HEALTH SERVICES UTILIZATION

Availability of and access to quality health care services directly affects all aspects of women's health. For women who have poor health status, disabilities, poverty, lack of insurance, and limited access to a range of health services, preventive treatment and rehabilitation can be critical in preventing disease and improving quality of life.

The following section presents data on women's health services utilization, including data on insurance coverage, usual source of care, satisfaction with care, use of medication, and use of various services, such as preventive care, HIV testing, and mental health services. The contribution of HRSA to women's health across the country is highlighted, as well.

USUAL SOURCE OF CARE

Women who have a usual source of care (a place they usually go when they are sick) are more likely to receive preventive care,[1] to have access to care (as indicated by use of a physician or emergency department, or not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3] In 2005, almost 90 percent of women reported having a usual source of care. Women of all racial and ethnic groups were more likely than men to have a usual source of care. Among women, non-Hispanic Whites were most likely to report a usual source of care (91.8 percent), followed by non-Hispanic Blacks (89.9 percent); Hispanic women were least likely to report a usual source of care (78.5 percent).

In 2005, 86.9 percent of women reported an office-based source of care (such as a physician's office), while fewer than 1 percent reported an emergency department was their usual source of care. This varied by family income level. Women with family incomes under 100 percent of the Federal poverty level (FPL) were more likely to report that hospital outpatient departments (1.5 percent) and emergency departments (1.9 percent) were the places they usually go when sick, and were more likely to have no usual source of care (17.1 percent) than those with higher income levels. Only 0.2 percent of women whose family incomes were at 300 percent or more of FPL named emergency departments as the place they usually go when sick, and only 6.1 percent had no usual source of care.

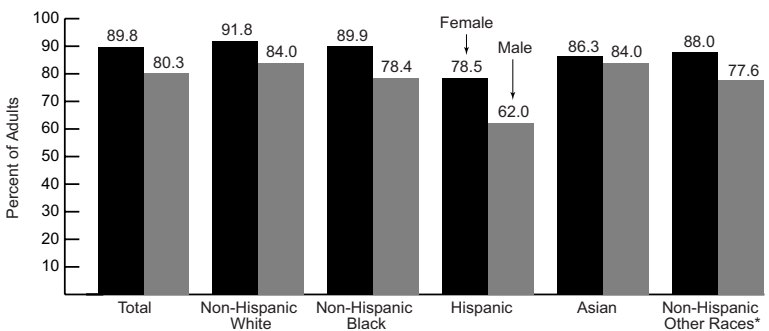
1 Ettner SL. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference? Medical Care 1999;37(6): 647-55.

2 Sox CM, Swartz K, Burstin HR, Brennan TA. Insurance or a regular physician: which is the most powerful predictor of health care? AJPH 1998;88(3):364-70.

3 Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. AJPH 1996;86(12):1742-7.

Adults Aged 18 and Older with a Usual Source of Care, by Sex and Race/Ethnicity, 2005

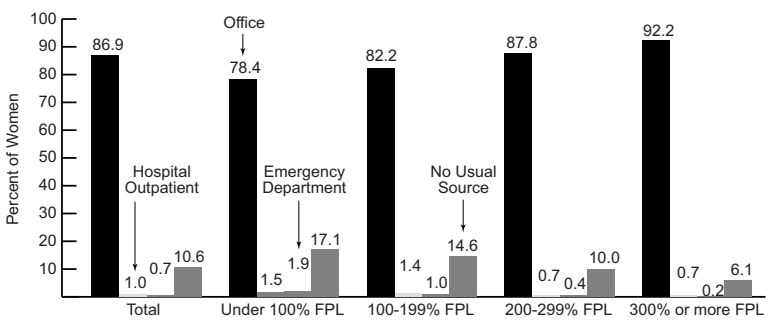
Source II.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**Includes American Indian/Alaska Natives and persons of more than one race.*

Usual Source of Care Among Women Aged 18 and Older, by Poverty Status,* 2005

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



**Federal poverty level (FPL) was $19,350 for a family of four in 2005; this amount is determined annually by the U.S. Department of Health and Human Services.*

HEALTH INSURANCE

People who are uninsured are less likely than those with insurance to seek preventive care, which can result in poor health outcomes and higher health care costs. In 2005, 44.4 million non-elderly individuals in the United States, representing 17.2 percent of that population, were uninsured.[1] The percentage of people who are uninsured varies considerably across a number of categories, including age, sex, race/ethnicity, income, and education.

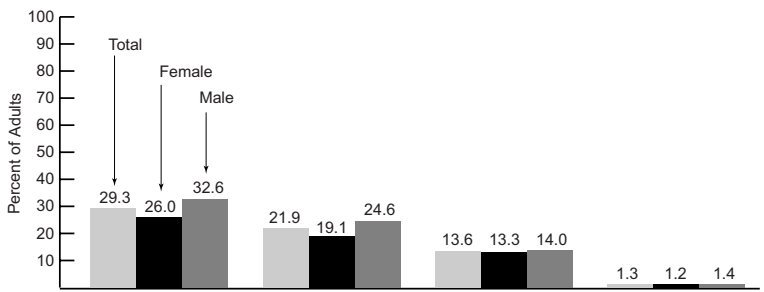
In 2005, among adults aged 18 and older, younger persons were most likely to lack health insurance, and men were more likely than women to be uninsured in every age group. The largest percentage of uninsured persons occurred among 18- to 24-year-old males (32.6 percent), which was significantly higher than the percentage for women of the same age group (26.0 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest rates of uninsured occurred among women and men aged 45–64 (13.3 and 14.0 percent); however, the gender disparity was less pronounced than in the younger age groups.

