LIFE EXPECTANCY

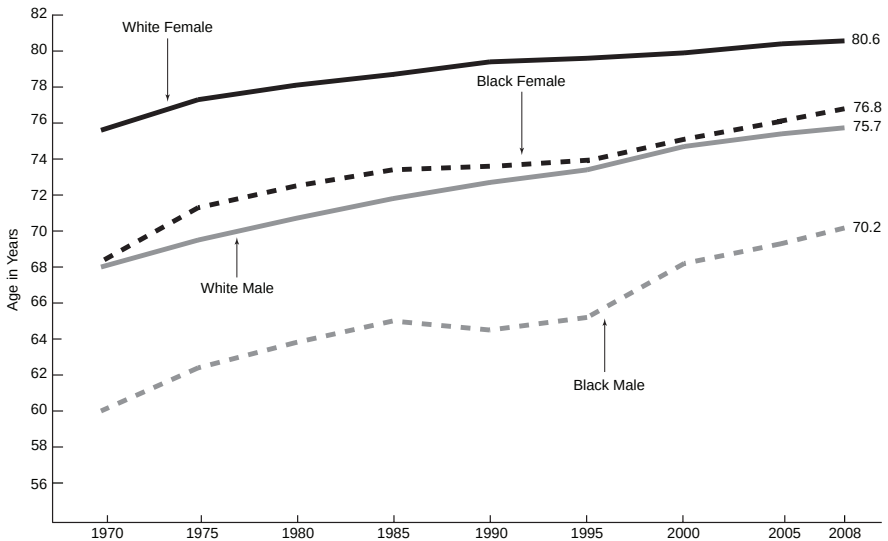
The overall life expectancy of a baby born in 2008 was 77.8 years (data not shown); this varied, however, by sex and race. A baby girl born in the United States in 2008 could expect to live 80.3 years, 5.0 years longer than a baby boy, whose life expectancy would be 75.3 years (data not shown). The differential between male and female life expectancy was greater among Blacks than Whites. Black males born in 2008 could expect to live 70.2 years, 6.6 years fewer than Black females (76.8 years). The difference between White males and females was 4.9 years, with life expectancies at birth of 75.7 and 80.6 years, respectively. White females could expect to live 3.8 years longer than Black females. The lower life expectancy among Blacks may be partly accounted for by higher infant mortality rates, as well as higher mortality rates throughout the lifespan.[10]

Life expectancy has increased since 1970 for males and females in both racial groups. Between 1970 and 2008, White males' life expectancy increased from 68.0 to 75.7 years (11.3 percent), while White females' life expectancy increased from 75.6 to 80.6 years (6.6 percent). During the same period, the life expectancy for Black males increased from 60.0 to 70.2 years (17.0 percent), while life expectancy increased from 68.3 to 76.8 years (12.4 percent) for Black females. Between 1970 and 2008, the greater gains in life expectancy for males than females and for Blacks than Whites have led to reduced disparities by sex and race.

While life expectancy estimates have not historically been calculated and reported for the Hispanic, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and multiple race populations, the U.S. Census Bureau has calculated projected life expectancies for these groups. Among females born in 2010, those who are Hispanic are projected to have the longest life expectancy (83.7 years) followed by those of multiple races (81.7 years), Native Hawaiian/Pacific Islanders (81.6 years), American Indian/Alaska Natives (81.5 years), and Asians (81.1 years). In comparison, non-Hispanic White females born in 2010 are projected to live 81.1 years (data not shown). Males of every race are projected to have a shorter life expectancy than their female counterparts.[11]

Life Expectancy at Birth, by Race* and Sex, 1970–2008**

Source II.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Both racial categories include Hispanics. **2008 data are preliminary.

LEADING CAUSES OF DEATH

In 2007, there were 1,200,336 deaths of women aged 18 and older in the United States. Of these deaths, nearly half were attributable to heart disease and malignant neoplasms (cancer), which were responsible for 25.5 and 22.4 percent of deaths, respectively. The next two leading causes of death were cerebrovascular diseases (stroke), which accounted for 6.8 percent of deaths, and chronic lower respiratory disease, which accounted for 5.5 percent.

Heart disease was the leading cause of death for women in most racial and ethnic groups; the exceptions were non-Hispanic Asian/Pacific Islander and non-Hispanic American Indian/Alaska Native women, for whom the leading cause of death was cancer. One of the most noticeable differences in leading causes of death by race and ethnicity is that diabetes mellitus was the seventh leading cause of death among non-Hispanic White women, while it was the fourth among all other racial and ethnic groups. Similarly, chronic lower respiratory disease was the fourth and fifth leading causes of death among non-Hispanic White and non-Hispanic American Indian/Alaska Native women, respectively, while it ranked seventh among other racial and ethnic groups. Nephritis, or kidney inflamation, was the fifth leading cause of death among non-Hispanic Black women, but ranked eighth and ninth among women of other races and ethnicities.

Hypertension was the tenth leading cause among non-Hispanic Black and non-Hispanic Asian/Pacific Islander women, accounting for 2.0 and 1.6 percent of deaths, respectively (data not shown). Also noteworthy is that non-Hispanic American Indian/Alaska Native women experienced a higher proportion of deaths due to unintentional injury (8.2 percent) and liver disease (4.8 percent; seventh leading cause of death) than women of other racial and ethnic groups. Liver disease was also the tenth leading cause of death among Hispanic women, accounting for 2.0 percent of deaths (data not shown).

Ten Leading Causes of Death Among Women Aged 18 and Older, by Race/Ethnicity, 2007

Source II.5: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian/Pacific Islander	Non-Hispanic American Indian/ Alaska Native
Cause of Death	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**	**% (Rank)**
Heart Disease	25.5 **(1)**	25.6 **(1)**	26.0 **(1)**	23.8 **(1)**	22.9 **(2)**	18.2 **(2)**
Malignant Neoplasms (cancer)	22.4 **(2)**	22.3 **(2)**	22.7 **(2)**	23.2 **(2)**	27.9 **(1)**	19.6 **(1)**
Cerebrovascular Diseases (stroke)	6.8 **(3)**	6.7 **(3)**	7.0 **(3)**	6.7 **(3)**	9.5 **(3)**	5.0 **(6)**
Chronic Lower Respiratory Disease	5.5 **(4)**	6.2 **(4)**	2.7 **(7)**	2.9 **(7)**	2.5 **(7)**	5.0 **(5)**
Alzheimer's Disease	4.4 **(5)**	4.8 **(5)**	2.6 **(8)**	3.0 **(6)**	2.4 **(8)**	N/A
Unintentional Injury	3.4 **(6)**	3.4 **(6)**	2.7 **(6)**	4.3 **(5)**	3.6 **(5)**	8.2 **(3)**
Diabetes Mellitus	3.0 **(7)**	2.5 **(7)**	5.1 **(4)**	5.8 **(4)**	4.2 **(4)**	6.7 **(4)**
Influenza and Pneumonia	2.4 **(8)**	2.4 **(8)**	N/A	2.4 **(8)**	3.0 **(6)**	2.1 **(9)**
Nephritis (kidney inflammation)	2.0 **(9)**	1.8 **(9)**	3.4 **(5)**	2.3 **(9)**	1.9 **(9)**	2.7 **(8)**
Septicemia (blood poisoning)	1.6 **(10)**	1.4 **(10)**	2.5 **(9)**	N/A	N/A	2.0 **(10)**

N/A = not in the top 10 leading causes of death for this racial/ethnic group.

HEALTH-RELATED QUALITY OF LIFE

Health-related quality of life has been defined as "an individual's or group's perceived physical and mental health over time."[12] Because health-related quality of life encompasses multiple aspects of health, it is often measured in different ways, including self-reported health status and the number of days in the past month that a person felt that either their physical or mental health was not good.

In 2007–2009, 53.2 percent of adults reported being in excellent or very good health, while 30.4 percent reported being in good health and 16.4 percent reported being in fair or poor health (data not shown). Self-reported health status was similar among men and women, with 53.9 percent of men and 52.6 percent of women reporting excellent or very good health. Among both sexes, self-reported health status declined with age. Among women, those aged 65 years and older were least likely to report excellent or very good health (38.0 percent), compared to 59.4 percent of women aged 18–44 years.

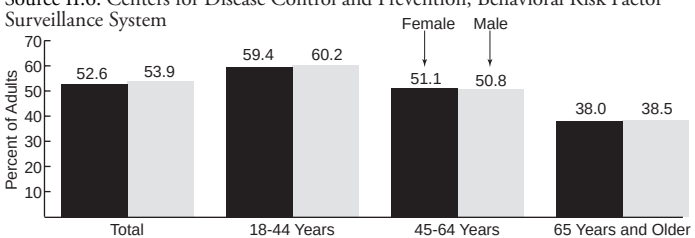
The proportion of women reporting excellent or very good health also varied by race and ethnicity (data not shown). More than half of non-Hispanic White, non-Hispanic Asian, and non-Hispanic Native Hawaiian/Other Pacific Islander women reported excellent or very good health. Hispanic, non-Hispanic American Indian/Alaska Native, and non-Hispanic Black women were least likely to report excellent or very good health (35.8, 39.3, and 40.9 percent, respectively).

In 2007–2009, women reported more physically and mentally unhealthy days than men. Women reported an average of 4.0 days of poor physical health, compared to 3.2 days per month for men. Similarly, women reported an average of 3.9 mentally unhealthy days, while men reported an average of 2.9 days per month (data not shown).

Among women, the average number of past-month physically and mentally unhealthy days varied by race and ethnicity. For both physical and mental health, non-Hispanic American Indian/Alaska Native and non-Hispanic women of multiple races reported the highest average number of unhealthy days in the past month (6.5 and 5.9 physically unhealthy days, respectively; 5.8 mentally unhealthy days for both groups). Non-Hispanic Asian women reported the lowest number of physically and mentally unhealthy days on average (2.5 and 2.4 unhealthy days, respectively).

