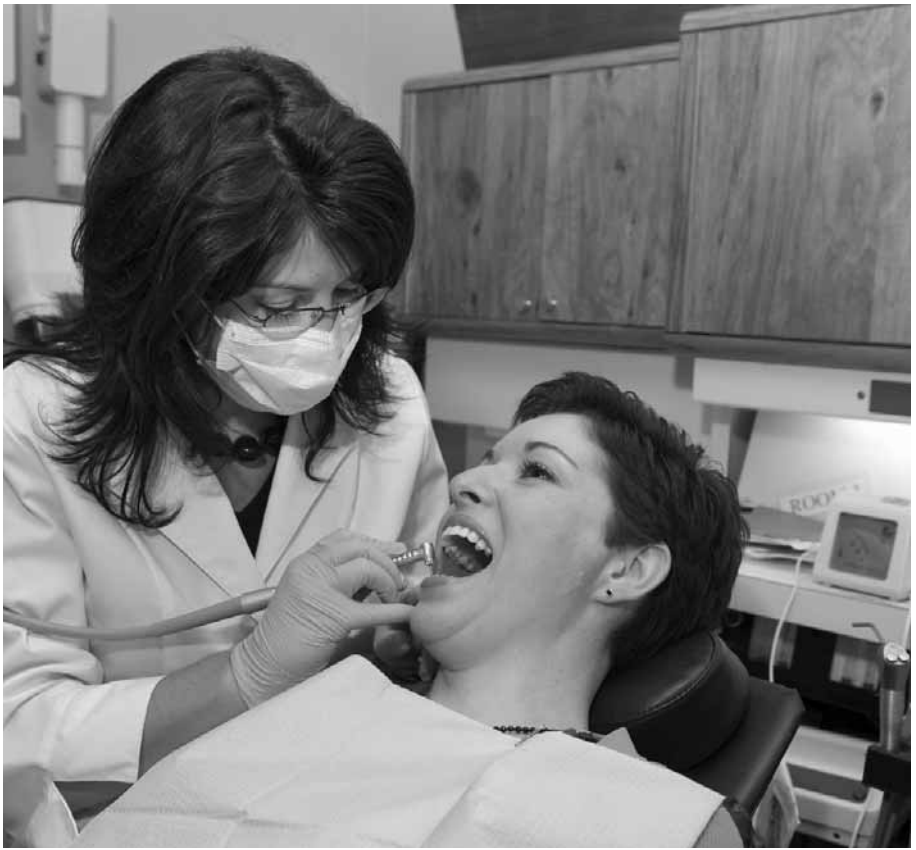
HEALTH SERVICES UTILIZATION

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.

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



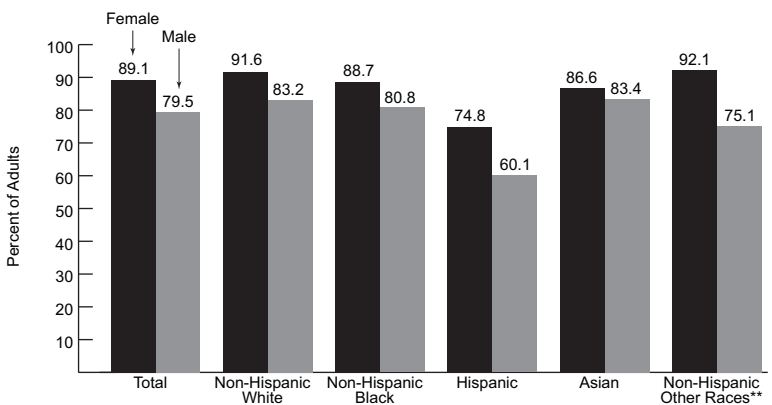
USUAL SOURCE OF CARE

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 2006, 89.1 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. Non-Hispanic women of other races and non-Hispanic White women were most likely to report a usual source of care (92.1 and 91.6 percent, respectively). Among women, Hispanics were least likely to report a usual source of care (74.8 percent).

In 2006, the percentage of women with a usual source of care varied by geographic region and poverty level. Among women with household incomes of 200 percent or more of poverty, there was little variation in having a usual source of care by geographic region. Among women with lower incomes, however, having a usual source of care varied significantly by geographic region. Women with incomes of less than 200 percent of poverty in the South and West were least likely to have a usual source of care (77.3 and 80.0 percent, respectively), while low-income women in the Northeast were most likely to have a usual source of care (91.3 percent).

Adults Aged 18 and Older with a Usual Source of Care, by Race/Ethnicity and Sex, 2006*

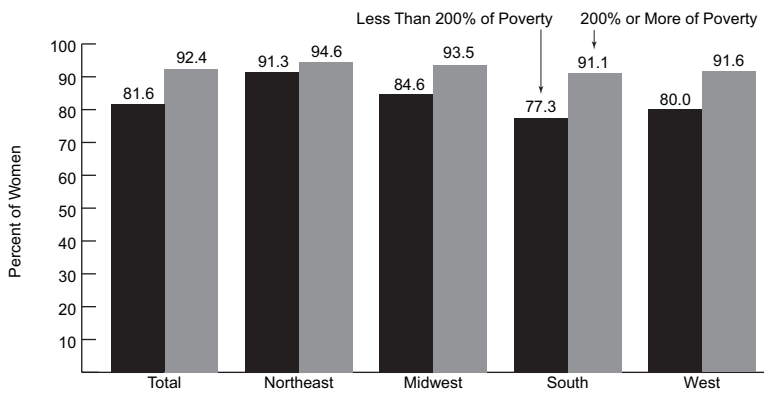
Source II.1: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Rates reported are not age-adjusted. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified.

Women Aged 18 and Older with a Usual Source of Care, by Geographic Region and Poverty Level,* 2006

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 $20,444 for a family of four in 2006. Rates reported are not age-adjusted.

