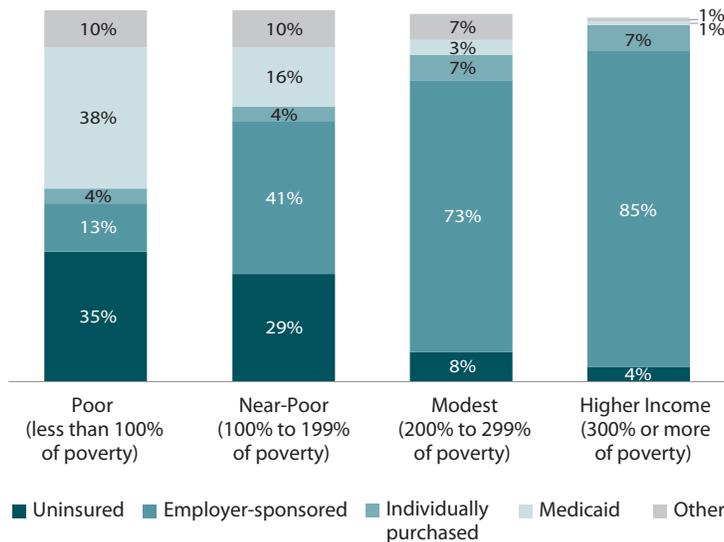
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Women who are young, working part-time, or unemployed are at highest risk for being uninsured. This is largely due to their lower incomes and lack of access to employment-based coverage. Full-time employment, however, is no guarantee of coverage, as nearly one in ten women (9%) who work full-time were uninsured.

Access to and affordability of coverage are also problems for a sizable share of women in poor health, with one in five (20%) reporting that they were uninsured. These women were disproportionately low-income and may have difficulty working due to their health problems; they also may not be able to afford or qualify for individual insurance because of pre-existing conditions.

EXHIBIT 2f

Health Insurance Coverage, by Poverty Level



Notes: Among women ages 18 to 64. 100% of the federal poverty threshold was \$17,600 for a family of three in 2008.

*Other includes Medicare, CHAMPUS, TRICARE, and unknown insurance.

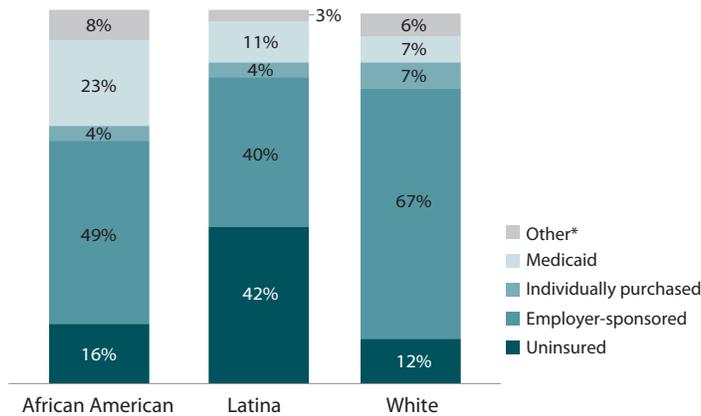
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Women with the lowest incomes, who had the least amount of money to spend on health care were most likely to be uninsured. While only 4% of higher-income women (family incomes of 300% or more of poverty) are uninsured, 35% of women under the poverty line and 29% of near-poor women (100 to 199% of poverty) were without coverage. Poor women are uninsured at nearly nine times the rate of women in the highest income level.

This disparity is due in part to differences in access to employer-based health coverage: higher-income women are 6.5 times as likely as poor women to have employer-sponsored health insurance (85% vs. 13%). Nearly three-fourths (73%) of poor women and half of near-poor women are either uninsured or on Medicaid. The availability of Medicaid, which covers 38% of poor women and 16% of near-poor women, gives many more women with limited resources access to coverage.

EXHIBIT 2g

Health Insurance Coverage, by Race/Ethnicity



Note: Among women ages 18 to 64.

*Other includes Medicare, CHAMPUS, TRICARE and unknown coverage.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Because women of color are more likely to work in low-wage jobs and have disproportionately lower incomes, they are also less likely to work in places that offer health insurance to their workers and more likely to qualify for Medicaid based on low income. Even when employers offer coverage to low-wage workers, it is more difficult for low-wage workers to afford the cost of premiums and some are forced to opt out.

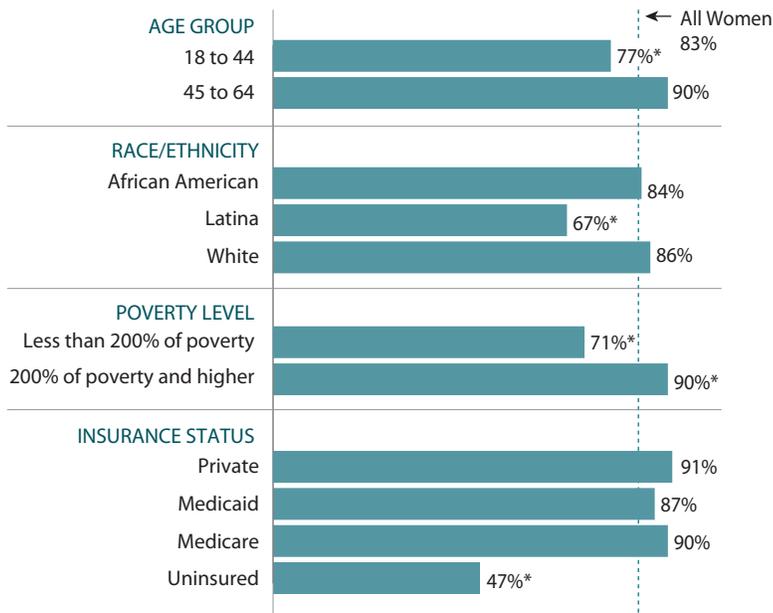
Lack of insurance is a problem for women of all races and ethnicities but a staggering 42% of non-elderly Latina women are uninsured, a rate 2.5 times higher than African American women and 3.5 times white women—and the highest rate of uninsurance of all groups of women examined in this survey. Just 40% of Latina women have employer-sponsored health insurance, as compared to 67% of white women. Like Latinas, African American women have lower rates of employer-sponsored health insurance (49%) but have higher rates of Medicaid coverage (23%) than white women.



CHAPTER 3:
Delivery System

EXHIBIT 3a

Women With a Regular Health Care Provider, by Selected Characteristics



Notes: Among women ages 18 to 64. 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

*Significantly different from reference groups (45 to 64, White, 200% of poverty and higher, Private), $p < .05$.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Having a regular health care provider helps women maintain a consistent relationship with the health care system, fosters their use of preventive services, and promotes their access to care. While most women (83%) have a regular provider, significant disparities exist within groups of women by age, race/ethnicity, poverty level, and insurance status.

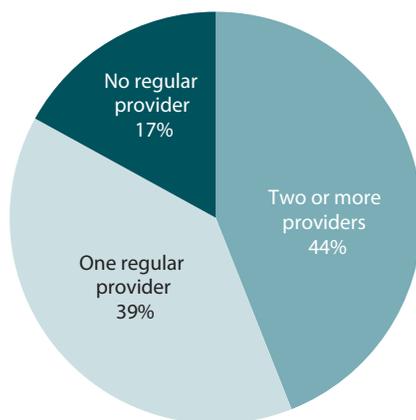
As women get older, they are more likely to have a regular provider. Nine in ten women ages 45 to 64 report they see a provider on a regular basis, compared to 77% of women ages 18 to 44. Only two-thirds (67%) of Latinas have a regular provider, a considerably lower rate than African American (84%) and white women (86%). Similarly, low-income women (71%) are much less likely to have a regular provider than higher income women (90%).

Insurance status is also associated with whether or not women have a regular provider. Fewer than half of uninsured women (47%) have a provider they see on a regular basis, compared to approximately nine in ten women with private insurance (91%), Medicare (90%) or Medicaid (87%).

EXHIBIT 3b

Number of Providers Women See

Percentage of women ages 18 to 64 reporting they see:



Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008

Among women who have regular providers, many (44%) also see more than one provider to care for their variety of health needs. Having multiple providers may help many women manage their wide range of health care needs, but it also raises the importance of continuity and coordination of care between providers. Conversely, 17% of women do not have an ongoing relationship with a provider.