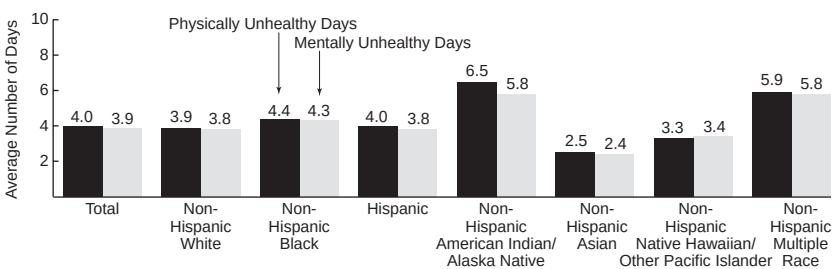
Adults Aged 18 and Older Reporting Excellent or Very Good Health, by Age and Sex, 2007–2009

Source II.6: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



Average Number of Physically and Mentally Unhealthy Days* in Past Month Among Women Aged 18 and Older, by Race/Ethnicity, 2007–2009

Source II.6: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Self-reported number of days in past 30 days that physical or mental health were not good.

ACTIVITY LIMITATIONS

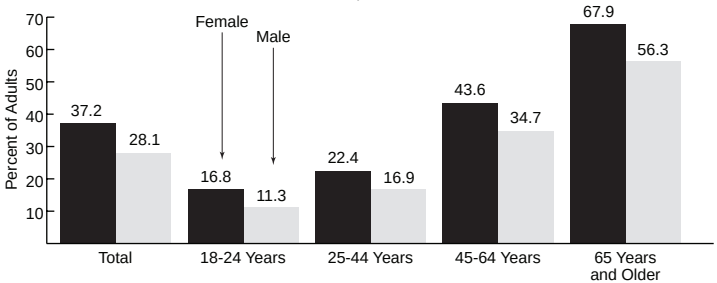
Activity limitations are defined in different ways. One common definition is whether a person is able to perform physical tasks (e.g., walking up ten steps, standing for two hours, carrying a ten pound object), or engaging in social activities and recreation (e.g., going shopping, visiting friends, sewing, reading) without the assistance of another person or using special equipment.[13] In 2007–2009, 32.8 percent of adults reported being limited in their ability to perform one or more of these common activities (data not shown). Women were more likely than men to report being limited in their activities (37.2 versus 28.1 percent, respectively).

The percentage of adults reporting activity limitations increased with age among both men and women. Only 16.8 percent of women aged 18–24 years reported activity limitations, compared to 22.4 percent of those aged 25–44 years, 43.6 percent of women aged 45–64 years, and 67.9 percent of women aged 65 years and older. A similar pattern was observed among males, with a smaller proportion of younger men reporting limitations (11.3 and 16.9 percent of men aged 18–24 and 25–44 years, respectively) compared to those aged 45–64 and 65 years and older (34.7 and 56.3 percent, respectively).

Activity limitations among women varied by poverty level. About 45 percent of women with household incomes less than 200 percent of poverty reported an activity limitation, compared to 34.3 percent of women with household incomes of 200 percent or more of poverty (data not shown). Some causes of activity limitations also varied by poverty status. For instance, women with household incomes below 100 percent of poverty were more likely to report that depression, anxiety, or other emotional problems caused activity limitations (16.7 percent), compared to women with household incomes of 100–199 percent and 200 percent or more of poverty (9.6 and 6.2 percent, respectively). The most common reported cause of activity limitations among women was arthritis (37.4 percent).

Adults Aged 18 and Older with Activity Limitations,* by Age and Sex, 2007–2009

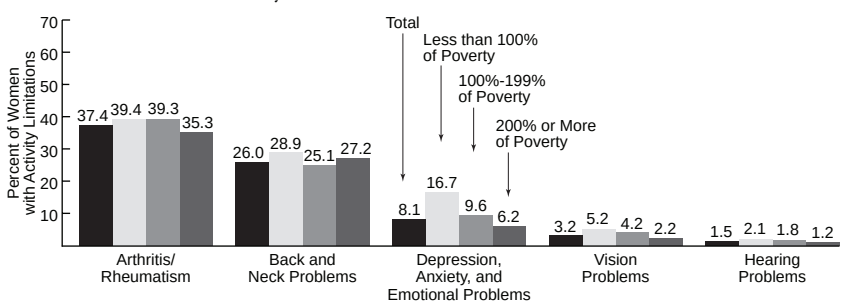
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Activity limitations are defined as having difficulty performing certain physical, social, or recreational activities without the assistance of another person or using special equipment.

Women Aged 18 and Older with Activity Limitations,* by Selected Conditions and Poverty Status, 2007–2009**

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



*Activity limitations are defined as having difficulty performing certain physical, social, or recreational activities without the assistance of another person or using special equipment. **Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

OVERWEIGHT AND OBESITY

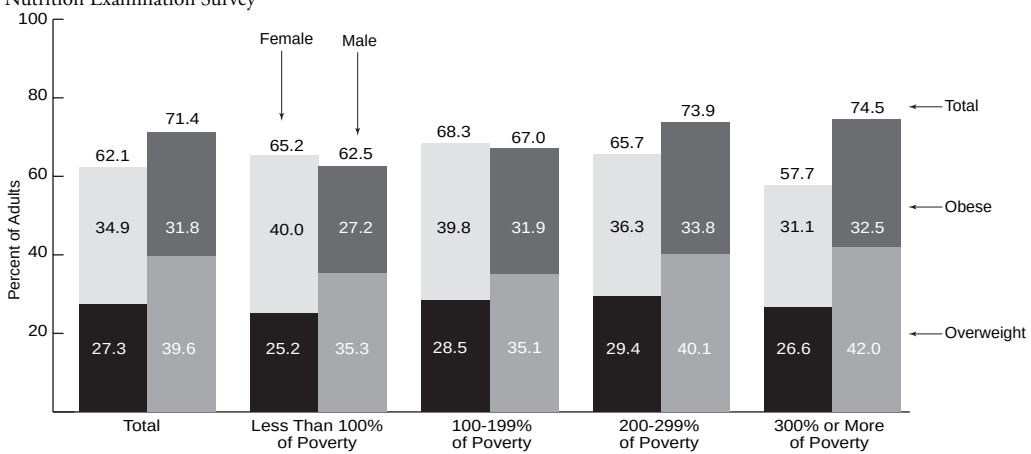
Being overweight or obese is associated with an increased risk of numerous diseases and conditions, including high blood pressure, Type 2 diabetes, heart disease, stroke, arthritis, certain types of cancer, and reproductive health risks.[14] The annual medical costs attributable to obesity are estimated to be as high as $147 billion.[14] Measurements of overweight and obesity are based on Body Mass Index (BMI), which is a ratio of weight to height. In 2005–2008, two-thirds of adults were overweight or obese; this includes 33.2 percent who were classified as overweight (BMI of 25.0 to 29.9) and 33.4 percent of adults who were classified as obese (BMI of 30.0 or more; data not shown).

In 2005–2008, women were less likely than men to be overweight (27.3 versus 39.6 percent, respectively) but more likely than men to be obese (34.9 versus 31.8 percent, respectively). The excess obesity among women compared to men was entirely restricted to extreme obesity defined by a BMI of 40.0 or more (7.1 versus 4.1 percent, respectively; data not shown). Overweight/obesity varied by poverty status in different ways for men and women. Among women, obesity was highest among those with household incomes of less than 100 percent of poverty, and there was no consistent pattern for overweight. Among men, however, both overweight and obesity tended to increase with household income. The sex difference in obesity was highest among those with household incomes of less than 100 percent of poverty (40.0 percent among women versus 27.2 percent among men) and disappeared among those with household incomes of 300 percent or more of poverty (31.1 percent among women versus 32.5 percent among men). With respect to overweight, women were less likely to be overweight than men at every income level.

Overweight/obesity also varies by race and ethnicity. In 2005–2008, non-Hispanic Black and Mexican-American women were significantly more likely to be obese than non-Hispanic White women (50.1 and 41.6 versus 32.7 percent, respectively; data not shown). Higher obesity rates have also been reported among American Indian/Alaska Native women.[15] Community prevention strategies that seek to address risk factors for overweight and obesity by promoting healthy eating and physical activity include efforts to improve access to healthy foods, parks, and recreational facilities.[16]

Overweight and Obesity* Among Adults Aged 18 and Older, by Poverty Status** and Sex, 2005–2008

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Overweight is defined as having a Body Mass Index (BMI) between 25.0 and 29.9; obesity is defined as having a BMI of 30.0 or more. Percentages may not add to totals due to rounding. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

DIABETES

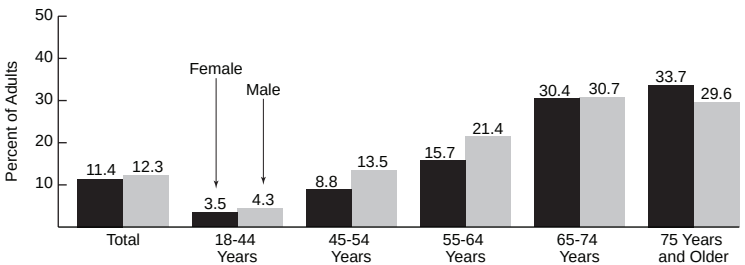
Diabetes mellitus is a chronic condition characterized by high blood sugar and is among the leading causes of death in the U.S.[17] Complications of diabetes are serious and may include blindness, kidney damage, heart disease, stroke, nervous system disease, and amputation. The main types of diabetes are Type 1, Type 2, and gestational (diabetes occurring or first recognized during pregnancy). Type 1 diabetes is usually diagnosed in children and young adults, but may occur at any age. Risk factors for Type 1 diabetes include autoimmune, genetic, and environmental factors. Type 2 diabetes accounts for 90–95 percent of all diabetes cases. While it is often diagnosed among adults, Type 2 diabetes has been increasing among children and adolescents, as well. Type 2 diabetes risk factors include obesity, physical inactivity, a family history of the disease, and gestational diabetes.