Among women aged 18–64 in 2005, 71.8 percent had private insurance, 14.6 percent had public insurance, and 17.8 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (79.0 percent), followed by Asian/Pacific Islander women (72.9 percent). Non-Hispanic Black females had the highest rate of public insurance (24.0 percent), and Hispanic females had the highest rate of being uninsured (36.9 percent), followed closely by American Indian/Alaska Native women (33.4 percent). [Respondents were able to report more than one type of coverage.]

1 This statistic does not include adults aged 65 and older because that is the age when people become eligible for Medicare coverage based on age.

Adults Aged 18 and Older Without Health Insurance, by Sex and Age, 2005*

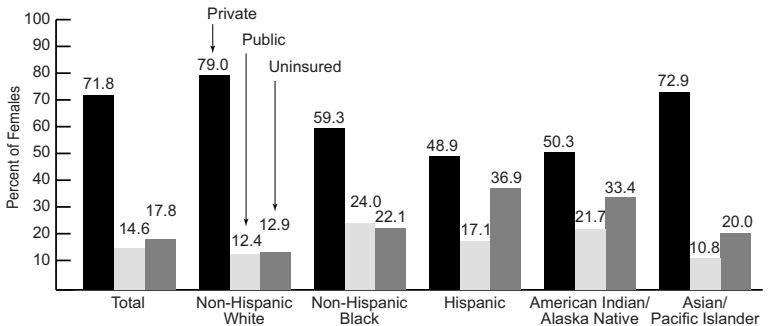
Source III.1: U.S. Census Bureau, Current Population Survey



**These data reflect changes to 2005 estimates that were released on April 10, 2007.*

Health Insurance Coverage of Women Aged 18-64, by Type of Coverage and Race/Ethnicity,* 2005

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



**Totals for each race/ethnicity may equal more than 100 percent because it was possible to report more than one type of coverage. These data reflect changes to 2005 estimates that were released on April 10, 2007.*

MEDICARE AND MEDICAID

Medicare is the Nation's health insurance program for people aged 65 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 is a managed care program now known as "Medicare Advantage;" and Part D, added in 2006, covers prescription drugs.

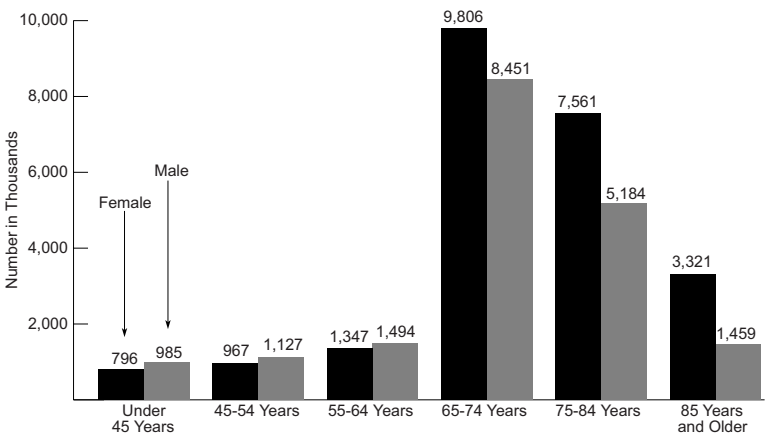
In 2005, 56 percent of Medicare's 42.5 million enrollees, were female. A majority of Medicare enrollees were aged 65 and older; the elderly represented 87 percent of female and 81 percent of male enrollees.

Of the 43 million enrollees eligible for the Medicare Part D prescription drug program in 2006, 55.8 percent were female. Of those who enrolled in stand-alone prescription drug plans, 6.6 million (61 percent) were female. Most women enrolled in Part D are in the 75- to 89-year-old age group with 2.85 million enrollees, followed by the 65- to 74-year-old age group with 2.76 million.

Medicaid is jointly funded by the Federal and State governments and provides coverage for low-income people and people with disabilities. In 2004, Medicaid covered 58 million individuals including children; the aged, blind, and disabled; and adults who are eligible for cash assistance programs. Overall, 59 percent of all Medicaid enrollees were female; of the adults enrolled in Medicaid, 69 percent were women (data not shown).

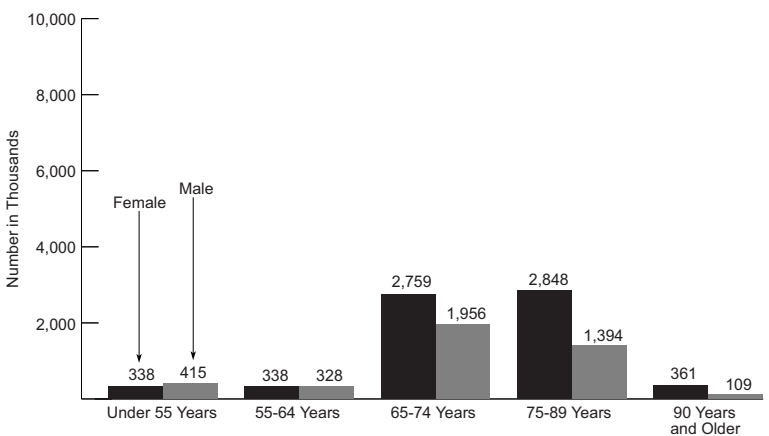
Medicare Enrollees (All Ages), by Age and Sex, 2005

Source III.2: Centers for Medicare and Medicaid Services



Medicare Part D Enrollees* (All Ages), by Age and Sex, 2006

Source III.2: Centers for Medicare and Medicaid Services



Enrollees in stand-alone prescription drug plans only.