EXHIBIT 3c

Provider Specialties, by Age Group**Among women who have a regular provider:**

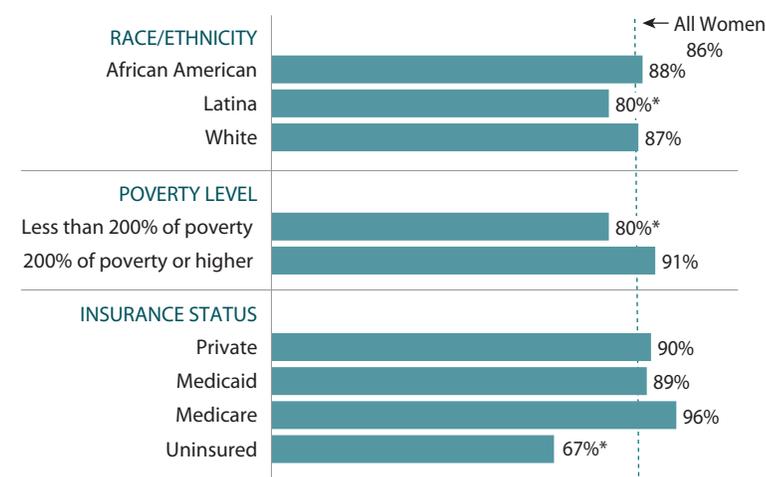
Provider Type	All Women	Women 18 to 44	Women 45 to 64
SPECIALTY OF REGULAR PROVIDER			
Family Practice or Internal Medicine	73%	70%	77%
Ob-Gyn	10%	14%	5%
Other Specialty	3%	2%	4%
Physician Assistant or Nurse Practitioner	8%	10%	9%
Don't Know	4%	4%	4%
Two or More Providers	53%	50%	56%

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Most women who have a regular provider see an internist or family practice physician (73%), with the share increasing slightly as women age. Ten percent of women state that an Ob-Gyn is their regular provider, more common among women in their reproductive years (14%) compared to just 5% of women in middle age. Overall, 8% of women with a regular provider report that provider is a physician assistant or nurse practitioner.

The type of provider changes slightly over the course of women's lives. During reproductive years, a common combination is a primary care provider and an Ob-Gyn. As women age, they are more likely to have at least two providers, but are also less likely to see an Ob-Gyn regularly.

EXHIBIT 3d

Provider Visit in Past Year**Percentage of women ages 18 to 64 reporting they have seen a health care provider in the past year:**

Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

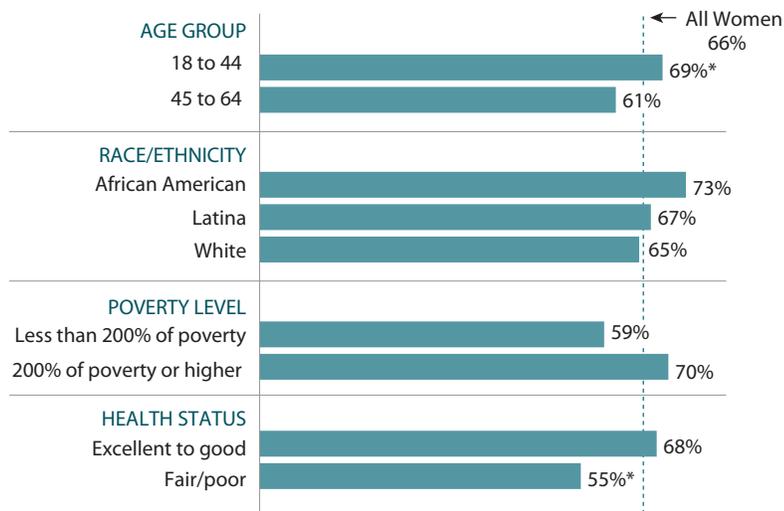
*Significantly different from reference group (White, 200% of poverty or higher, Private), $p < .05$.Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

The vast majority (86%) of women have had at least one visit with a health care provider in the past year. There were not large differences between women of different age groups or race/ethnicities, but Latina women, who overall are a younger population and more likely to be uninsured, were significantly less likely to have seen a provider in the past year. Low-income women were also less likely to have seen a provider. The starkest disparity was for uninsured women (67%), who were much less likely to have seen a provider, compared to women with any form of insurance.

EXHIBIT 3e

Use of Gynecological Care, by Selected Characteristics

Percentage of women ages 18 to 64 with an Ob-Gyn visit in the past year:



*Significantly different from reference group (45 to 64, White, 200% of poverty or higher, Excellent to good), $p < .05$. 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

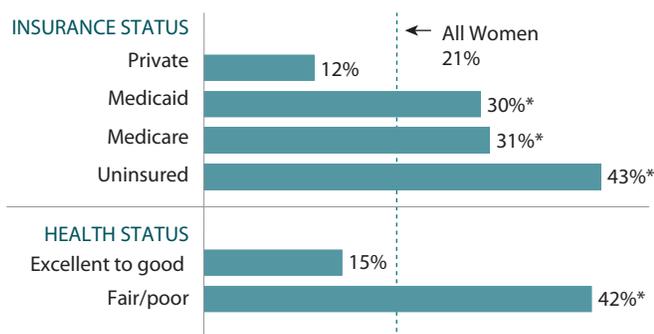
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Two-thirds of women had a visit to an Ob-Gyn in the past year. Not surprisingly, women in their reproductive years (69%) were more likely to have visited an Ob-Gyn in the past year than older women. A smaller share of low-income women saw an Ob-Gyn, as did women in poorer health, compared to women in better health status.

EXHIBIT 3f

Access to Specialists, by Selected Characteristics

Percentage of women ages 18 to 64 reporting that in the past year they were not able to see a specialist when they thought one was needed:



*Significantly different from reference group (Private, Excellent to good), $p < .05$.

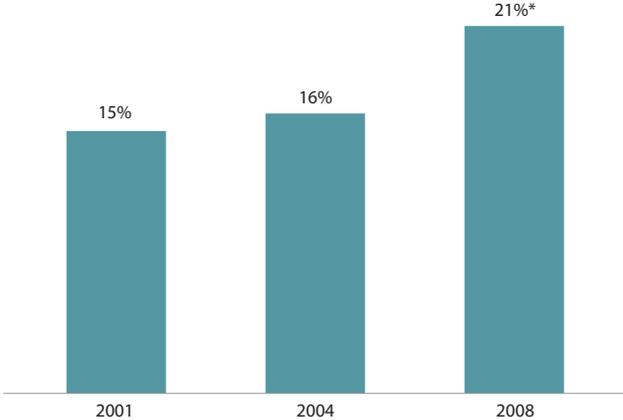
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Specialists provide a range of important services for women with chronic illnesses or more advanced acute conditions. However access to specialty care can be a problem for a significant minority of women. One in five women reported that they could not see a specialist in the past year when they thought it was needed. Women with private insurance fared better than women with public coverage, but still 12% had problems accessing specialty care. More than four in ten uninsured women (43%) and women in poorer health (42%) reported they could not see a specialty provider when needed.

EXHIBIT 3g

Worsening Access to Specialty Care

Percentage of women ages 18 to 64 reporting that in the past year they were not able to see a specialist when thought one was needed:



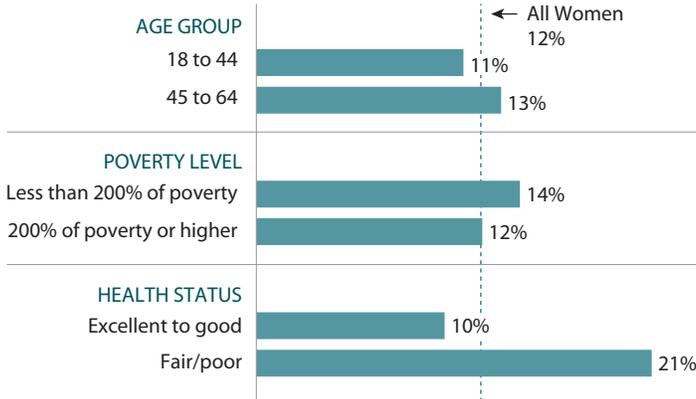
*Significantly different from 2001 and 2004, p< .05.
Source: Henry J. Kaiser Family Foundation, 2001, 2004, 2008 Kaiser Women's Health Surveys.

Over time, access to specialists has worsened for women, with one-fifth (21%) of women reporting they could not see a specialist by 2008, compared to 16% just four years earlier. Although this survey is not able to analyze the reason for this rise in access problems, this could be attributable to increased costs, greater number of women without coverage, and increasing enrollment in managed care plans with more restrictive gatekeeper arrangements.