In 2005–2008, 22 million or 11.8 percent of adults were found to have diabetes (tested positive for the condition on a fasting plasma glucose test, glycohemoglobin A1C test, or 2-hour oral glucose test; data not shown). Diabetes prevalence did not vary by sex and generally increased with age for both men and women. Women aged 65 years and older were significantly more likely than younger women to have diabetes. More than 30 percent of women aged 65 years and older had diabetes, compared to 15.7 percent of 55- to 64-year-olds and 8.8 percent of those aged 45–54 years. Other data indicate higher diabetes prevalence in certain minority groups, particularly Hispanic, non-Hispanic Black, and American Indian/Alaska Native populations.[17]

Diabetes can be successfully managed through diet modification, physical activity, glucose monitoring, and medication.[17] Diagnosis is critical to develop a treatment plan and prevent serious complications. Among women aged 18 years and older who were found to have diabetes, only 54.9 percent reported that they had been told by a health professional that they have diabetes. Non-Hispanic Black women were more likely than non-Hispanic White women to have ever been told by a health professional that they have diabetes (63.7 versus 49.1 percent, respectively). Other observed differences were not statistically significant.

Adults Aged 18 and Older Who Have Diabetes,* by Age and Sex, 2005–2008

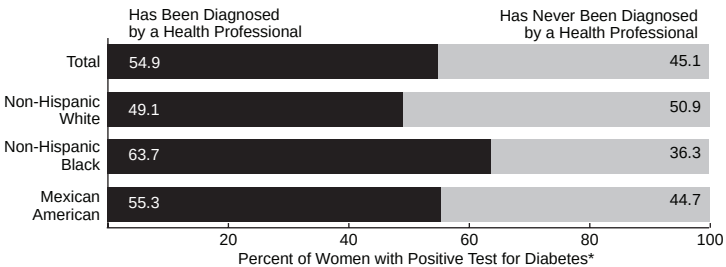
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Tested positive on a Fasting Plasma Glucose (FPG) test, glycohemoglobin A1C test, or 2-hour oral glucose test.*

Women Aged 18 and Older Who Have Diabetes,* by Race/Ethnicity and Diagnosis Status,† 2005–2008**

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Tested positive on a Fasting Plasma Glucose (FPG) test, glycohemoglobin A1C test, or 2-hour oral glucose test. **The samples of Other Hispanic, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple races were too small to produce reliable results. †Reported a health professional has ever told them they have diabetes.*

HIGH BLOOD PRESSURE

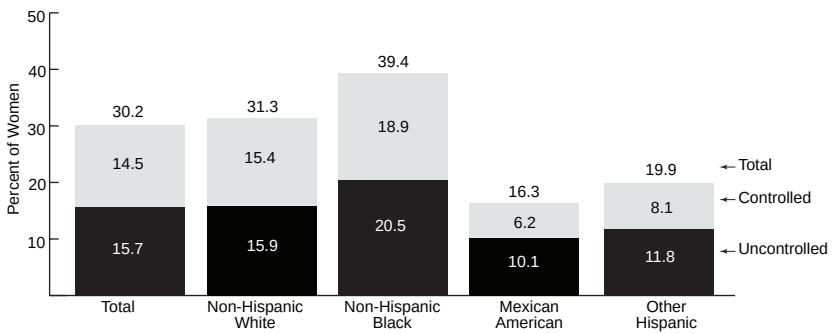
High blood pressure, or hypertension, is a risk factor for a number of conditions, including heart disease and stroke. It is defined as a systolic blood pressure (during heartbeats) of 140 mmHg or higher, a diastolic blood pressure (between heartbeats) of 90 mmHg or higher, or current use of blood pressure-lowering medication. In 2005–2008, about 30 percent of both women and men were identified as having high blood pressure. This includes about 14 percent of adults with controlled hypertension, who had a normal blood pressure measurement and reported using blood pressure-lowering medication, and about 16 percent with uncontrolled hypertension, who had a high blood pressure measurement with or without the use of medication. High blood pressure can also be controlled by losing excess body weight, participating in regular physical activity, and adopting a healthy diet with lower sodium intake.[18]

The prevalence of hypertension varies by race and ethnicity. For example, 39.4 percent of non-Hispanic Black women had high blood pressure compared to 16.3 percent of Mexican American women.

Among women with uncontrolled high blood pressure in 2005–2008, 54.4 percent had been previously diagnosed by a health professional and were taking medication for the condition; 11.9 percent had been previously diagnosed but were not taking medication; and 33.7 percent had never been diagnosed. Diagnosis status among women with uncontrolled high blood pressure varied by age as well as race and ethnicity. Younger women aged 18–44 were most likely to be undiagnosed (41.0 percent), while older women aged 65 and over were most likely to be diagnosed and taking medication (64.0 percent). With respect to race and ethnicity, Mexican American women with uncontrolled high blood pressure were most likely to be undiagnosed (45.6 percent), while non-Hispanic Black women were most likely to have been diagnosed and taking medication (61.3 percent; data not shown).

Women Aged 18 and Older with High Blood Pressure,* by Race/ Ethnicity, 2005–2008**

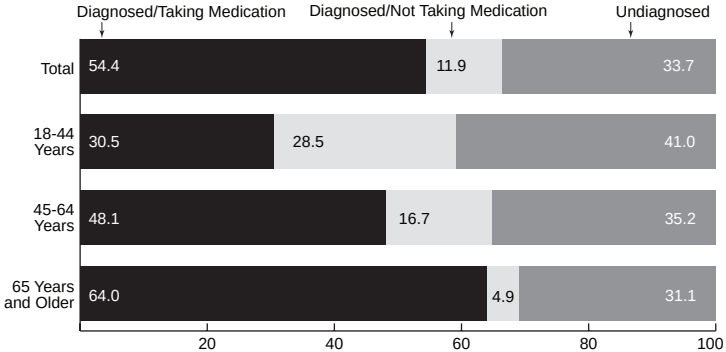
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Includes a measured systolic pressure (during heartbeats) of ≥140mmHg or a diastolic blood pressure (between heartbeats) ≥90mmHg (uncontrolled hypertension, with or without blood pressure-lowering medication) and normal blood pressure (≤140/90mmHg) with reported current medication use (controlled hypertension). Percentages may not add to totals due to rounding. **The samples of American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.

Diagnosis Status* Among Women Aged 18 and Older with Uncontrolled High Blood Pressure, by Age, 2005–2008**

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported whether they had ever been told by a health professional that they have high blood pressure and whether they were taking blood pressure-lowering medication. **Includes a measured systolic pressure (during heartbeats) of ≥140mmHg or a diastolic blood pressure (between heartbeats) ≥90mmHg.

HEART DISEASE AND STROKE

Cardiovascular disease is an abnormal function of the heart and blood vessels. Coronary heart disease and stroke are the most common forms of cardiovascular disease and are the first and third leading causes of death for both men and women in the United States.[19] Risk factors for both include high blood pressure and cholesterol, excess weight, physical inactivity, age, and family history. Stroke involves blocked blood flow to the brain, whereas coronary heart disease involves reduced blood flow to the heart, which can result in a heart attack. Chest pain is a common heart attack symptom but women are more likely than men to have other symptoms, such as shortness of breath, nausea and vomiting, and back or jaw pain.[20] Stroke symptoms can include numbness, headache, dizziness, and blurred vision.

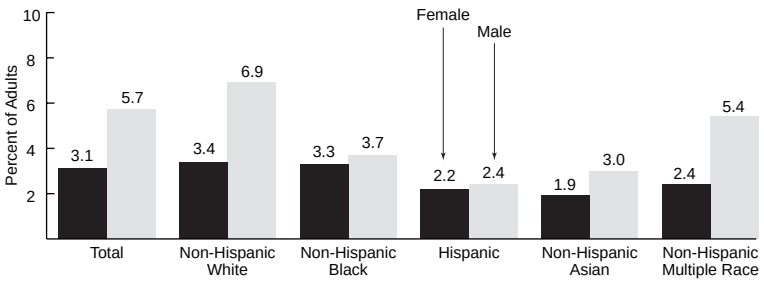
In 2007–2009, men were more likely than women to have been diagnosed with coronary heart disease (5.7 versus 3.1 percent, respectively). However, this difference was significant only among non-Hispanic Whites. The proportion of women with coronary heart disease was higher among non-Hispanic White and non-Hispanic Black women (3.4 and 3.3 percent, respectively) than among Hispanic and non-Hispanic Asian women (2.2 and 1.9 percent, respectively).

In 2007–2009, the percentage of adults reporting that they had ever been diagnosed with a stroke was slightly higher among women than men (2.9 versus 2.4 percent, respectively). Among both men and women, the proportion of persons ever having had a stroke was higher among those with lower household incomes. For example, among women, those with household incomes below 200 percent of poverty are more than twice as likely to have had a stroke as those with household incomes of 400 percent or more of poverty (4.1 versus 1.7 percent, respectively).

There is evidence that women diagnosed with cardiovascular disease are less likely than men to receive certain treatments that have been reported to improve outcomes. For reasons that are poorly understood, 42 percent of women will die within a year of having a heart attack compared to 24 percent of men.[21] Although differences in treatment may contribute, women also tend to get heart disease at older ages than men and they are more likely to have other chronic conditions.

Adults Aged 18 and Older with Coronary Heart Disease,* by Race/Ethnicity and Sex, 2007–2009**

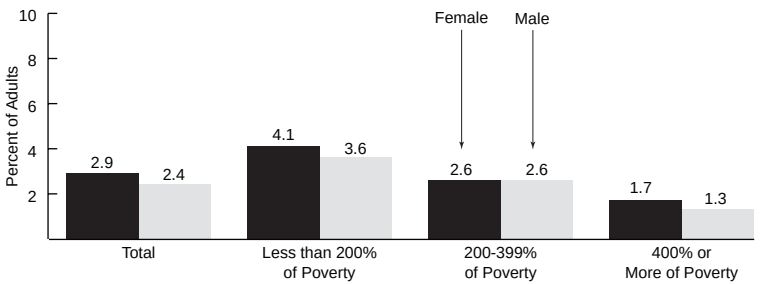
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional had ever told them that they had coronary heart disease. Rates reported are not age-adjusted. **The sample of American Indian/Alaska Natives and Native Hawaiian/Pacific Islanders was too small to produce reliable results.