QUALITY OF WOMEN'S HEALTH CARE

Indicators of the quality of health care can provide important information about the effectiveness, safety, timeliness, and patient-centeredness of women's health services.

Indicators used to monitor women's health care in managed care plans include the timeliness of prenatal care, receipt of postpartum checkups after delivery, screening for chlamydia, screening for cervical cancer, and receipt of mammograms. In 2005, the rate of perinatal services and chlamydia screening increased, while the rate of cervical cancer screening among women in commercial plans rose after a decrease during 2004.

Perinatal services—prenatal care and postpartum checkups—appear to be more accessible in commercial (private) plans than in public-sector plans financed by Medicaid. The same is true of cervical cancer screening, which is received at least once every 3 years by nearly 82 percent of commercially-insured women and 65 percent of women covered by Medicaid.

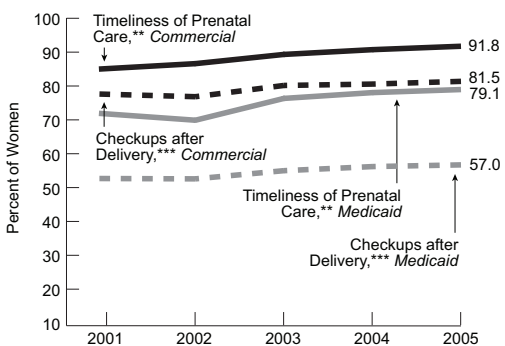
Chlamydia screening is the one screening service that is more common among Medicaid-enrolled women than those with private coverage: 52.4 percent of Medicaid-enrolled women aged 21–25 had a chlamydia screen in the previous year, compared to 35.2 percent of commercially-insured women.

In 2005, the rate of mammograms for women aged 52–69 was approximately the same for women with private coverage and those covered through Medicare. However, Medicaid-enrolled women were considerably less likely to receive a mammogram at least once every 2 years.

Patients' personal experiences of health care also reflect on the quality of care, as those who are not satisfied with their providers may be less likely to

HEDIS®* Measures of Perinatal Care, by Payer, 2001-05

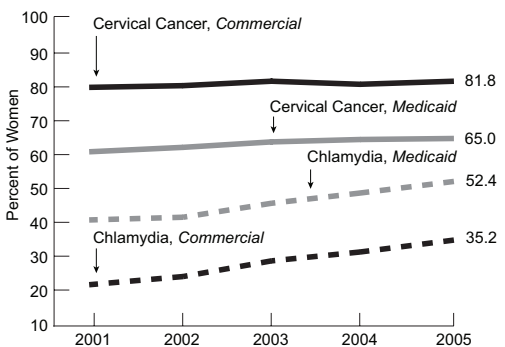
Source III.3: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The proportion of women beginning prenatal care in the first trimester or within 43 days of enrollment if pregnant at enrollment. ***The proportion of women who had a visit to a health care provider between 21 and 56 days after delivery.*

HEDIS®* Rates of Chlamydia,** Cervical Cancer*** Screening, by Payer, 2001-05

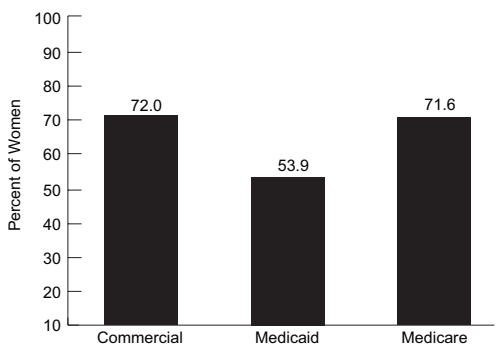
Source III.3: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active plan members aged 21-25 who had at least one test for chlamydia in the past year. ***The percentage of women aged 21-64 who had at least one Pap test in the past 3 years.*

HEDIS®* Rates of Mammograms,** by Payer, 2005

Source III.3: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 52-69 years who had at least one mammogram in the past 2 years. Note: Data from 2004 and later cannot be compared to previous years because of changes in the specification of the measure.*

continue with treatments and seek further services.[1] Two aspects that may contribute to better outcomes are patients' perceptions of how well their doctors or other health care providers communicate with them and access to necessary health care services, such as appointments with doctors or specialists, or obtaining necessary tests or treatments. In 2005, women under age 75 were consistently less satisfied than men with their personal experiences of both of these aspects of care.