EXHIBIT 3h

Use of Mental Health Care, by Selected Characteristics

Percentage of women ages 18 to 64 who had a visit with a mental health professional in past year:



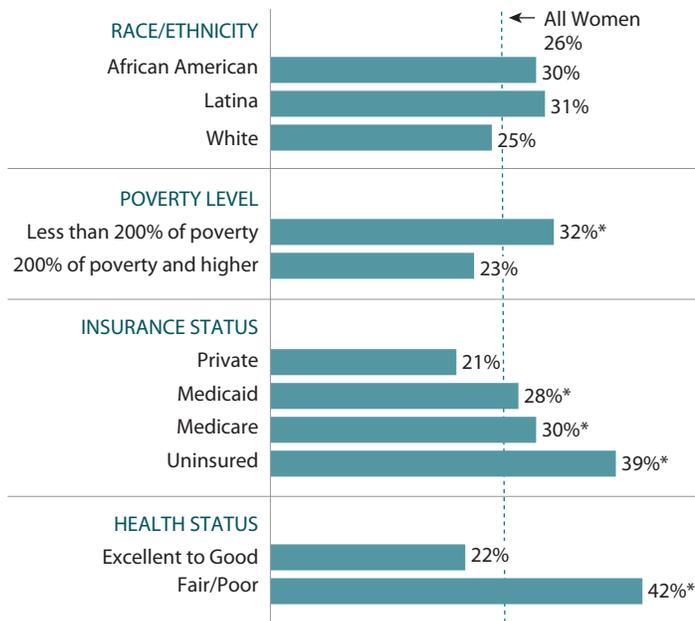
Notes: Includes visits to psychiatrist, therapist, counselor, and other mental health providers. 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.
*Significantly different from reference group (45 to 64, 200% of poverty or higher, excellent to good), p<.05.
Source: Henry J. Kaiser Family Foundation, Kaiser Women's Health Survey, 2008

Mental health care services can be a critical element of care for many women, as women are at greater risk for experiencing conditions such as anxiety and depression than men. Overall, 25% of women reported that they had been diagnosed with anxiety or depression (Exhibit 1e), and 12% of women reported seeing a mental health professional in the past year. The rate among women reporting poorer health status (21%) was double that for women reporting better health status (10%).

EXHIBIT 3i

Concerns About Quality of Care

Percentage of women ages 18 to 64 reporting they had concerns about the quality of health care they received in the past year:



Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

*Significantly different from reference group (White, 200% of poverty and higher, Private, Excellent to Good).

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

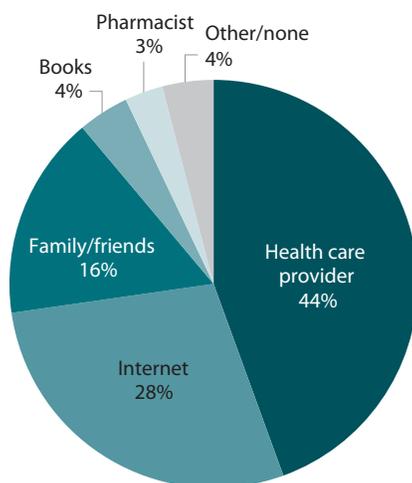
In recent years, there has been growing recognition of the importance of quality of health care. Overall, one in four women (26%) expressed concerns about the quality of health care they received in the past year.

Low-income women (32%) in particular were more likely to express concerns about health care quality than women with higher incomes (23%). There are also differences by insurance status, with uninsured women (39%) and women who have Medicare (30%) or Medicaid (28%) all more likely to express concerns about quality than women with private insurance. Four in ten (42%) women in fair or poor health expressed concerns with quality compared to 22% of women in better health.

EXHIBIT 3j

Sources of Health Information

Percentage of women ages 18 to 64 who turn to particular source first when seeking health information:



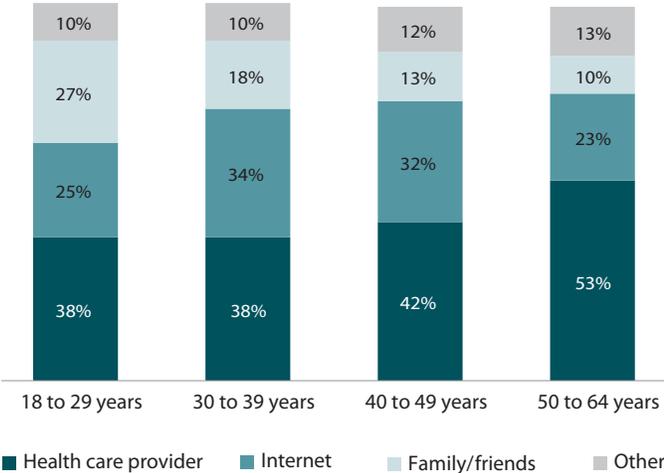
Source: Henry J. Kaiser Family Foundation, *2008 Kaiser Women's Health Survey*.

Over time, new sources of health information have developed, namely through technology and the web. However, women are still most likely to turn to a provider when seeking information, with 44% reporting providers as their leading source. The growing presence of the Internet is evidenced though by the fact that more than a quarter of women (28%) turn to it first for health information, making it the second leading provider of information. 16% of women first turn to family and friends when they are searching for health information.

EXHIBIT 3k

Sources of Health Information, by Age Group

Percentage of women ages 18 to 64 who turn to particular source first when seeking health information:



There are noticeable generational differences in how women get health information. While health care providers are the primary source for women of all ages, they are less dominant among younger women, who also rely heavily on family and friends and the Internet. The Internet plays the greatest role for women in their thirties and forties, acting as the leading source for almost a third of women in these age groups. Older women are the most likely to seek information from a provider, yet even among women in their fifties and sixties, almost a quarter (23%) turn to the Internet first.

Source: Henry J. Kaiser Family Foundation, 2008 Kaiser Women's Health Survey.



CHAPTER 4:
Prevention and Screening

EXHIBIT 4a

Screening Tests, by Selected Characteristics

Percentage of women ages 18 to 64 reporting they received a screening test in past two years:

Screening Test	AGE GROUP			INSURANCE STATUS			
	ALL	18 to 44	45 to 64	Private	Medicaid	Medicare	Uninsured
Physical/clinical breast exam	76%	73%*	81%	84%	65%*	87%	51%*
Mammogram (ages 40 and older)	75%	67%*	77%	79%	67%	84%	50%*
Pap smear	78%	80%*	74%	82%	76%	72%*	65%*
Colon cancer (ages 50 and older)	40%	N/A	40%	42%	~	51%	21%*
Blood pressure	91%	89%*	93%	96%	86%*	92%	74%*
Blood cholesterol	63%	52%*	77%	71%	47%*	78%	37%*

N/A Not applicable

~ Sample size too small for reliable estimate.

*Significantly different from reference group (45 to 64, Private), p < .05.

Source: Kaiser Family Foundation, *Kaiser Women's Health Survey, 2008.*

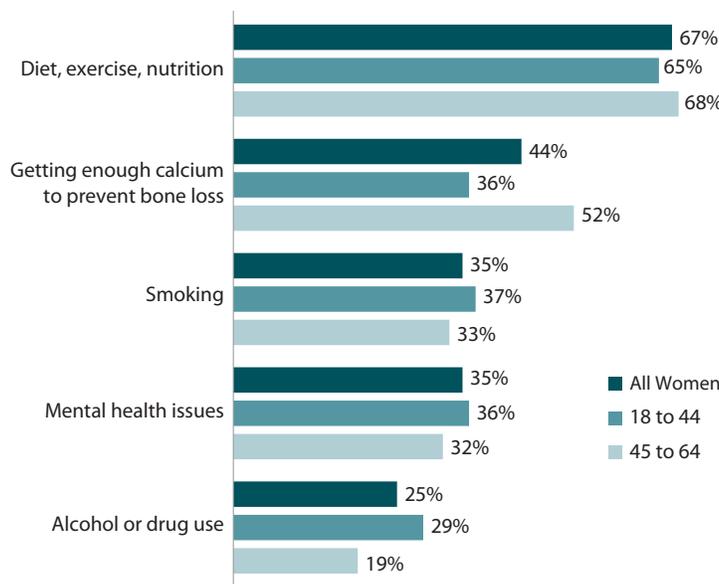
Screening is another critical tool in the provision of prevention services, early identification, and management of many chronic illnesses. Recommendations for screening tests are reviewed regularly, and often there are differences between various professional groups which can lead to confusion. Screening rates increase with age, as more women fall into the recommended age groups and the incidence of clinical health problems rises.