Adults Aged 18 and Older Who Have Had a Stroke,* by Poverty Status and Sex, 2007–2009**

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



*Reported a health professional had ever told them that they had a stroke. Rates reported are not age-adjusted. **Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

CANCER

Cancer is the second leading cause of death for both men and women. It is estimated that 774,370 new cancer cases will be diagnosed among females and more than 270,000 females will die of cancer in 2011. Based on prior years, lung and bronchus cancer is expected to be the leading cause of cancer death among females, accounting for 71,340 deaths, or 26 percent of all cancer deaths, followed by breast cancer, which will be responsible for 39,520, or 15 percent of deaths. Colorectal cancer, pancreatic cancer, and ovarian cancer will also be major causes of cancer deaths among females, accounting for an additional 57,890 deaths combined.

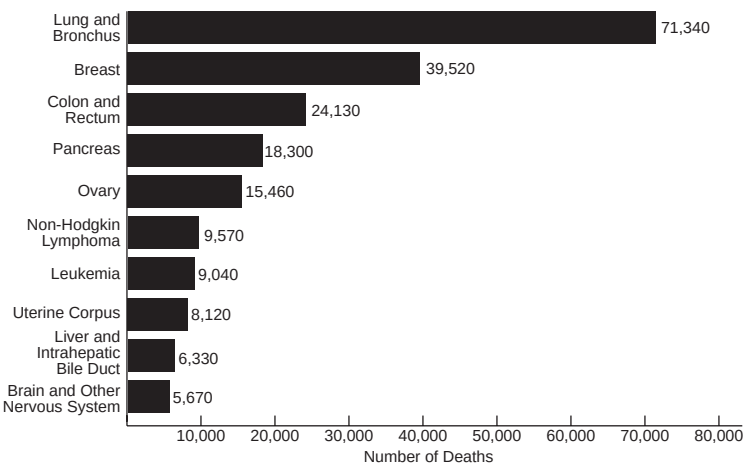
Due to the varying survival rates for different types of cancer, the most common causes of death from cancer are not always the most common types of cancer. For instance, although lung and bronchus cancer causes the greatest number of deaths, breast cancer is more commonly diagnosed among females. In 2007, invasive breast cancer occurred among 120.4 per 100,000 females, whereas lung and bronchus cancer occurred in only 54.5 per 100,000. Other types of cancer that are commonly diagnosed but are not among the top 10 causes of cancer death include thyroid, melanoma, and cervical cancer.

Recommended screening can help detect several forms of cancer in early, more treatable stages, including breast, colorectal, and cervical cancer, and is shown to reduce mortality.[22] Vaccines are also available to help prevent hepatitis B and human papillomavirus (HPV) which can cause liver and cervical cancer, respectively.

Racial and ethnic disparities in cancer incidence may be explained by differences in behavioral risk factors, such as smoking, heavy alcohol consumption, obesity, poor nutrition, and physical inactivity that are largely a product of

Leading Causes of Cancer Deaths Among Females (All Ages), by Site, 2011 Estimates

Source II.7: American Cancer Society



Invasive Cancer Incidence Rates per 100,000 Females (All Ages), by Site and Race/Ethnicity, 2007*

Source II.8: Centers for Disease Control and Prevention and National Cancer Institute

	Total (Rank)	White**	Black**	Hispanic†	American Indian/Alaska Native**†	Asian/ Pacific Islander**†
Breast	120.4 (1)	121.0	117.0	88.2	67.3	83.4
Lung and Bronchus	54.5 (2)	55.9	50.3	26.0	35.8	26.9
Colon and Rectum	39.7 (3)	38.5	47.1	32.6	28.8	31.1
Uterine Corpus	23.3 (4)	23.7	20.8	18.2	13.8	16.1
Thyroid	17.2 (5)	18.0	10.1	16.4	8.5	17.7
Non-Hodgkin Lymphoma	15.7 (6)	16.1	11.4	14.4	8.5	9.5
Melanoma	15.4 (7)	17.3	1.1	4.3	4.4	1.2
Ovary	12.2(8)	12.6	9.1	10.2	8.0	9.0
Cervix	7.9 (13)	7.5	10.2	11.5	7.0	6.9

**All rates are age-adjusted. **May include Hispanics. †Results should be interpreted with caution.*

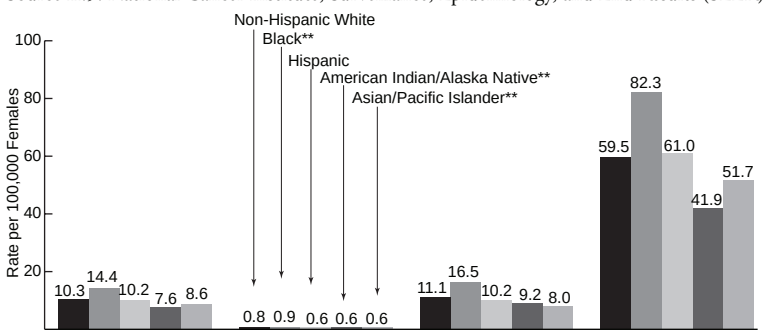
socioeconomic differences.[22] Healthy behavioral choices are not as accessible in poor or disadvantaged neighborhoods. Racial and ethnic disparities in cancer death rates tend to be even greater because they are a function of differences in incidence, as well as stage at diagnosis, treatment, and patient survival, which are greatly influenced by health care access and quality.

Pancreatic cancer is the tenth most common cancer in women but the fourth leading cause of cancer death. It is generally not diagnosable in early stages and is highly lethal, with only 6 percent surviving 5 years beyond diagnosis.[22] In 2000–2008, pancreatic cancer incidence rates ranged from 7.6 per 100,000 for American Indian/Alaska Native females to 14.4 for Black females. Risk of pancreatic cancer increases greatly with age as well as smoking, diabetes, and obesity.[22] Overall, Black women aged 65 years and older were most likely to have developed pancreatic cancer (82.3 per 100,000 women).

In contrast to pancreatic cancer, breast cancer can be detected by mammography in the early or localized stage and can be successfully treated. In 2000–2007, more than 90 percent of non-Hispanic White women survived 5 years after breast cancer diagnosis, compared to about 80 percent of Black, Hispanic, and American Indian/Alaska Native women. The lower 5-year survival rate for these minority women is related to detection at more advanced stages, when treatment is less successful, as well as lower survival rates at any given stage of diagnosis. For example, only 51.9 percent of breast cancer cases among Black women were diagnosed in the early, localized stage, compared to 63.1 percent of breast cancer cases among non-Hispanic White women (data not shown). Black women also had lower survival rates than non-Hispanic White women at every stage of diagnosis, including the most advanced stage in which cancer has spread to distant organs (17.7 versus 30.7 percent, respectively). Additional health conditions and unequal access to care and treatment may contribute to lower survival rates among minority women.[23]

Pancreatic Cancer Incidence Among Females, by Age and Race/Ethnicity, 2000–2008*

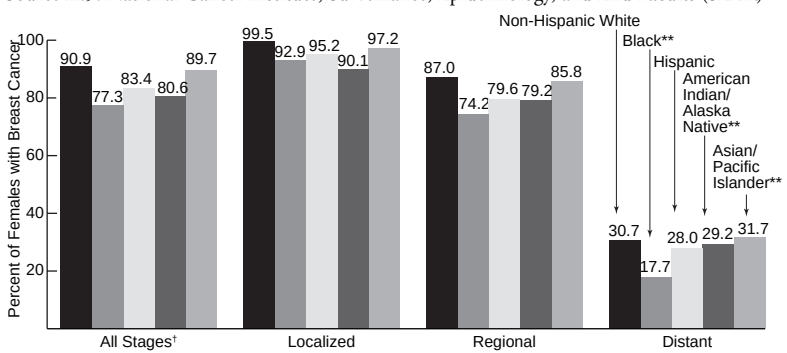
Source II.9: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER)



*All rates are age-adjusted. **May include Hispanics.

Five-year Period Survival Rates for Breast Cancer Among Females, by Stage* and Race/Ethnicity, 2000–2007

Source II.9: National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER)



*Localized cancer is limited to the organ in which it began (no evidence of spread); regional cancer has spread beyond the primary site; distant cancer has spread to distant organs or lymph nodes. **May include Hispanics. †Includes cancers with undetermined stage.

SECONDHAND TOBACCO SMOKE EXPOSURE

Exposure to secondhand tobacco smoke among nonsmokers can cause heart disease and lung cancer in adults, as well as sudden infant death syndrome, respiratory and ear infections, and asthma exacerbation among children.[24] Nonsmoking adults and children may be exposed at home, worksites or daycare centers, and public places.

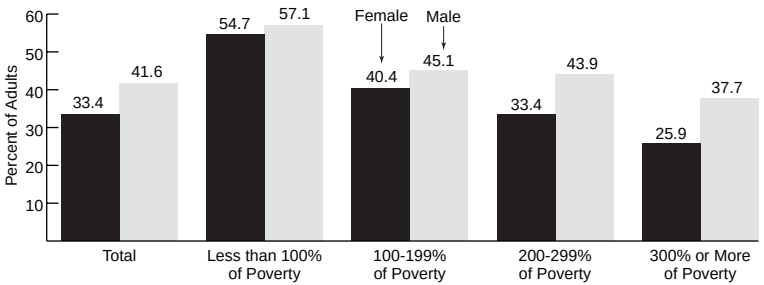
In 2005–2008, an estimated 50.3 million or 37.0 percent of nonsmoking adults were exposed to secondhand tobacco smoke exposure, determined by detection of a tobacco marker in a blood sample. Overall, secondhand smoke exposure was more common among men than women (41.6 versus 33.4 percent, respectively). However, this sex difference was not observed among adults living in households with incomes below the poverty level, where more than half of adults were exposed to secondhand smoke. Secondhand smoke exposure decreased as income increased, but more so for women than men. Since only 6.3 percent of nonsmoking adults reported living in a household with a smoker (data not shown), the majority of secondhand smoke exposure occurs outside the home.

