HEALTH SERVICES UTILIZATION

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

This section presents data on women's use of health services, including data on women's health insurance coverage, usual source of care, health care expenditures, and use of various services, such as preventive care, HIV testing, hospitalization and home health care, and mental health services. Two new additions to this section address oral health care utilization and barriers to health care.

HEALTH INSURANCE

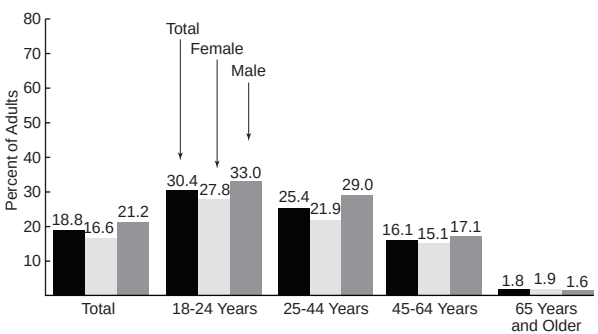
People who are uninsured face substantial financial barriers to health care, which can result in delayed diagnoses and poor health outcomes, including premature death.[1] In 2009, 43.1 million adults (18.8 percent) were uninsured, up from 37.5 million adults (16.7 percent) in 2007 (2007 data not shown). The recent rise in the uninsured population has been attributed to job loss and the economic recession.[1] The percentage of people who are uninsured varies considerably across a number of factors, including age, sex, marital status, race and ethnicity, income, and education.

Among adults in 2009, those aged 18–24 years were most likely to lack health insurance (30.4 percent). Men aged 18–64 years were more likely than women of the same age to be uninsured. The highest rate of uninsurance occurred among 18- to 24-year-old men (33.0 percent), which was higher than the percentage of women of the same age (27.8 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest rate was found among women and men aged 45–64 (15.1 and 17.1 percent, respectively); the sex disparity in this age group is less pronounced than in the younger age groups.

Among women aged 18–64 years in 2009, 67.6 percent had private insurance, 16.9 percent had public insurance, and 19.9 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White women were most likely to have private insurance coverage (75.4 percent), while Hispanic women were least likely to be covered by private insurance (44.7 percent). About 1 in 4 non-Hispanic Black, non-Hispanic American Indian/Alaska Native, non-Hispanic Native Hawaiian/other Pacific Islander, and non-Hispanic women of multiple races had public insurance. Hispanic women were most likely to lack insurance (38.9 percent), followed by non-Hispanic American Indian or Alaska Native and non-Hispanic Black women (30.5 and 24.6 percent, respectively). [Respondents could report more than one type of coverage.]

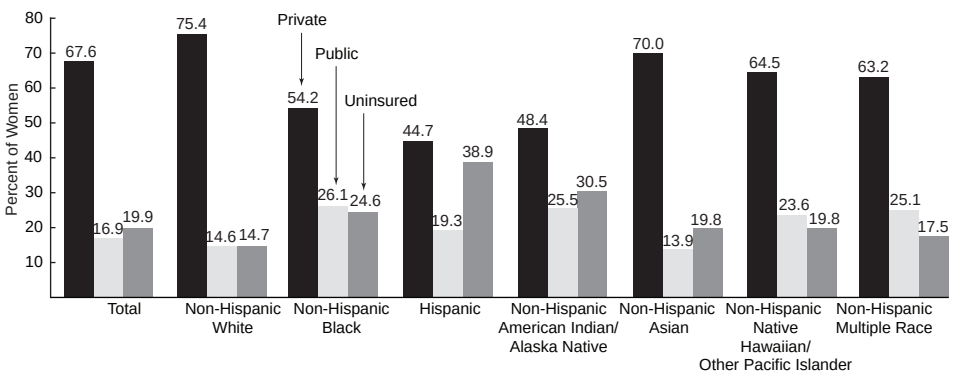
Adults Aged 18 and Older Without Health Insurance, by Age and Sex, 2009

Source I.6: U.S. Census Bureau, Current Population Survey



Health Insurance Coverage of Women Aged 18–64, by Race/Ethnicity and Type of Coverage,* 2009

Source I.6: U.S. Census Bureau, Current Population Survey



*Percentages may add to more than 100 because it was possible to report more than one type of coverage.

MEDICAID AND MEDICARE

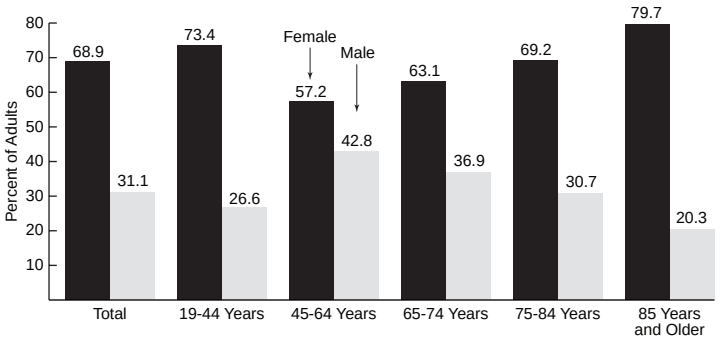
Medicaid, jointly funded by Federal and State governments, provides medical coverage to certain categories of low-income people.[2] In 2008, Medicaid covered 60.9 million people including low-income pregnant women, children, parents, elderly individuals, and those with disabilities. Adults aged 19 and older accounted for nearly half of Medicaid enrollees (30.2 million), and women accounted for 68.9 percent of all adult enrollees. Medicaid serves as a critical safety net for those who might otherwise be uninsured; enrollment has increased in the current recession, but more notably for children than adults due to greater eligibility and expansions for children.[1]

Women accounted for a larger proportion of adult Medicaid enrollees in every age group, most noticeably among those aged 19–44 and 85 years and older (73.4 and 79.7 percent, respectively). Nearly 12.9 million women, representing 61.8 percent of adult female Medicaid enrollees, were of childbearing age (data not shown). Because the Medicaid eligibility threshold is lowered in the postpartum period, 28 States have expanded family planning through a federal waiver or state plan amendments to cover women who would not otherwise be eligible for Medicaid.[3]