Uninsured women in particular are less likely to have received any screening test, compared to women with employer-sponsored insurance, not surprising given they have less access to providers and no coverage for the costs of the tests. Women on Medicaid also have lower use of some screenings than women with employer-based insurance, but still have higher screening rates than uninsured women.

EXHIBIT 4b

Counseling About Health Behaviors, by Age Group

Percentage of women ages 18 to 64 reporting they have discussed topic with doctor or nurse in past 3 years:



Source: Kaiser Family Foundation, *Kaiser Women's Health Survey, 2008.*

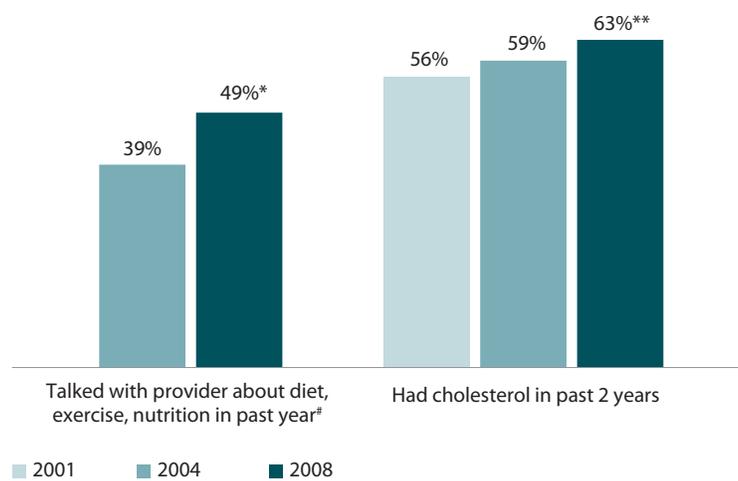
Counseling and education are key elements of prevention, management, and treatment of health issues. Many women reported they had not recently had a conversation with a provider about specific health risks and health behaviors which are considered to be important to women's health. The most frequently discussed issue was diet, exercise and nutrition, with 67% of women saying that their doctor asked about these health habits in the past three years.

The next most frequently discussed topic was getting enough calcium to prevent bone loss (44%). Reflecting the increasing prevalence of bone loss with age, women ages 45-64 (52%) were more likely to discuss this topic with their doctor than women ages 18 to 44 (36%), but still below recommended rates. Discussion of other topics was less frequent. About one-third of women had talked with a provider about smoking (35%) and mental health issues (35%) in the past three years. A quarter had recently discussed alcohol or drug use (25%), with older women less likely to have discussed this with a provider than younger women (19% and 29%, respectively).

EXHIBIT 4c

Growing Attention to Obesity and Related Conditions

Percentage of women ages 18 to 64 reporting they:



[#]Question not asked in 2001.

*Significantly different from 2004, $p < .05$.

**Significantly different from 2001 and 2004, $p < .05$.

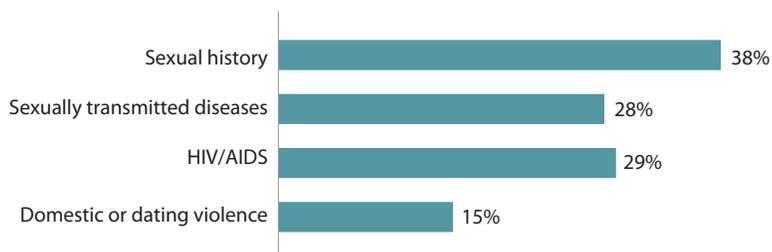
Source: Henry J. Kaiser Family Foundation, 2001, 2004, 2008 Kaiser Women's Health Surveys.

There has been growing interest and awareness among the public about the rising prevalence in chronic illnesses, and in particular the role of prevention. Between 2001 and 2008, the share of women who reported that they had been diagnosed with obesity in the prior five years rose from 11% to 16%. At the same time, there seems to be growing awareness among providers as well. Between 2004 and 2008, the share of women who had talked with a provider in the prior year about diet, exercise, and nutrition issues increased from 39% to 49%. Rates of screening for high cholesterol also increased from 56% in 2001 to 63% in 2008.

EXHIBIT 4d

Counseling About Sexual Health

Percentage of women ages 18 to 44 reporting they have discussed topic with doctor or nurse in past 3 years:



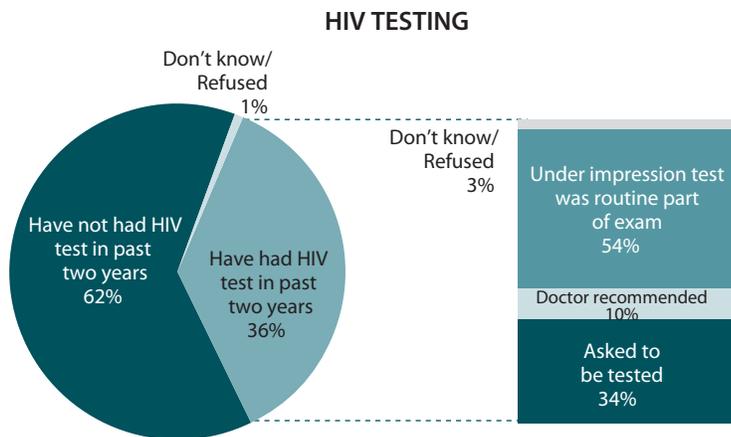
Source: Kaiser Family Foundation, Kaiser Women's Health Survey, 2008.

Counseling on sexual health topics can be a sensitive topic for both patients and health care providers. Despite the importance of sexual health for women throughout their lifespan, counseling is infrequent even among women in their peak reproductive years. Just thirty-eight percent of women ages 18 to 44 had a recent conversation with a provider about their sexual history. While prevention and treatment of sexually transmitted diseases (STDs) continues to be a major public health challenge, fewer than one in three women in their reproductive years had discussed STDs (28%) or HIV/AIDS (29%) with a health care provider in the past three years. Discussion of domestic or dating violence (15%) was even more limited.

EXHIBIT 4e

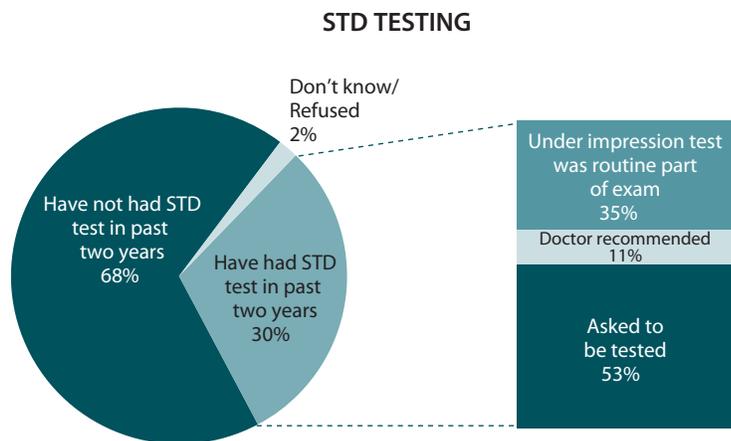
HIV and STD Testing

Percentage of women ages 18 to 49 who received test in past two years:



Many women in their reproductive years are at risk for sexually transmitted infections, such as HPV, chlamydia, and HIV. Testing for STDs such as Chlamydia and Gonorrhea is important for early identification and intervention. Yet only thirty percent of women ages 18 to 49 report that they have been tested for an STD in the past two years. The actual figure is likely lower, however since 35% of these women were under the impression that STD testing was a routine part of an exam, which cannot be assumed.

The story is similar for HIV testing, but there even greater uncertainty. Thirty-six percent of women reported having an HIV test in the past two years, but more than half (53%) assumed it was a routine part of an exam, which is often not the case.

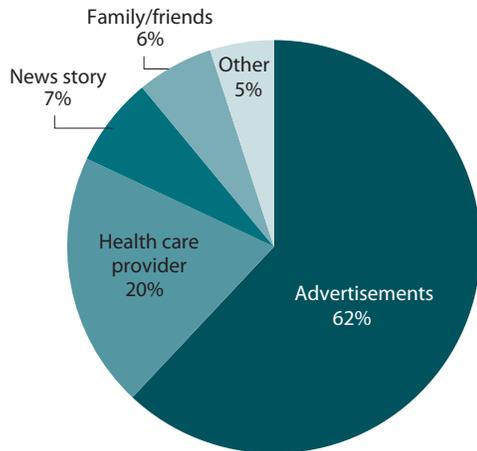


Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008

EXHIBIT 4f

Sources of Information on HPV Vaccine

Of women ages 18 to 64 who have heard of vaccine, the percentage who heard through:



Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008

In June 2006, the FDA approved a new vaccine against Human Papillomavirus (HPV) for use in women ages 9-26. Following an extensive media campaign by the manufacturer and many news stories, by summer 2008, most women had heard of the vaccine. Advertising was the leading source of information, with the majority of women (62%) reporting that as the medium for hearing about the vaccine. Health care providers continue to play an important role, with 20% of saying they learned about the vaccine from a provider.