Exposure to secondhand smoke also varies by race and ethnicity. Over half of non-Hispanic Black women were exposed to secondhand smoke compared to about 30 percent of non-Hispanic White and Hispanic women. While this racial and ethnic disparity may partly reflect racial and ethnic differences in the metabolic clearance of the tobacco marker,[25] nonsmoking Black women were also more likely than their non-Hispanic White counterparts to report living in a household with a smoker (10.2 versus 5.4 percent, respectively; data not shown).

Although the prevalence of secondhand tobacco smoke exposure has declined by over 20 percent in the past decade, only half of all states and the District of Columbia have comprehensive smoke-free laws covering workplaces, restaurants, and bars.[25] National Healthy People 2020 objectives include universal state adoption of comprehensive smoke-free laws and a 10 percent reduction in the proportion of nonsmoking persons exposed to secondhand smoke.[26]

Secondhand Smoke Exposure* Among Nonsmoking Adults Aged 18 and Older, by Poverty Status and Sex, 2005–2008**

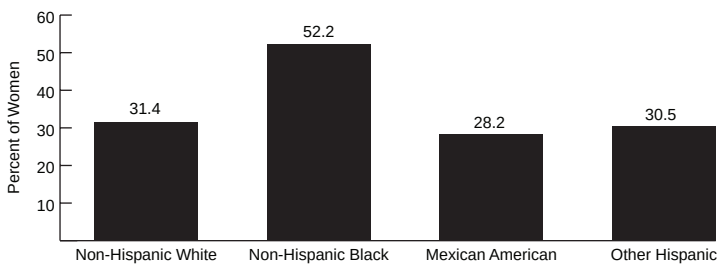
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Defined as a serum cotinine level ≥0.05ng/mL among nonsmokers who did not report current smoking and had a serum cotinine level ≤10ng/mL. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.*

Secondhand Smoke Exposure* Among Nonsmoking Women, by Race/Ethnicity, 2005–2008**

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



**Defined as a serum cotinine level ≥0.05ng/mL among non-smokers who did not report current smoking and had a serum cotinine level ≤10ng/mL. **The samples of American Indian/Alaska Native, Asian, and Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.*

ASTHMA

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of wheezing, chest tightness, shortness of breath, and coughing. This disorder may be aggravated by allergens, environmental tobacco smoke and air pollution, poor housing conditions (mold, cockroaches, and dust mites), infections of the respiratory tract, and exercise.[27] However, by taking certain precautions, persons with asthma may be able to effectively manage this disorder and participate in daily activities.

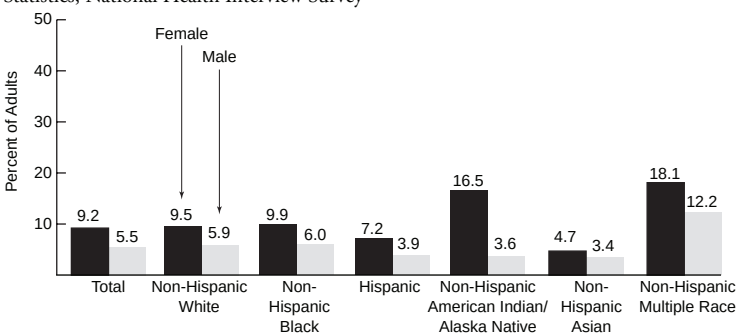
In 2007–2009, women were more likely to have asthma than men (9.2 versus 5.5 percent, respectively); this was true for all racial and ethnic groups. Non-Hispanic women of multiple races and non-Hispanic American Indian/Alaska Native women were most likely to have asthma (18.1 and 16.5 percent, respectively), while Hispanic and non-Hispanic Asian women were least likely to have asthma (7.2 and 4.7 percent, respectively).

A visit to the emergency room due to an asthma attack may indicate that asthma is not being effectively controlled or treated. In 2007–2009, 23.2 percent of women with an asthma attack in the past year sought emergency care for their condition. The proportion of women suffering an asthma attack who visited the emergency room varies by income. Women with household incomes below 100 percent of poverty were most likely to have visited an emergency room (32.4 percent), compared to 18.1 percent of those with incomes of 400 percent or more of poverty.

Women with asthma can effectively manage their condition by creating an asthma management plan with their doctor and knowing about and avoiding asthma triggers.[27] Consistent access to and use of medication can reduce the likelihood of an asthma attack, as well as the use of hospital and emergency care for people with asthma.[28]

Adults Aged 18 and Older with Asthma,* by Race/Ethnicity and Sex, 2007–2009**

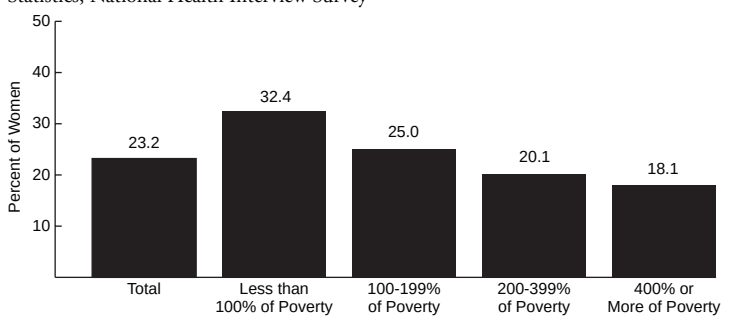
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that (1) a health professional has ever told them that they have asthma, and (2) they still have asthma. Rates reported are not age-adjusted. **The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.

Emergency Room Visits Among Women Suffering an Asthma Attack* in the Past Year, by Poverty Status, 2007–2009**

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



*Reported that (1) a health professional has ever told them that they have asthma, and (2) they had an asthma attack in the past year. **Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

MENTAL ILLNESS

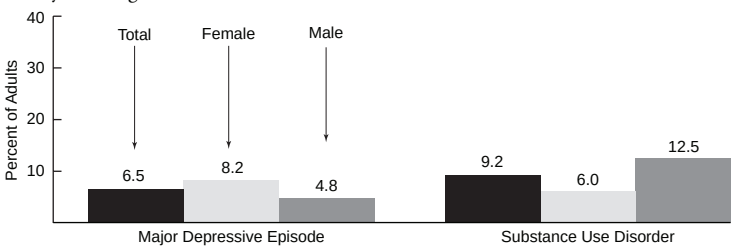
Overall, mental illness affects both women and men equally and about half of all Americans will meet the criteria for a diagnosable mental disorder over the course of their lives.[29] However, types of mental disorders vary with sex. Women are more likely than men to experience an anxiety or mood disorder, such as depression, while men are more likely than women to experience an impulse-control or substance use disorder.

A major depressive episode is defined according to the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image. In 2009, an estimated 9.6 million women aged 18 years and older, comprising 8.2 percent of that population, reported experiencing a major depressive episode in the past year, compared to 5.2 million or 4.8 percent of men. Although women were more likely than men to experience a past-year major depressive episode, men were twice as likely as women to experience a past-year substance use disorder (12.5 versus 6.0 percent, respectively).

Suicide accounts for more than 30,000 deaths in the United States each year and is the third leading cause of death for women and men aged 18–35 years.[30] The overwhelming majority of suicides are accompanied by mental illness. While completed suicide is more common among men than women, women tend to have more nonfatal suicide attempts.[31] In 2007, the age-adjusted suicide death rate was 6.1 per 100,000 women aged 18 and older, compared to 24.1 per 100,000 men of the same age. By contrast, the age-adjusted rate of self-inflicted non-fatal injury was higher among women than men (162 versus 131 per 100,000 population; data not shown). Among both men and women, suicide rates are highest for non-Hispanic Whites and non-Hispanic American Indian/Alaska Natives. Treatment of mental illness and suicidal behavior through psychotherapy and medication can help to prevent suicide.[31,32]

Past Year Major Depressive Episode* and Substance Use Disorder Among Adults Aged 18 and Older, by Sex, 2009**

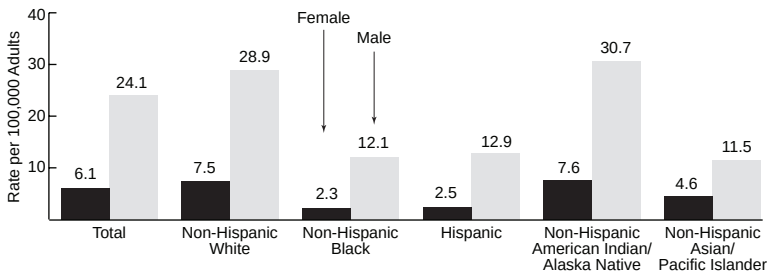
Source II.10: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



**A past year major depressive episode is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.*
***Past year substance use disorder defined as abuse or dependence on alcohol or illicit drugs; abuse relates to social problems due to substance use, such as problems with work, family, or the law; dependence relates to health and emotional problems, such as tolerance or withdrawal.*

Suicide Deaths per 100,000 Adults Aged 18 and Older,* by Race/Ethnicity and Sex, 2007

Source II.5: Centers for Disease Control and Prevention, National Vital Statistics System



**Age-adjusted to the 2000 population distribution.*

VIOLENCE AGAINST WOMEN

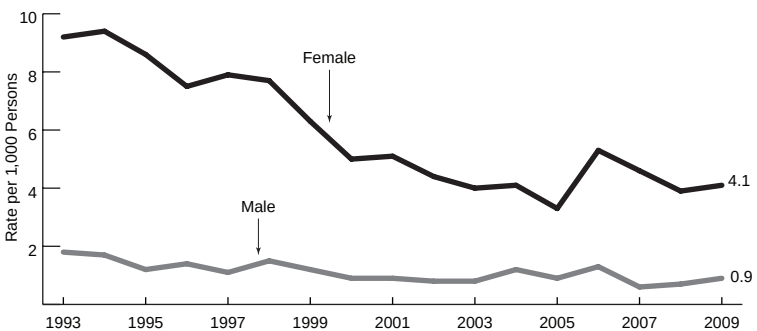
In 2009, an estimated 4.3 million nonfatal violent crimes were committed in the United States, reflecting a significant decline over the previous year and a 39 percent decline since 2000. Males were more likely than females to experience nonfatal violent crime victimization overall (18.4 versus 15.8 per 1,000 persons aged 12 and older, respectively; data not shown).[33] However, females were more likely to experience nonfatal intimate partner violence (IPV) than males (4.1 versus 0.9 per 1,000 persons aged 12 and older). This reflects a significant decrease in the rate of nonfatal IPV since the early 1990s; in 1993 the rate of nonfatal IPV reported by females aged 12 and older was 9.2 per 1,000 females.[34] Intimate partner violence includes victimization committed by spouses or ex-spouses, boyfriends or girlfriends, and ex-boyfriends or ex-girlfriends.