Medicare is the Nation's health insurance program for people aged 65 years and older, some people under age 65 with disabilities, and those with end-stage renal disease (permanent kidney failure). Medicare has four components: Part A covers hospital, skilled nursing, home health, and hospice care; Part B covers physician services, outpatient services, and durable medical equipment; Part C (Medicare Advantage Plans) allows beneficiaries to purchase coverage through private insurers; and Part D allows for coverage of prescription drugs through private insurers.[2]

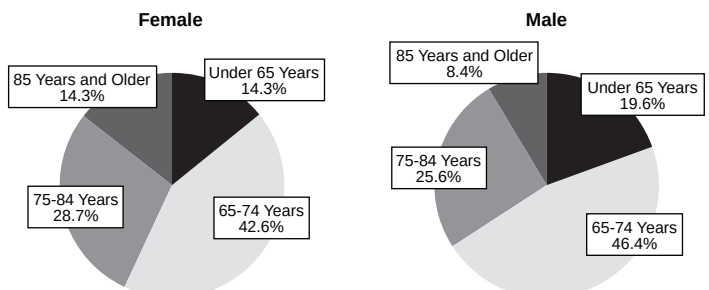
In 2009, 55.3 percent of Medicare's 46.5 million enrollees were female (data not shown). Due to age-related eligibility, those in older age groups accounted for a greater proportion of overall enrollment among both women and men. However, male enrollees were more likely to be under 65 than female enrollees (19.6 versus 14.3 percent). In contrast, adults aged 85 years and older comprised a greater proportion of female than male enrollees (14.3 versus 8.4 percent), due to the longer life expectancy of women.

Adult Medicaid Enrollees Aged 19 and Older, by Age and Sex, 2008*
Source III.1: Centers for Medicare and Medicaid Services



Based on Federal Fiscal Year (October to September).

Medicare Enrollees, by Sex and Age, 2009*
Source III.1: Centers for Medicare and Medicaid Services



Enrolled as of July 1, 2009. Percentages may not add to 100 due to rounding.

BARRIERS TO CARE AND UNMET NEED FOR CARE

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

In 2007–2009, 11.4 percent or 25.3 million adults reported that they delayed getting medical care in the past year due to various logistical or structural factors, such as not being able to get an appointment soon enough and inconvenient office hours (data not shown). Women were more likely than men to report having delayed care due to logistical barriers in the past year (13.0 versus 9.6 percent, respectively). For both men and women, those with lower household incomes were more likely to report having delayed care as a result of logistical factors. For example, 18.9 percent of women living in households with incomes below the poverty level reported having delayed care, compared to 12.2 percent of women in households with incomes of 200 percent or more of poverty.

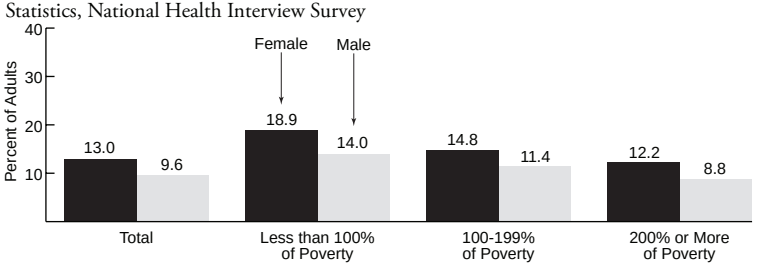
Women were also slightly more likely than men to have forgone needed health care due to cost (9.3 versus 7.8 percent, respectively). For both women and men, those who were uninsured were significantly more likely to not have received needed care due to cost than those who were insured with either public or private insurance. Among women, 32.4 percent of those who were uninsured experienced an unmet need for health care due to cost, compared to 4.5 percent of those with private insurance and 6.1 percent with public insurance.

Unmet needs for health care also varied by race and ethnicity. About 11 to 12 percent of Hispanic and non-Hispanic Black women had an unmet need for health care due to cost, compared to 8.5 percent of non-Hispanic Whites and 4.1 percent of non-Hispanic Asian women (data not shown).

The Affordable Care Act of 2010 helps to remove financial barriers to care by expanding Medicaid eligibility for more low-income people, mandating employer-sponsored coverage for large employers, establishing state-based insurance exchanges, and requiring insurance coverage of preventive services without copays.[5]

Adults Aged 18 and Older who Delayed Care Due to Logistical Barriers* in Past Year, by Poverty Status and Sex, 2007–2009**

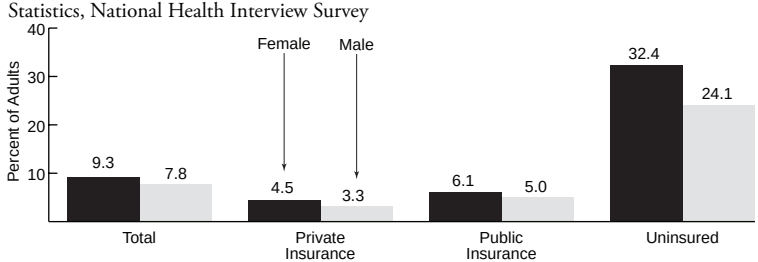
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Reported that they delayed getting medical care in the past year due to any of five reasons: couldn't get through on phone, couldn't get appointment soon enough, office room wait too long, inconvenient office hours, no transportation. **Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

Adults Aged 18 and Older with Unmet Need for Health Care Due to Cost,* by Health Insurance Coverage and Sex, 2007–2009

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



*Reported that they needed but did not get medical care because they could not afford it; excludes dental care.