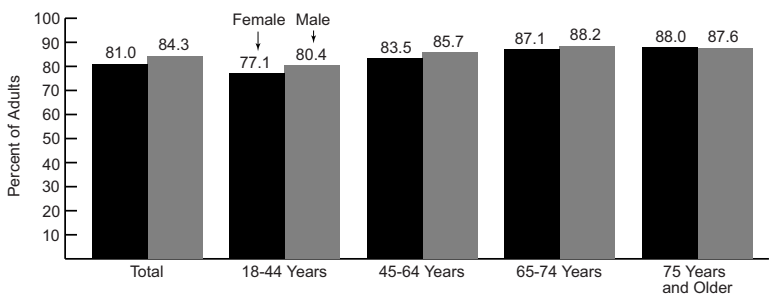
In 2005, fewer females were satisfied with how well their doctors communicated (81.0 percent), compared to males (84.3 percent). However, this varied across age groups. Younger men and women were least likely to be satisfied, and women were less satisfied than men in every age group, except those 75 and older. Among 18- to 44-year-olds, 77.1 percent of women and 80.4 percent of men were satisfied, while 88.0 percent of women and 87.6 percent of men aged 75 and older reported satisfaction with how well doctors communicate. Non-Hispanic White women (83.0 percent) were also more likely than non-Hispanic Black or Hispanic women (76.8 and 76.7 percent, respectively) to be satisfied (data not shown).

In 2005, men were more likely than women (67.0 versus 62.5 percent) to be satisfied with their ability to get necessary care from physicians or specialists—including obtaining treatments or tests—though women aged 75 and older were more likely than their male counterparts (76.9 versus 74.8 percent) to be satisfied. Older men and women were also more likely than their younger counterparts to be satisfied with their access to necessary care. Among females, 60.0 percent of 18- to 44-year-olds were satisfied compared to 72.8 percent of those aged 65–74 and nearly 77 percent of those aged 75 and older.

1 Fan VS, Burman M, McDonnell MB, Fihn SD. Continuity of Care and Other Determinants of Patient Satisfaction with Primary Care. Journal of General Internal Medicine. 2005; 20:226-233.

Satisfaction with How Well Doctors Communicated,* by Sex and Age, 2005

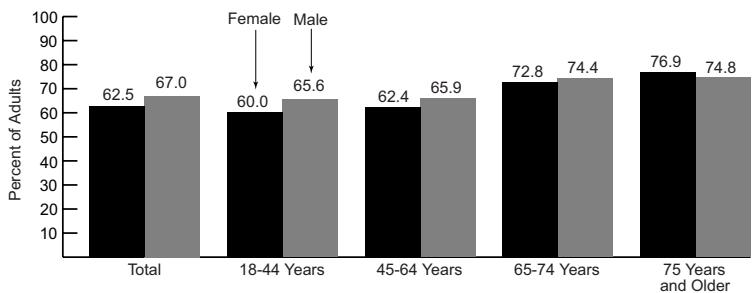
Source III.4: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



**Based on questions related to care received from doctors or other health providers in the past 6 (Medicaid respondents) or 12 months (commercial health plan respondents).*

Satisfaction with Access to Necessary Care,* by Sex and Age, 2005

Source III.4: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



**Based on questions related to receiving regular physician's visits or specialists visits, obtaining necessary treatments or tests, and delays caused by health plan approval in the last 6 (Medicaid respondents) or 12 months (commercial health plan respondents).*

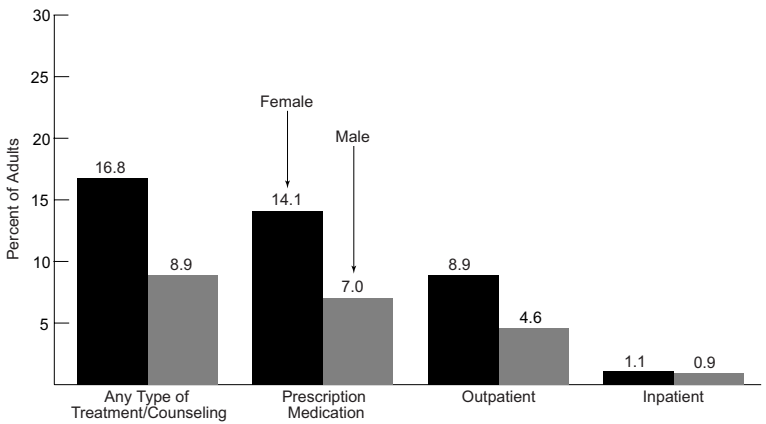
MENTAL HEALTH CARE UTILIZATION

In 2005, over 28 million adults in the United States reported receiving mental health treatment in the past year. Women represented approximately two-thirds of users of mental health services. The most common type of treatment obtained was prescription medication, followed by outpatient treatment. Almost 16 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.1 percent of women aged 18 and older, compared to 7.0 percent of men. Outpatient treatment was reported by 8.9 percent of women, and inpatient treatment was reported by 1.1 percent of women.

Mental health services are needed, but not received, by millions of adults in the United States. In 2005, 3.7 percent of women and 2.3 percent of men reported an unmet need for mental health treatment or counseling. Cost or no insurance was the most commonly reported reason for not receiving needed services, reported by 47.1 percent of women and 51.8 percent of men with unmet mental health treatment needs. Others mentioned feeling that they could handle their problems without treatment (reported by 34.3 percent of women and 28.8 percent of men with unmet needs). In addition, stigma, including concern about the opinions of others, effects on employment, or feelings of shame, embarrassment, or fear prevented 19.6 percent of women and 24.0 percent of men with unmet needs from receiving treatment.

