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Authors

Wyn, Roberta
Hastert, Theresa A.
Peckham, Erin

Publication Date

2008-08-01

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HEALTH POLICY RESEARCH



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The UCLA Center for Health Policy Research is based in the UCLA School of Public Health and affiliated with the UCLA School of Public Affairs.

The California Wellness Foundation funded the research and development of this report.



*california
health
interview
survey*

The California Health Interview Survey (CHIS) is the largest state health survey and one of the largest health surveys in the United States. Overseen by the UCLA Center for Health Policy Research, CHIS is a collaboration of numerous funders, including the California Department of Public Health, the California Department of Health Care Services and the Public Health Institute. For more information about CHIS, visit www.chis.edu.

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executive summary

Executive Summary

This report examines important health concerns of nonelderly women (ages 18-64) in California, including their health status, selected health behaviors, health insurance coverage, usual source of care and access to health care. We address how these health measures vary among women by family income and by race/ethnicity, with a focus on women often disproportionately affected by lack of consistent policies that promote health and access to health care. We also look at differences by age group, to examine the changing health care issues and needs of women at different points in their lives.

This report uses data from the 2005 and 2001 California Health Interview Surveys. The first section of the report examines women's self-reported health status, activity limitations and health condition prevalence. Next, selected health behaviors—physical activity level, smoking, and alcohol use—are examined. The third section looks at the current state of health insurance coverage for women, including the characteristics of uninsured women. Finally, the report addresses issues of access to care: where women receive care; their use of safety-net providers; and their use of physician services and preventive screenings.

All comparative statements in the report reflect statistically significant differences ($p < .05$) unless otherwise noted.

SUMMARY OF KEY FINDINGS

Health Status and Conditions

- Slightly under one in five women (17.9%) report fair or poor health and 14.1% have a health condition that limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying.
 - Chronic health conditions affect all age groups, but most are more prevalent in women ages 55-64.
- Among these women, four in ten have been diagnosed with high blood pressure and arthritis in their lifetime, and more than one in ten have been diagnosed with asthma, cancer or diabetes. Over one-quarter of women ages 55-64 have a health condition that limits one or more of the basic physical activities.
- Asthma was the one health condition examined that did not increase by age. The asthma prevalence rate was nearly constant across age groups.
 - Women with low incomes (family incomes below 200% Federal Poverty Level, FPL) generally have poorer health status than higher income women. They are three times as likely to report their health as fair or poor and, among those who are ages 45-64, have higher rates of several of the health conditions measured—arthritis, diabetes, heart disease and high blood pressure.
 - Latinas, Asian/Pacific Islander women, American Indian/Alaska Native women and African-American women were all more likely to report fair or poor health than white women. And 30% of American Indian/Alaska Native women have a health condition that limits their basic activity level—the highest rate of any racial/ethnic group.
 - Prevalence rates of the health conditions examined vary by racial/ethnic group, but generally American Indian/Alaska Native and African-American women have the highest rate of several of the health conditions measured.
 - Among women ages 45-64, hypertension affects approximately one in three Latinas, Asian/Pacific Islander women, and white women; four in ten American Indian/Alaska Native women and over one-half of African-American women.

- Based on self reported height and weight, 20.6% of women are obese and 25.5% are overweight. While the overall prevalence rate of obesity among nonelderly women did not increase between 2001 and 2005, the prevalence of obesity did increase for women ages 18-29, going from 12.4% in 2001 to 14.9% in 2005. This was the only age group that saw an increase.
- Higher rates of obesity are seen among women who are older, African American, have lower incomes, have not completed high school, and report their health as fair or poor.

Selected Health Behaviors

- One in three women obtains the recommended amount of regular physical activity; six in ten get some physical activity, but not the recommended level; and one in ten is inactive.
- American Indian/Alaska Native and white women are the most likely to get the recommended level of physical activity, and Latinas, Asian/Pacific Islander and African-American women are the least likely.
- 12.8% of women currently smoke cigarettes—approximately 1.4 million. The proportion of women who smoke in 2005 has decreased since 2001, when 14.9% smoked.
- Smoking prevalence is similar across age groups, but the proportion of women who have quit smoking increases with age. One in three women ages 55-64 is a former smoker, as are nearly one-quarter of women ages 45-54.
- The highest rates of smoking are among American Indian/Alaska Native women (25.8%), African-American women (17.7%) and white women (17.2%).
- 5.3% of women who do not themselves smoke are exposed to secondhand smoke in their homes.

- More than one-half of California women consume alcohol, with higher rates among white women and those with higher incomes. Among underage women (ages 18-20), 38.8% report having at least one alcoholic beverage in the past month.
- 12.3% of women report binge drinking (i.e., four or more drinks on one occasion during the past month), including 15.3% of women ages 18-20.

Health Insurance Coverage

- 22.3% of women—approximately 2.5 million—were uninsured for all or part of 2005, with the highest risk of being uninsured among those with low incomes, Latinas, non-citizens, single women, those in fair or poor health and younger women.
- Uninsured rates for women with family incomes below 100% FPL (44%) and at 100-199% FPL (41%), are four times higher than for women with family incomes 300% FPL and above (9.7%).
- The uninsured rate for Latinas is three times higher than the rate for white women (39.3% vs. 13.4%), and among the Latina ethnic groups examined, well over one-third of Salvadoran, Mexican and Guatemalan women were uninsured.
- Among the Asian ethnic groups examined, Korean women had the highest uninsured rate—38.1% were uninsured for all or part of 2005.
- Medi-Cal is an important coverage source for women with family incomes below 100% FPL (39.2%) and for single parents (29.3%), preventing even higher uninsured rates.
- The majority of uninsured women are low income (62.6%); 29.1% have family incomes below 100% FPL, and 33.5% have family incomes of 100-199% FPL.

-
- The proportion of women with employment-based coverage through a family member declined between 2001 and 2005, from 23.2% to 20.4%. During this same time period, the proportion with employment-based coverage through their own coverage (primary coverage) increased from 31.3% to 35.3%.

Usual Source of Health Care and Utilization of Selected Services

- Most women have a usual place where they seek medical care: for the majority of women it is a doctor's office or HMO setting, and a sizeable share use safety-net providers. But one in ten women lacks a usual source of care or "medical home."
- Younger women, those with low incomes, Latinas and the uninsured are all more likely to lack a regular place to go for medical care.
- Safety-net providers serve as a primary source of care for 23.4% of women, approximately 2.6 million. One-third of women who were uninsured all or part of 2005 rely on safety-net providers as do four in ten women who receive Medi-Cal.
- While 87.3% of women had a physician visit in the past year, the uninsured and those with no usual source of care were much less likely to have seen a provider.
- 85% of nonelderly women had a Pap test within the past three years. Pap test rates are lower for young women, Asian/Pacific Islander women, and those with family incomes below 300% of the FPL.
- Pap test screening rates are lower for women receiving Medi-Cal and for uninsured women than for women with employment-based insurance.

- 77.4% of women ages 40-64 had a mammogram within the past two years. Mammography screening rates are lower for women ages 40-49, women with family incomes below 300% FPL, Asian/Pacific Islander women, Latinas and American Indian/Alaska Native women.

- Among women ages 40-64, mammography screening rates are lower for women on Medi-Cal and women who are uninsured.

The findings in this report highlight the considerable variation among California nonelderly women in their health conditions and health activities, health insurance coverage and measures of access to care. A sizeable portion of women face serious disparities—which persist across the indicators measured.

Acknowledgements

The authors appreciate the assistance of several people at the UCLA Center for Health Policy Research who contributed to this report. Programming support was provided by YaQun Wang, Ruxi Zhang and Jenny Chia, PhD, and statistical support and oversight was provided by Hongjian Yu, PhD. Nadereh Pourat, PhD, provided critical review of a draft of the report. Gwendolyn Driscoll and Celeste Maglan oversaw the production and dissemination of the report.

Sheri Penney of Penney Layne Productions provided valuable editorial assistance and Ikkanda Design designed and produced the report.

The report is funded by a grant from The California Wellness Foundation (TCWF). Created in 1992 as an independent, private foundation, TCWF's mission is to improve the health of the people of California by making grants for health promotion, wellness education and disease prevention programs. The authors are very grateful for the support provided by Saba Brelvi at The California Wellness Foundation.

demographics

Demographics

This report provides information on health status and conditions, selected health behaviors, health insurance coverage, usual source of care and selected health care use measures for nonelderly women in California. There are approximately 11.2 million women who are between 18 and 64 years of age in California: 26.2% are between the ages of 18 and 29, 36.4% are 30-44, 22% are 45-54, and 15.4% are 55-64 years of age. Slightly under one-half of nonelderly women are non-Latino white; Latinas comprise the next largest group (27.2%); 13.3% are Asian; 6.5% are African American; 1.1% are American Indian/Alaska Native; Pacific Islanders represent under 1% of nonelderly women; and women of another single or multiple race represent 2.9%.

One-third of nonelderly California women are low income, with family incomes below 200% of the Federal Poverty Level (FPL).¹ This includes 14.8% with family incomes below the Federal Poverty Level and 18.2% with family incomes of 100-199% FPL. Twelve percent of nonelderly women have family incomes of 200-299% FPL and 55% have family incomes of 300% FPL and above.

1 The Federal Poverty Level (FPL) varies by family income and family size. In 2005, the federal poverty level was \$9,973 for one person, \$12,755 for a two-person family, and \$15,577 for a three-person family.

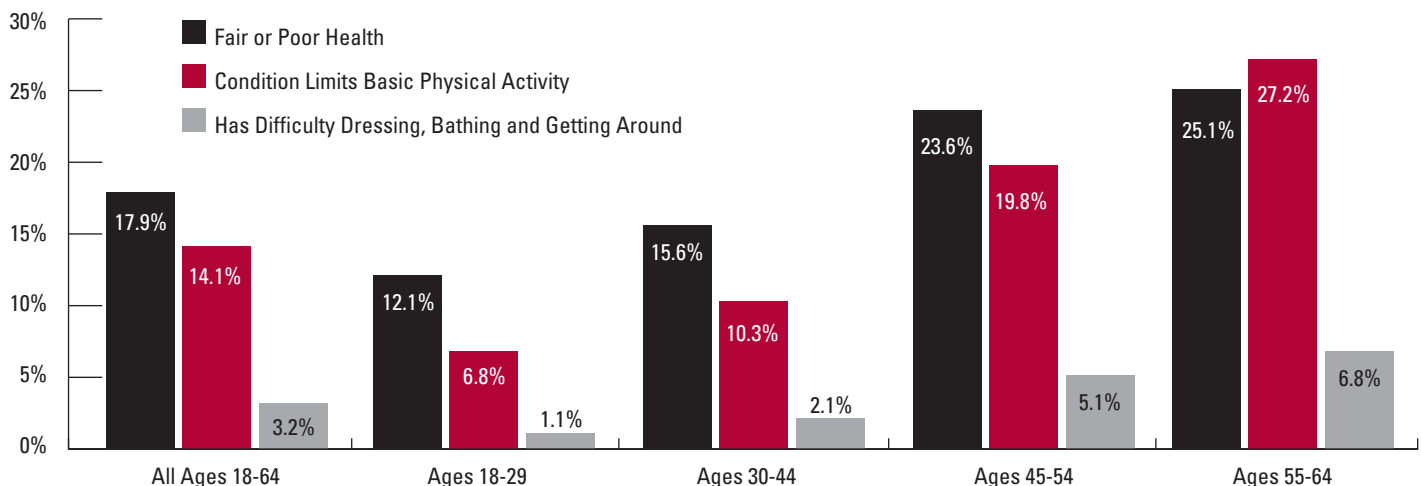
status and conditions

Health Status and Conditions

Information on women's health status and conditions and how it varies across subgroups of women provides an important backdrop for discussions focused on health behaviors, health insurance coverage, access to care issues and health disparities among women. Women's perceived health status and the prevalence of selected health conditions, as well as social and racial/ethnic disparities in health, are examined in this section. Some of the key findings include:

- 14.1% of all nonelderly women and over one-quarter of women ages 55-64 (27.2%) report they have a health condition that limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying.
- Health conditions affect women of all ages, but are the most prevalent in women ages 55-64. Among these women, approximately 40% have been diagnosed with arthritis or high blood pressure in their lifetime, and more than one in ten have been diagnosed with asthma, cancer or diabetes.
- Low-income women are three times as likely as higher income women to report their health as fair or poor. Among low-income women ages 45-64, lifetime prevalence of arthritis, diabetes, heart disease and high blood pressure are higher.
- The prevalence of health conditions varies among women by racial/ethnic group, but generally American Indian/Alaska Native and African-American women have the highest rates of many of the conditions measured.
- 20.6% of women are obese and 25.5% are overweight. While the overall obesity prevalence did not increase between 2001 and 2005, obesity prevalence did increase for women ages 18-29, going from 12.4% in 2001 to 14.9% in 2005.