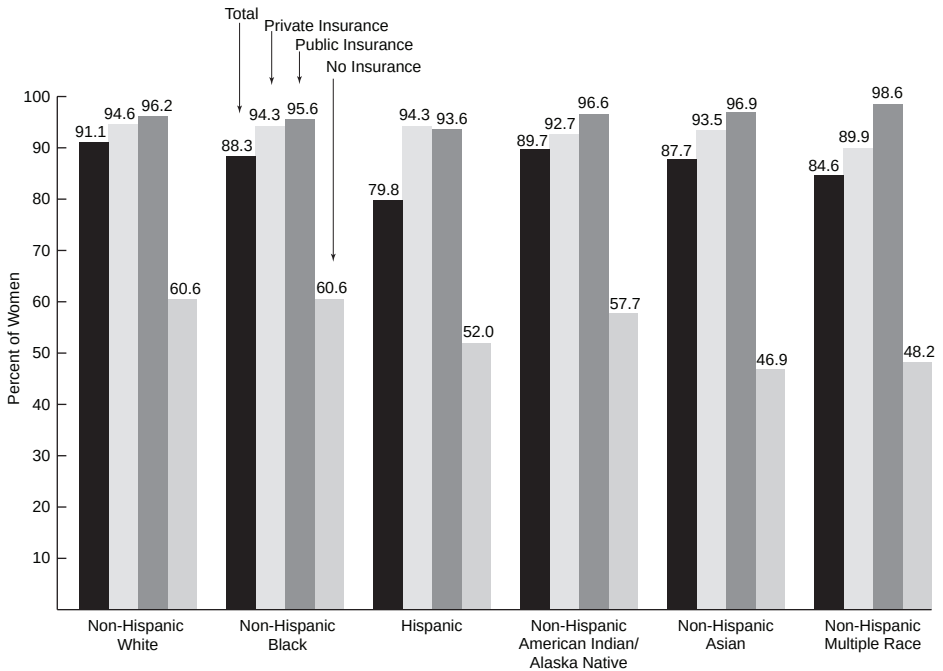
USUAL SOURCE OF CARE

In 2007–2009, 89.1 percent of women reported having a usual source of care, compared to 79.5 percent of men (data not shown). Women who have a usual source of care (a place they usually go when they are sick, such as a physician's office or health center) are more likely to receive preventive care,[6] experience fewer delays in obtaining care,[7] and receive higher quality care.[7]

Overall, non-Hispanic White women were most likely to report a usual source of care (91.1 percent), while Hispanic women were least likely to do so (79.8 percent). The proportion of women of different races and ethnicities who have a usual source of care varied with health insurance status. Among women with private or public insurance, those reporting a usual source of care generally exceeded 90 percent for all racial and ethnic groups. Women lacking health insurance were least likely to have a usual source of care (57.4 percent; data not shown), with significant variation by race and ethnicity. Among women without health insurance, non-Hispanic White and non-Hispanic Black women were most likely to report a usual source of care (60.6 percent), while non-Hispanic women of multiple races and non-Hispanic Asian women were least likely to do so (48.2 and 46.9 percent, respectively).

Women Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity* and Health Insurance Status, 2007–2009**

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



The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results. Respondents could have private or public insurance or both; items are not mutually exclusive. Rates reported are not age-adjusted.*

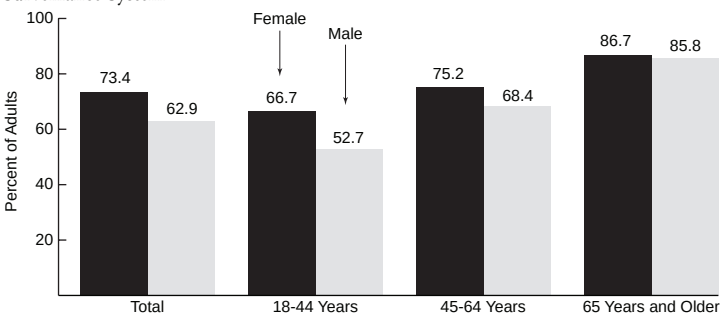
PREVENTIVE CARE

Preventive health care, including counseling, education, and screening, can help prevent or minimize the effects of many serious health conditions. In 2007–2009, 68.3 percent of adults reported that they had received a routine checkup or general physical exam that was not for a specific injury, illness, or condition (data not shown). Women aged 18 and older were more likely than men to report having had a past-year preventive health care visit (73.4 versus 62.9 percent, respectively). This sex difference was most prominent among 18- to 44-year-olds, when women may receive annual reproductive health care, and was absent among those aged 65 years and older. For both men and women, the receipt of preventive health care increased with age.

The U.S. Preventive Services Task Force recommends specific screening tests, counseling, immunizations, and preventive medications for a variety of diseases and conditions including several types of cancer, cardiovascular disease, injury, infectious diseases, mental health, and substance abuse.[8] For example, biennial breast cancer screenings (mammograms) are recommended for every woman aged 50–74 years and cervical cancer screenings (Pap smears) are recommended every 3 years after the onset of sexual activity or age 21, whichever comes first, up to age 65. In 2008, 78.8 percent of women aged 50–74 years reported receiving a mammogram within the past 2 years and 81.8 percent of women aged 21–65 reported receiving a Pap smear within the past 3 years. There were no significant differences in receipt of a mammogram in the past 2 years among women of different races and ethnicities; however, non-Hispanic Asian women were less likely than women of other racial and ethnic groups to have reported receiving a Pap smear in the past 3 years (70.4 versus 81.8 percent overall). The Affordable Care Act requires that new insurance plans cover essential preventive services, including well woman visits, free of charge as of August 2012.[9]

Past Year Preventive Check-up Among Adults Aged 18 and Older,* By Age and Sex, 2007–2009

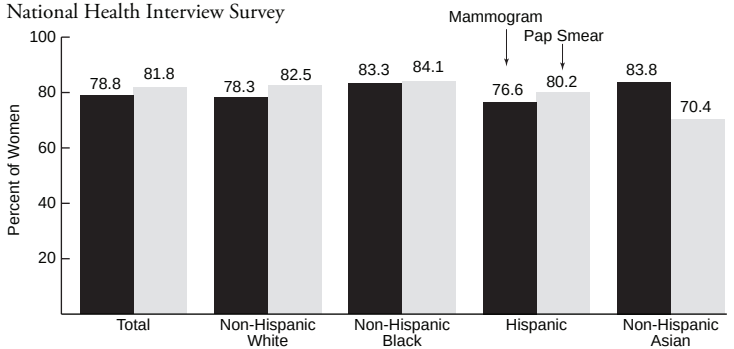
Source II.6: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System



*Reported a routine checkup in the past year, defined as a general physical exam that was not for a specific injury, illness, or condition.