HEALTH INSURANCE

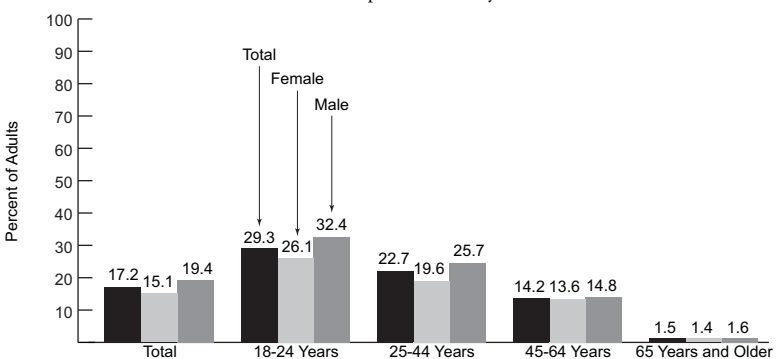
People who are uninsured are less likely than those with insurance to seek health care, which can result in poor health outcomes and higher health care costs. In 2006, 37.8 million adults aged 18–64 years in the United States, representing 20.2 percent of that population, were uninsured (data not shown).[4] The percentage of people who are uninsured varies considerably across a number of categories, including age, sex, race/ethnicity, income, and education.

In 2006, 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 (32.4 percent), which was significantly higher than the percentage for women of the same age group (26.1 percent). The lowest rate of uninsurance was among adults aged 65 and older, most of whom are eligible for Medicare coverage. The next lowest percentage of uninsured occurred among women and men aged 45–64 (13.6 and 14.8 percent, respectively); the sex disparity in this age group was less pronounced than in the younger age groups.

Among women aged 18–64 in 2006, 71.5 percent had private insurance, 14.4 percent had public insurance, and 18.1 percent were uninsured. This distribution varied by race and ethnicity: non-Hispanic White females had the highest rate of private insurance coverage (78.9 percent), followed by Asian/Pacific Islander women (74.8 percent). Non-Hispanic Black females had the highest rate of public insurance (22.1 percent) followed closely by American Indian/Alaska Native women (21.2 percent). Hispanic females had the highest rate of uninsurance (38.7 percent), followed by American Indian/Alaska Native women (36.0 percent). [Respondents were able to report more than one type of coverage.]

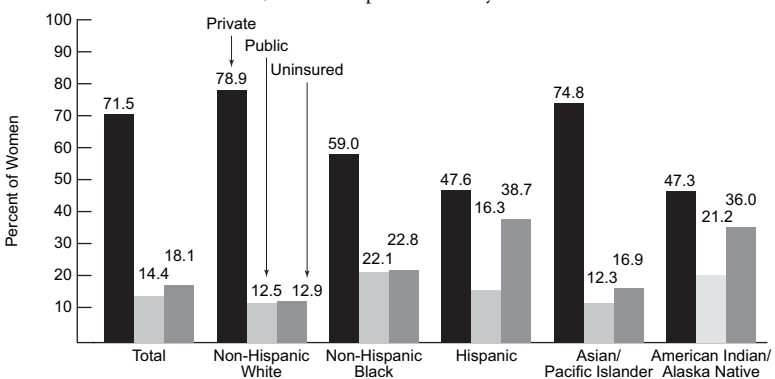
Adults Aged 18 and Older Without Health Insurance, by Sex and Age, 2006

Source I.3: U.S. Census Bureau, Current Population Survey



Health Insurance Coverage of Women Aged 18–64, by Type of Coverage and Race/Ethnicity,* 2006

Source I.3: U.S. Census Bureau, Current Population Survey



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

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 (Medicare Advantage Plans) allows beneficiaries to purchase additional insurance coverage through private insurers, and Part D allows coverage for prescription drugs through private insurers.

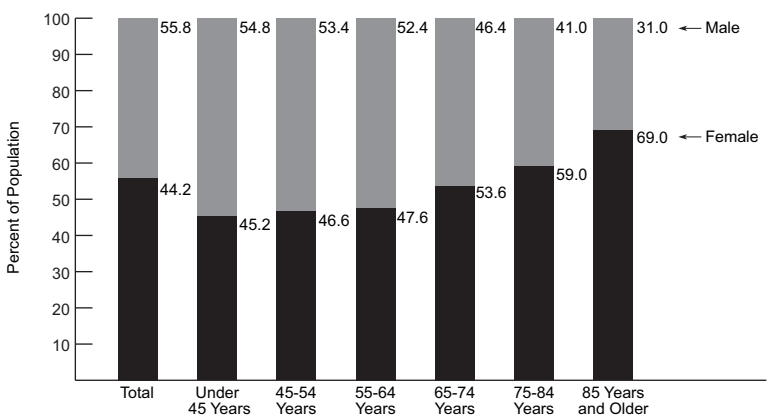
In 2006, 55.8 percent of Medicare's 43.3 million enrollees were female. As age increases the proportion of female enrollees increases while the proportion of male enrollees decreases. For instance, among Medicare enrollees under 45 years of age, 45.2 percent were female while 54.8 percent were male. Among adults aged 85 years and older, however, females accounted for 69.0 percent of enrollees, and males accounted for 31.0 percent.

Of the 16.7 million enrollees in the Medicare Part D stand-alone prescription drug program in 2007, 61.5 percent were female. Females accounted for a larger proportion of Part D enrollees in every age group, excluding those under 55 years, in which 46.5 percent were female and 53.5 percent were male. Among enrollees aged 75–89 years, 68.8 percent, or 4.0 million, were women.

Medicaid, jointly funded by Federal and State governments, provides coverage for low-income people and people with disabilities. In 2005, Medicaid covered 58.7 million including children; the aged, blind, and disabled; and adults who were eligible for cash assistance programs. Overall, 59.4 percent of all Medicaid enrollees were female; of adults enrolled in Medicaid, 69.4 percent were women (data not shown).

Medicare Enrollees,* by Age and Sex, 2006

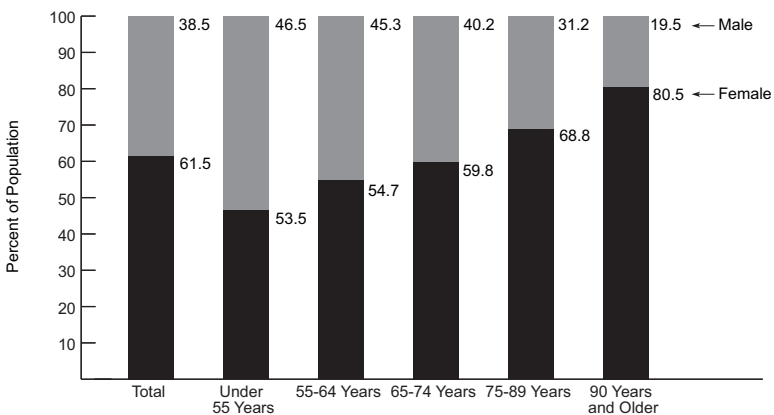
Source III.1: Centers for Medicare and Medicaid Services



*Enrolled as of July 1, 2006.