EXHIBIT 1: HEALTH STATUS AND FUNCTIONING BY AGE GROUP, WOMEN AGES 18-64, CALIFORNIA, 2005



Source: 2005 California Health Interview Survey

DIFFERENCES BY AGE GROUP

Health Status and Functioning

As women age, they experience poorer health status and an increased prevalence of conditions that interfere with their functioning. Among women ages 18-64, nearly one in five (17.9%) report they are in fair or poor health (Exhibit 1). The proportion of women reporting their health as fair or poor increases steadily with age, from 12.1% of women ages 18-29 to approximately one-quarter of women ages 45 and over.

Fourteen percent of nonelderly women—nearly 1.6 million—report they have a condition that limits one or more of the basic physical activities (i.e., walking, climbing stairs, reaching, lifting or carrying). The prevalence of activity limitations rises dramatically with age, from 6.8% of women ages 18-29, 10.3% of women ages 30-44, 19.8% of women ages 45-54, and over one-quarter of women 55-64 years of age (27.2%). Far fewer nonelderly women—overall 3.2% or 361,000—have difficulty conducting everyday living activities, such as dressing, bathing and getting around. Yet, for 6.8% of women ages 55-64, these basic everyday activities present difficulties.

Health Conditions

Exhibit 2 displays the prevalence of several health conditions among nonelderly women by age group.² Arthritis prevalence, which also includes those who reported a diagnosis of gout, lupus or fibromyalgia, is 16.4% or 1.8 million nonelderly women. Among women ages 18-29, 3.9% report ever having been diagnosed with arthritis, increasing to 9.9% of women ages 30-44, one-quarter of women ages 45-54, and four in ten women ages 55-64 (40.3%). For women age 45 and over, this is one of the highest prevalence conditions reported.

The prevalence of asthma among nonelderly women is 13.7%, representing 1.5 million women.³ Asthma rates do not show as pronounced an age-related pattern as the other chronic conditions, affecting nearly equal proportions of women across all age groups.

The cancer prevalence is 6% of nonelderly women (677,000). For each age group, the lifetime prevalence of cancer increases, from 2% of women ages 18-29, 4.2% for women ages 30-44, 9.3% of women ages 45-54, to the highest prevalence of 12.5% among women ages 55-64.

EXHIBIT 2: HEALTH CONDITIONS BY AGE GROUP, WOMEN AGES 18-64, CALIFORNIA, 2005

DIAGNOSED HEALTH CONDITIONS*	Ages 18-64	Ages 18-29	Ages 30-44	Ages 45-54	Ages 55-64
ARTHRITIS	16.4%	3.9%	9.9%	25.1%	40.3%
ASTHMA	13.7%	13.9%	12.4%	14.3%	15.7%
CANCER	6.0%	2.0%	4.2%	9.3%	12.5%
DIABETES**	4.5%	1.3%	3.0%	6.3%	11.0%
HEART DISEASE	3.3%	1.1%	2.1%	4.3%	8.5%
HIGH BLOOD PRESSURE	17.3%	6.6%	11.3%	24.4%	39.6%

* Health condition is based on women reporting that they have ever been diagnosed with the condition.

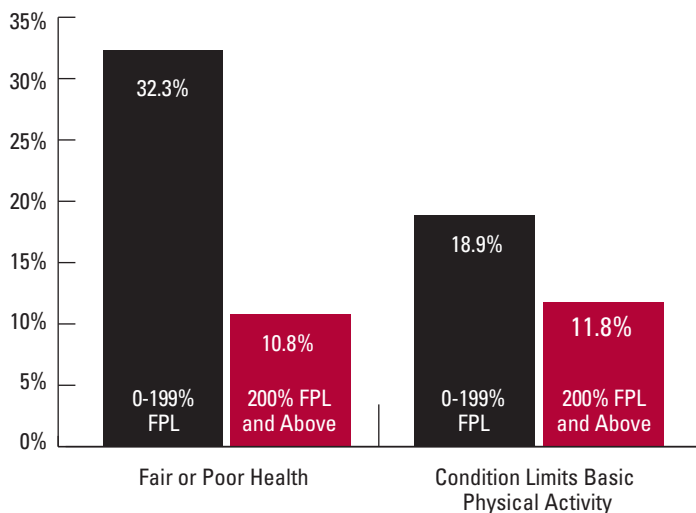
**Diabetes rate excludes gestational diabetes.

Source: 2005 California Health Interview Survey

2 Health condition prevalence is based on women reporting that they have ever been diagnosed with the condition.

3 While this section reports asthma prevalence rates for those ever diagnosed with asthma, the California Health Interview Survey also collects information on current asthma prevalence. In 2005, the current asthma rate for women ages 18-64 was 9.2%.

EXHIBIT 3: HEALTH STATUS AND FUNCTIONING BY FEDERAL POVERTY LEVEL, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

The diabetes prevalence among nonelderly women is 4.5% (505,000 women). Each successive age group has a higher prevalence rate, going from 1.3% of women ages 18-29 to 11% of women ages 55-64.

A diagnosis of heart disease was reported by 3.3% of nonelderly women or 368,000. The prevalence of heart disease doubles with each age group, beginning with 1.1% of women ages 18-29 and reaching 8.5% of women ages 55-64.

The lifetime prevalence of high blood pressure is 17.3% or 1.9 million nonelderly women. This high prevalence condition has a lifetime prevalence of 6.6% among women ages 18-29, which increases with each

4 Adler N, Newman K. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*. 2002; 21:60-76.

successive age group. One-quarter of women ages 45-54 and four in ten women ages 55-64 have been diagnosed with high blood pressure.

DIFFERENCES BY FAMILY INCOME

Health Status and Functioning

Lower socioeconomic status is linked to a wide range of health issues.⁴ Women with family incomes below 200% of the Federal Poverty Level (FPL) are three times as likely to report fair or poor health as women with family incomes above this level (32.3% vs. 10.8%; Exhibit 3). These differences by income hold across age groups: among women ages 18-44, the difference in fair or poor health between income groups is 25.3% vs. 7.4%; and for women ages 45-64 it is 50% vs. 15.6% (data not shown).

Low-income women are also more likely to report limits in their activity due to health problems. Nearly two in ten low-income women (18.9%) report a health condition that limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying, compared with 11.8% of higher income women.

Health Conditions

Exhibit 4 displays the rates of selected health conditions by family income for all nonelderly women and for women ages 45-64, the age group where health conditions are more prevalent.⁵

Among nonelderly women, those with family incomes below 200% FPL have higher rates of diabetes and heart disease; in contrast, arthritis, asthma and cancer rates are higher among women with family incomes of 200% FPL and above. Among women ages 45-64, those with

5 Health condition prevalence is based on health care provider diagnosis, which requires access to the health care system. Women with limited or inconsistent access to care, such as women with low incomes or who are uninsured, may be less likely to see a health care provider and therefore less likely to be diagnosed with a health condition.

EXHIBIT 4: HEALTH CONDITIONS BY FEDERAL POVERTY LEVEL, WOMEN AGES 18-64 AND 45-64, CALIFORNIA, 2005

DIAGNOSED HEALTH CONDITIONS*	Ages 18-64		Ages 45-64	
	<199% FPL	200% FPL and Above	<199% FPL	200% FPL and Above
ARTHRITIS	15.0%	17.0%	35.4%	30.1%
ASTHMA	11.9%	14.6%	15.0%	14.8%
CANCER	4.9%	6.6%	9.3%	11.0%
DIABETES**	6.4%	3.6%	13.6%	6.4%
HEART DISEASE	3.9%	2.9%	8.8%	5.1%
HIGH BLOOD PRESSURE	18.1%	16.9%	35.8%	29.0%

* Health condition is based on women reporting that they have ever been diagnosed with the condition.

**Diabetes rate excludes gestational diabetes.

Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

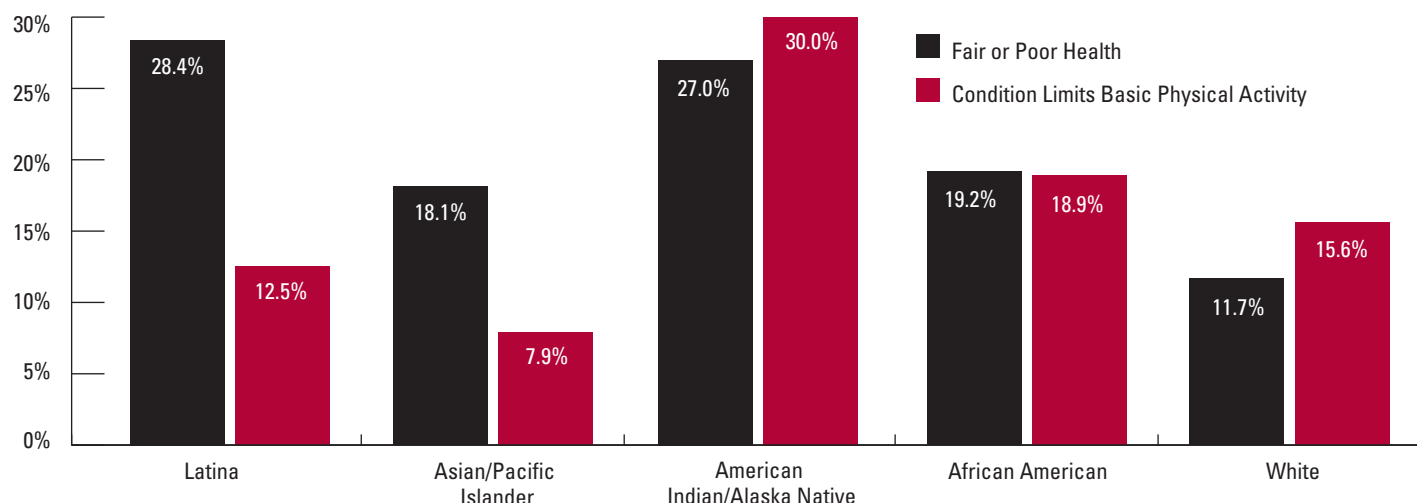
low incomes have higher rates of most health conditions compared with women with family incomes of 200% FPL and above: these include arthritis (35.4% vs. 30.1%); diabetes (13.6% vs. 6.4%); heart disease (8.8% vs. 5.1%); and high blood pressure (35.8% vs. 29%). The prevalence rates of asthma and cancer are statistically the same between lower and higher income women.

DIFFERENCES BY RACIAL/ETHNIC GROUP

Health Status and Functioning

Each race and ethnic group has higher reported rates of fair or poor health compared with white women (Exhibit 5). The highest rates of fair or poor health are reported by Latinas (28.4%) and American Indian/Alaska Native women (27%).