Receipt of Recommended Breast and Cervical Cancer Screening Among Women,* by Race/Ethnicity, 2008**

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



*Based on U.S. Preventive Services Task Force recommendations of biennial mammography for women aged 50 to 74 years and a Pap smear every three years for women aged 21 to 65 years. **The sample of American Indian/Alaska Native and Native Hawaiian/Pacific Islanders was too small to produce reliable results.

VACCINATION

Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in mortality and morbidity for many infectious diseases. An annual influenza, or flu, vaccination is now recommended for all persons aged 6 months and older; however, it is especially important for certain groups, including older adults, who experience more serious complications.[10] Influenza vaccination efforts should begin as soon as the seasonal influenza vaccine is available in September and continue throughout the influenza season, generally into February. During the 2008–2009 flu season, only 43.7 percent of women aged 50–64 years reported receiving a flu vaccine; this did not vary significantly by race and ethnicity. Women aged 65 years and older were more likely to report receiving a flu vaccine (65.8 percent). However, non-Hispanic Black and Hispanic women aged 65 and older were much less likely to receive the flu vaccine than non-Hispanic White women of the same age (48.6 and 50.9 versus 69.0 percent, respectively).

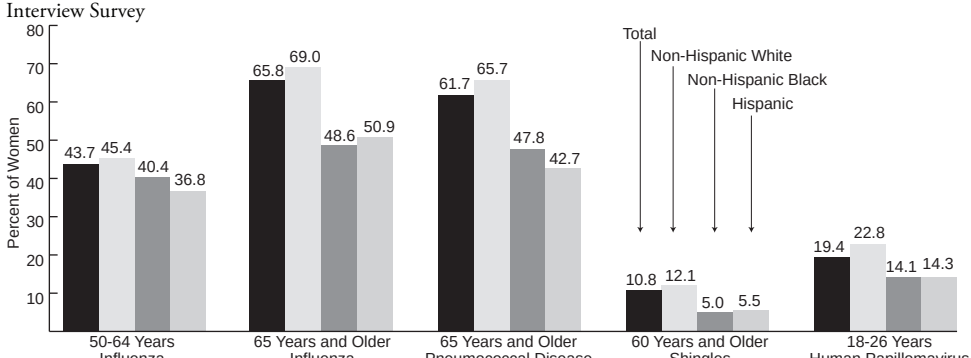
A pneumococcal vaccination protects against a bacterial infection that may cause a form of pneumonia, meningitis, or ear infection. It is recommended for young children, adults aged 65 years and older, and those with certain health conditions or behaviors such as asthma and cigarette smoking.[11] In 2009, 61.7 percent of women aged 65 and older reported ever receiving a pneumococcal vaccination. However, less than half of all non-Hispanic Black and Hispanic women aged 65 and older had received the pneumococcal vaccination compared to 65.7 percent of non-Hispanic White women of the same age.

Two newer vaccinations, first recommended in 2006, protect against shingles and human papillomavirus (HPV) infection. Shingles is a reactivation of the virus that causes chickenpox. It occurs mostly in older adults and produces a skin rash that can create debilitating pain lasting months or even years. The shingles vaccination is recommended for all persons aged 60 years and older without certain conditions that may weaken the immune system.[12] In 2009, only 10.8 percent of women aged 60 years and older reported receiving shingles vaccination.

Genital HPV is the most common sexually transmitted infection in the United States and some HPV types can cause cervical cancer in women. Vaccination is universally recommended for girls aged 11–12 years. Catch-up vaccination is recommended for females aged 13–26 years who have not been previously vaccinated.[13] In 2009, only 19.4 percent of women aged 18–26 years had received HPV vaccination. Non-Hispanic White women were more likely to have been vaccinated for shingles and HPV than non-Hispanic Black or Hispanic women.

Receipt of Selected Vaccinations* Among Women, by Recommended Age Group and Race/Ethnicity, 2009**

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



**Having received the flu shot or nasal spray from September 2008 through February 2009; having ever received the pneumonia shot; having ever received the zoster or Shingles vaccine; and having ever received the HPV shot or cervical cancer vaccine. **The sample of American Indian/Alaska Natives, Asians, and Native Hawaiian/Pacific Islanders was too small to produce reliable results.*

HIV TESTING

People aware of and receiving appropriate care for positive HIV serostatus may be able to live longer and healthier lives because of newly available, effective treatments. It is recommended that people who meet any of the following criteria be tested at least annually for HIV: those who have injected drugs or steroids, or shared drug use equipment (such as needles); have had unprotected sex with men who have sex with men, anonymous partners, or multiple partners; have exchanged sex for drugs or money; have been diagnosed with hepatitis, tuberculosis, or a sexually transmitted infection; received a blood transfusion between 1978 and 1985; or have had unprotected sex with anyone who meets any of these criteria.[14] In addition, the CDC recommends that all health care providers include HIV testing as part of their patients' routine health care and that all pregnant women be tested during their pregnancy.

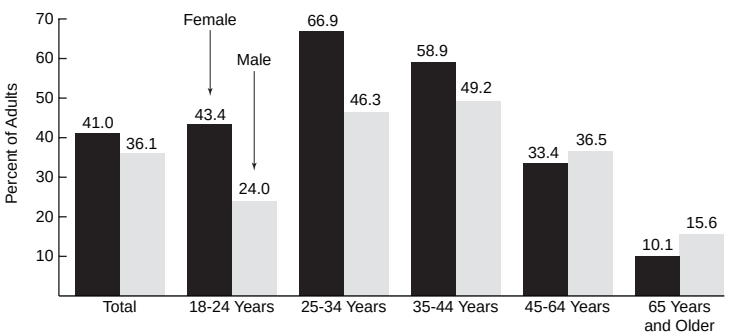
In 2007–2009, 38.6 percent of adults in the United States had ever been tested for HIV (data not shown). Overall, women were slightly more likely than men to have been tested (41.0 versus 36.1 percent, respectively). Within younger age groups (18–44 years), women were more likely to have been tested than men, while men were more likely to have been tested at older ages (45 years and older).