Medicare Part D Enrollees,* by Age and Sex, 2007

Source III.1: Centers for Medicare and Medicaid Services



*Enrollees in stand-alone prescription drug plans only, as of July 1, 2007.

PREVENTIVE CARE

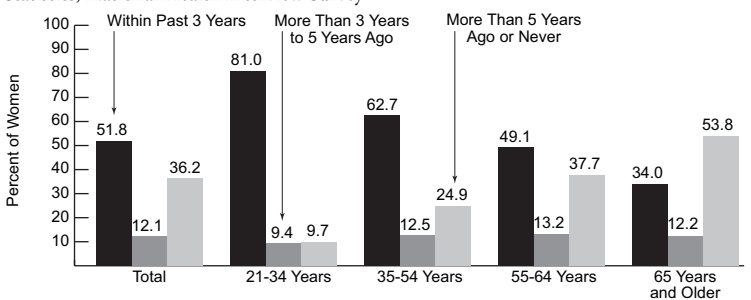
Counseling, education, and screening can help prevent or minimize the effects of many serious health conditions. In 2005, females of all ages made 560 million physician office visits. Of these visits, 19.7 percent were for preventive care, including prenatal care, health screening, and insurance examinations (data not shown).[5] Routine Pap smears, which detect the early signs of cervical cancer, are recommended at least every 3 years beginning within 3 years of initiation of sexual activity, or by age 21.[6] Among women aged 21 years and older in 2005, 51.8 percent received a Pap smear in the past 3 years, while another 12.1 percent had received a Pap smear more than 3 but less than 5 years ago. More than 36 percent of women aged 21 years and older had no Pap smear within the past 5 years.

The percentage of women receiving a Pap smear within the recommended timeframe decreases with age. In 2005, women aged 21–34 years were most likely to have had a Pap smear in the previous 3 years (81.0 percent), and were least likely to have not had a Pap test in the previous 5 years (9.7 percent). Women aged 65 years and older were least likely to have received a Pap test in the past 3 years (34.0 percent) and most likely to have not had one in the past 5 years (53.8 percent). Nearly 25 percent of women aged 35–54 and 37.7 percent of women aged 55–64 had not had a Pap test in the previous 5 years.

High cholesterol is a risk factor for heart disease. The Healthy People 2010 goal is to increase the percentage of adults aged 20 and over who receive a cholesterol screening at least every 5 years.[7] In 2005, 72.1 percent of women aged 20 years and older had received a cholesterol test within the previous 5 years. Non-Hispanic White and non-Hispanic Black women were more likely to have had the test (75.7 and 71.3 percent, respectively), compared to Hispanic women and non-Hispanic women of other races (53.5 and 64.7 percent, respectively).

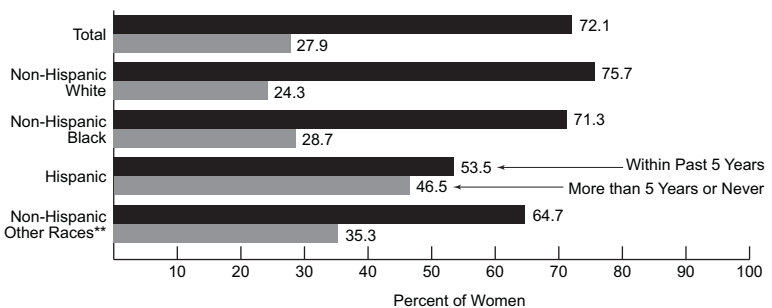
Receipt of Pap Smears Among Women Aged 21 and Older, by Age and Time Since Last Test, 2005

Source II.12: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Receipt of Cholesterol Screening Among Women,* by Race/Ethnicity and Time Since Last Test, 2005–2006

Source I.4: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey



*Women aged 20 and older only. **Includes Asian/Pacific Islander, American Indian/Alaska Native, persons of more than one race, and persons of all other races unspecified.*

VACCINATION

Vaccination prevents the spread of infectious diseases. Vaccination for influenza is recommended for young children, pregnant women, persons with certain chronic medical conditions, and adults aged 50 years or older.[8] In 2006, nearly 40 percent of women aged 55–64 years and 64.6 percent of women aged 65 years and older reported receiving a flu vaccine in the past year; this varied, however, by race and ethnicity. Non-Hispanic White women were more likely than women of other races and ethnicities to have received the flu vaccine; 41.6 percent of 55- to 64-year-olds and 67.3 percent of those aged 65 years and older did so. Fewer than 48 percent of non-Hispanic Black and Hispanic women aged 65 years and older received the flu vaccine.

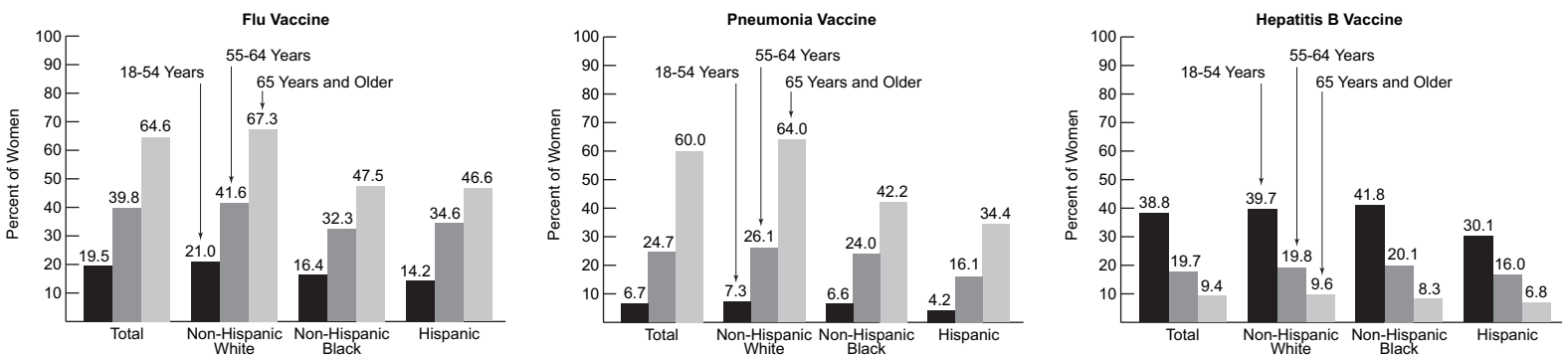
Pneumonia vaccine is recommended for adults aged 65 years and older and for people with certain health conditions. In 2006, 60.0 percent of women aged 65 and older reported ever receiving the vaccine. In this age group, Non-Hispanic White women were most likely to have ever received the pneumonia vaccine (64.0 percent), compared to 34.4 percent of Hispanic women and 42.2 percent of non-Hispanic Black women.