EXHIBIT 5: HEALTH STATUS AND FUNCTIONING BY RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Source: 2005 California Health Interview Survey

American Indian/Alaskan Native women also are the most likely to report having a health condition that limits one or more of the basic physical activities (30%). Next highest are African-American women, 18.9% of whom report limitations in their physical activities due to a health condition. Asian/Pacific Islander women are the least likely to report a limiting health condition (7.9%).

Health Conditions

As was seen with the general measures of health status, the prevalence of specific health conditions varies across racial/ethnic groups (Exhibit 6). Rates are presented for all nonelderly women and for women ages 45-64.

Arthritis

Arthritis affects a substantial percent of women in each racial/ethnic group. Among women ages 18-64, American Indian/Alaska Native women have the highest prevalence of arthritis with nearly one-third (32.5%) reporting this health condition. Approximately one in five African-American and white women report a diagnosis of arthritis in their lifetime, higher than the rate for Latinas and Asian/Pacific Islander women

(around one in ten report this condition). Among women ages 45-64, the prevalence of arthritis ranges from 18.2% of Asian/Pacific Islander women to 49.3% of American Indian/Alaska Native women.

Asthma

Many women in the state have been affected by asthma and there is considerable disparity in the prevalence of this health condition by race and ethnic group. Among women ages 18-64, the lifetime prevalence of asthma is highest among American Indian/Alaska Native women, with nearly three in ten (28.4%) reporting this health condition. This rate is 1.5 times higher than the prevalence for African-American and white women (17.7% and 17.1% respectively) and about three times as high as for Latina and Asian/Pacific Islander women (around 8%). Unlike other health conditions examined, the lifetime prevalence of asthma does not change markedly with age.

EXHIBIT 6: HEALTH CONDITIONS BY RACE/ETHNICITY, WOMEN AGES 18-64 AND 45-64, CALIFORNIA, 2005

DIAGNOSED HEALTH CONDITIONS*	Latina		Asian/Pacific Islander		American Indian/Alaska Native		African American		White	
	Ages 18-64	Ages 45-64	Ages 18-64	Ages 45-64	Ages 18-64	Ages 45-64	Ages 18-64	Ages 45-64	Ages 18-64	Ages 45-64
ARTHRITIS	9.8%	27.3%	9.1%	18.2%	32.5%	49.3%	20.4%	38.0%	21.3%	34.2%
ASTHMA	8.2%	10.3%	8.4%	6.5%	28.4%	30.7%	17.7%	18.8%	17.1%	17.2%
CANCER	3.3%	6.3%	1.6%	3.4%	11.0%	13.5%	5.0%	7.0%	9.0%	13.8%
DIABETES**	5.6%	13.4%	3.7%	8.7%	8.7%	14.4%	6.8%	12.7%	3.6%	5.8%
HEART DISEASE	2.4%	5.9%	2.8%	5.7%	3.8%	—	5.2%	8.3%	3.7%	5.9%
HIGH BLOOD PRESSURE	13.6%	29.9%	14.6%	29.0%	25.3%	39.0%	29.3%	53.8%	18.5%	28.5%

* Health condition is based on women reporting that they have ever been diagnosed with the condition.

**Diabetes rate excludes gestational diabetes.

Note: "—" = Estimate not reliable due to small sample size.

Source: 2005 California Health Interview Survey

Cancer

Cancer lifetime prevalence for women ages 18-64 ranges from 1.6% to 11%. American Indian/Alaska Native women and white women have the highest rates. Among women ages 45-64, the cancer prevalence ranges from 3.4% of Asian/Pacific Islander women to 13.5% for American Indian/Alaska Native women and 13.8% for white women. American Indian/Alaska Native women have higher rates than Asian/Pacific Islander women and Latinas. White women have higher rates than all other racial/ethnic groups except American Indian/Alaska Native women.

Diabetes

Among women ages 18-64, diabetes prevalence is higher for American Indian/Alaska Natives (8.7%), African Americans (6.8%) and Latinas (5.6%) than for whites and Asian/Pacific Islanders (each around 4%). Diabetes among women ages 45-64 shows a similar pattern, as prevalence rates range from 5.8% of white women to 14.4% of American Indian/Alaska Native women.

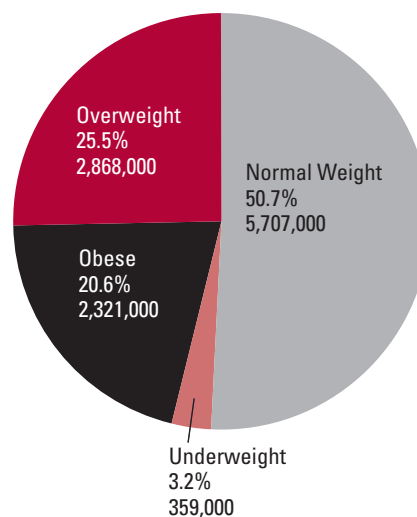
Heart Disease

Among all nonelderly women, the prevalence of diagnosed heart disease ranges from 2.4% of Latinas to 5.2% of African-American women. African-American women have a higher prevalence of heart disease than Latinas and Asian/Pacific Islander women. Rates among women ages 45-64 range from 5.7% to 8.3% with no significant differences among rates.

High Blood Pressure

Among women ages 18-64, approximately one in seven Latinas and Asian/Pacific Islander women, two in ten white women, and one-quarter or more of American Indian/Alaska Native and African-American women have been diagnosed with hypertension. Among women ages 45-64, at least one in three women in each race or ethnic group has been diagnosed with high blood pressure. African-American women have the highest prevalence with over one-half (53.8%) diagnosed with high blood pressure.

EXHIBIT 7: BODY MASS INDEX, WOMEN AGES 18-64, CALIFORNIA, 2005

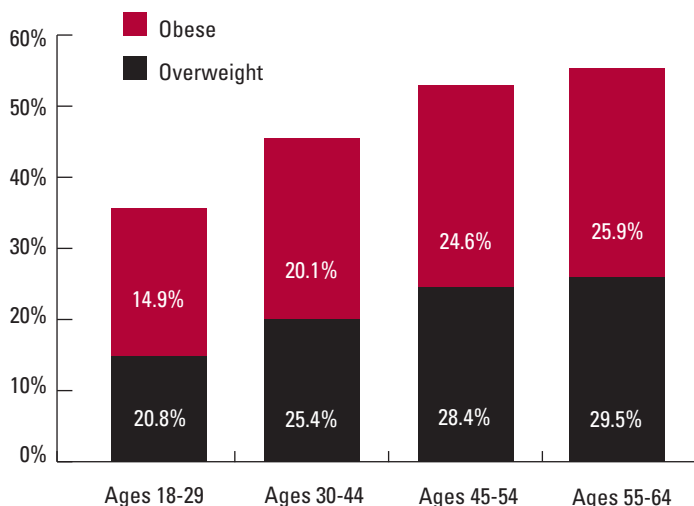


Notes: Body Mass Index (BMI) is based on self-reported height and weight. Underweight is defined as a BMI of under 18.5, normal weight is a BMI of 18.5-24.9, overweight is a BMI of 25.0-29.99, and obese is a BMI of 30 or above.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

EXHIBIT 8: PREVALENCE OF OVERWEIGHT AND OBESITY BY AGE GROUP, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: Body Mass Index (BMI) is based on self-reported height and weight. Overweight is defined as a BMI of 25.0-29.99 and obese is defined as a BMI of 30 or above.

Source: 2005 California Health Interview Survey

OBESITY AND OVERWEIGHT

Obesity is associated with several diseases and health conditions, such as hypertension, heart disease, diabetes, osteoarthritis and certain cancers.^{6,7,8}

Based on body mass measurement, one in five nonelderly women (20.6%) is obese, one in four (25.5%) is overweight, one-half are normal weight (50.7%) and 3.2% are underweight (Exhibit 7).⁹

Obesity prevalence increases with age (Exhibit 8). Women ages 18-29 have the lowest prevalence of obesity (14.9%). Obesity prevalence increases to 20.1% among women ages 30-44, 24.6% of women ages 45-54, and 25.9% among women ages 55-64. Women ages 18-29 are the only age group that saw a significant increase in obesity prevalence between 2001 and 2005 (from 12.4% to 14.9%).

While this report focuses on obesity prevalence, overweight is also a health concern, and in Exhibit 8 overweight prevalence is also provided for age groups. The proportion of women who are overweight follows a similar age-related pattern as obesity. The lowest rate is among women ages 18-29, one-fifth of whom are overweight. Overweight prevalence increases to 25.4% of women ages 30-44 and further increases to approximately three in ten women ages 45-64.

The combined prevalence of obesity and overweight is 35.7% for women ages 18-29; 45.5% for women ages 30-44; and over one-half of women ages 45-54 (53%) and 55-64 years of age (55.4%).

Obesity prevalence is negatively associated with family income and educational attainment (Exhibit 9). The lowest rates of obesity are among women with family incomes at 300% Federal Poverty Level (FPL) and above. Obesity prevalence among women with family incomes below 100% FPL is nearly double that of women with family incomes at 300% FPL and above (29.3% vs. 16.1%). Results are similar—and more

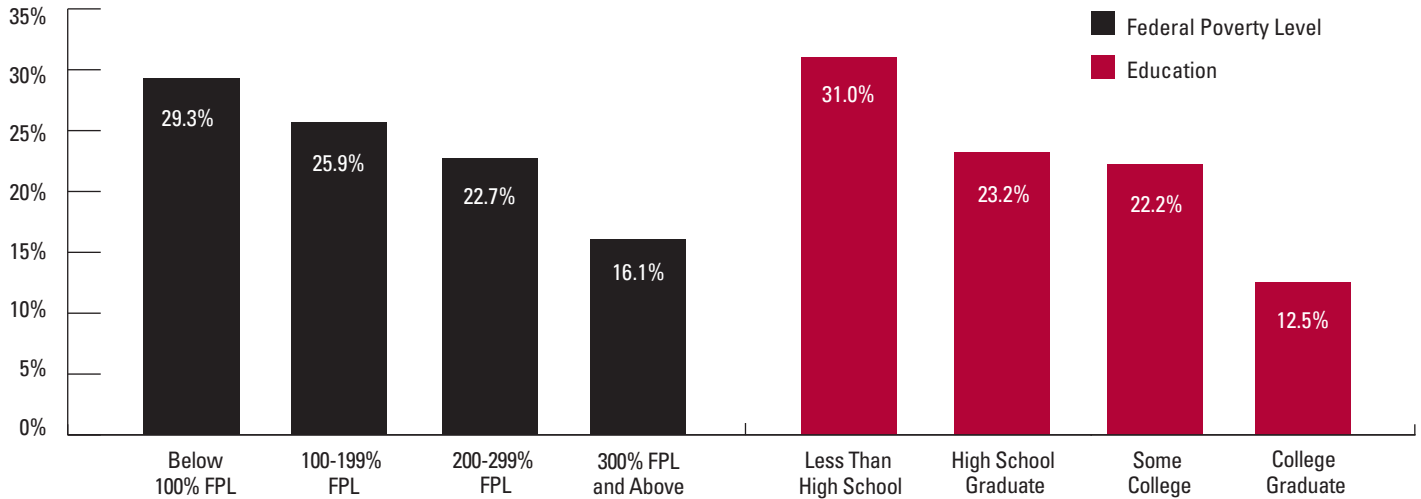
6 Must A, Spadano J, Coakley EH, Field AE, Colditz G, Dietz WH. The Disease Burden Associated with Overweight and Obesity. *JAMA*. 1999;282(16):1523-1529.

7 Mokdad AH, Serdula MK, Dietz WH, Bowman BA, Marks JS, Koplan JP. The Spread of the Obesity Epidemic in the United States, 1991-1998. *JAMA*. 1999;282(16):1519-1522.