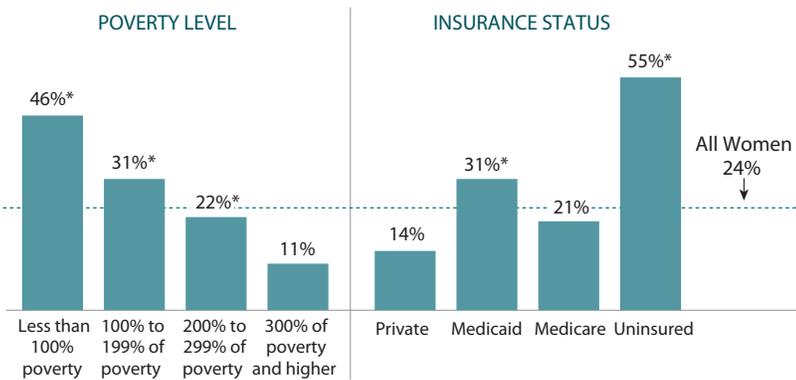


CHAPTER 5:
Access and Affordability

EXHIBIT 5a

Delayed or Went Without Care Because of Cost, by Poverty and Insurance Status

Percentage of women ages 18 to 64 reporting they delayed or went without care they thought they needed in the past year because of the cost:



*Significantly different from reference group (300% of poverty and higher, Private), $p < .05$.
 Note: 100% of the federal poverty threshold was \$17,600 for a family of three in 2008.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Affordability of care a major concern for many health care consumers. Health care costs, such as insurance premiums, co-payments, deductibles, and services that are not covered, can quickly escalate and limit access to care.

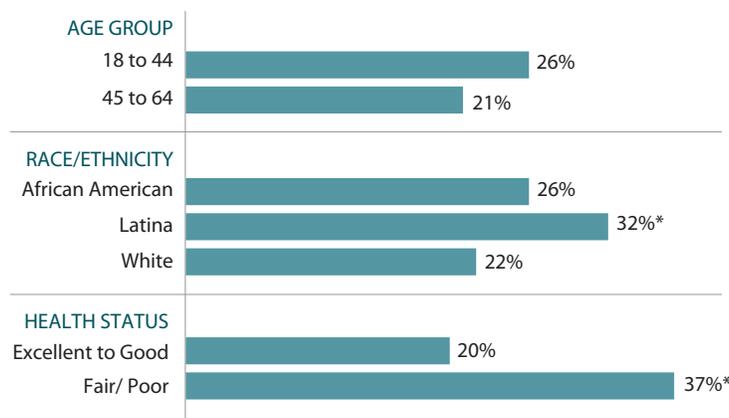
One out of four women (24%) report that they went without care they thought they needed because they could not afford it. Not surprisingly, women with lower incomes who have the hardest time paying for health care, are much more likely than their higher-income counterparts to delay or go without services. Almost half (46%) of poor women and almost one-third (31%) of near-poor women skipped or delayed needed care because of the costs, compared to 11% of the highest income group.

Women without insurance are also at much higher risk for postponing or foregoing care, with more than half (55%) of uninsured women doing so, compared to 31% of women on Medicaid, 21% of women on Medicare, and 14% of women with private insurance. However, these data also illustrate that even women with insurance can face affordability barriers.

EXHIBIT 5b

Delayed or Went Without Care Because of Cost, by Selected Characteristics

Percentage of women ages 18 to 64 reporting they delayed or went without care they thought they needed in the past year because of the cost:



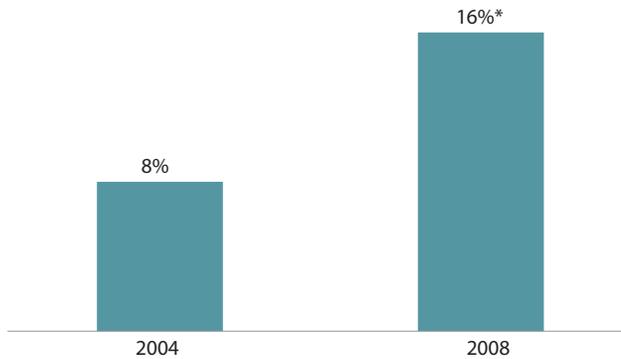
*Significantly different from reference group (45 to 64, White, excellent to good), $p < .05$.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Younger women, who typically have lower earnings are more likely to delay care because of costs, as are women of color, and those in the worst health status. These are groups who have higher rates of lack of insurance and in many cases, particularly those who face poor health, have a greater need for health care services.

EXHIBIT 5c

More Evidence of Tradeoffs to Pay for Health Care

Percentage of women ages 18 to 64 reporting they spent less on other basic needs in the past year to have enough money for health care:



Note: Other basic needs include food, utilities, and other items.

*Significantly different from 2004, $p < .05$.

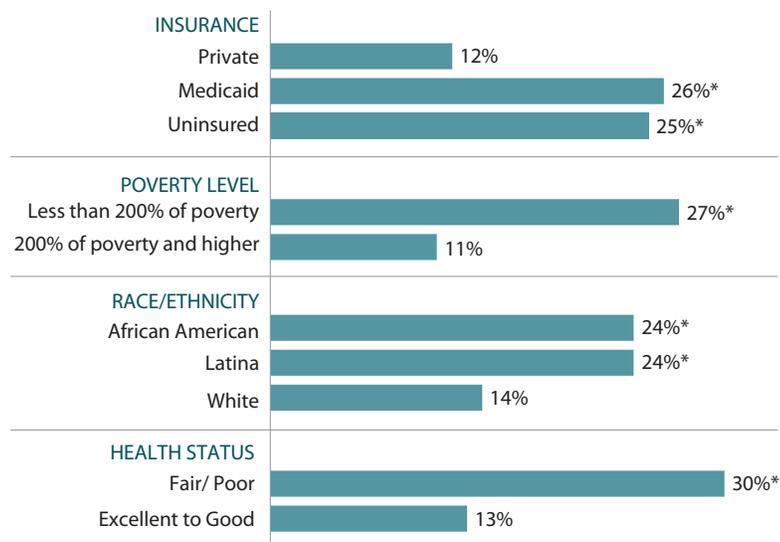
Source: Henry J. Kaiser Family Foundation, 2004, 2008 *Kaiser Women's Health Surveys*.

Some women deal with health care cost pressures by making tradeoffs with other expenses, and this seems to be getting worse. Between 2004 and 2008, the share of women reporting they had to spend less on other basic needs to pay for health care doubled from 8% to 16%. The dual pressures of increasing health care costs and the recession have likely strained many women and affected their ability to make ends meet and pay for care. This survey was conducted in the earlier days of the economic crisis and this number may have been even higher during the peak of the crisis.

EXHIBIT 5d

Financial Tradeoffs to Pay for Health Care

Percentage of women ages 18 to 64 reporting they spent less on other basic needs in the past year to have enough money for health care:



Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

*Significantly different from reference group (Private, 200% of poverty and higher, White, excellent to good), $p < .05$.

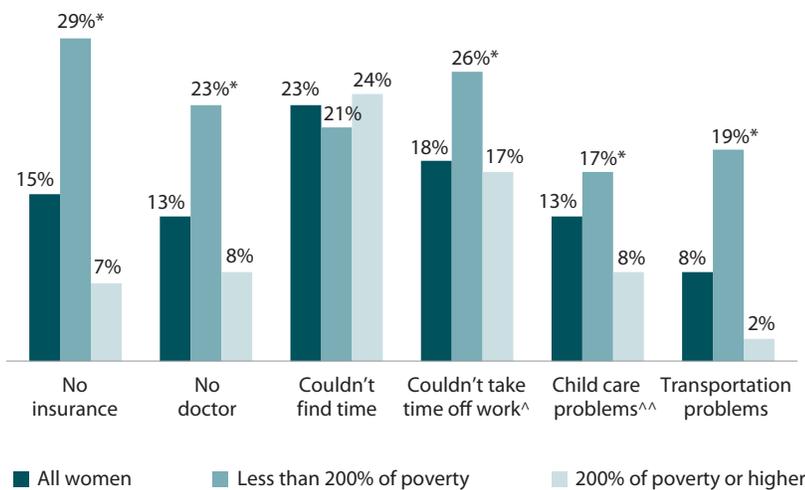
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Not surprisingly poorer and uninsured women are more likely to make tradeoffs in order to pay for health care. Approximately a quarter of women who are uninsured (25%), on Medicaid (26%), low-income (27%), African American (24%), or Latina (24%) report spending less on other basic needs to have enough money to pay for health expenses. The rate is even higher among women in the worst health status (30%), and is more than twice as high than women in better health (13%).