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Sex and Type, 2005

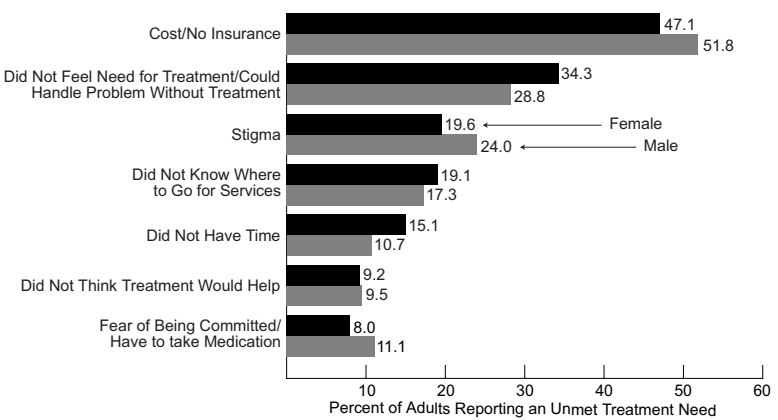
Source II.4: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



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

Reasons for Unmet Mental Health Treatment Needs Among Adults Aged 18 and Older,* by Sex, 2005

Source III.5: 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 reason.

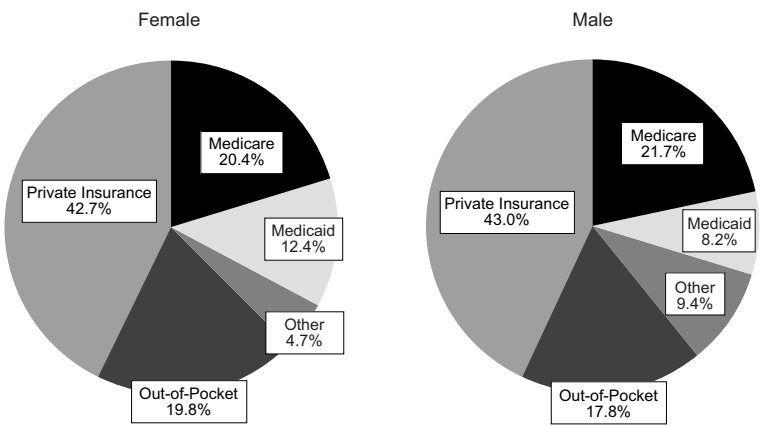
HEALTH CARE EXPENDITURES

In 2004, the majority of health care expenses of both females and males were covered by public or private health insurance. For females, nearly one-third of expenses were covered by either Medicare or Medicaid, while almost 43 percent were covered by private insurance. Although the percentage of expenditures paid through private insurance was approximately equal for both sexes, health care costs of females were more likely than those of males, to be paid by Medicaid or out-of-pocket.

Nearly 90 percent of females had at least one health care expenditure in 2004, compared to 80 percent of males. Among those who had at least one health care expense in 2004, the average per person expenditure including expenses covered by insurance and those paid out-of-pocket, was slightly higher for females ($4,158) than for males ($3,554). However, males' average expenditures exceeded females' for hospital inpatient services ($16,007 compared to $12,292) and hospital outpatient services, while females' expenditures exceeded males' in the categories of home health services, office-based medical services, and prescription drugs. While the gender gap in health care expenditures has narrowed somewhat since 1998, overall per capita health care expenditures have increased substantially among both men and women. Males' expenses have gone up by 67 percent over this period while females' have increased by 53 percent.

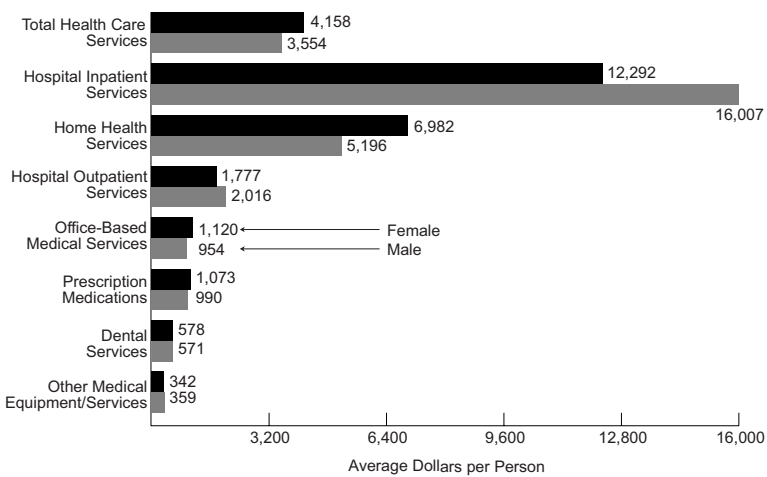
Health Care Expenses, by Source of Payment and Sex (All Ages), 2004

Source III.6: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Annual Mean Health Care Expenses for Persons (All Ages) with an Expense, by Sex and Category of Service, 2004

Source III.6: U.S. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



PREVENTIVE CARE

Counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2004, females of all ages made 535 million physician office visits. Of these visits, 18.6 percent were for preventive care, including prenatal care, screenings, and insurance examinations.[1]

Routine Pap smears, which detect the early signs of cervical cancer, are recommended within 3 years of initiation of sexual activity, or by age 21. In 2004, 5.3 percent of all physician visits made by women aged 18 or older included a Pap smear. This rate was higher among the younger age groups, and occurred in 9.9 percent of office visits made by women aged 18–24 years compared to only 5.2 percent of visits by women aged 45–64 and 1.2 percent of visits made by women aged 65 years and older.