Among women in 2007–2009, non-Hispanic Black women and non-Hispanic women of multiple races were most likely to have ever been tested (58.7 and 55.8 percent, respectively). About half of all Hispanic and non-Hispanic American Indian/Alaska Native women had been tested (50.8 and 47.3 percent, respectively). Non-Hispanic White and Asian women were much less likely to have reported ever being tested (36.0 and 36.1 percent, respectively).

Among women who had not been tested, 78.9 percent reported that they had not been tested because they thought it was unlikely they had been exposed and 19.1 percent reported that there was no particular reason they had not done so (data not shown).

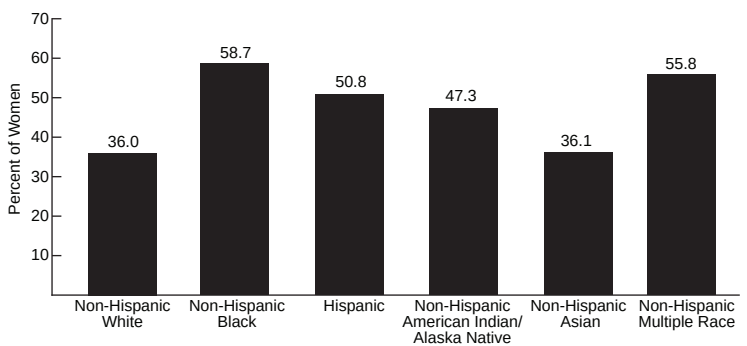
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Age and Sex, 2007–2009

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



Women Aged 18 and Older Who Have Ever Been Tested for HIV, by Race/Ethnicity,* 2007–2009

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



**The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results.*

MENTAL HEALTH CARE UTILIZATION

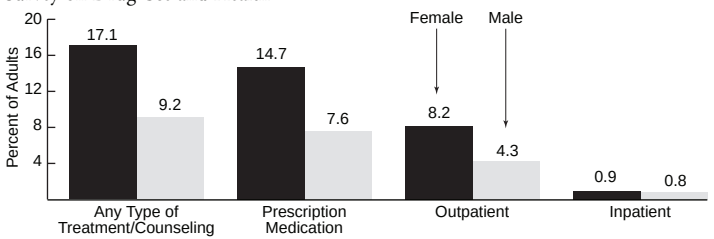
In 2009, more than 30 million adults in the United States reported receiving mental health treatment in the past year for a mental, behavioral, or emotional disorder other than a substance use disorder. Women represented two-thirds of users of mental health services, which is roughly commensurate with the higher prevalence of mental illness (excluding substance use disorder) among women.[15] More than 17 million women aged 18 years and older reported using prescription medication for treatment of a mental or emotional condition, representing 14.7 percent of the population, which is almost twice the proportion of men using prescription medication for treatment (7.6 percent). Women were also nearly twice as likely as men to report receiving outpatient mental health treatment (8.2 versus 4.3 percent, respectively). Inpatient treatment was reported equally by men and women. Not every person with a mental illness receives treatment; among adults with a mental illness, women were more likely than men to report utilization of prescription medication and outpatient care (data not shown).

In 2007–2009, mental health services were needed, but not received, by about 11.3 million adults annually (on average), corresponding to 5 percent of adults in the United States. Due in part to greater need, women were twice as likely as men to have an unmet need for mental health treatment or counseling in the past year (6.7 versus 3.3 percent, respectively; data for men not shown). Unmet need for treatment among women varies by race and ethnicity. Compared to non-Hispanic White women, unmet need was higher among non-Hispanic women of multiple races (12.2 percent) and significantly lower among non-Hispanic Asian and Hispanic women (2.7 and 4.9 percent, respectively).

Among women, cost or lack of adequate insurance coverage was the most commonly reported reason for not receiving needed services (49.5 percent; data not shown). However, non-Hispanic Black women were significantly less likely than non-Hispanic White women to report a problem with cost or lack of adequate insurance (40.6 versus 51.1 percent). Other commonly reported reasons for unmet need included a fear of stigma—such as concerns about confidentiality, the opinions of others, or the potential effect on employment—and not knowing where to go for services (21.0 and 14.8 percent, respectively); these did not vary significantly by race and ethnicity.

Past Year Mental Health Treatment/Counseling* Among Adults Aged 18 and Older, by Sex, 2009

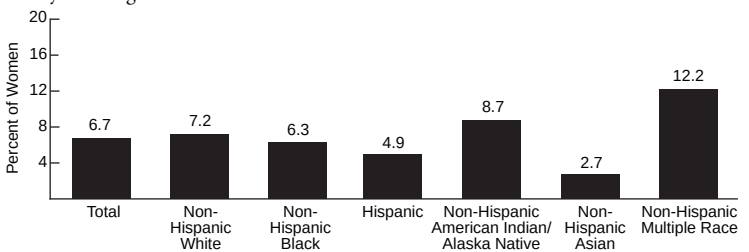
Sources II.10: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*Excludes treatment for alcohol or drug use. Respondents could report more than one type of treatment.

Unmet Need for Mental Health Treatment/Counseling* Among Women Aged 18 and Older, by Race/Ethnicity, 2007–2009**

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



*Defined as a perceived need for mental health treatment/counseling that was not received. **The sample of non-Hispanic Native Hawaiian/Other Pacific Islanders was too small to produce reliable results.