EXHIBIT 5e

Reasons for Delaying or Going Without Care, by Poverty Level

Percentage of women ages 18 to 64 reporting they delayed or went without care they thought was needed in the past 12 months due to:



Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

*Significantly different from 200% of poverty and higher, p<.05.

[^]Among women who are employed.

^{^^}Among women with children younger than 18 years living in household.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008

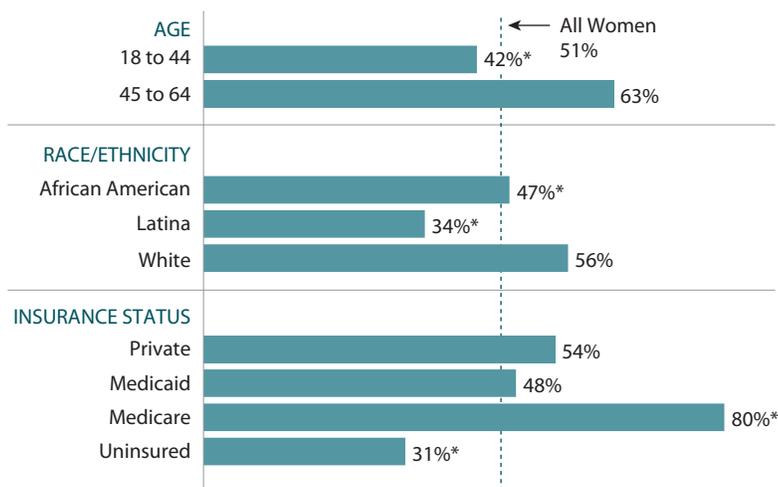
Women's access to health care intersects with a host of other health-related issues, as well as family, work, and economic responsibilities. More than one in ten women stated that they delayed or went without needed care because they did not have insurance (15%) or a personal physician (13%). Twenty-three percent of women cited time as a factor in delaying or preventing receipt of care, and 18% stated that they couldn't take time off work. For mothers, lack of childcare also plays a role, as 13% stated they didn't receive care when they needed it because of problems finding child care. Almost one in ten (8%) stated transportation was the problem in getting health care.

Virtually across the board, low-income women reported higher rates of these challenges, often two to three times as high. The one exception was lack of time, which affected all women almost equally.

EXHIBIT 5f

Use of Prescription Drugs, by Selected Characteristics

Percentage of women ages 18 to 64 reporting they use at least one prescription drug on a regular basis:



*Significantly different from reference group (45 to 64, White, Private), p<.05.

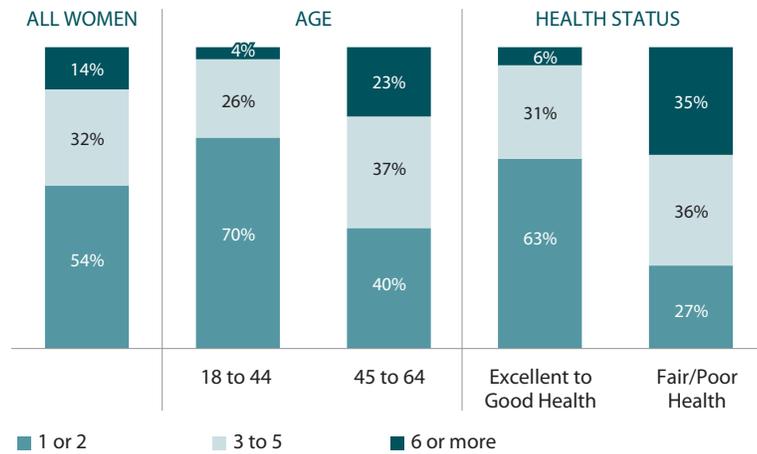
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008

Half (51%) of women rely on a prescription medicine on an ongoing basis. Use of prescription drugs is shaped by health needs, access to care, and affordability of medications. The proportion of women who rely on drugs on a regular basis increases with age, as the rate of chronic illnesses also increases and the need for medications rises. White women (56%) are more likely than women of color to take a prescription medicine regularly, likely due to their higher rates of insurance and relatively higher incomes and better access to care. Not surprisingly, there are also sharp differences by insurance status. The vast majority (80%) of younger women ages 18 to 64 on Medicare, take a prescription medicine regularly, not surprising since most have severe disabilities. About half of women with private insurance (54%) or Medicaid (48%) use a prescription medicine regularly, a much higher share than women who are uninsured (31%) and have no coverage at all to cover the costs of drugs and more limited access to care.

EXHIBIT 5g

Number of Prescription Drugs, by Age and Health Status

Among women ages 18 to 64 who take at least one prescription medicine on a regular basis, the number of drugs they take:



Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008

Among women who use prescription drugs on a regular basis, most use only one or two prescriptions regularly (54%), but a sizable minority (14%) do take at least six different medications on a regular basis. Not surprisingly, there are major differences by age and health status. Women who are 45-64 years old (23%) are about six times as likely as younger women to take at least six medications on an ongoing basis. The same is true when comparing women in the poorest health (35%) to women in the best health status (6%).

EXHIBIT 5h

Prescription Drug Costs, by Selected Characteristics

Percentage of women ages 18 to 64 reporting that in the past year they:	ALL WOMEN	HEALTH STATUS		POVERTY LEVEL	
		Excellent to Good	Fair or Poor	Less than 200% of Poverty	200% of Poverty and Higher
Did not fill prescription medicine due to cost	23%	19%	38%*	35%*	18%
Skipped or took smaller doses of prescription medicines to make them last longer	18%	14%	36%*	28%*	14%

Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

*Significantly different from reference group (excellent to good, 200% of poverty and higher) $p < .05$.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

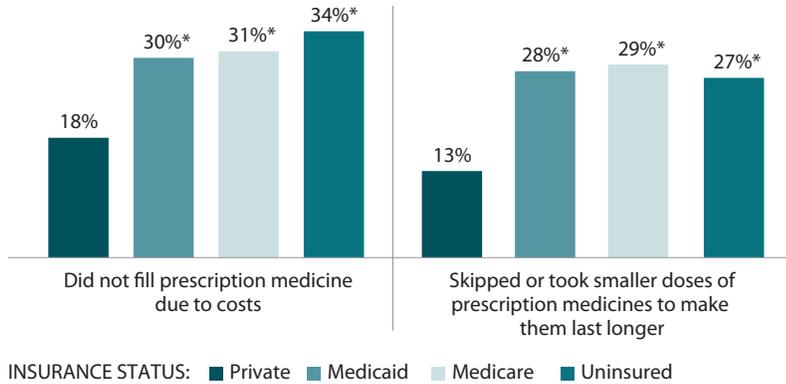
Drug costs are a sizable concern for many women. Nearly one-quarter of women (23%) reported that they did not fill a prescription medicine due to costs, and almost one in five (18%) women skipped or took smaller doses of medications to make them last longer. Of those women who did not fill a prescription or skipped or took smaller doses, 55% reported that they had told a doctor of these tradeoffs (Data not shown).

Not surprisingly, a larger share of women in fair/poor health (73%) than women in excellent to good health (47%) take a prescription medication on a regular basis (Data not shown). However, women in poorer health are also at least twice as likely to compromise medication use because of cost. Thirty-eight percent of women in poorer health did not fill a prescription because of the costs, compared to 19% of women in better health. Similarly, 36% of women in poorer health skipped or took smaller doses to stretch out medications, compared to 14% of women in better health. This is of particular concern, given that missing medications may jeopardize women's health, particularly those in poorer self-reported health status. Lower-income women were also more likely to skip prescriptions or cut doses in the face of cost challenges.