8 National Task Force on the Prevention and Treatment of Obesity. Overweight, Obesity, and Health Risk. *Archives of Internal Medicine*. 2000;160(7):898-904.

9 Body mass index (BMI) is calculated by dividing weight in pounds by height in inches squared and multiplied by a conversion factor of 703 based on respondent's self report of height and weight. "Underweight" is defined as a BMI of under 18.5, "normal weight" is a BMI of 18.5-24.9, "overweight" is a BMI of 25.0-29.9, and "obese" is a BMI of 30.0 or above. Accessed at www.cdc.gov/nccdphp/dnpa/bmi/index.htm.

EXHIBIT 9: PREVALENCE OF OBESITY BY FEDERAL POVERTY LEVEL AND EDUCATION, WOMEN AGES 18-64, CALIFORNIA, 2005

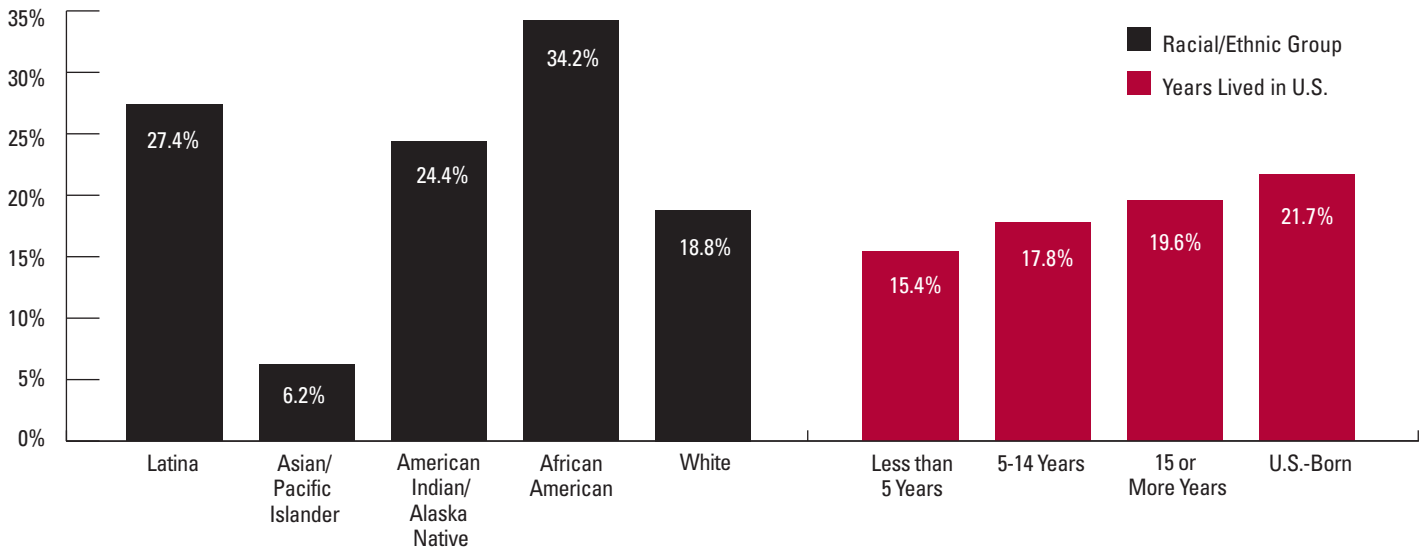


Notes: Body Mass Index (BMI) is based on self-reported height and weight. Obese is defined as a BMI of 30 or above.

The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

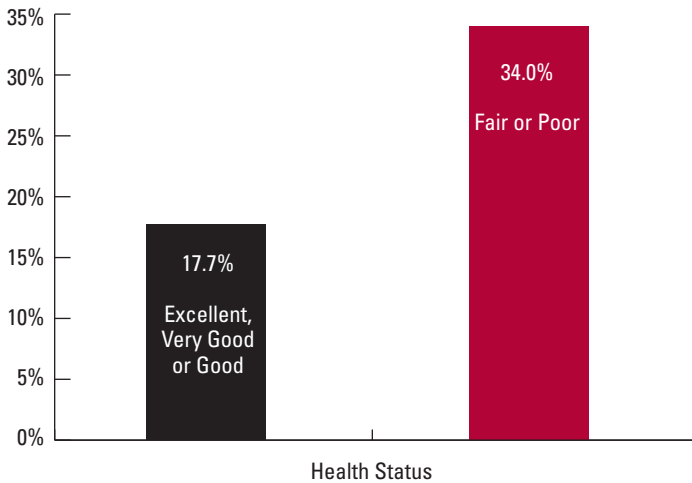
EXHIBIT 10: PREVALENCE OF OBESITY BY RACE/ETHNICITY AND YEARS LIVED IN THE UNITED STATES, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: Body Mass Index (BMI) is based on self-reported height and weight. Obese is defined as a BMI of 30 or above.

Source: 2005 California Health Interview Survey

EXHIBIT 11: PREVALENCE OF OBESITY BY HEALTH STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: Body Mass Index (BMI) is based on self-reported height and weight. Obese is defined as a BMI of 30 or above.

Source: 2005 California Health Interview Survey

striking—for educational attainment. Obesity is 2.5 times more prevalent among women who did not finish high school (31%) compared with women who completed college (12.5%).

Obesity prevalence varies significantly by race and ethnic group (Exhibit 10). African-American women have a higher prevalence of obesity (34.2%) than women in each of the other racial/ethnic groups. This is followed by Latinas and American Indian/Alaska Native women (whose rates are not statistically different at 27.4% and 24.4%, respectively), then 18.8% of white women and 6.2% of Asian/Pacific Islander women.

Women born in the U.S. have higher obesity rates (21.7%) than immigrant women (15.4-19.6%). There was no difference in obesity rates among immigrant women regardless of their length of time in the U.S.

Obesity prevalence varies significantly with self-reported health status. Among women who report good to excellent health, the obesity rate is 17.7%, compared to 34% among women who consider their health to be fair or poor (Exhibit 11).

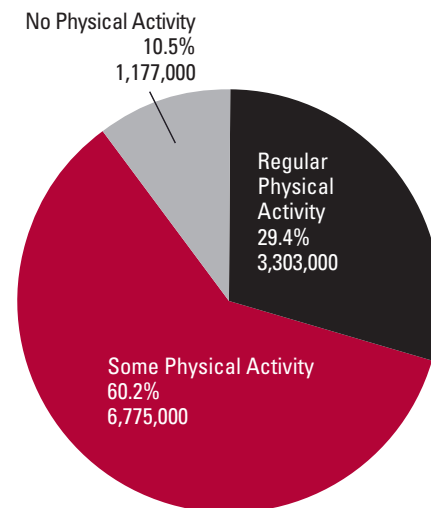
behaviors and activities

Selected Health Behaviors and Activities

The practice of health-promoting behaviors can have an enormous impact on health and can complement the provision of health care. Behaviors such as getting regular physical activity, avoiding cigarette smoke and drinking alcohol in moderation are instrumental in protecting health and preventing chronic disease. This section examines these health behaviors. Key findings include:

- One in three nonelderly women gets the recommended amount of regular physical activity while one in ten is inactive.
- About 1.4 million nonelderly women (12.8%) currently smoke cigarettes, a decrease from 2001 when 14.9% smoked.
- 5.3% of nonelderly women who do not smoke (nearly 520,000) are exposed to secondhand smoke in their homes. The highest rates of secondhand smoke exposure are for low- to middle-income women and Asian/Pacific Islander and African-American women.
- Nearly four in ten underage women ages 18-20 (38.8%) report drinking alcohol in the previous month.
- 12.3% of nonelderly California women engaged in binge drinking in the previous month, including 15.3% of women ages 18-20.

EXHIBIT 12: LEVEL OF PHYSICAL ACTIVITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: The "regular physical activity" group performed vigorous activity for at least 20 minutes on at least three days in the previous week, or at least 30 minutes of moderate activity/walking on at least five days. The "no physical activity" group did not engage in at least 10 minutes of walking, other moderate activity or vigorous activity in the previous week. The "some physical activity" group performed some physical activity but did not meet the criteria for "regular physical activity."

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

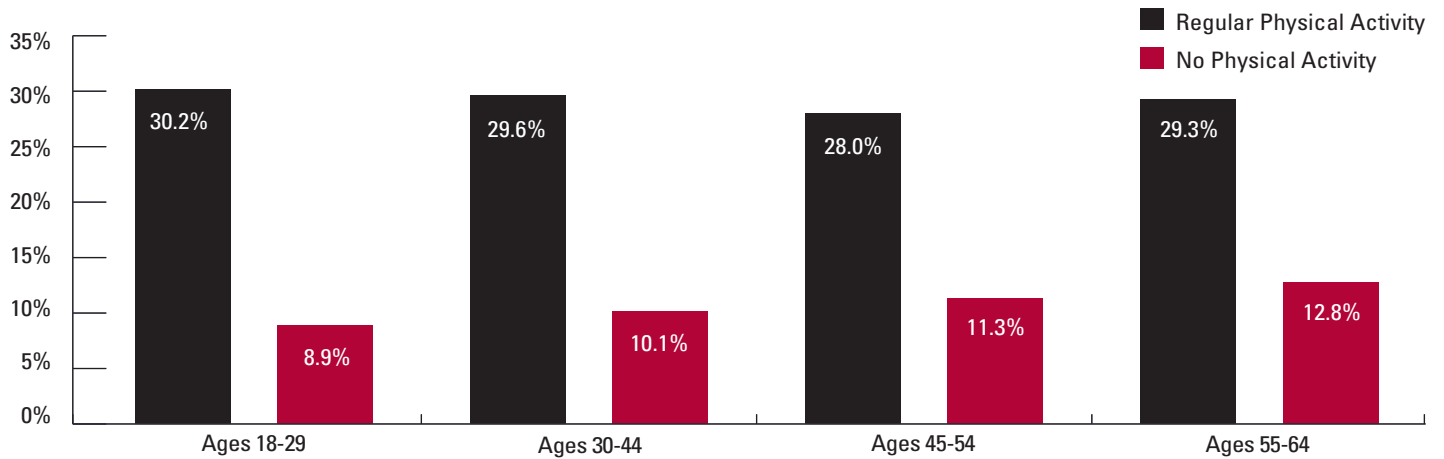
PHYSICAL ACTIVITY LEVELS

Regular physical activity is recommended to help improve cardiovascular health, prevent conditions such as diabetes, heart disease and osteoporosis, and to help maintain a healthy body weight.¹⁰ Approximately three in ten nonelderly California women (29.4%) get the recommended amounts of physical activity, referred to as "regular physical activity" (Exhibit 12).¹¹ Most women (60.2%) perform some activity for at least 10 minutes during the week, but do not meet physical activity guidelines, and one in ten (10.5%) get no physical activity (they do not get at least 10 minutes of physical activity at any one time during the week).

10 Centers for Disease Control. *Physical Activity and Health. A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, 1996.

11 Current guidelines recommend at least 30 minutes of moderate physical activity on at least five days each week, or at least 20 minutes of vigorous physical activity on at least three days each week. Accessed at <http://www.cdc.gov/nccdpp/dnpa/physical/recommendations/index.htm>.