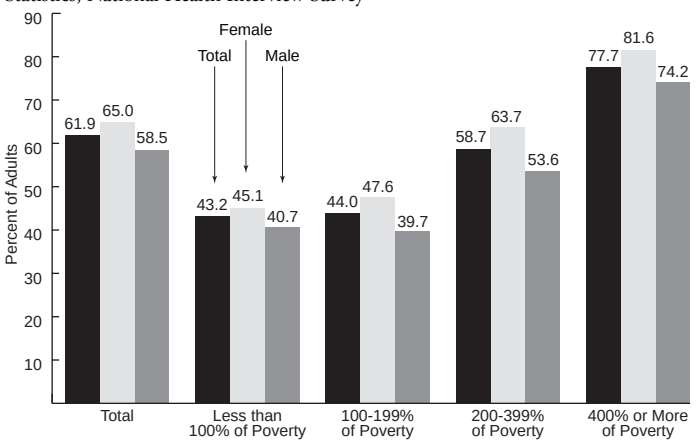
ORAL HEALTH CARE UTILIZATION

Regular dental care is essential to promote oral health and to prevent and treat tooth decay and infection. Untreated dental disease can produce significant pain and disability, and can result in tooth loss. In addition to daily brushing and flossing, the American Dental Association recommends regular dental exams and cleanings.[16] Overall, 61.9 percent of adults reported having a dental visit in 2007–2009. Women were somewhat more likely to have a past-year dental visit than men (65.0 and 58.5 percent, respectively). Among both men and women, those with greater household incomes were more likely to have had a dental visit. For example, 81.6 percent of women with household incomes of 400 percent or more of poverty had a past year dental visit, compared to only 45.1 percent of women with incomes less than 100 percent of poverty.

Cost is a significant barrier to appropriate utilization of dental care. In 2007–2009, 15.1 percent of women reported that they did not obtain needed dental care in the past year because they could not afford it. Health insurance helps to reduce cost as a barrier to health care. Only about 10 percent of women with health insurance reported that they did not obtain needed dental care in the past year due to costs, compared to 42.6 percent of women without health insurance. Among persons under 65 years of age with private health insurance, about one in four lack coverage for dental services.[17]

Adults Aged 18 and Older Who Had a Dental Visit in the Past Year, by Poverty Status* and Sex, 2007–2009

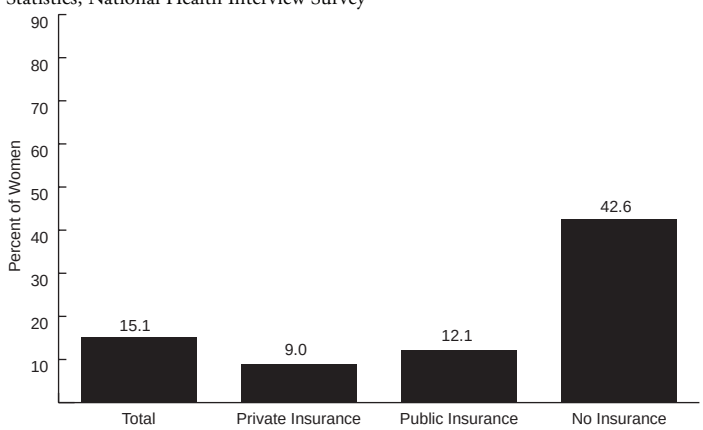
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Poverty level, defined by the U.S. Census Bureau, was $21,954 for a family of four in 2009.

Women Aged 18 and Older with an Unmet Need for Dental Care Due to Cost,* by Health Insurance Coverage, 2007–2009

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



Reported needing but not receiving dental care in the past year because of cost.

HOSPITALIZATION AND HOME HEALTH CARE

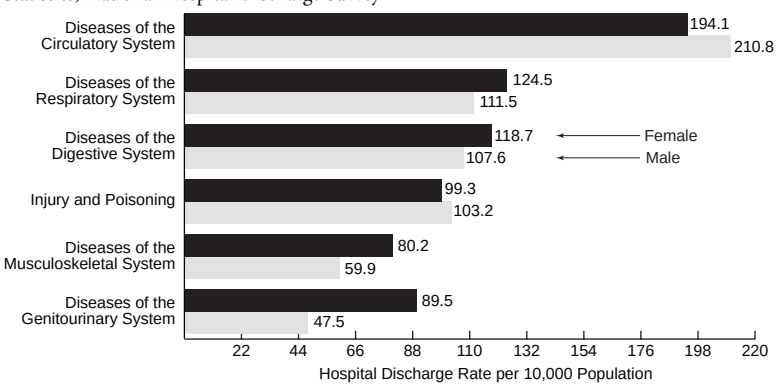
In 2008, there were 35.7 million short-stay hospital discharges. Overall, females had a higher hospital discharge rate than males and accounted for 60 percent of all discharges (1,385.2 versus 964.9 per 10,000 population; data not shown). However, nearly 20 percent of hospital stays for all females were due to childbirth. When discharges due to childbirth are not counted, the hospital discharge rate for females is more comparable to that for men (1,116.0 per 10,000 population). Six diagnostic categories accounted for over two-thirds of all hospitalizations, excluding childbirth. These included diseases of the circulatory, respiratory, digestive, musculoskeletal, and genitourinary systems, as well as injury and poisoning. Of these, women had a significantly higher hospital discharge rate than men for diseases of the genitourinary system (89.5 versus 47.5 per 10,000 population), which includes urinary tract infections. Among specific diagnoses, women had a hospitalization rate more than twice that of men for urinary tract infections and hip fractures (data not shown).

On any given day in 2007, there were about 1.5 million people receiving home health care services. Overall, women account for a greater proportion of users of home health care than men (64.8 versus 35.2 percent, respectively). The proportion of home health care users that are women increases with age. Among those aged 85 years or older, 72.3 percent were women.

As the U.S. population ages, there will be a greater reliance on home health care and on those providing care in the home. Research has found that the burden of care-giving may have numerous physical and emotional health consequences including increased likelihood of chronic disease, fatigue and loss of sleep, stress or anxiety, pain, depression, and headaches.[18] As such, the health needs of female caregivers will also need to be addressed.