EXHIBIT 5i

Prescription Drug Costs, by Insurance Status

Percentage of women ages 18 to 64 reporting that in the past year they:



*Significantly different from Private, p<.05.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

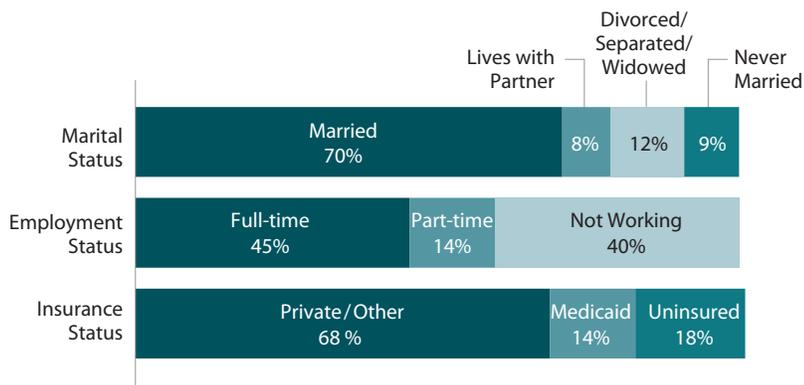
Although insurance is an important factor in affordability of prescription medicines, it does not completely eliminate cost barriers. Eighteen percent of women with employer-based insurance said they did not fill a prescription, and 13% skipped or took smaller doses to make medicines last longer because of costs. However, cost problems affected a significant share of women who are uninsured, on Medicaid, or Medicare, who are disproportionately low income and have fewer resources even for minimal co-payments.



CHAPTER 6:
Work, Family, and Caregiving

EXHIBIT 6a

Characteristics of Mothers and Guardians of Dependent Children



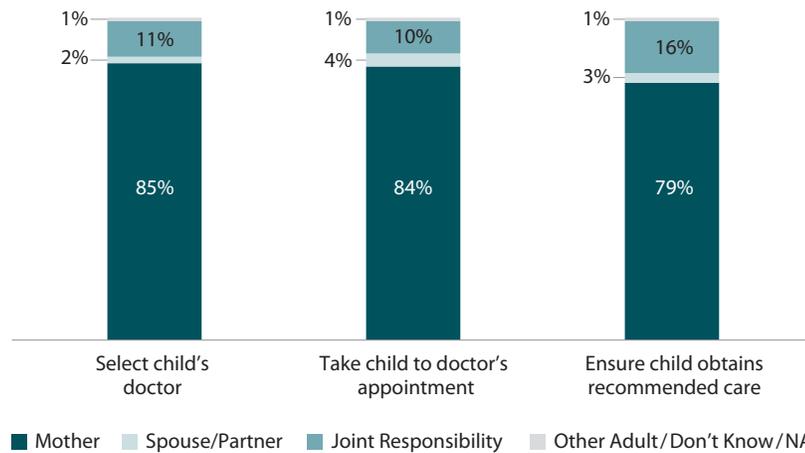
Nearly half (46%) of adult women have children under age 18 at home (data not shown). Women with children often face challenging time constraints and must balance multiple obligations. In their roles as mothers, women are the primary caretakers of their children's needs, including managing their health care. About one in five (21%) mothers are single parents and six in ten (59%) work outside the house either full-time or part-time. Many mothers also contend with their own health concerns. In particular, 18% are uninsured.

Note: Mothers/guardians refers to women with children under 18 in the household.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

EXHIBIT 6b

Caring for Children's Health

Percentage of mothers/guardians who usually:

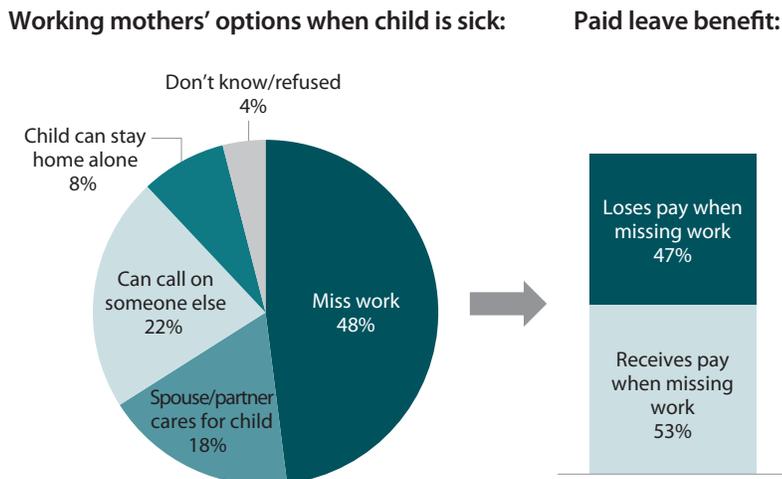


Women are the primary coordinators of health care for their children. The vast majority of mothers select their children's doctor (85%), take them to doctor's appointments (84%), and ensure that they obtain recommended care (79%). A small portion of mothers report that they share these responsibilities with their spouses and partners.

Note: Mothers are women with children under 18 in the household.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

EXHIBIT 6c

Impact of Family Health Responsibilities



As the primary coordinators of health care for their children, many working women (48%) must take time off when their children get sick. About one-fifth of women reported that their spouses (18%) or somebody else (22%) could take care of their children when needed. However, on top of shouldering primary responsibility for caring for sick children, about half (47%) of women who don't have child care alternatives lose pay when they stay home to care for a sick child.

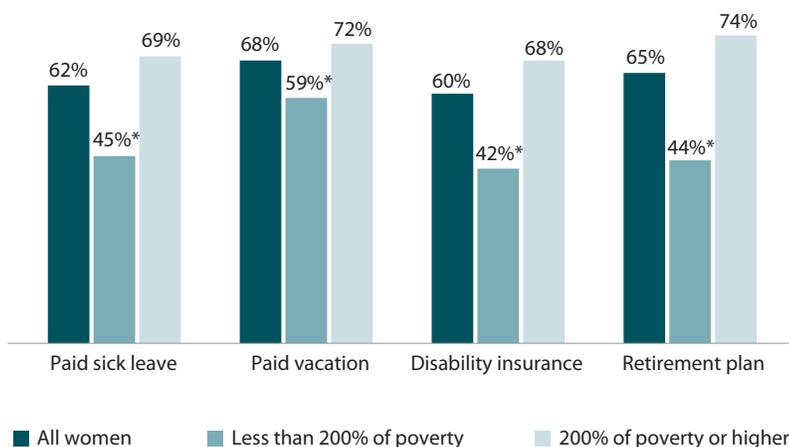
Note: Among mothers of children under 18 in the household, who are working full-time or part-time.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

EXHIBIT 6d

Workplace Benefits

Percentage of working women ages 18 to 64 reporting their employer offers them:



Nearly six in ten (59%) women work outside the home, either full-time or part-time. Work related fringe benefits like paid sick leave and vacation time allow workers to take time off in the case of an illness, to attend to family matters, take a vacation, and a host of other reasons. Disability insurance can offer important financial protection in the event of an injury that prevents a worker from being able to work. Retirement plans, such as a 401(k) help workers plan and save for expenses in the retirement years when they may live on fixed incomes. Over six in ten women working outside the home report that their employers offer them these benefits.

Despite the importance of these benefits in economic security, across the board, working low-income women are less likely to have access to any of them. Fewer than half of low-income women are offered paid sick leave (45%), disability insurance (42%), or a retirement plan (44%), whereas approximately seven in ten women with higher incomes work for employers offering these benefits.

Note: Among women who are employed full-time or part-time.

*Significantly different from 200% of poverty or higher.