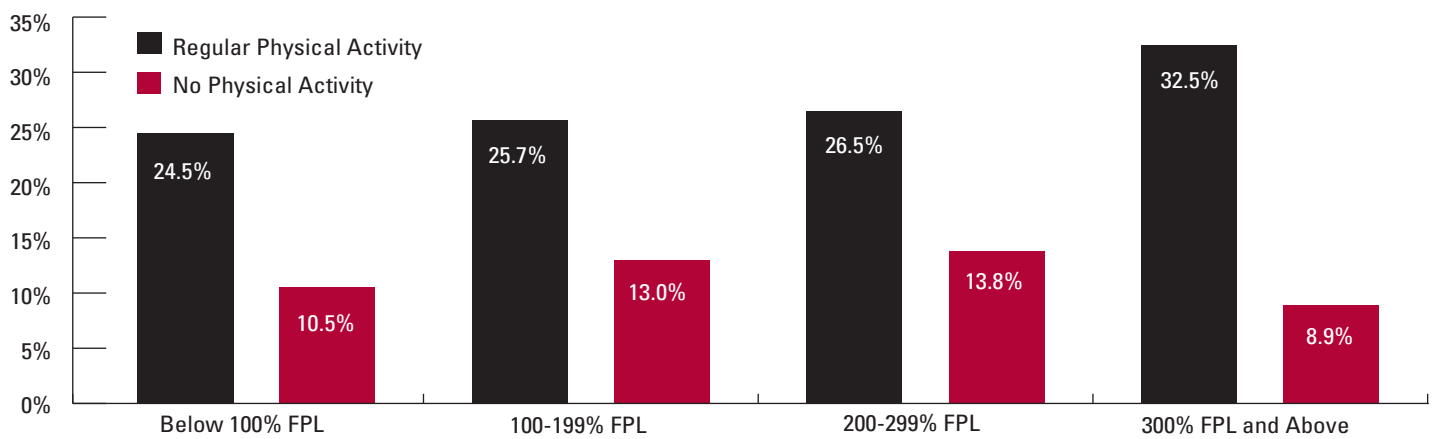
EXHIBIT 13: LEVEL OF PHYSICAL ACTIVITY BY AGE GROUP, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The "regular physical activity" group performed vigorous activity for at least 20 minutes on at least three days in the previous week, or at least 30 minutes of moderate activity/walking on at least five days. The "no physical activity" group did not engage in at least 10 minutes of walking, other moderate activity or vigorous activity in the previous week.

Source: 2005 California Health Interview Survey

EXHIBIT 14: LEVEL OF PHYSICAL ACTIVITY BY FEDERAL POVERTY LEVEL, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: The "regular physical activity" group performed vigorous activity for at least 20 minutes on at least three days in the previous week, or at least 30 minutes of moderate activity/walking on at least five days. The "no physical activity" group did not engage in at least 10 minutes of walking, other moderate activity or vigorous activity in the previous week.

The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

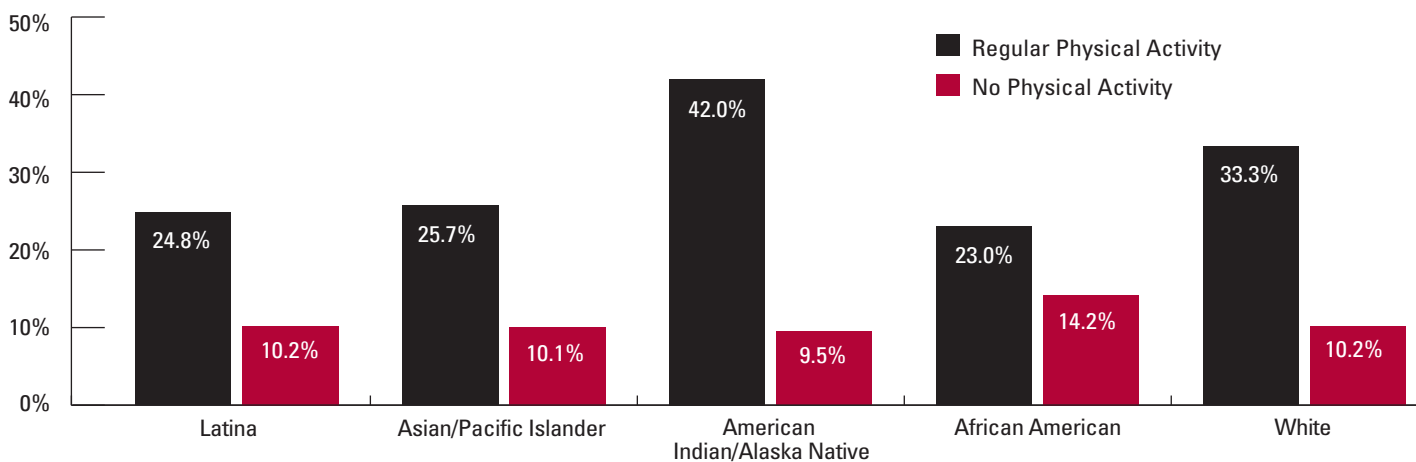
The proportion of women who engage in regular physical activity does not vary across age groups, but rather remains constant at approximately 29% (Exhibit 13). Even though middle-aged and older women have more health conditions and activity limitations, their regular activity level is similar to younger women. However, the prevalence of women performing no physical activity does vary by age, from 8.9% of women ages 18-29 to 12.8% of women ages 55-64.

Higher family income is associated with positive physical activity behaviors among nonelderly women (Exhibit 14). Among women with family incomes of at least 300% of the Federal Poverty Level, 32.5% get regular physical activity, significantly higher than for women with family incomes below this level (24.5-26.5%). Likewise, women with family incomes of at least 300% FPL have a

significantly lower prevalence of physical inactivity (8.9%) than women with family incomes from 100-299% FPL. Interestingly, women from the lowest-income families (less than 100% FPL) have a relatively low prevalence of physical inactivity (10.5%). This could be due to additional time spent walking for transportation among those from the lowest-income households.¹²

Physical activity levels vary significantly by racial/ethnic group (Exhibit 15). More than four in ten American Indian/Alaska Native women (42%) and one-third of white women (33.3%) report engaging in regular physical activity, rates significantly higher than for Latinas (24.8%), Asian/Pacific Islander women (25.7%), and African-American women (23%). African-American women have the highest prevalence of no physical activity (14.2%).

EXHIBIT 15: LEVEL OF PHYSICAL ACTIVITY BY RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005

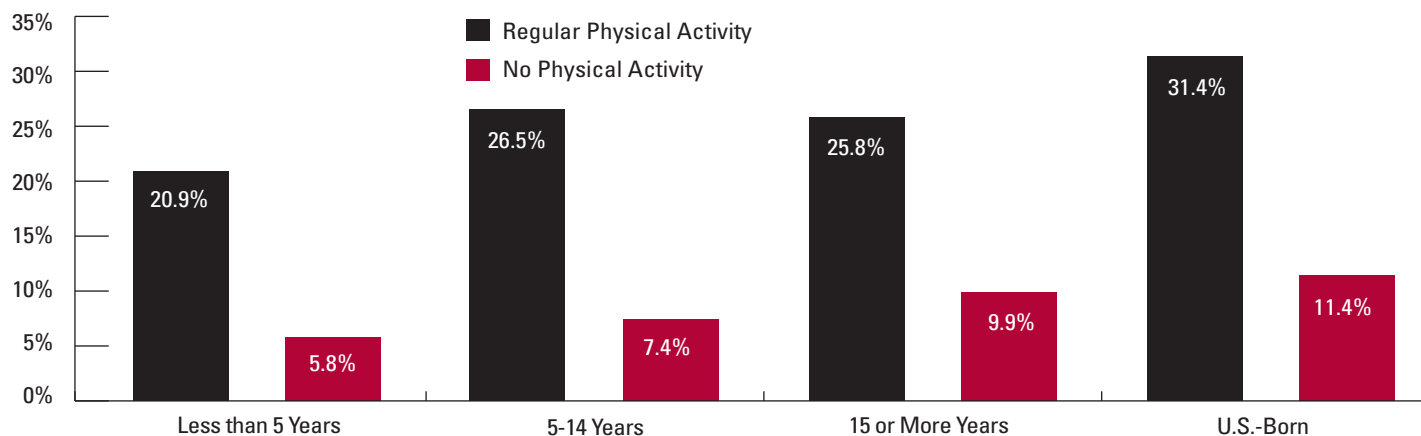


Note: The "regular physical activity" group performed vigorous activity for at least 20 minutes on at least three days in the previous week, or at least 30 minutes of moderate activity/walking on at least five days. The "no physical activity" group did not engage in at least 10 minutes of walking, other moderate activity or vigorous activity in the previous week.

Source: 2005 California Health Interview Survey

12 Brown ER, Babey SH, Hastert TA, Diamant AL. *Half of California Adults Walk Less Than One Hour Each Week*. Los Angeles, CA: UCLA Center for Health Policy Research, 2005.

EXHIBIT 16: LEVEL OF PHYSICAL ACTIVITY BY YEARS IN THE UNITED STATES, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The "regular physical activity" group performed vigorous activity for at least 20 minutes on at least three days in the previous week, or at least 30 minutes of moderate activity/walking on at least five days. The "no physical activity" group did not engage in at least 10 minutes of walking, other moderate activity or vigorous activity in the previous week.

Source: 2005 California Health Interview Survey

Additional time lived in the U.S. is associated with both a higher prevalence of regular physical activity and also a higher prevalence of no physical activity (Exhibit 16). Among U.S.-born women, 31.4% are regularly active, a higher rate than women who are immigrants (20.9-26.5%). Prevalence of no physical activity is also higher for U.S.-born women (11.4%) than for immigrant women who have been here for less than 15 years (5.8-7.4%). Women in the U.S. for 15 or more years have similar rates of no physical activity to U.S.-born women.

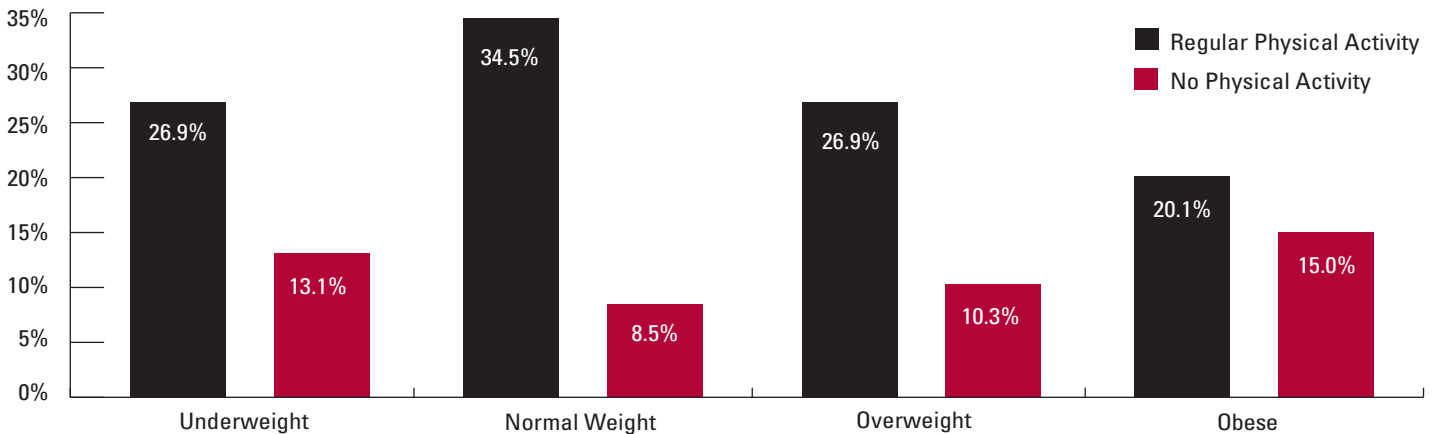
Weight status is significantly associated with physical activity levels (Exhibit 17). Among normal-weight women, 34.5% get regular physical activity, compared with 26.9% of overweight women and 20.1% of obese women. Likewise, only 8.5% of normal-weight women get no physical activity, compared to 10.3% of overweight women, 15% of obese women, and 13.1% of underweight women.

CIGARETTE SMOKING STATUS

Approximately one in eight nonelderly California women—about 1.4 million or 12.8%—currently smoke cigarettes, 17.8% are previous smokers, and the majority, 69.5%, report they never smoked regularly (Exhibit 18). The proportion of women who currently smoke has decreased since 2001, when 14.9% of nonelderly women smoked.