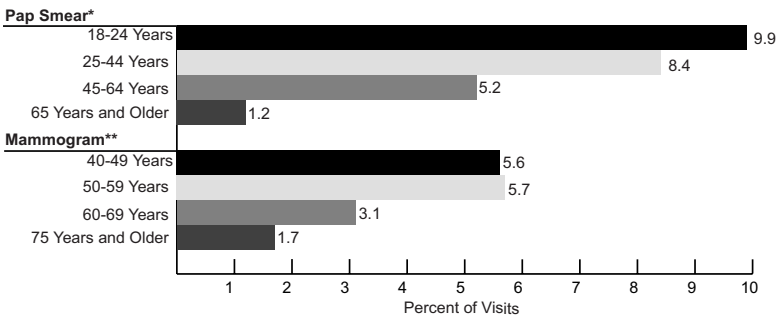
Among women 40 and older, 3.9 percent of all office visits included a mammogram, which is recommended every 1–2 years to screen for breast cancer among this age group. The proportion of office visits including a mammogram was highest among the younger age groups: 5.6 and 5.7 percent of visits, respectively, among women aged 40–49 years and 50–59 years, compared to 1.7 percent among women 75 years and older.

Vaccination is another important preventive measure. Vaccination for influenza is generally recommended for young children, older adults, and adults with chronic health conditions. In 2005, 60.5 percent of women aged 65 and older reported receiving a flu vaccine in the past year. Pneumonia vaccine is also recommended for older adults and people with certain health conditions. In 2005, almost 60 percent of women aged 65 and older reported ever receiving the vaccine. Non-Hispanic White women were most likely to have ever received the pneumonia vaccine (63.2 percent), compared to 28.5 percent of Hispanic and 35.4 percent of Asian women.

1 Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2004 Summary. Advance Data from Vital and Health Statistics, No. 374, June 2006. http://www.cdc.gov/nchs/data/ad/ad374.pdf. Viewed 4/18/07.

Women's Self-Report of Pap Smears and Mammograms During Physician Office Visits, by Age, 2004

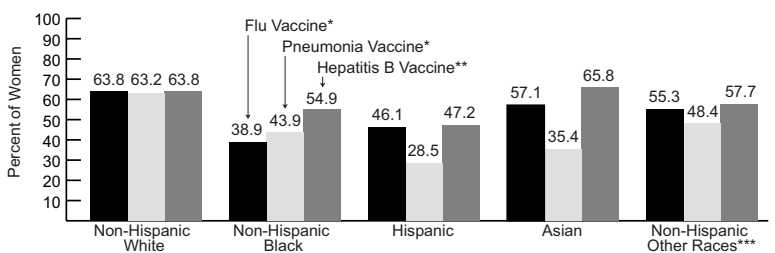
Source III.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



**Among women aged 18 and older. **Among women aged 40 and older.*

Selected Vaccinations Received by Women, by Race/Ethnicity, 2005

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



**Flu vaccine among women aged 65 or older; received either a shot or nasal spray in the last 12 months. Pneumonia vaccine among women aged 65 or older; ever received the vaccine. **Hepatitis B vaccine among women aged 18–24; ever received at least one dose of the vaccine (in a three dose series). ***Includes American Indian/Alaska Natives and persons of more than one race.*

HIV TESTING

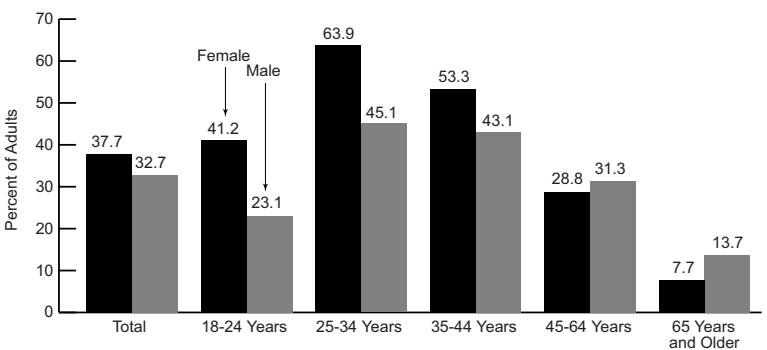
Today, people aware of their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek appropriate care. HIV testing requires only a simple blood or saliva test, and it is often offered through confidential or anonymous sources. It is recommended that people who meet any of the following criteria be tested for HIV: have injected drugs or steroids, or shared drug use equipment (such as needles) with others; 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 the previous criteria.[1]

In 2005, just over 35 percent of adults in the United States had ever been tested for HIV. Overall, women were more likely than men to have been tested (37.7 versus 32.7 percent). Women were more likely to have been tested at younger ages, while men were more likely to have been tested at older ages. This difference may be due in part to Centers for Disease Control and Prevention (CDC) guidelines that recommend HIV testing for pregnant women. In 2006, new CDC guidelines were released that recommend all health care providers include HIV testing as part of their patients' routine health care. Among women, in 2005, non-Hispanic Blacks had the highest testing rate (52.5 percent), followed by Hispanics (47.3 percent). Non-Hispanic White women had the lowest rate (33.5 percent).

1 Centers for Disease Control and Prevention, National HIV Testing Resources. Frequently asked questions about HIV and HIV testing. http://www.hivtest.org. Viewed 4/18/07.