Although fatal intimate partner violence has also declined since the early 1990s, females are more than twice as likely as males to be killed by intimate partners.[34] There is also a racial disparity in intimate partner violence, with Black females experiencing higher rates of both fatal and nonfatal violence than White females.[34]

Overall, the majority of nonfatal violent crimes (67.5 percent) against females aged 12 and older in 2009 were committed by non-strangers, including intimate partners, family members or other relatives, and friends or acquaintances. In comparison, less than half of male victims of violent crime knew their attackers (45.1 percent; data not shown). The proportion of violent crimes committed against females in which the offender was known by the victim was highest for rape and sexual assault (79.4 percent), followed by simple and aggravated assault (70.2 and 64.5 percent, respectively). Only robberies were committed about equally between strangers and non-strangers (47.5 and 46.4 percent, respectively).

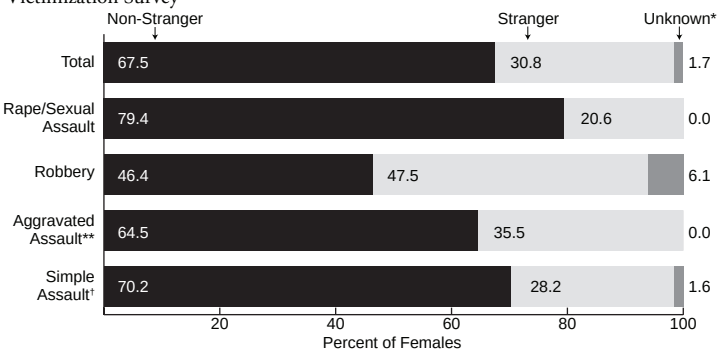
Nonfatal Intimate Partner Violence Perpetrated Against Persons Aged 12 and Older, by Sex, 1993–2009

Source II.11: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



Nonfatal Violent Crime Experienced by Females Aged 12 and Older, by Type of Offense and Relationship to Perpetrator, 2009

Source II.12: U.S. Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey



**Use extreme caution when interpreting; estimates based on 10 or fewer sample cases. **Defined as an attack or attempted attack with a weapon, regardless of whether an injury occurred, and an attack without a weapon when serious injury results. †Defined as an attack or attempted attack without a weapon resulting in less serious or no injury.*

SEXUALLY TRANSMITTED INFECTIONS

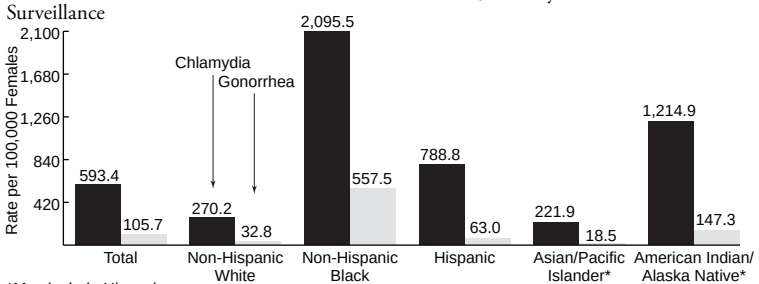
Sexually transmitted infections (STIs) are considered a hidden epidemic because symptoms are often absent and the causes are not openly discussed. Yet there are approximately 19 million new STI cases in the United States each year at an annual health care cost of nearly 16 billion dollars.[35] Active infections can increase the likelihood of contracting another STI, such as HIV, and untreated STIs can lead to pelvic inflammatory disease, infertility, and adverse pregnancy outcomes. Safer sex practices, screening, and treatment can help reduce the burden of STIs.

The Centers for Disease Control and Prevention requires state and local reporting of new chlamydia, gonorrhea, syphilis, and HIV cases (see page on HIV/AIDS). Reported STI rates among females of all ages vary by age and race and ethnicity. Rates are highest among adolescents and young adults; over 70 percent of all chlamydia and gonorrhea cases in females occurred among those under 25 years of age in 2009 (data not shown). With the exception of Asian/Pacific Islanders, minority females had higher STI rates than non-Hispanic White females. For example, compared with non-Hispanic White females, the chlamydia rate was 7.8 times higher for non-Hispanic Black females, 4.5 times higher for American Indian/Alaska Native females, and 2.9 times higher for Hispanic females. The syphilis rate was also highest among non-Hispanic Black females (8.2 versus 1.4 per 100,000 females overall; data not shown).

Although chlamydia, gonorrhea, and syphilis can be cured with appropriate antibiotics, viral STIs, such as herpes, HIV, and human papillomavirus (HPV) cannot be cured but can be monitored and managed to prevent symptoms and disease progression.[36] HPV is the most common STI with over 40 different types, some of which can cause genital warts and cervical cancer among women. Overall, 41.3 percent of women aged 18–59 tested positive for one or more HPV types in 2005–2008. While HPV cannot be treated, it may clear on its own over time. HPV was detected in over 50 percent of 18- to 24-year-olds compared to about 40 percent of women aged 25–59. Non-Hispanic Black women also had a higher prevalence of HPV infection than non-Hispanic White and Mexican American women (57.7 versus 38.5 and 45.1 percent, respectively; data not shown). A vaccine for high-risk HPV types is available and recommended for girls and young adult women. Pap smears can also detect early disease signs that can be treated to prevent cervical cancer.[36]

Rates of Chlamydia and Gonorrhea Among Females (All Ages), by Race/Ethnicity, 2009

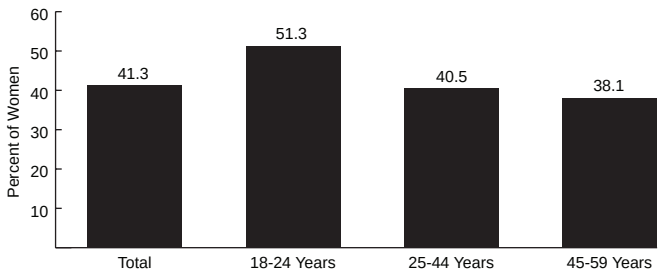
Source II.13: Centers for Disease Control and Prevention, Sexually Transmitted Disease Surveillance



*May include Hispanics.

HPV Infection* Among Women Aged 18–59, by Age, 2005–2008

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Based on lab results from a vaginal swab.

HIV/AIDS

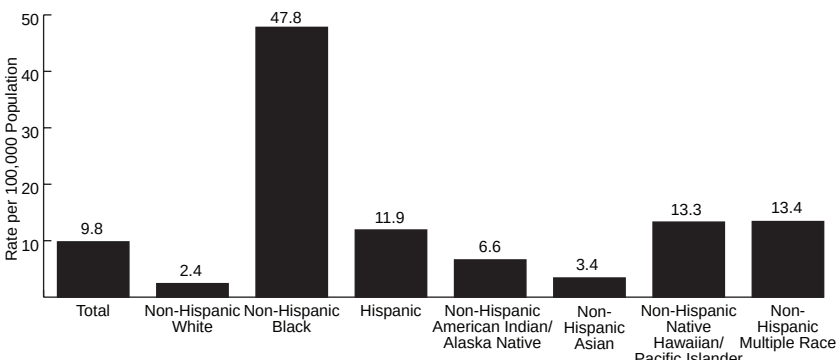
Acquired immunodeficiency syndrome (AIDS) is the final stage of infection with the human immunodeficiency virus (HIV), which destroys or disables the cells that are responsible for fighting infection. AIDS is diagnosed when HIV has weakened the immune system enough that the body has difficulty fighting infections.[37] HIV is predominantly transmitted through sexual contact and injection drug use. While HIV and AIDS disproportionately affect men who have sex with men, an increasing proportion of HIV/AIDS diagnoses occur among women and particularly minority women. In 2009, adolescent and adult females accounted for about one-fourth of new HIV and AIDS diagnoses, up from 7 percent in 1985.[38] The rate of new HIV diagnoses was 32.7 per 100,000 males (data not shown) and 9.8 cases per 100,000 females aged 13 and older in 2009.

Rates of new cases among adolescent and adult females vary dramatically by race and ethnicity. HIV disproportionately affects non-Hispanic Black females at a rate that was nearly twenty times higher than among non-Hispanic White females (47.8 versus 2.4 cases per 100,000 females). In 2009, new HIV diagnoses were also elevated among females of every minority group, but especially Hispanic, non-Hispanic Native Hawaiian/Other Pacific Islander and non-Hispanic females of multiple races (11.9, 13.3, and 13.4 cases per 100,000 females, respectively).