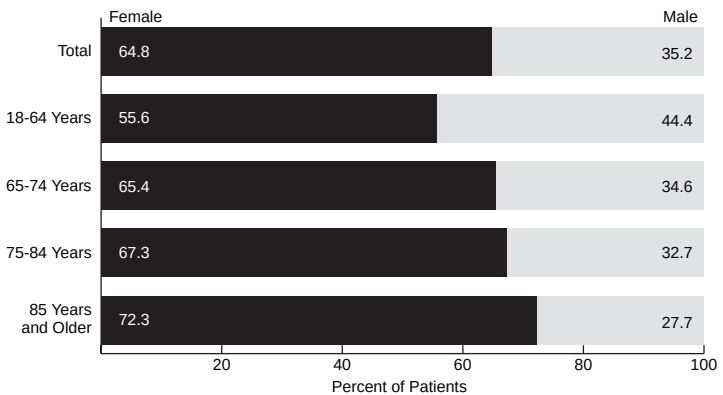
Hospital Discharge Rate from Non-Federal, Short-Stay Hospitals, by Diagnosis and Sex, 2008

Source III.3: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



Current Home Health Patients, by Age and Sex, 2007

Source III.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Home Health and Hospice Care Survey



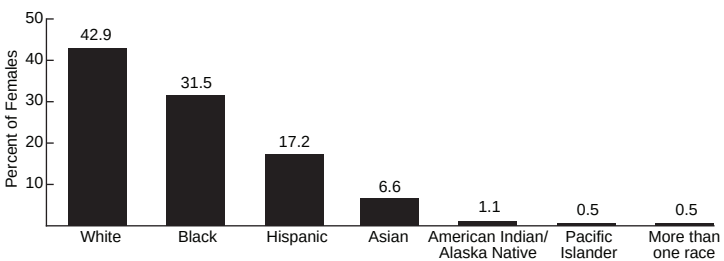
ORGAN TRANSPLANTATION

Since 1988, there have been 507,043 organ transplants in the United States. More than 28,000 of those transplants occurred in 2010, when 14,503 people donated organs. Overall distribution of organ donation by sex was nearly even (7,173 male and 7,330 female organ donors), though females made up the majority of living donors (60.0 percent), while most deceased donors were male (58.9 percent; data not shown).

The need for donated organs greatly exceeds availability, so waiting lists for organs are growing. As of March 4, 2011, there were 110,506 people awaiting an organ transplant, and females accounted for 40.8 percent of those patients. Of the 45,125 females waiting for an organ transplant, White females accounted for 42.9 percent, followed by Black (31.5 percent), Hispanic (17.2 percent), and Asian females (6.6 percent). Compared to population estimates for 2009, these data highlight racial and ethnic disparities in the need for organs: while Black women comprise almost one-third of those on the waiting list, they represented only 12.5 percent of the female population. Conversely, Hispanic women comprise about 17 percent of females waiting for organs, while representing over one-fifth of the female population.

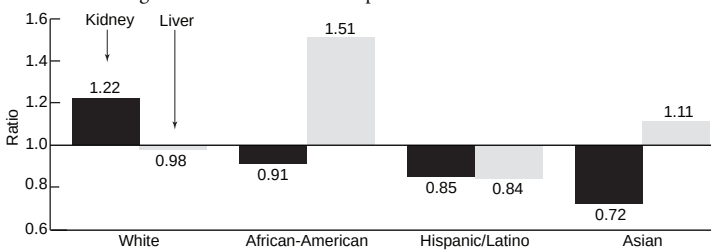
In 2010, there were 10,784 organ transplants performed for females in the United States. The most commonly transplanted organ was the kidney (6,613 transplanted), followed by the liver (2,229). Different patterns were seen in access to liver and kidney transplantation by race and ethnicity. Comparing the racial and ethnic distribution of persons receiving a transplant to the distribution of those wait-listed for an organ transplant is one way to describe these differences. Among kidney transplant recipients, Whites were transplanted at a rate above their representation on the waiting list with a ratio of 1.22, comparing the proportion of transplant recipients who were White to the proportion of wait-list candidates who were white. In other words, the proportion of Whites who received a kidney transplant was greater than the proportion of Whites on the waiting list. In contrast, African-Americans, Hispanics, and Asians received kidney transplants at rates below their representation on the waiting list (0.91, 0.85, and 0.72, respectively). Among liver transplant recipients, African-Americans and Asians were transplanted at rates above their representation on the waiting list.

Females on Organ Waiting Lists,* by Race/Ethnicity, 2011
Source III.5: Organ Procurement and Transplantation Network



As of March 4, 2011. Percentages may not add to 100 because respondents could select more than one race and ethnicity.

Ratio of Transplant Recipients* to Candidates on Waiting List for Liver and Kidney Transplants, by Race/Ethnicity, 2008
Source III.6: Organ Procurement and Transplantation Network



*Transplants from deceased donors only.

HEALTH CARE EXPENDITURES

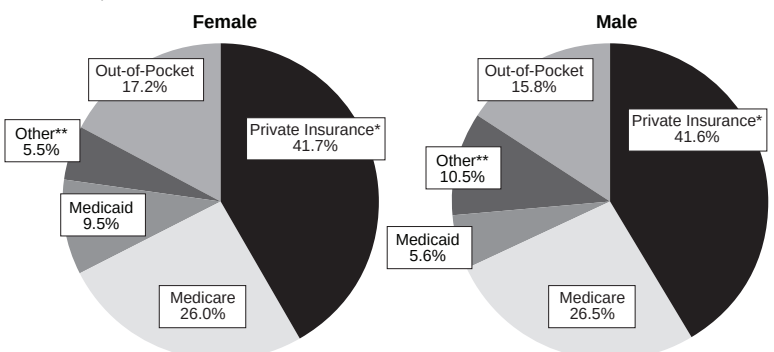
In 2008, the majority of health care expenses for both women and men were covered by public or private health insurance. Among women, more than one-third of expenses were covered by either Medicare or Medicaid, while 41.7 percent of expenses were covered by private insurance, and 17.2 percent of expenses were paid out-of-pocket. Although the percentage of expenditures paid through private insurance was similar for both sexes, health care costs of women were more likely than those of men to be paid by Medicaid (9.5 versus 5.6 percent, respectively).