The proportion of current smokers is similar across age groups (Exhibit 19). However, as age increases so does the number of women who report that they quit smoking, increasing from 8.9% among women ages 18-29 to 30.9% among women ages 55-64. Women ages 18-29 are the most likely to report that they never smoked regularly (79%), and the prevalence of never smoking regularly decreases with each successive age group, reaching 56.5% among women ages 55-64. This likely indicates that over time, anti-smoking campaigns

EXHIBIT 17: LEVEL OF PHYSICAL ACTIVITY BY BODY MASS INDEX, WOMEN AGES 18-64, CALIFORNIA, 2005



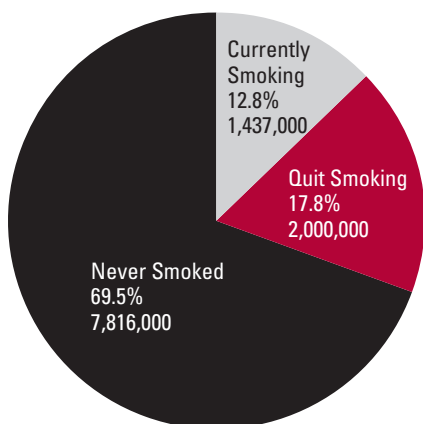
Notes: The "regular physical activity" group performed vigorous activity for at least 20 minutes on at least three days in the previous week, or at least 30 minutes of moderate activity/walking on at least five days. The "no physical activity" group did not engage in at least 10 minutes of walking, other moderate activity or vigorous activity in the previous week.

Body Mass Index (BMI) is based on self-reported height and weight. Obese is defined as a BMI of 30 or above.

Source: 2005 California Health Interview Survey

have been successful at encouraging women who smoked to quit smoking, while also discouraging younger women from ever becoming smokers. It is also significant to note the lifetime smoking experience of women in the middle-age groups: over one-third of women ages 45-54 (36.8%) and over four in ten ages 55-64 (43.5%) either currently smoke or did so at some point in their lifetime.

EXHIBIT 18: SMOKING STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005

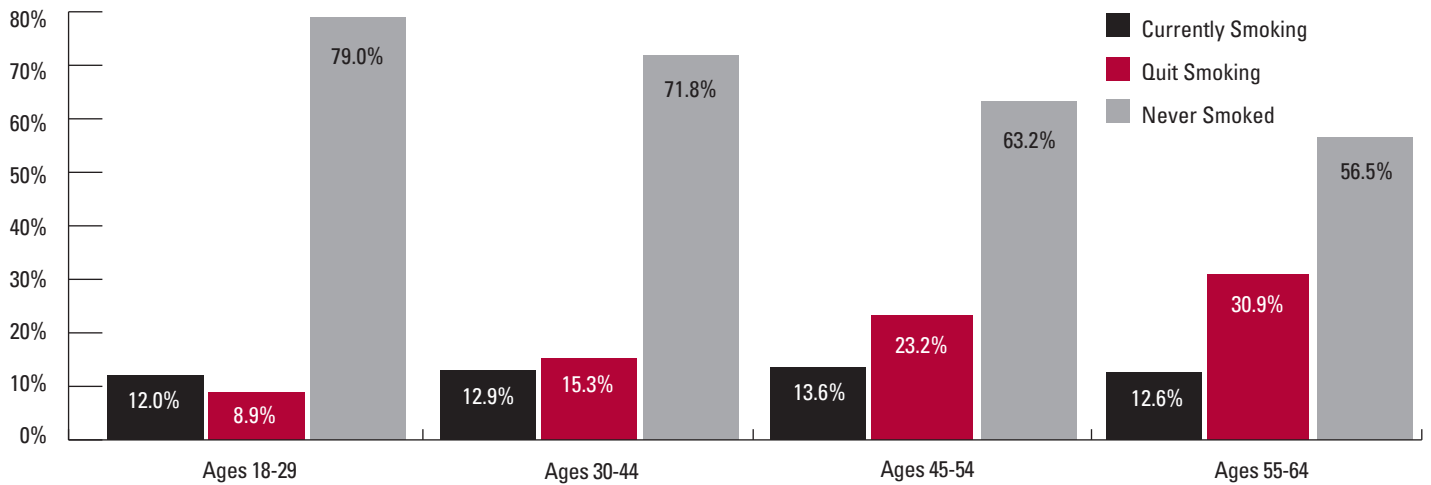


Note: Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

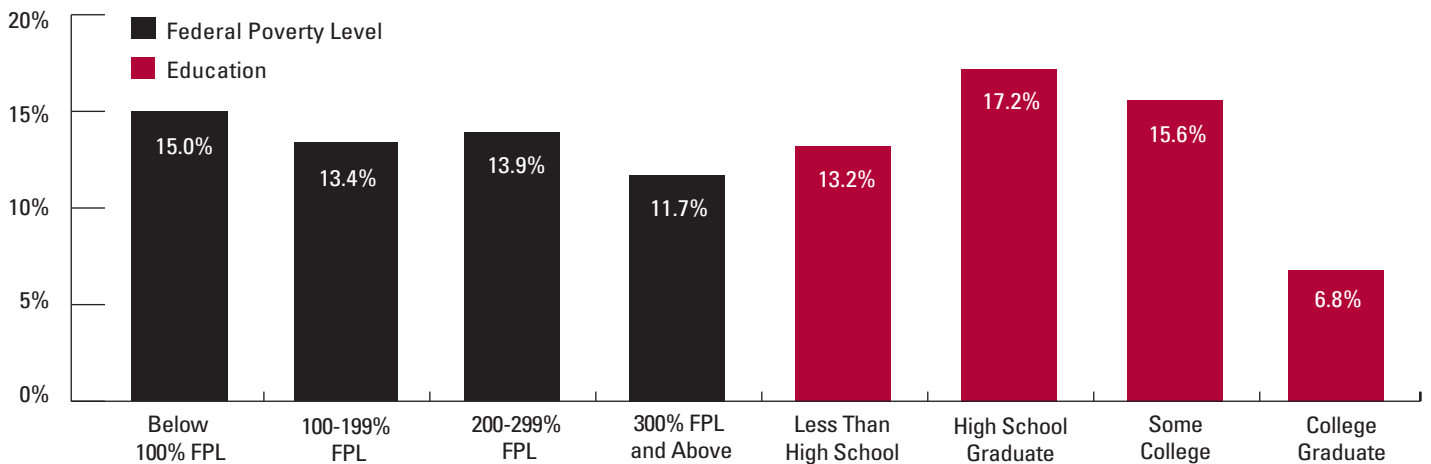
Compared to women with family incomes of 300% FPL or above, women with family incomes below 100% FPL and those with family incomes of 200-299% FPL are more likely to smoke (Exhibit 20). Women with family incomes of 100-199% FPL have similar rates of smoking as women with higher incomes. The relationship between smoking and education is similarly inconsistent. Prevalence of current smoking is lower in women with college degrees (6.8%) compared with women with less educational attainment (13.2-17.2%). However, women with less than a high school education also are less likely to smoke than women who are high school graduates or have completed some college coursework.

EXHIBIT 19: SMOKING STATUS BY AGE GROUP, WOMEN AGES 18-64, CALIFORNIA, 2005



Source: 2005 California Health Interview Survey

EXHIBIT 20: CURRENT SMOKER BY FEDERAL POVERTY LEVEL AND EDUCATION, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

EXHIBIT 21: CURRENT SMOKER BY RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005

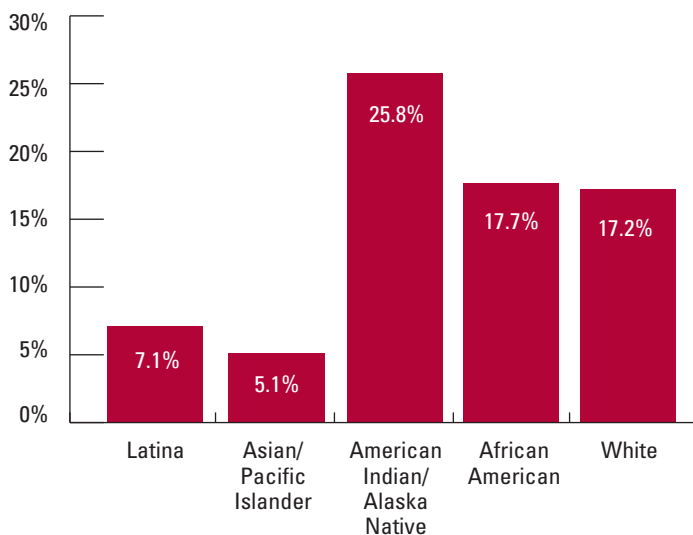
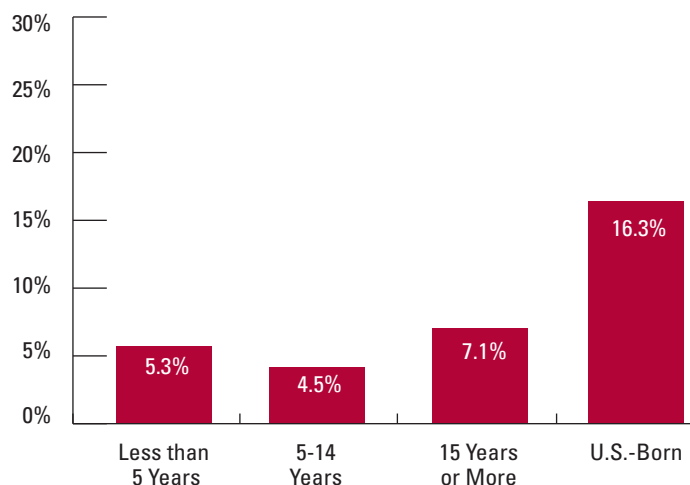


EXHIBIT 22: CURRENT SMOKER BY YEARS IN THE UNITED STATES, WOMEN AGES 18-64, CALIFORNIA, 2005



Source: 2005 California Health Interview Survey

Source: 2005 California Health Interview Survey

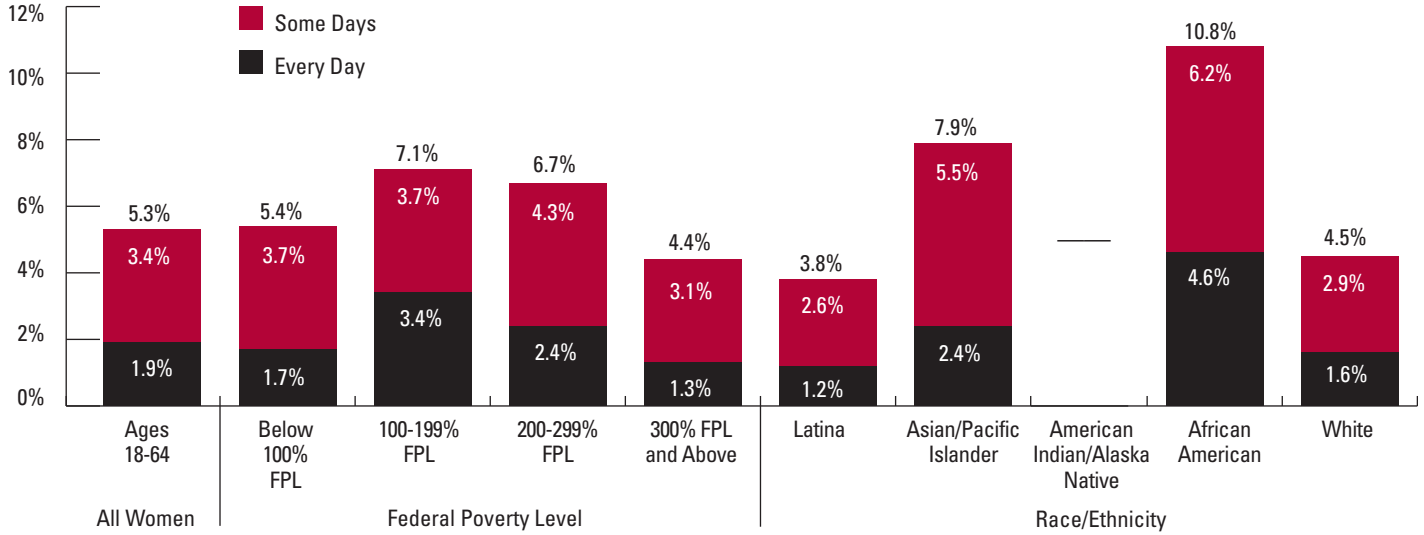
There is a five-fold difference in smoking prevalence across racial/ethnic groups (Exhibit 21). Approximately one-quarter of American Indian/Alaska Native women smoke (25.8%). This prevalence is higher than for African-American women (17.7%), white women (17.2%), Latinas (7.1%), and Asian/Pacific Islander women (5.1%). Also, white and African-American women are more likely to smoke than Latinas and Asian/Pacific Islander women.