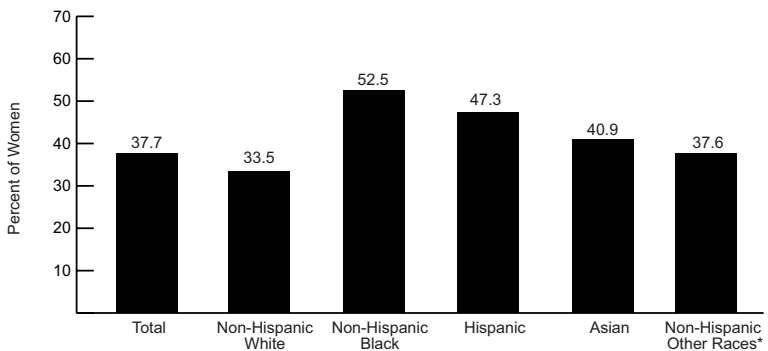
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Sex and Age, 2005

Source II.2: 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, 2005

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



**Includes American Indian/Alaska Natives and persons of more than one race.*

MEDICATION USE

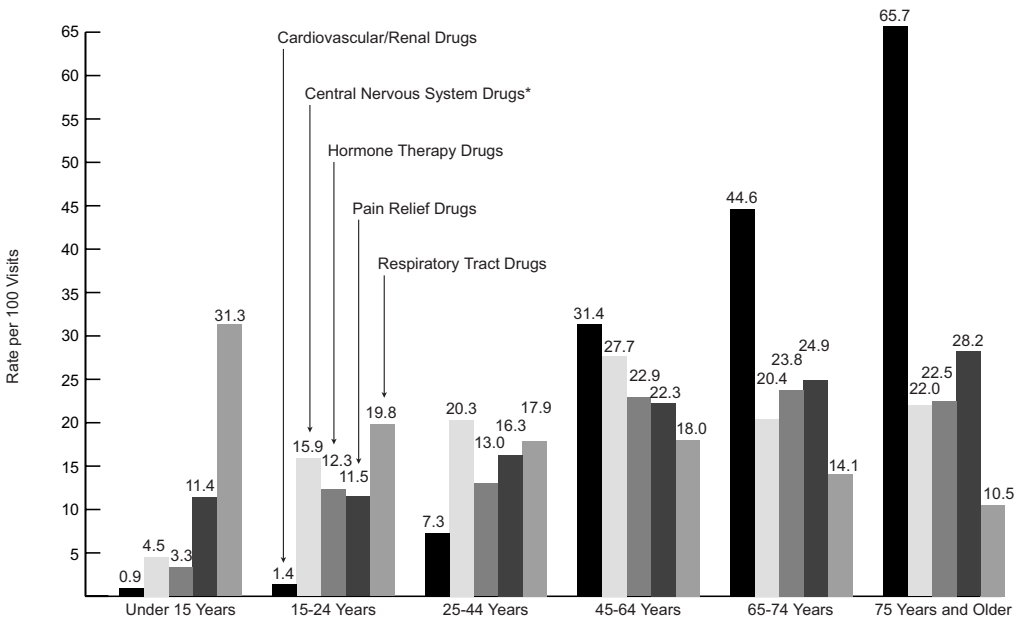
In 2004, medication was prescribed or provided at more than 585 million physician office visits; multiple drug prescriptions were recorded at 38.9 percent of all visits. The percent of visits with one or more drugs prescribed or provided was similar for males and females (64.6 and 64.0 percent). Among females, 36.0 percent of visits did not involve prescribing or providing any drugs, 25.3 percent of visits involved the prescription or provision of one drug, and 14.4 percent of visits involved two drugs.[1]

The prescription or provision of medications among females varies by age and drug type. In 2004, the rate of cardiovascular/renal and pain relief drugs prescribed or provided at physician office visits generally increased with age, while respiratory tract drugs decreased with age. Prescription or provision of nervous system drugs, including mental health medications such as antidepressants, during physician visits were most common among women 45–64 years (27.7 per 100 visits). The highest rate of drug prescription or provision was 65.7 per 100 visits, which was for cardiovascular/renal drugs among women 75 years and older. Among females under 15 years, the lowest rate of drug prescription or provision (0.9 per 100 visits) was for cardiovascular/renal drugs, and the highest rate was for respiratory tract drugs (31.3 per 100 visits).

1 Hing E, Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2004 summary. Advance Data from Vital and Health Statistics, No. 374; 2006 June.

Medication Use Reported for Females During Physician Office Visits, by Age, 2004

Source III.7: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



**Includes antidepressants, antipsychotics, sedatives, and anxiety medications.*

ORGAN TRANSPLANTATION

Between January 1 and November 30, 2006, 26,691 organ transplants occurred in the United States. In 2006, the gender distribution of organ donors was nearly even (6,993 males and 6,589 females), though most of the organs donated by living people were from women (58.5 percent). Since 1988, there have been 391,233 transplants.

The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of February 16, 2007, there were 94,692 people awaiting a life-saving organ transplant. Females were 41.9 percent of those patients, but made up only 37.3 percent of those who received a transplant in 2006.[1] Among women waiting for an organ transplant, 46.5 percent were White, 29.6 percent were Black, and 16.1 percent were Hispanic. The kidney was in highest demand, with 29,437 females awaiting this organ as of February 16, 2007.