In 2008, 90.1 percent of women had at least one health care expenditure, compared to 78.2 percent of men (data not shown). Among adults who had at least one health care expense, the average expenditure per person, including expenses covered by insurance and those paid out-of-pocket, was slightly higher for women ($5,635) than for men ($4,952). However, men's average expenditures significantly exceeded women's for hospital inpatient services ($18,984 versus $12,997, respectively). Women's expenditures significantly exceeded men's only in the category of office-based medical services ($1,556 versus $1,323, respectively). The overall mean health care expense was greater for women because of the greater percentage of women incurring more expensive services. For instance, 10.8 percent of women had hospital inpatient services, compared to 6.4 percent of men, which contributes to a higher mean expenditure overall. Hospital inpatient services include childbirth delivery.

Overall per capita health care expenditures have increased substantially in the past decade. In 2008, the annual mean health care expenses for women and men were 71.6 and 72.7 percent higher than in 1999 (data not shown).

Health Care Expenses of Adults Aged 18 and Older, by Sex and Source of Payment, 2008

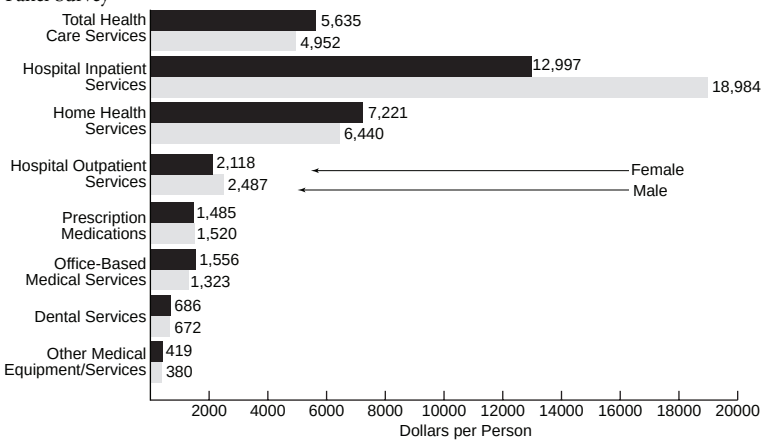
Source III.7: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



*Includes Tricare (Armed-Forces-related coverage). **Includes other public programs, such as Department of Veterans Affairs and Indian Health Service, and other unclassified sources.

Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Category of Service and Sex, 2008

Source III.7: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



QUALITY OF WOMEN'S HEALTH CARE

Health care quality indicators can provide important information about the effectiveness, safety, timeliness, patient-centeredness, and efficiency of health services.[19] Some common indicators used to monitor women's health care in managed care plans include screening for chlamydia and cervical cancer, and the receipt of timely prenatal and postpartum care.[20]

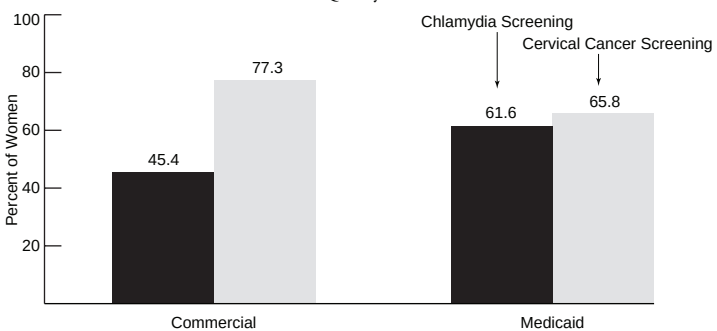
In 2009, women aged 21–24 years enrolled in Medicaid were more likely than those enrolled in commercial plans to have had a chlamydia screening (61.6 versus 45.4 percent, respectively). Since 2001, the percentage of sexually active females screened for chlamydia has increased by 120 percent among those in commercial plans and 50 percent among Medicaid participants (data not shown).

By contrast, cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Among women aged 21–64 years, cervical cancer screenings were received at least once during the previous 3 years by 77.3 percent of commercially-insured women and 65.8 percent of those covered by Medicaid.

In 2009, women with commercial insurance coverage were also more likely than those with Medicaid to have received timely prenatal and postpartum care. More than 93 percent of commercially-insured women received prenatal care in either their first trimester or within 42 days of enrollment, compared to 83.4 percent of those covered by Medicaid. Similarly, 83.6 percent of women with commercial coverage had a postpartum visit between 21 and 56 days after delivery, compared to 64.1 percent of women participating in Medicaid. Although Medicaid-insured women are less likely to have received timely prenatal and postpartum care than commercially-insured women, they have made greater improvements since 2001. For example, the proportion of women receiving timely postpartum care increased 20.9 percent among Medicaid participants, compared to 8.6 percent among commercially-insured postpartum women.

HEDIS®* Screening for Chlamydia and Cervical Cancer,† by Payer, 2009**

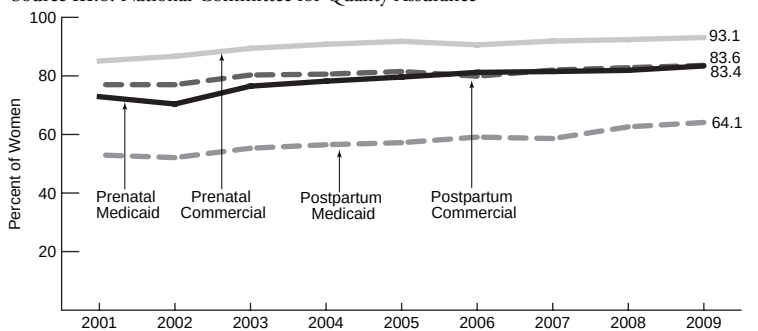
Source III.8: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active women aged 21–24 years who had at least one test for Chlamydia in the past year. †The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years.*

HEDIS®* Timeliness of Prenatal and Postpartum Care,† by Payer, 2001–2009**

Source III.8: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of pregnant women who received a prenatal care visit in either the first trimester or within 42 days of enrollment. †The percentage of women who had a postpartum visit on or between 21 and 56 days after delivery.*