Hepatitis B vaccine is recommended to reduce the spread of hepatitis B, which may result in cirrhosis of the liver, liver cancer, liver failure, and even death.[9] Hepatitis B vaccination also varied by race/ethnicity and age. Younger women were most likely to have received at least one of the three recommended doses, and non-Hispanic White and non-Hispanic Black women in every age group were more likely than Hispanic women to have received the vaccine.

Genital human papillomavirus (HPV) can cause cervical cancer and other diseases in women. In 2006, the HPV vaccine was recommended for adolescent females and young women aged 9–26 years;[10] since 2006, 10 percent of women aged 18–26 years have been vaccinated for HPV (data not shown).[11]

Receipt of Selected Vaccinations* Among Women Aged 18 and Older, by Race/Ethnicity** and Selected Age Group, 2006

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



*Having received the flu vaccine in the past 12 months; having ever received the pneumonia vaccine; and having ever received at least one dose of the three-dose hepatitis B vaccine. **Sample sizes for Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified were too small to produce reliable results. Totals include all races/ethnicities.

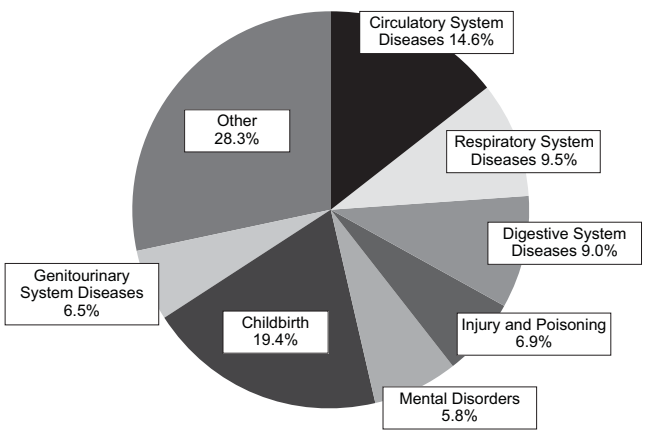
HOSPITALIZATIONS

Females represented 59.9 percent of the 34.7 million short-stay hospital discharges in 2005. More than 19 percent of hospital stays for all females were due to childbirth, while 14.6 percent were due to diseases of the circulatory system. Other common reasons for hospitalization included diseases of the respiratory, digestive, and genitourinary systems; injury and poisoning; and mental disorders. Overall, females had a higher hospital discharge rate than males in 2005 (1,382.2 versus 959.0 per 10,000 population; data not shown).

Males and females also had different rates of procedures for discharges from short-stay hospitals. Overall procedure rates were 1,794.5 procedures per 10,000 females (this includes 456.5 obstetrical procedures per 10,000 females) and 1,241.1 procedures per 10,000 males. Several of the procedures for which females had a higher hospital discharge rate than males included operations on the digestive system (210.7 versus 166.5 per 10,000) and operations on the reproductive organs, including hysterectomy (130.9 versus 16.1 per 10,000). Males had a higher rate than females for operations on the cardiovascular system (280.2 versus 194.8 per 10,000). Among females, the highest rate of procedures for discharges from short-stay hospitals was obstetrical procedures (456.5 per 10,000).

Discharges from Non-Federal, Short-Stay Hospitals Among Females of All Ages,* by Diagnosis, 2005

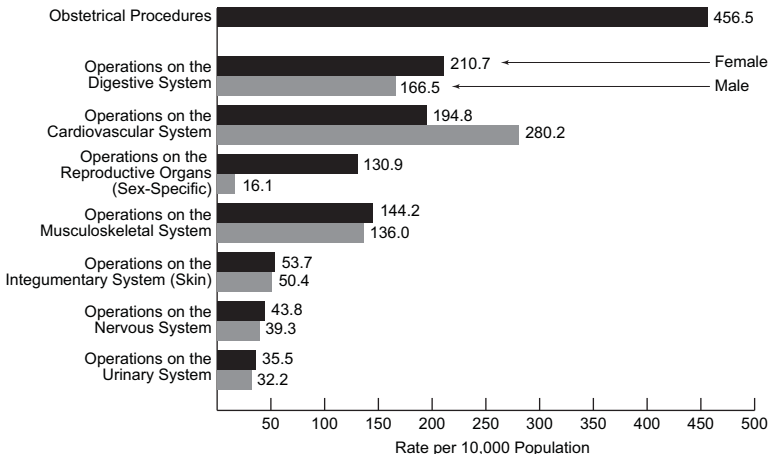
Source III.2: Centers for Disease Control and Prevention, National Center for Health Statistics, National Hospital Discharge Survey



*Excludes newborn infants.

Discharges from Non-Federal, Short-Stay Hospitals, by Sex and Procedure Category, All Ages,* 2005

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



*Excludes newborn infants.

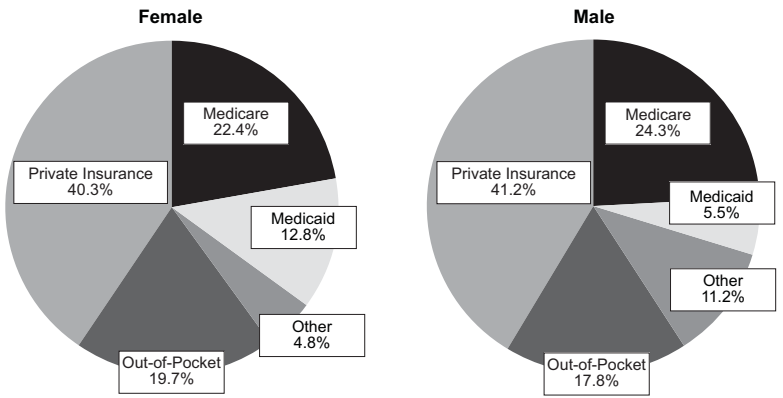
HEALTH CARE EXPENDITURES

In 2005, the majority of health care expenses of 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 40.3 percent of expenses were covered by private insurance. 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 or out-of-pocket.