Smoking rates vary among women by their immigration status (Exhibit 22). More than twice as many U.S.-born women smoke (16.3%) compared with women born outside of the U.S. Rates are quite low for immigrant women, ranging from 4.5% among women in the U.S. for 5-14 years to 7.1% among immigrant women in the U.S. for 15 years or more.

Exhibit 23 displays the proportion of women who do not smoke but are exposed to secondhand tobacco smoke at home either some days or every day in a typical week. Secondhand smoke exposure has several adverse health effects.¹³ Nearly 520,000 women (5.3% of those who do not currently smoke) are exposed to environmental tobacco smoke in their homes on at least some days each week. Women with family incomes between 100-199% FPL and 200-299% FPL have higher rates of secondhand smoke exposure in their homes than women with family incomes at or above 300% FPL. A higher proportion of African-American and Asian/Pacific Islander women who do not smoke are exposed to secondhand smoke in their homes compared with Latinas and white women. This is especially notable for Asian/Pacific Islander women who have low smoking rates, but are still at risk for health problems because of their relatively high exposure to secondhand smoke in the home.

13 U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006.

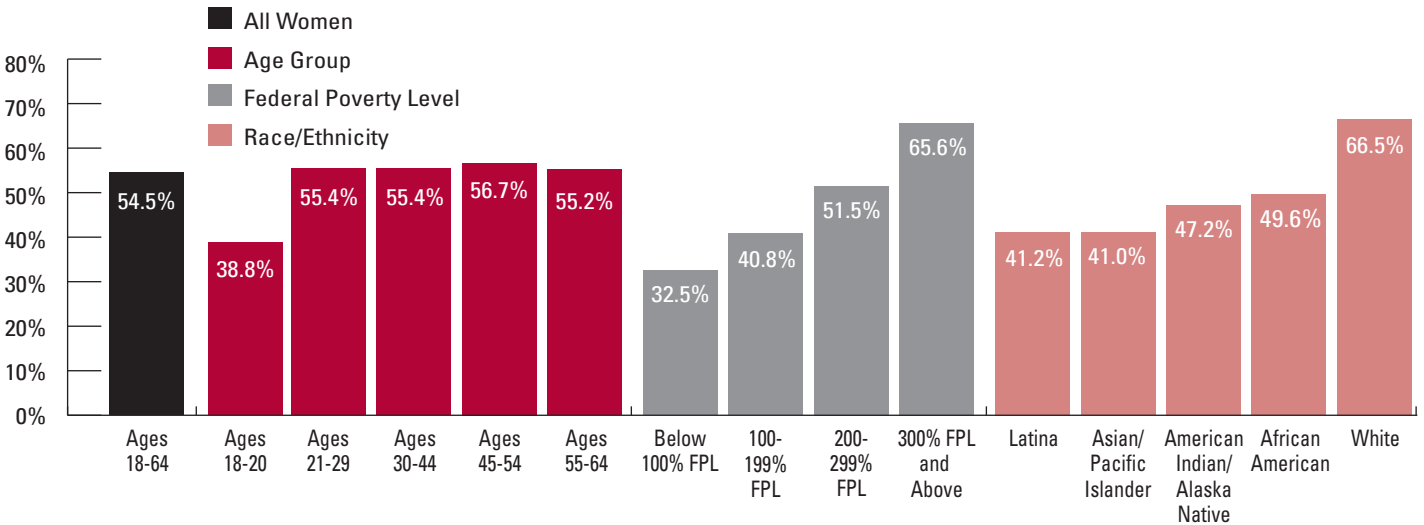
EXHIBIT 23: PREVALENCE OF SECOND-HAND SMOKE IN THE HOME EVERY DAY AND SOME DAYS DURING THE WEEK AMONG WOMEN WHO DO NOT SMOKE, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.
 "—" = Estimate not reliable due to small sample size.

Source: 2005 California Health Interview Survey

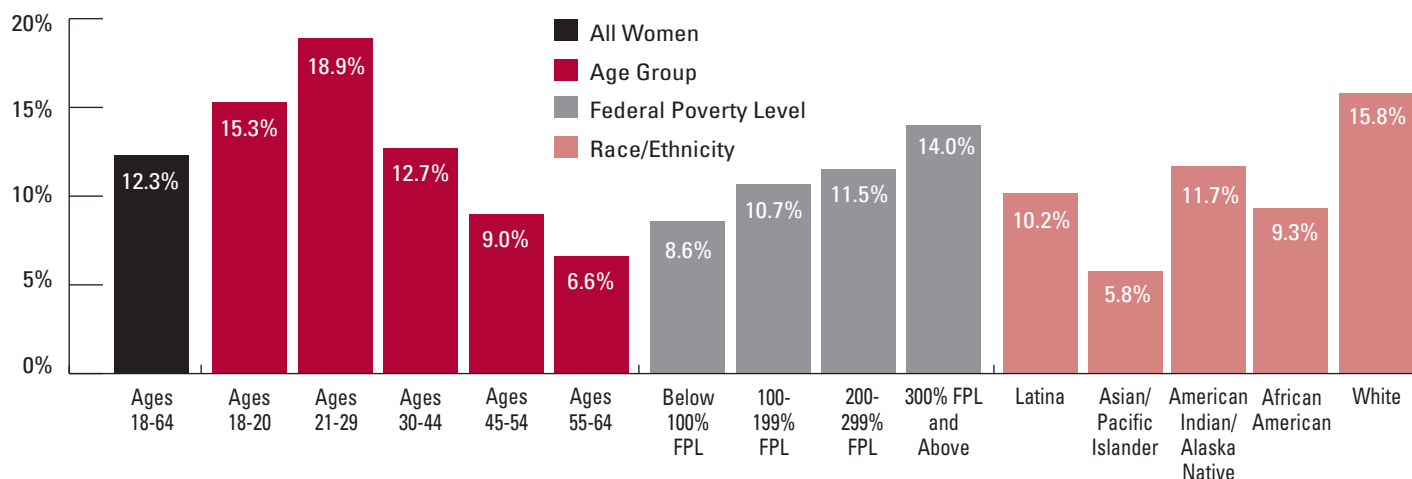
EXHIBIT 24: PREVALENCE OF HAVING ONE OR MORE DRINKS IN THE PAST 30 DAYS BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

EXHIBIT 25: PREVALENCE OF BINGE DRINKING IN THE PAST 30 DAYS BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

ALCOHOL USE

More than one-half of California nonelderly women (54.5%) had at least one alcoholic beverage in the previous 30 days (Exhibit 24). Prevalence of consuming alcohol did not vary by age for women legally old enough to drink, with approximately 55% of all women ages 21-64 consuming at least one alcoholic drink in the previous 30 days. Among women ages 18-20, 38.8% reported drinking alcohol in the previous 30 days; a high rate in a population that is not legally allowed to purchase or possess alcohol. Underage drinking has been identified as a major public health concern.¹⁴

Rates of alcohol use in the previous month are positively associated with family income. Twice as many women with family incomes at or above 300% of the Federal Poverty Level drink alcohol compared to women living below the poverty line (65.6% vs. 32.5%). Also, a higher proportion of white women consumed alcohol in the previous month (66.5%) compared with women from the other racial/ethnic groups (41-49.6%).

BINGE DRINKING

Among all nonelderly California women, 12.3% report binge drinking in the past 30 days (Exhibit 25).¹⁵ Binge drinking has been associated with several health problems, such as unintentional and intentional injury, alcohol poisoning, cardiovascular health problems and liver disease.¹⁶ Although alcohol consumption does not vary with age among women 21 and older, binge drinking steadily declines with age from 18.9% for women ages 21-29 to 6.6% among women ages 55-64.

14 U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking*. Office of the Surgeon General, 2007.

15 The National Institute of Alcohol Abuse and Alcoholism defines binge drinking as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams percent or above. This usually occurs when women consume four or more drinks in about two hours, Centers for Disease Control and Prevention, Quick Stats Binge Drinking, accessed at www.cdc.gov/alcohol/quickstats/binge_drinking.htm. The 2005 California Health Interview Survey asks about number of drinks consumed "on one occasion" rather than within a two-hour period.

16 Centers for Disease Control and Prevention. Quick Stats Binge Drinking, accessed at www.cdc.gov/alcohol/quickstats/binge_drinking.htm.

Notably, women ages 18-20 have the second highest prevalence of binge drinking (15.3%) even though they are not legally allowed to purchase or possess alcohol. As with prevalence of alcohol consumption in the previous thirty days, prevalence of binge drinking is also highest among white women (15.8%) and higher income women (14%).

health insurance

Health Insurance Coverage

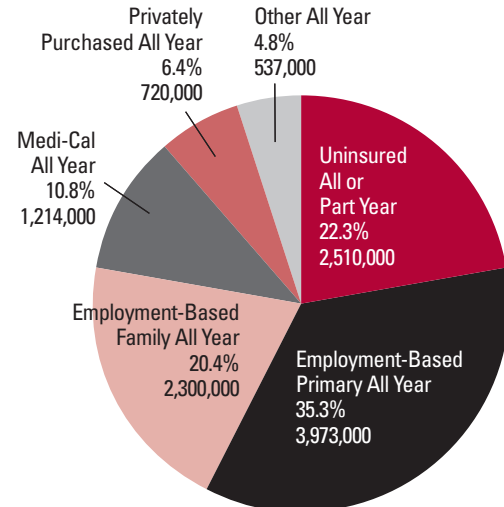
Health insurance coverage is a key component of access to the health care system. Studies have shown a strong association between health insurance and access to primary and preventive care, treatment of acute health issues and management of chronic health conditions.¹⁷ Key findings include:

- 22.3% of nonelderly women—2.5 million—were uninsured for all or part of 2005.
- Many women face a disproportionate risk of being uninsured. Uninsured rates are higher for women with low incomes, Latinas, non-citizens, single women, those whose health is fair or poor and younger women.
- The majority of uninsured women are low income (62.6%), but lack of coverage affects all income groups. Nearly one-quarter of uninsured women have family incomes 300% or more of the Federal Poverty Level.
- The proportion of women with employment-based coverage through a family member has declined between 2001 and 2005, from 23.2% to 20.4%.

Among women ages 18-64, nearly one-quarter (22.3% or 2.5 million nonelderly women) were uninsured for all or part of 2005 (Exhibit 26): 16.1% were uninsured at the time of the survey (currently uninsured); and an additional 6.2% had coverage when interviewed, but were uninsured at some point in the previous year.