The number of organs donated remained roughly static from 1990–2003. In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. In 2004, donations increased by an unprecedented 12 percent over the previous year, and in 2005 they increased by another 12 percent; in 2005–06, the number dropped slightly but was still well above 2002 levels. One of the challenges of organ donation is obtaining consent from the donor family or legal surrogate. Consent rates may vary due to religious perceptions, poor communication between health care providers and grieving families, perceived inequities in the allocation system, and lack of knowledge of the wishes of the deceased.[2]

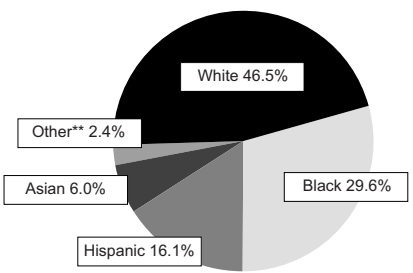
The Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients are managed by HRSA's Healthcare Systems Bureau (HSB). Other HSB programs include: the National Marrow Donor Program, the National Cord Blood Stem Cell Bank, the National Vaccine Injury Compensation Program, and the Smallpox Emergency Personnel Protection Act Program.

1 2006 Data are from January 1–November 30, 2006.

2 2003 OPTN/SRTR Annual Report: Transplant Data 1992-2002. HHS/HRSA/SPB/DOT; UNOS; URREA.

Distribution of Females on Organ Waiting List,* by Race/Ethnicity, 2007

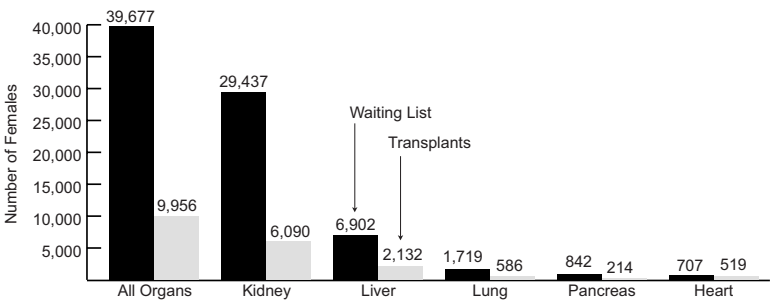
Source III.8: Organ Procurement and Transplantation Network



**As of February 16, 2007. **Includes American Indian/Alaska Natives, Pacific Islanders and persons of more than one race.*

Female Transplant Recipients, 2006, and Females on Transplant Waiting Lists,* 2007, by Organ

Source III.8: Organ Procurement and Transplantation Network



**As of February 16, 2007.*

HRSA PROGRAMS

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports a wide range of programs that increase and promote access to health care for vulnerable populations. **HRSA's Office of Women's Health (OWH)** coordinates many efforts that address women's health across their lifespan. A key project of OWH is the Bright Futures for Women's Health and Wellness (BFWHW) initiative, which provides materials for young women (adolescents) and adult women on topics such as physical activity and healthy eating, emotional wellness, and maternal wellness. These and other consumer-friendly resources, including data books and research reports, can be found on the OWH Web site (www.hrsa.gov/womenshealth).

The HRSA Web site (www.hrsa.gov) provides information about each of HRSA's bureaus and offices, several of which administer programs that directly affect women's health and access to health care. For example, **Maternal and Child Health Bureaus (MCHB)** administers the MCH Block Grant, a Federal-State partnership to improve the health of all mothers and children. MCHB also works to end violence and bullying in schools through the Stop Bullying Now! Campaign online at www.stopbullyingnow.hrsa.gov.

HRSA programs facilitate partnerships to advance women's health. The **Bureau of Health Professions** regularly assesses the health workforce, conducting numerous studies of capacity and diversity in health professions in which women predominate, such as nursing. The **Office of Rural Health Policy** has partnered with OWH to adapt BFWHW Physical Activity and Healthy Eating materials for young women (adolescents) and adult women in rural communities. The **HIV/AIDS Bureau** addresses the needs of women living with HIV/AIDS through all of its programs, especially Part D (formerly Title IV) of the Ryan White Program, which targets services to women, infants, children, youth, and their families. The **Healthcare Systems Bureau** oversees a variety of programs that affect access to lifesaving procedures for women, including the Organ Procurement and Transplantation Network, described on page 74, as well as the 340B Drug Pricing Program, and Hill-Burton Free and Reduced Cost Health Care.

The **Bureau of Primary Health Care** manages the Health Center Program, which funds a national network of more than 1,000 health center grantees at over 3,800 comprehensive, primary health care service delivery sites comprised of community health centers, migrant health centers, health care for the homeless health centers, and public housing primary care health centers. These health centers deliver preventive and primary care services to patients regardless of their ability to pay; charges for health care services are set according to income. Almost 40 percent of the patients treated at health centers have no insurance coverage and others have inadequate coverage.

In 2001, President Bush announced a Health Centers Initiative to increase access to health care in 1,200 communities through new or expanded health center sites. Since then, HRSA has awarded 900 grants to create new health center sites or expand operations at existing centers, and the number of patients has risen from 10.3 million in 2001 to an estimated 14.8 million in 2006.

Finally, HRSA's Health Disparities Collaboratives (HDCs) were developed to transform primary health care practices to improve quality and eliminate health disparities. The HDCs have focused on diabetes, asthma, depression, cardiovascular disease, cancer screening/planned care, finance/redesign, prevention, diabetes prevention, perinatal/patient safety, and oral health. Over 85 percent of health centers have participated in the HDCs as of April 2007.

Health Centers Supported by the Bureau of Primary Health Care

Source: Uniform Data System, Bureau of Primary Health Care, HRSA, HHS, 2005.

Type	*Number*
Community Health Center	851
Migrant Health Center	135
Homeless Health Center	176
School-based Health Center	78
TOTAL	**1,240**