In 2005, 91.0 percent of women had at least one health care expenditure, compared to 77.7 percent of men. Among those who had at least one health care expense in 2005, the average per person expenditure, including expenses covered by insurance and those paid out-of-pocket, was higher for women ($5,211) than for men ($4,514). However, men's average expenditures exceeded women's for hospital inpatient services ($17,401 versus $12,556, respectively) and hospital outpatient services ($2,440 versus $1,909). Women's expenditures exceeded men's in the categories of home health services, office-based medical services, and prescription drugs. Overall per capita health care expenditures have increased substantially and at about the same rate for both men and women since the 1990's. In 2005, the annual mean health care expenses for both men and women were approximately 58 percent higher than in 1999.

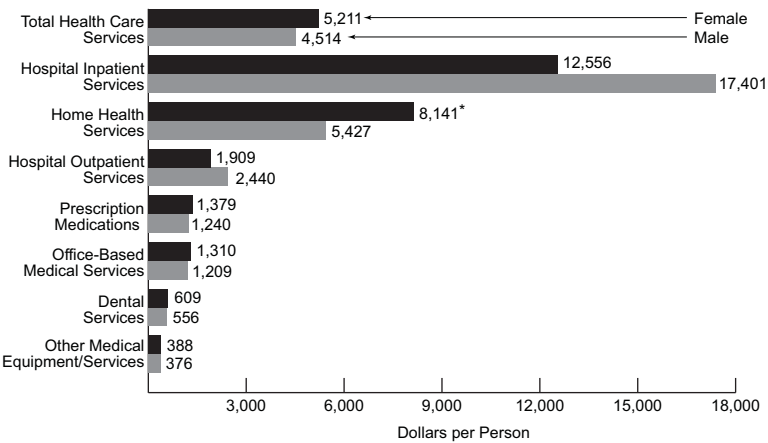
Health Care Expenses of Adults Aged 18 and Older, by Source of Payment and Sex, 2005

Source III.3: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



Mean Health Care Expenses of Adults Aged 18 and Older with an Expense, by Sex and Category of Service, 2005

Source III.3: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey



*This statistic should be interpreted with caution; the relative standard error is greater than 30 percent.

MEDICATION USE

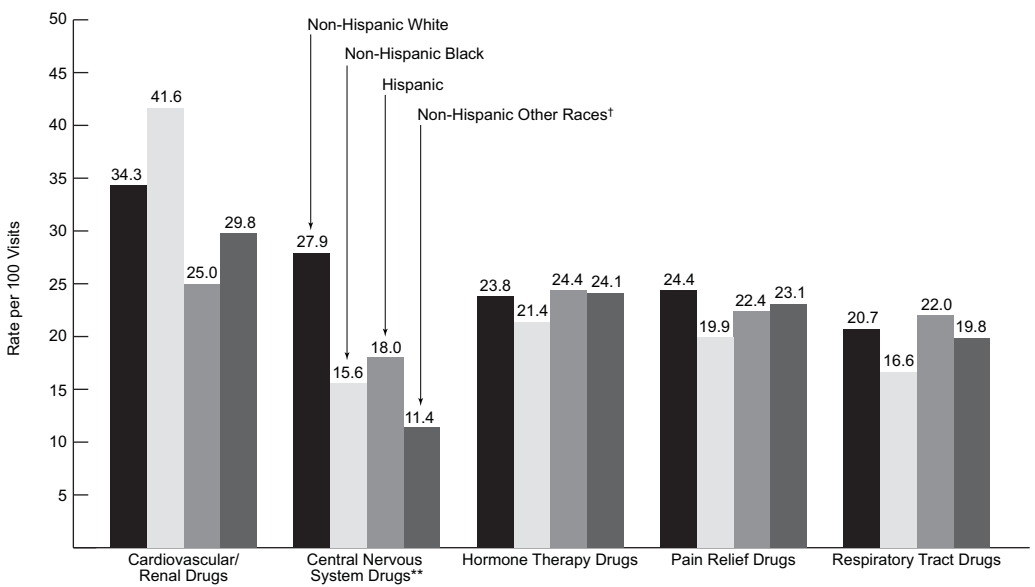
In 2005, medication was prescribed or provided by a physician at nearly 680 million, or 70.5 percent of, physician office visits; multiple drug prescriptions were recorded at 45.9 percent of all visits. The percent of visits with one or more drugs prescribed or provided was similar for males and females (70.9 and 69.9 percent, respectively). Among females of all ages, 29.1 percent of visits did not involve prescribing or providing any drugs, 24.9 percent of visits involved the prescription or provision of one drug, and 14.0 percent of visits involved two drugs. An additional 32.1 percent of visits involved the prescription or provision of 3 or more drugs.[12]

The prescription and provision of medications to females varies by race/ethnicity and drug type. In 2005, the rate of cardiovascular/renal drugs prescribed or provided at physician office visits was highest among non-Hispanic Black females (41.6 per 100 office visits), while non-Hispanic white females were most likely to receive central nervous system drugs (anti-depressants, antipsychotics, sedatives, and anxiety medications; 27.9 per 100 visits). Hispanic females were the most likely to have respiratory tract drugs provided or prescribed (22.0 per 100 visits). There was little variation between females of different races and ethnicities in the use of hormone therapy drugs.

The rate of medications provided and prescribed to females during physician office visits also varies by age. For instance, women aged 45–64 years were the most likely to have central nervous system drugs prescribed or provided (34.1 per 100 visits), while women aged 75 and older were most likely to receive cardiovascular/renal drugs (85.9 per 100 visits) and pain relief drugs (34.6 per 100 visits). Respiratory drugs were most likely to be prescribed or provided to girls under 15 years of age (25.9 per 100 visits, data not shown).

Medications Reported* During Physician Office Visits Among Females (All Ages), by Race/Ethnicity, 2005

Source II.11: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey



*Medications that were prescribed, provided, or continued. **Includes antidepressants, antipsychotics, sedatives, and anxiety medications.
†Includes Asian/Pacific Islanders, American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified.