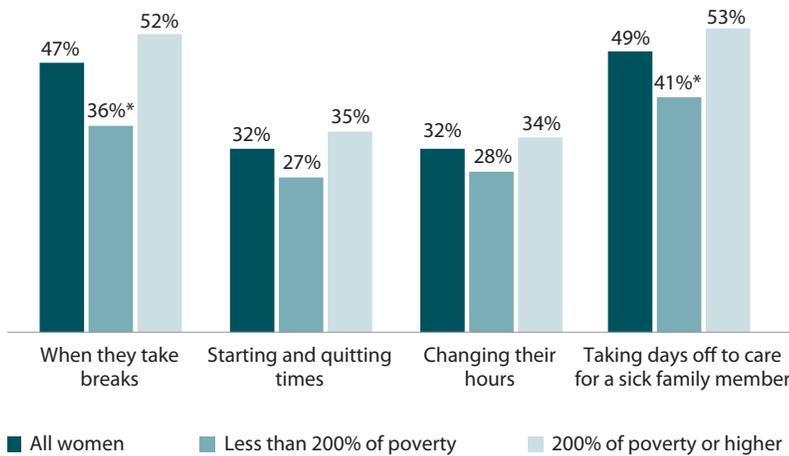
Note: 200% of the federal poverty threshold was \$35,200 for a family of three in 2008.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

EXHIBIT 6e

Flexibility in Work Day

Percentage of working women ages 18 to 64 reporting they have a great deal of flexibility in their work day in:



Notes: Among those who are employed full-time or part-time. 200% of the federal poverty threshold was \$35,200 for a family of three in 2008. Response scale: a great deal, moderate amount, very little, none at all. *Significantly different from 200% of poverty or higher. Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

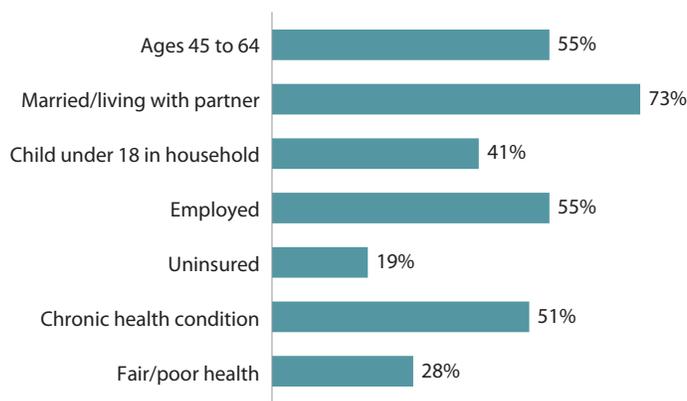
Women who work outside the home often juggle their careers with other responsibilities such as childrearing, caregiving, and community work. Thus, flexibility in the workday is an important factor for working women. About half of working women report that they have a great deal of flexibility in when they take breaks or when they take days off to care for a sick family member. Fewer women (32%) report a great deal of flexibility in their starting and quitting times and changing their hours. This type of flexibility is particularly important in terms of getting medical care while caring for health of family members.

Low-income women report less flexibility in most aspects of their work day compared to women with higher incomes. The starkest disparity is in taking breaks. Just over one-third (35%) of low-income women have flexibility in break times, compared to just over half (52%) of women with incomes at 200% and higher of poverty.

EXHIBIT 6f

Profile of Family Caregivers

Percentage of family caregivers* who are:

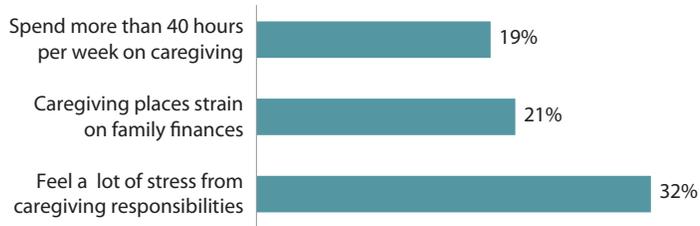


*Caregivers are women ages 18 to 64 who are caring for a chronically ill or disabled relative. Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

In addition to their regular family obligations, 12% of women care for a family member who is chronically ill or disabled. In nearly two-thirds of cases (62%), these women are the primary caregivers for these individuals, and manage a wide range of their medical, household, and daily needs (data not shown).

Caregivers often juggle multiple responsibilities and face economic and health challenges of their own. Four in 10 (41%) caregivers have children under 18 and over half (55%) are employed. Many caregivers also deal with their own health challenges, 19% are uninsured, over half (51%) have a chronic health condition, and 28% describe their own health as fair or poor.

EXHIBIT 6g

Impact of Caregiver Responsibilities**Percentage of family caregivers* reporting:**

*Caregivers are women ages 18 to 64 who are caring for a chronically ill or disabled relative.
 Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

Many caregivers devote a significant amount of time to caring for their sick or disabled family member. Approximately one-fifth (19%) of informal caregivers spend the equivalent of a full-time job -more than 40 hours- caring for their chronically ill relative. Family caregivers generally do not receive pay for their time, and for those who do it on a full-time basis, their ability to earn income through outside work is compromised. In fact, 21% of caregivers report that caregiving strains their household finances. One-third (32%) say that the caregiving itself results in a lot of stress.

METHODS

The data in the Kaiser Women's Health Care Chartbook are based on telephone interviews with a nationally representative sample of 2,015 women aged 18 to 64 living in the continental United States. Interviews were completed in both English and Spanish, according to the preference of the respondent and were conducted from May 21 through July 29, 2008.

The Kaiser Family Foundation contracted with Princeton Survey Research Associates International (PSRAI) to conduct the fieldwork for this survey. The selected sample is a random digit sample of telephone numbers selected from telephone exchanges in the continental United States. The telephone sample was provided by Survey Sampling International, LLC (SSI) according to PSRAI specifications. The sample is based on a disproportionately stratified random-digit sample of telephone numbers so that the final sample of completed interviews would contain a disproportionately large number of African-American and Latina respondents as well as a larger number of women medically uninsured, low-income or receiving Medicaid. The data are weighted in analysis to remove the disproportion from the selection rates by stratum and to make the data fully representative of non-elderly adult women in the continental United States.

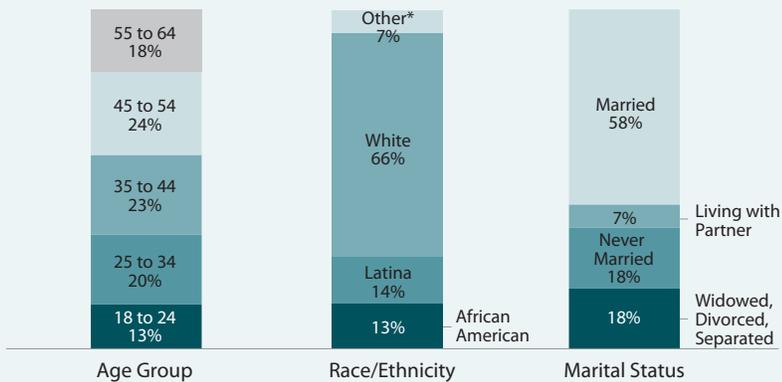
At least 10 attempts were made to complete an interview at every sampled telephone number. The calls were staggered over times of day and days of the week to maximize the chances of making a contact with a potential respondent. When appropriate, interview break-offs and refusals were re-contacted in order to attempt to convert them to completed interviews.

The weighting of the sample was accomplished in three stages: a first stage sampling weight to adjust for the designed oversampling in minority areas, a second stage adjustment for household demographics and a third stage weight to adjust person-level demographics.

Of the residential numbers in the sample 86 percent were contacted by an interviewer and 43 percent agreed to cooperate with the screener questions. Forty-six percent were found eligible for the interview. Furthermore, 87 percent of eligible respondents completed the interview. Therefore, the final response rate is 32 percent.

For results based on the total sample, one can say with 95% confidence that the error attributable to sampling is within approximately plus or minus 3 percentage points. Error for sub-groups is likely to be larger. Whenever possible, statistically significant differences are noted. The following tables provide demographic information about women ages 18 to 64 in the United States.

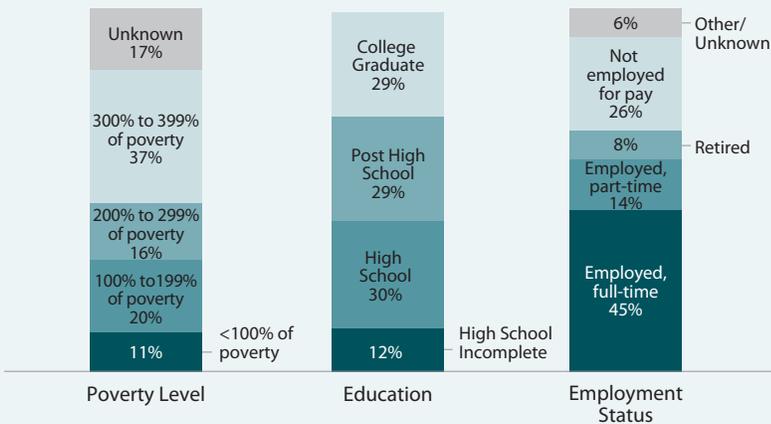
FIGURE A
Selected Demographic Characteristics of Women



*Includes Asian, Pacific Islander, American Indian, Alaska Native, people of multiple races and those who identified themselves as "other."

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.

FIGURE B
Selected Socio-Economic Characteristics of Women



Note: 100% of the federal poverty threshold was \$17,600 for a family of three in 2008. Some totals may not equal 100% due to rounding.

*Includes those who are disabled, students and unknown work status.

Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2008.



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The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.