Early detection of HIV infection is critical in preventing transmission of the virus to others, and persons aware of their HIV infection can benefit from advances in medicine that may significantly prolong their lives. Early entry to care can also produce significant cost savings for medical treatment.[39] Despite these individual and societal benefits, a large proportion of people identified as HIV-positive receive an AIDS diagnosis simultaneously or within a year of HIV diagnosis. In 2008, 31 percent of HIV-positive females of all ages received an AIDS diagnosis within 12 months of their HIV diagnosis, which was slightly less than among males (34 percent). Women and younger persons tend to receive earlier diagnoses perhaps due, in part, to more frequent testing opportunities (e.g. routine reproductive health visits) and greater risk awareness.[40]

Estimated Rates of New HIV Cases Reported Among Females Aged 13 and Older,* by Race/Ethnicity, 2009

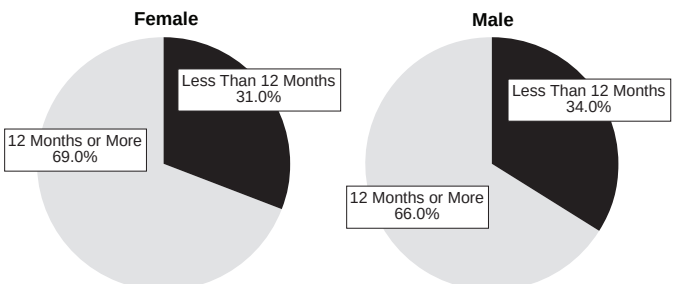
Source II.14: Centers for Disease Control and Prevention, HIV Surveillance Report



*Data collected from 40 states with confidential name-based reporting.

Time to an AIDS Diagnosis After a Diagnosis of HIV Infection, by Sex, 2008

Source II.14: Centers for Disease Control and Prevention, HIV Surveillance Report



ARTHRITIS

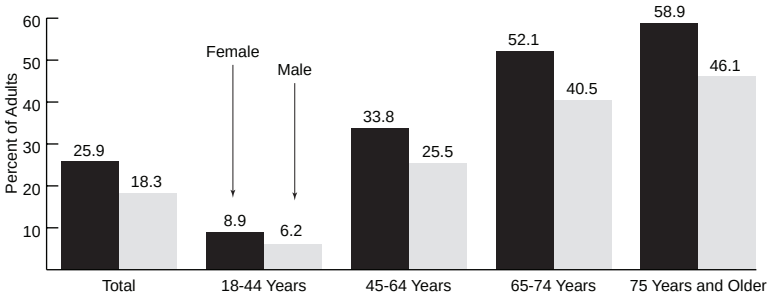
Arthritis is the leading cause of disability and activity limitations among United States adults.[41] Arthritis comprises more than 100 different diseases that affect areas in or around the joints.[42] The most common type is osteoarthritis, which is a degenerative joint disease that causes pain and loss of movement due to deterioration in the cartilage covering the ends of bones in the joints. Types of arthritis that primarily affect women include lupus arthritis, fibromyalgia, and rheumatoid arthritis, which is the most serious and disabling type of arthritis.[42]

In 2007–2009, 22.2 percent of adults in the United States reported that they had ever been diagnosed with arthritis (data not shown); this represents more than 49 million adults among whom 21 million had an arthritis-attributable activity limitation.[41] Arthritis was more common among women than men (25.9 versus 18.3 percent, respectively). The proportion of adults with arthritis increases dramatically with age for both sexes. Fewer than 9 percent of women aged 18–44 years had ever been diagnosed with arthritis, compared to 52.1 percent of women aged 65–74 years, and 58.9 percent of women aged 75 years and older. Similarly, only 6.2 percent of men aged 18–44 had ever been diagnosed with arthritis compared to 40.5 percent of those aged 65–74 and 46.1 percent of those aged 75 and older.

Obesity has been associated with the onset and progression of osteoarthritis.[41] Between 2007–2009, nearly one-third of obese adults and one-quarter of overweight adults had been diagnosed with arthritis, compared to 16.4 percent of normal/underweight adults. Arthritis was more common among obese women (34.8 percent) than obese men (24.6 percent) and among overweight women (27.2 percent) than overweight men (18.4 percent). Nearly one-fifth (18.9 percent) of normal/underweight women had been diagnosed with arthritis compared to 12.7 percent of normal/underweight men.

Adults Aged 18 and Older with Arthritis,* by Age and Sex, 2007–2009

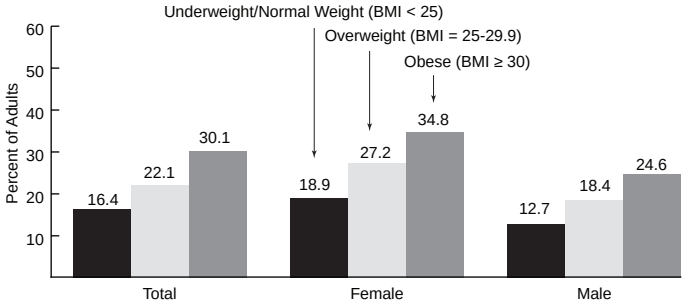
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported a health professional has ever told them they have arthritis.

Adults Aged 18 and Older with Arthritis,* by Sex and Body Mass Index, 2007–2009**

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



*Reported a health professional has ever told them they have arthritis. **Body Mass Index (BMI) is a ratio of weight to height.

OSTEOPOROSIS

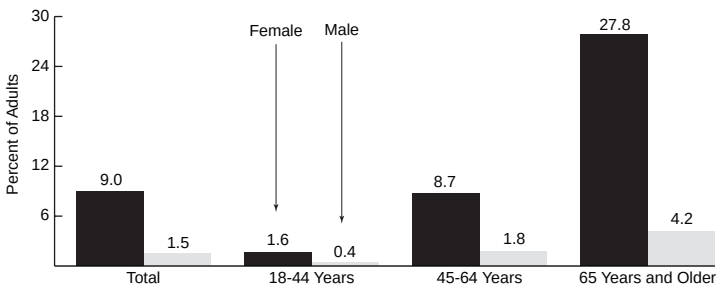
Osteoporosis is a bone weakness characterized by low bone density with symptoms that generally occur only after the disease is advanced.[43] Bone fractures are the most common consequence; others include loss of height, stooped posture, and back and neck pain from spinal fractures. Risk of osteoporosis increases with age and is much more common among women than men. In 2005–2008, an estimated 9.8 million women (9.0 percent) and 1.5 million men (1.5 percent) had osteoporosis. More than one in four women aged 65 and older had been diagnosed with osteoporosis, compared with 4.2 percent of men. Among women aged 65 and older, osteoporosis varied significantly by race and ethnicity. About 30 percent of non-Hispanic White and Hispanic women aged 65 and older reported that they had been diagnosed with osteoporosis, compared to 11.1 percent of non-Hispanic Black women of the same age (data not shown).

Osteoporosis may be prevented and treated by getting the recommended amounts of calcium, vitamin D, and regular weight-bearing physical activity (such as walking), and by taking prescription medication when appropriate.[43,44] To promote early diagnosis and the prevention of complications, bone density tests are recommended for all women aged 65 and older and younger women who have a risk factor, including low weight, smoking, heavy alcohol consumption, and family history of a broken hip.[45]

Bone fractures among the elderly most commonly occur among those with osteoporosis and can have devastating consequences. For example, 1 in every 5 hip fracture patients die within a year of their injury.[44] Falls are a common direct cause of osteoporosis-related fracture and are the leading cause of injury—both fatal and nonfatal—among adults aged 65 and older. In 2009, there were 2.2 million unintentional nonfatal fall injuries treated in emergency departments among adults aged 65 and older (data not shown). The rate of nonfatal fall injury was higher among women than men and increased with age. Among both women and men, the rate of nonfatal fall injury was about five times higher among those aged 85 and older than those aged 65–69. Fall prevention efforts can include muscle strengthening, home hazard assessments and modifications, and avoiding sedative medications that may impair balance and coordination.[44]

Diagnosed Osteoporosis* Among Adults Aged 18 and Older, By Age and Sex, 2005–2008

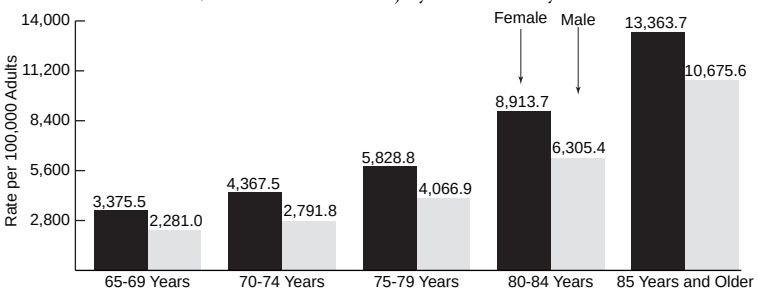
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported a health professional had ever told them they had osteoporosis.

Nonfatal Unintentional Injury Due to Falls* per 100,000 Adults Aged 65 and Older, by Age and Sex, 2009

Source II.5: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, National Electronic Injury Surveillance System



*Treated in hospital emergency departments.

ALZHEIMER'S DISEASE

Alzheimer's disease is the most common form of dementia.[46] Early signs include difficulty remembering names and completing familiar tasks, with later disease progression leading to disorientation, personality changes, and difficulty speaking, swallowing, and walking. Although the risk for Alzheimer's disease increases with age, it is not a normal part of aging. Risk factors include a family history, head trauma or traumatic brain injury, and cardiovascular disease risk factors such as high cholesterol, hypertension, diabetes, smoking, and physical inactivity.

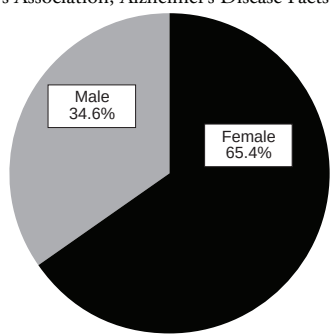
In 2011, 5.2 million or 13 percent of U.S. adults aged 65 and older are estimated to have Alzheimer's disease and another 200,000 below age 65 are thought to have younger-onset Alzheimer's. Due to the aging of the population, the number of adults aged 65 and older with Alzheimer's disease is expected to triple by 2050.[46] Women constitute 3.4 million or nearly two-thirds of adults aged 65 and older with Alzheimer's.