MENTAL HEALTH CARE UTILIZATION

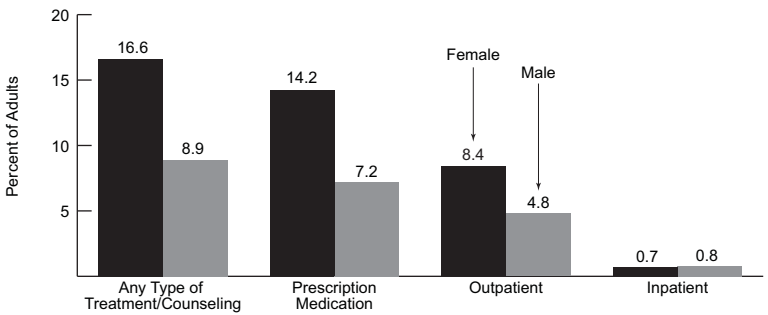
In 2006, more than 28 million adults in the United States reported receiving mental health treatment in the past year. Women represented two-thirds of users of mental health services, including inpatient and outpatient care and prescription medications. More than 16 million women reported using prescription medication for treatment of a mental or emotional condition, representing 14.2 percent of women aged 18 and older, compared to 7.2 percent of men. Outpatient treatment was reported by 8.4 percent of women, and inpatient treatment was reported by 0.7 percent of women.

Mental health services were needed, but not received, by an estimated 10 million adults in the United States. In 2006, 5.9 percent of women and 3.2 percent of men reported an unmet need for mental health treatment or counseling. Cost or lack of adequate insurance coverage was the most commonly reported reason for not receiving needed services, reported by 50.1 percent of women and 43.7 percent of men with unmet mental health treatment needs. Others mentioned feeling that they could handle their problems without treatment (reported by 28.5 percent of women and 33.3 percent of men with unmet needs). In addition, stigma, including concern about confidentiality or the opinions of others, or the potential effect on employment, prevented 20.4 percent of women and 29.6 percent of men with unmet needs from receiving treatment.

Among women, unmet need for treatment varied by race and ethnicity. Non-Hispanic American Indian/Alaska Native women were most likely to report an unmet need for treatment (8.2 percent), followed by non-Hispanic White women (6.4 percent). Additionally, 4.7 percent of non-Hispanic Black women, and 4.1 percent of Hispanic women had an unmet need for treatment. Asian/Pacific Islander women were least likely to report an unmet need for mental health treatment (3.6 percent; data not shown).

Adults Aged 18 and Older Receiving Mental Health Treatment/Counseling,* by Sex and Type, 2006

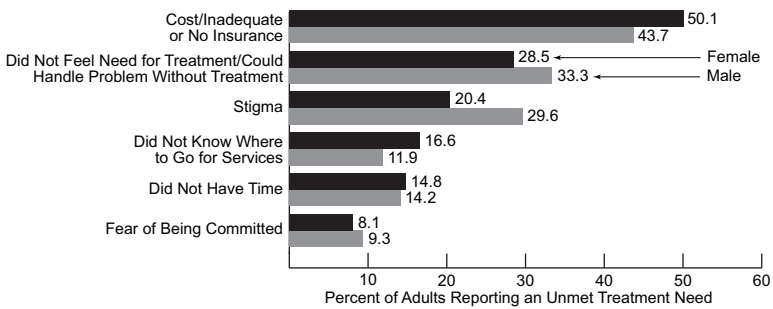
Source II.4: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health



*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, 2006

Source II.3: 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.

HIV TESTING

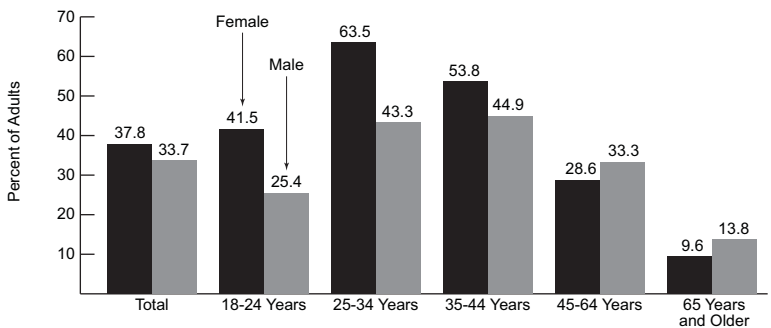
Today, people aware of and receiving appropriate care for their human immunodeficiency virus (HIV) status may be able to live longer and healthier lives because of newly available, effective treatments. Testing for HIV, the virus that causes AIDS, is essential so that infected individuals can seek care and prevent the spread of HIV. HIV testing requires only a simple blood or saliva test, and it is often offered confidentially or anonymously. It is recommended that people who meet any of the following criteria be tested periodically 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.[13] In addition, the CDC recommends that all pregnant women be tested for HIV during their pregnancy. In 2006, new CDC guidelines were released that recommend all health care providers include HIV testing as part of their patients' routine health care. Counseling patients on ways to prevent HIV infection or spreading the virus is part of good primary care practice.

In 2006, nearly 36 percent of adults in the United States had ever been tested for HIV. Overall, women were more likely than men to have been tested (37.8 versus 33.7 percent). Women were more likely to have been tested at younger ages, while men were more likely to have been tested at older ages.

Among women, in 2006, non-Hispanic Blacks were most likely to have ever been tested (53.7 percent), followed by Hispanics (46.1 percent), while non-Hispanic White women were least likely (33.5 percent).

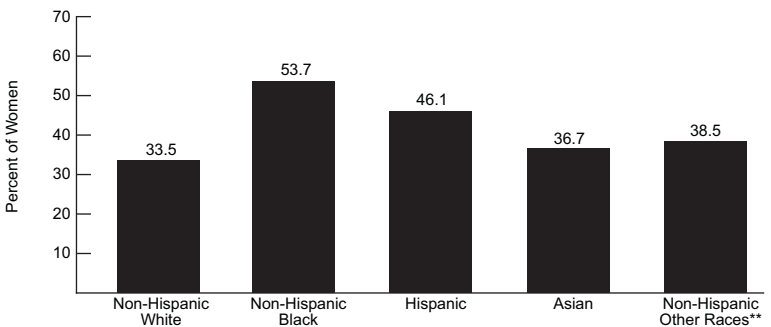
Adults Aged 18 and Older Who Have Ever Been Tested for HIV, by Sex and Age, 2006

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, 2006*

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



*Rates reported are not age-adjusted. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of all other races not specified.

ORGAN TRANSPLANTATION

Between January 1 and November 30, 2007, 26,021 organ transplants occurred in the United States. In 2007, the sex distribution of organ donors was nearly even (6,939 males and 6,284 females), though 57.8 percent of organs donated by living people were from women, and 60.5 percent of organs from deceased donors were from men. Since 1988, there have been 419,520 transplants.

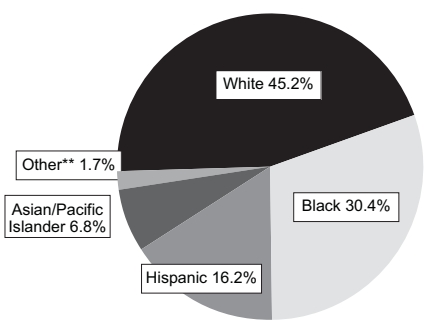
The need for donated organs greatly exceeds their availability, so waiting lists for organs are growing. As of February 1, 2008, there were 97,686 people awaiting a life-saving organ transplant. Females accounted for 41.9 percent of those patients but made up only 36.8 percent of those who received a transplant in 2007.[14] Among women waiting for an organ transplant, 45.2 percent were White, 30.4 percent were Black, and 16.2 percent were Hispanic. The kidney was in highest demand, with 31,323 females awaiting this organ as of February 1, 2008.

The number of organs donated has increased significantly since 1988, from 5,909 to 14,756 at year's end 2006. In 2003, the donation community began to work together through the Organ Donation Breakthrough Collaborative and other grassroots efforts to increase donation. From 2003 to 2006, organ donation among deceased donors increased by an unprecedented 24.3 percent. One of the challenges of organ donation is obtaining consent from the donor's family or legal surrogate. Consent rates may vary due to religious beliefs, 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.[15]

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 Vaccine Injury Compensation Program, and the C.W. Bill Young Cell Transplantation Program.

Females on Organ Waiting List,* by Race/Ethnicity, 2008

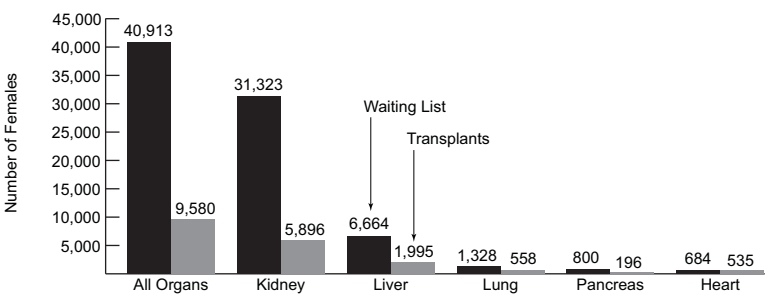
Source III.4: Organ Procurement and Transplantation Network



*As of February 1, 2008. **Includes American Indian/Alaska Natives, persons of more than one race, and persons of unspecified race.

Female Transplant Recipients,* 2007, and Females on Organ Waiting Lists,** 2008, by Organ

Source III.4: Organ Procurement and Transplantation Network



*Transplants occurring between January 1, 2007 and November 30, 2007, as of January 25, 2008.
**As of February 1, 2008.

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 screening for chlamydia, screening for cervical cancer, and receipt of mammograms.

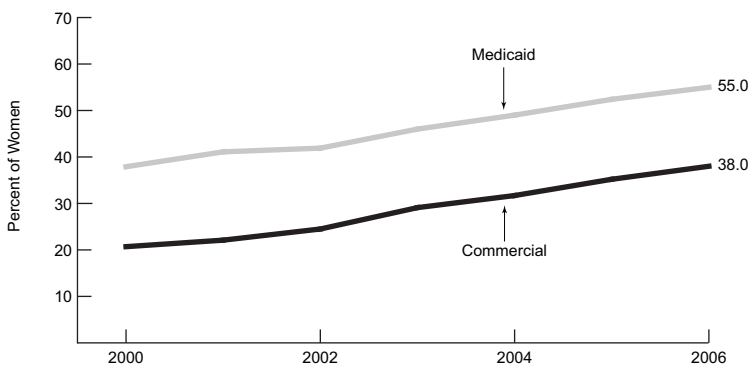
In 2006, chlamydia screenings increased for women aged 21–25 years enrolled in commercial (private) health care plans or Medicaid. As in previous years, females with Medicaid coverage were more likely to have received a chlamydia screening in the previous year than those with private coverage (55.0 versus 38.0 percent, respectively). Since 2000, the percentage of sexually active females screened for chlamydia has increased by nearly 84 percent among those in commercial plans and 45 percent among Medicaid enrollees.

In 2006, receipt of mammograms for women aged 40–69 was approximately the same for women with private coverage and those covered through Medicaid (68.9 and 69.5 percent, respectively). However, Medicare-enrolled women were considerably less likely to have received a mammogram at least once during the previous 2 years (49.1 percent).

Cervical cancer screenings appear to be more accessible to women with commercial coverage than to those covered by Medicaid. Cervical cancer screenings were received at least once every 3 years by nearly 81.0 percent of commercially-insured women and 65.7 percent of women covered by Medicaid.

HEDIS®* Chlamydia** Screening Among Women Aged 21–25 Years, by Payer, 2000–2006

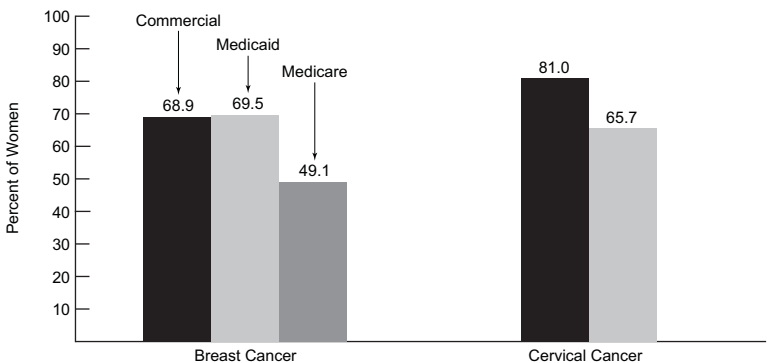
Source III.5: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of sexually active females who had at least one test for chlamydia in the past year.*

HEDIS®* Breast** and Cervical Cancer Screening,† by Payer, 2006

Source III.5: National Committee for Quality Assurance



**Health Plan Employer Data and Information Set is a registered trademark of NCQA. **The percentage of women aged 40–69 years who had at least one mammogram in the past 2 years. †The percentage of women aged 21–64 years who had at least one Pap test in the past 3 years; Medicare data was not available. Note: Data cannot be compared to previous years due to changes in the age range presented.*

SATISFACTION WITH HEALTH CARE

Patients' utilization of health care is influenced by the quality of care; those who are not satisfied with their providers may be less likely to continue with treatment or seek further services.[16] Some aspects of patients' experience of care that may contribute to better outcomes are patients' perceptions of how well their doctors or other health care providers communicate with them and individuals' experiences with their health plans.