Alzheimer's disease is the fifth leading cause of death among men and women aged 65 and older.[46] Severe dementia causes complications, such as immobility and swallowing disorders, that can lead to death. In 2007, 1.9 per 1,000 or nearly 74,000 adults aged 65 and older, 70 percent of whom were women, died of Alzheimer's. The risk of death due to Alzheimer's increases greatly with age, from 0.2 deaths per 1,000 for those aged 65–74 years to 8.5 deaths per 1,000 for those aged 85 and older. Overall, women are nearly twice as likely as men to die of Alzheimer's disease (2.4 versus 1.3 deaths per 1,000 aged 65 and older). The greater rates of Alzheimer's prevalence and mortality among women are related to their longer life expectancy rather than an increased age-specific risk of disease.[46]

Not only are women more likely than men to have Alzheimer's, they are also more likely to be caregivers for someone with Alzheimer's. Of the nearly 15 million Americans who provide unpaid care for a person with Alzheimer's or another dementia, 60 percent are women and they report a high level of emotional and physical stress.[46,47] Given the large and increasing burden of Alzheimer's disease, advances in prevention, early diagnosis, and treatment are greatly needed. Recently, a new diagnostic category of "preclinical Alzheimer's disease" was developed to aid research for early detection and treatment prior to the onset of symptoms.[46]

Adults Aged 65 and Older with Alzheimer's Disease,* By Sex, 2011

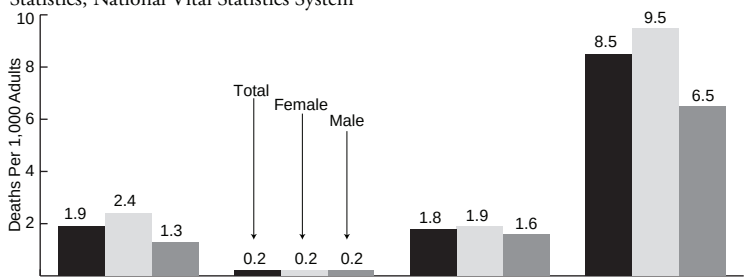
Source II.15: Alzheimer's Association, Alzheimer's Disease Facts and Figures.



**Estimates are from the Chicago Health and Aging Project incidence rates converted to prevalence estimates and applied to 2011 U.S. Census Bureau estimates of the population aged 65 and older.*

Deaths Due to Alzheimer's Disease* per 1,000 Adults Aged 65 and Older, By Age and Sex, 2007

Source II.16: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



**Deaths with Alzheimer's disease listed as underlying cause.*

SLEEP DISORDERS

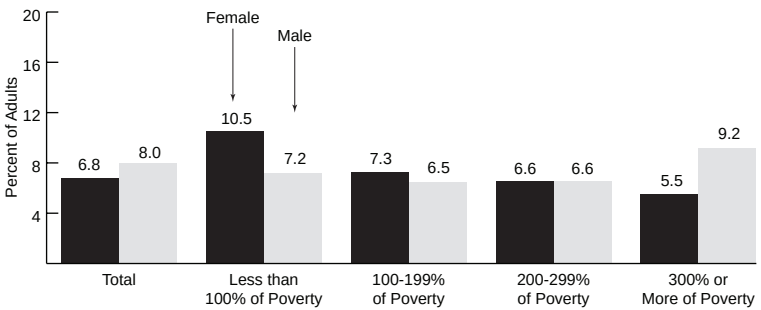
An estimated 50 to 70 million adults in the United States suffer from a chronic sleep or wakefulness disorder, which can impair functioning and increase the risk of injury and various chronic conditions, including diabetes and cardiovascular disease.[48] Common forms of sleep disorders include insomnia, narcolepsy, restless legs syndrome, and sleep apnea.[49] Chronic snoring may be an indicator of obstructive sleep apnea—a serious disorder in which the airway is obstructed during sleep and there is momentary oxygen disruption followed by gasping or snorting.[49,50] Sleep apnea results in reduced sleep quality and fatigue and can produce severe cardiovascular complications as a consequence of disordered breathing. Treatments for sleep apnea can include behavioral modifications, such as weight loss and smoking cessation, as well as certain devices and surgery.

In 2005–2008, 6.8 percent of women and 8.0 percent of men reported that they had ever been told by a health professional that they had a sleep disorder. Among women, sleep disorders were more common among those with lower incomes. For example, 10.5 percent of women with household incomes below 100 percent of poverty had reported that that they had been diagnosed with a sleep disorder, compared to 5.5 percent of women with incomes of 300 percent or more of poverty. Among men, however, sleep disorders were most common at higher income levels. Over 9 percent of men with household incomes of 300 percent or more of poverty reported that they had ever been told by a health professional that they had a sleep disorder, compared to 6.5 percent of men with incomes between 100–199 percent of poverty.

The prevalence of sleep disorders also varies by body mass index—a ratio of weight to height. Obesity can increase the risk of sleep apnea by obstructing the upper airway; however, sleep disorders can occur at any weight. In 2005–2008, women who were obese were three times more likely to have been diagnosed with a sleep disorder than women who were not overweight or obese (11.4 versus 3.8 percent, respectively). Weight loss can resolve some cases of sleep apnea.[50]

Sleep Disorders* Among Adults Aged 18 and Older, by Poverty Status and Sex, 2005–2008**

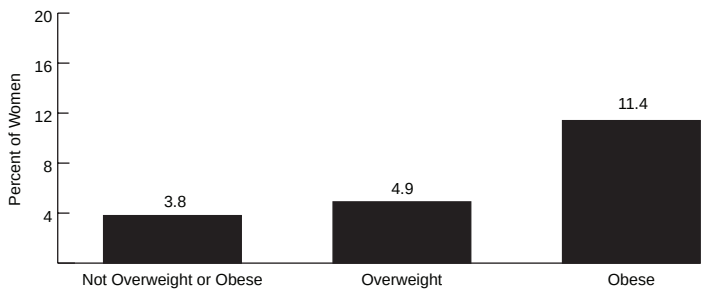
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported that a health professional has ever told them they have a sleep disorder: this may include insomnia, restless legs, sleep apnea, and other conditions. **Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

Sleep Disorders* Among Women Aged 18 and Older, by Body Mass Index, 2005–2008**

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Reported that a health professional has ever told them they have a sleep disorder: this may include insomnia, restless legs, sleep apnea, and other conditions. **Body Mass Index (BMI) is a ratio of weight to height; overweight is defined as a BMI of 25.0 to 29.9; obesity is defined as a BMI of 30.0 or higher.

ORAL HEALTH

Poor oral health can cause chronic pain of the mouth and face and can impair the ability to eat normally. To prevent caries (tooth decay) and periodontal (gum) disease, the American Dental Association recommends brushing at least twice a day and flossing at least once per day, and receiving regular dental checkups.[51]

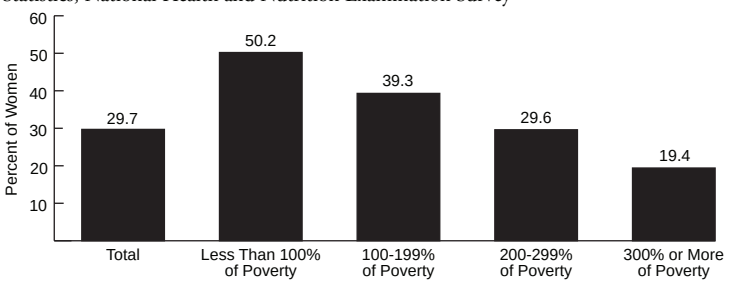
In 2005–2008, about 30 percent of adults reported that their teeth were in fair or poor condition (30.8 percent; data not shown). Self-reported oral health status did not vary by sex but did vary greatly by poverty status and race and ethnicity. For example, 50.2 percent of women with household incomes of less than 100 percent of poverty reported that their teeth were in fair or poor condition compared to 19.4 percent of women with household incomes of 300 percent or more of poverty. Nearly 50 percent of Mexican American women and more than 40 percent of Other Hispanic and non-Hispanic Black women reported fair or poor oral health compared to about 25 percent of non-Hispanic White women (data not shown).

Dental restoration, such as fillings or crowns, can be used to treat cavities caused by caries. In 2005–2008, 21.0 percent of adults had untreated dental decay and 78.9 percent had at least one tooth restored (data not shown). Men were somewhat more likely than women to have untreated dental decay (24.5 versus 17.7 percent, respectively) and less likely to have had dental restoration (75.9 versus 81.6 percent, respectively; data for men not shown).

Dental decay and restoration vary by poverty status and race and ethnicity. Dental decay was about twice as high among non-Hispanic Black and Mexican American women (34.1 and 28.9 percent, respectively) compared to non-Hispanic White and Other Hispanic women (14.0 and 16.8 percent, respectively). Conversely, dental restoration was higher among non-Hispanic White and Other Hispanic women (84.0 and 86.5 percent, respectively) compared to non-Hispanic Black and Mexican American women (70.6 and 73.2 percent, respectively). Women with household incomes below poverty were three times more likely to have untreated dental decay than women living in households at 300 percent or more of poverty (30.3 versus 10.3 percent, respectively) and were less likely to have had dental restoration (68.3 versus 89.9 percent, respectively; data not shown).

Self-Reported Fair/Poor Oral Health Status Among Women Aged 18 and Older, by Poverty Status,* 2005–2008

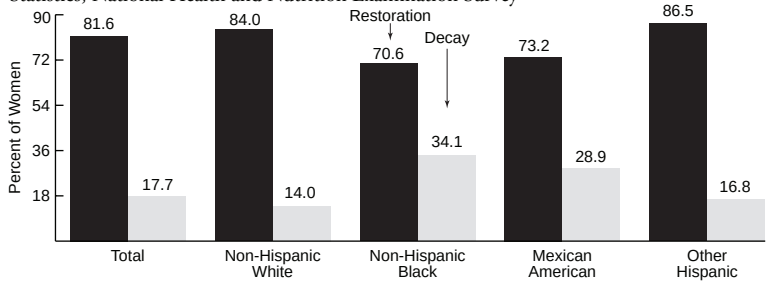
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



Poverty level, defined by the U.S. Census Bureau, was $22,025 for a family of four in 2008.

Presence of Tooth Restoration and Decay Among Women Aged 18 and Older, by Race/Ethnicity,* 2005–2008

Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



The samples of American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple race were too small to produce reliable results.