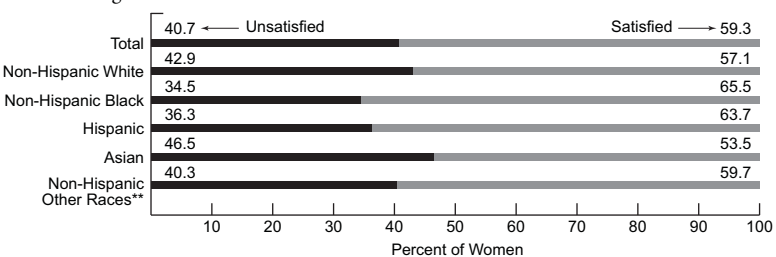
In 2006, 40.7 percent of women were not satisfied with their experiences related to their health plans, which could include health plan customer service, understanding or finding information related to their plan, and completing or submitting paperwork for the plan. This varied by race and ethnicity. Asian women were most likely to be dissatisfied (46.5 percent), followed by non-Hispanic White women (42.9 percent). Fewer than 35 percent of non-Hispanic Black women and 36.3 percent of Hispanic women were unsatisfied with their experiences related to their health plans.

Satisfaction with how well doctors communicate also varies by women's race and ethnicity. In 2006, Hispanic women (25.9 percent) and Asian women (24.0 percent) were more likely to be dissatisfied with how well their doctors communicate than women of other races. Fewer than 20 percent of non-Hispanic Black women and 15.7 percent of non-Hispanic White women were not satisfied with aspects of communication with their doctors.

More than 36 percent of women were not satisfied with their experiences in getting the care they need when they needed it, including seeing specialists; getting necessary care, tests or treatment; and delays in receiving care caused by waiting for health plan approval. The percentage of women reporting dissatisfaction was greatest among Asian women (47.1 percent). Nearly 40 percent of Hispanic women and 34 percent each of non-Hispanic Black and non-Hispanic White women were also not satisfied with getting the care they needed (data not shown).

Women's Satisfaction with Experiences Related to Health Plans,* by Race/Ethnicity, 2006

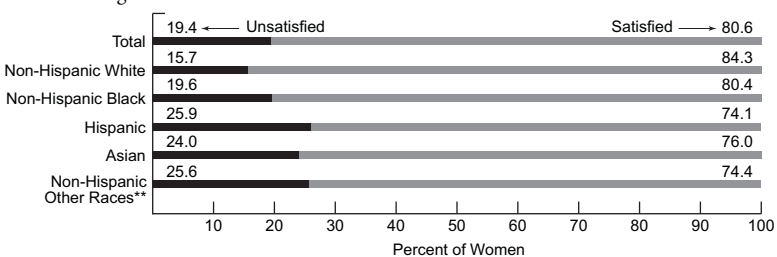
Source III.6: U.S. Agency for Healthcare Research and Quality, National CAHPS® Benchmarking Database



*Based on questions related to respondents' experiences with their health plans in the past 6 (Medicaid respondents) or 12 months (commercial health plan respondents). **Includes American Indian/Alaska Natives, all other races not specified, and multiple races.

Women's Satisfaction with How Well Doctors Communicate,* by Race/Ethnicity, 2006

Source III.6: 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). **Includes American Indian/Alaska Natives, all other races not specified, and multiple races.

HRSA PROGRAMS RELATED TO WOMEN'S HEALTH

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) supports several programs that promote access to health care for vulnerable populations. HRSA's Office of Women's Health (OWH) coordinates efforts that address women's health across their lifespan. The Bright Futures for Women's Health and Wellness Initiative provides materials on topics such as physical activity and healthy eating, emotional wellness, and maternal wellness. These tools, data books, and research reports can be found on the OWH Web site at www.hrsa.gov/womenshealth.

The HRSA Web site, at www.hrsa.gov, provides information about HRSA's bureaus and offices. HRSA's Maternal and Child Health Bureau (MCHB), online at www.mchb.hrsa.gov, administers the MCH Block Grant, a Federal-State partnership to improve the health of mothers and children. *Depression During and After Pregnancy: A Resource for Women, Their Partners, Family and Friends (2007)* and *The Business Case for Breastfeeding: Steps for Creating a Breastfeeding-Friendly Worksite* are two new HRSA publications available for consumers.

The Bureau of Health Professions (BHPr) provides national leadership in the development, distribution, and retention of a culturally competent health workforce. In 2006, women represented 62 percent of those who received assistance from the Centers of Excellence and 71 percent of those involved with the Health Careers Opportunity Programs.

The HIV/AIDS Bureau (HAB) addresses the needs of women living with HIV/AIDS through the Ryan White Program including Part D, which targets services to women, infants, children, youth, and their families. HAB aims to improve access and retention in care through training and technical assistance programs, culturally competent border health initiatives, oral health care programs, and Special Projects of National Significance.

The new Bureau of Clinician Recruitment and Services' (BCRS) mission is to improve the health of the Nation's underserved communities by coordinating recruitment and retention of health professionals to build integrated and sustainable systems of care. Clinicians participating in the National Health Service Corps program provide staffing support to Federally Qualified Health Centers.

The Bureau of Primary Health Care (BPHC) manages the Health Center Program, which funds a national network of 1,002 grantees at over 3,800 comprehensive, primary health care service delivery sites. Through community health centers, school-based centers, and other centers focused on migrant health, health care for the homeless, and public housing, the Program delivers preventive and primary care services to patients regardless of their ability to pay. Almost 40 percent of patients have no insurance coverage. Overall, the number of patients served has risen from 10.3 million in 2001 to an estimated 15 million in 2006. In 2006, 59 percent of patients served were women.

Health Centers Supported by the Bureau of Primary Health Care, 2005

Source III.7: Uniform Data System, Bureau of Primary Health Care, HRSA, HHS

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