Employment-based coverage is the main coverage source for women. Slightly more than one-half of nonelderly women (55.7% or nearly 6.3 million) were insured through this source: slightly over one-third (35.3%) have coverage through their own employer (primary coverage); and 20.4% are covered through a family member (dependent or family coverage). Medi-Cal, California's Medicaid program, also plays an important role for women in the state. One in ten women (10.8%) received Medi-Cal for the entire year in 2005. Privately-purchased coverage, which can be an expensive insurance option, covered 6.4%. And 4.8% of women had other forms of coverage, such as CHAMPUS, VA and Medicare, or combinations of coverage.

EXHIBIT 26: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: Other coverage includes CHAMPUS, VA and Medicare, as well as any combination of insurance sources over the last 12 months during which the person was never uninsured.

The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

17 Hoffman C and Paradise J. Health Insurance and Access to Health Care in the United States. *Annals of the New York Academy of Sciences*. 2008; 1-12.

EXHIBIT 27: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY AGE GROUP, WOMEN AGES 18-64, CALIFORNIA, 2005

AGE GROUP	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
AGES 18-29	33.7%	38.4%	14.6%	7.2%	6.1%	100%
AGES 30-44	21.1%	59.5%	10.6%	5.0%	3.8%	100%
AGES 45-54	17.2%	63.9%	7.8%	6.7%	4.4%	100%
AGES 55-64	13.1%	64.6%	8.9%	8.1%	5.4%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Source: 2005 California Health Interview Survey

Numbers may not add to 100% due to rounding.

EXHIBIT 28: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY FEDERAL POVERTY LEVEL, WOMEN AGES 18-64, CALIFORNIA, 2005

FEDERAL POVERTY LEVEL	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
BELOW 100% FPL	44.0%	9.8%	39.2%	2.3%	4.7%	100%
100-199% FPL	41.0%	30.3%	18.3%	4.6%	5.8%	100%
200-299% FPL	25.3%	53.9%	6.8%	6.8%	7.2%	100%
300% FPL AND ABOVE	9.7%	76.9%	1.5%	8.0%	3.9%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

EXHIBIT 29: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005

RACE/ETHNICITY	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
LATINA	39.3%	37.6%	16.3%	2.3%	4.4%	100%
ASIAN/PACIFIC ISLANDER	20.9%	59.7%	8.0%	6.9%	4.5%	100%
AMERICAN INDIAN/ALASKA NATIVE	21.2%	46.7%	25.0%	—	—	100%
AFRICAN AMERICAN	19.2%	49.4%	22.0%	2.4%	7.0%	100%
WHITE	13.4%	66.1%	6.4%	9.3%	4.8%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

“—” = Estimate not reliable due to small sample size.

Source: 2005 California Health Interview Survey

Numbers may not add to 100% due to rounding.

VARIATION IN INSURANCE COVERAGE RATES

The proportion of women uninsured decreases by age group. One-third—or 991,000—women ages 18-29 were uninsured for all or part of 2005 (Exhibit 27). These young adults have the highest uninsured rate of any age group. One-fifth of women ages 30-44—nearly 867,000—lack insurance, the second highest uninsured rate by age group. And while uninsured rates decline further among women age 45 and over, still 17.2% of women 45-54 years old (425,000 women) and 13.1% of women ages 55-64 (227,000) were uninsured for all or part of the year.

Differences in employment-based coverage account for some of the variation in uninsured rates. The lowest rate of employment-based coverage is among young women, with not quite four in ten covered through this source. The proportion with employment-based coverage rises sharply to six in ten women ages 30-44 (59.5%) and slightly over six in ten women age 45 and above.

Medi-Cal covers 14.6% of women ages 18-29, preventing ever higher uninsured rates in this age group. Rates of Medi-Cal decrease by age group and then stabilize among women age 45 and over.

Whether or not a woman has coverage, and the source of that coverage, varies by family income. Women with low incomes are the most likely to be uninsured (Exhibit 28). Over four in ten women (44%) with family incomes below the Federal Poverty Level and 41% of women who are near-poor (100-199% FPL) were uninsured for all or part of 2005, four times the rate of women with family incomes at 300% FPL and above. And one-quarter of women with family incomes of 200-299% FPL were uninsured for all or part of 2005.

The proportion of women covered through employment-based coverage increases as family income increases. Only a small portion of women with family

incomes below poverty (9.8%) have employment-based coverage. Coverage rates increase for women with family incomes of 100-199% FPL, yet still only 30.3% of women in this income group have this form of coverage. Among women with modest family incomes of 200-299% FPL, slightly over one-half (53.9%) are covered by employment-based insurance. Women with family incomes at 300% FPL and above have the best employment-based coverage rates, with 76.9% covered through this source.

Medi-Cal prevents the income-related gap in coverage from being even larger, by covering women with limited incomes. Medi-Cal covers four in ten women with family incomes below poverty and a smaller portion of women with family incomes of 100-199% of poverty, still leaving many women with limited resources without coverage.

Differences in access to employment-based coverage, and variations in Medi-Cal and privately purchased coverage, are associated with disparities in insured rates among women by racial/ethnic group (Exhibit 29). Uninsured rates are higher for women of color than for white women. Latinas have the highest uninsured rate with nearly four in ten (39.3%) uninsured all or part year, three times the rate of white women (13.4%). Approximately two in ten Asian/Pacific Islander, African-American, and Alaskan Native/American Indian women were uninsured all or part of the year.

White women have the highest level of employment-based coverage of any group (66.1%) and Latinas the lowest (37.6%). Rates of employment-based insurance for other groups fall in-between—Asian/Pacific Islander women (59.7%), African-American women (49.4%) and American Indian/Alaska Native women (46.7%). There are also differences across groups in the source of their employment-based coverage. Approximately four in ten Asian/Pacific Islander women (38.4%), African-American women (40.7%),

EXHIBIT 30: UNINSURED ALL OR PART YEAR BY ASIAN ETHNIC GROUPS, WOMEN AGES 18-64, CALIFORNIA, 2005

ETHNIC SUBGROUPS	Uninsured All or Part Year
CHINESE	17.4%
FILIPINO	18.7%
SOUTH ASIAN	17.6%
KOREAN	38.1%
VIETNAMESE	24.0%

Note: Information reported for subgroups where there was sufficient sample size.
Source: 2005 California Health Interview Survey

and white women (41.3%) have primary coverage in their own name (as the primary policyholder through their own work) compared with approximately two in ten Latinas (22.6%) and American Indian/Alaska Native women at 23.6% (data not shown).

Medi-Cal provides an important safety net for women across all racial/ethnic groups, but plays more of a role for Latinas, American Indian/Alaska Native women, and African-American women with from 16.3-25% receiving this benefit. Privately-purchased coverage, which is often expensive, covers fewer than 10% of women in each racial/ethnic group. Asian/Pacific Islander and white women are the most likely to have this coverage source.

A closer look at Asian women and Latinas identifies some subgroup differences in insurance coverage often masked by aggregating them together. Korean women—38.1% of whom were uninsured for all or part of 2005—had higher uninsured rates than women in the other groups (Exhibit 30). Approximately one-quarter of Vietnamese women, 17.4% of Chinese women, 18.7% of Filipino women and 17.6% of South Asian women were uninsured for all or part of 2005. Sample sizes were too small to report information for other groups.

EXHIBIT 31: UNINSURED ALL OR PART YEAR BY LATINA ETHNIC GROUPS, WOMEN AGES 18-64, CALIFORNIA, 2005

ETHNIC SUBGROUPS	Uninsured All or Part Year
MEXICAN	38.3%
SALVADORAN	46.3%
GUATEMALAN	36.6%
SOUTH AMERICAN	35.1%

Note: Information reported for subgroups where there was sufficient sample size.
Source: 2005 California Health Interview Survey

Over four in ten Salvadoran women (46.3%), and over one-third of Mexican, Guatemalan and South American women (38.3%, 36.6% and 35.1%, respectively) were without coverage for all or part of 2005 (Exhibit 31). Despite apparent differences, rates were statistically similar due to small sample sizes.

California is unique from many other states in its mix of immigrants and U.S.-born women. Two-thirds of nonelderly women are U.S.-born, 16% are naturalized citizens, and approximately 18% are non-citizens. Women who are non-citizens have a higher rate of uninsurance and lower rate of job-based coverage than women in the other citizen groups (Exhibit 32). Non-citizen women—46.5% of whom were uninsured all or part of the year in 2005—are nearly three times as likely as U.S.-born women (15.9%) and twice as likely as women who are naturalized citizens (20.9%) to be uninsured. This reflects their more limited access to employment-based coverage. Non-citizen women are half as likely as naturalized citizens and U.S.-born women to have employment-based coverage (29.4% vs. 59.5% and 62.2%, respectively).

A further factor that affects women's access to insurance coverage is family structure. In California, 10.4% of nonelderly women are single mothers, 31.4%

EXHIBIT 32: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY CITIZENSHIP STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005

CITIZENSHIP STATUS	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
U.S.-BORN CITIZEN	15.9%	62.2%	9.5%	7.3%	5.1%	100%
NATURALIZED CITIZEN	20.9%	59.5%	9.0%	6.4%	4.2%	100%
NON-CITIZEN	46.5%	29.4%	16.9%	3.0%	4.3%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

are single with no children, 36.4% are married mothers, and 21.9% are married with no children. Single women, with or without children, have higher uninsured rates and lower job-based coverage rates than women who are married (Exhibit 33). Slightly over one-quarter of single mothers (26.2%) were uninsured for all or part of 2005. They are less likely than other women to be covered through employment-based insurance (37.7%). Medi-Cal plays a crucial role for these women who head their households, covering 29.3% of them. Single women without children have uninsured rates (27.5%) comparable to single mothers. Yet their employment-based coverage rates are higher and they are less likely to receive Medi-Cal, because of eligibility requirements.

Exhibit 34 displays information on coverage rates by work status. Women not in the labor force are more likely to be uninsured (27.4%) than women who work either part time or full time.¹⁸ They also have the lowest rate of employment-based coverage (40.1%) and the highest rate of Medi-Cal.

Women who work part time have higher uninsured rates than full-time workers (23.6% vs. 17.5%). They also have lower rates of employment-based coverage than women who work full time (52.2% vs. 69.6%). Privately-purchased coverage (10.4%) and Medi-Cal (9.3%) augment the coverage of women who work part time.

EXHIBIT 33: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY FAMILY STRUCTURE, WOMEN AGES 18-64, CALIFORNIA, 2005

FAMILY STRUCTURE	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
SINGLE MOTHERS	26.2%	37.7%	29.3%	2.7%	4.1%	100%
SINGLE, NO CHILDREN	27.5%	47.2%	10.4%	9.0%	6.0%	100%
MARRIED MOTHERS	21.5%	59.0%	10.5%	5.0%	4.0%	100%
MARRIED, NO CHILDREN	14.4%	71.2%	3.0%	6.7%	4.7%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

18 Part time is defined as working fewer than 40 hours per week and full time is 40 or more hours per week.

EXHIBIT 34: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY WORK STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005

WORK STATUS	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
FULL TIME	17.5%	69.6%	5.5%	3.8%	3.6%	100%
PART TIME	23.6%	52.2%	9.3%	10.4%	4.6%	100%
NOT EMPLOYED	27.4%	40.1%	19.1%	6.8%	6.5%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

Women who report their health as fair or poor have a different pattern of health insurance coverage than women in better health (reported as excellent, very good, or good). Women in fair or poor health are more likely to be uninsured (33.1%) than women whose health is better (20%; Exhibit 35). Also, women in fair or poor health are nearly half as likely to have employment-based coverage (34.2% vs. 60.4%) and rely more on public programs such as Medi-Cal (22.9%) and other coverage sources (7.1%). The majority of women in fair or poor health are low income (nearly six in ten), and unlikely to be able to afford privately-purchased coverage.

Exhibit 36 displays the uninsured rate among women with specific diagnosed health conditions, ranging from 14.8% of women with arthritis to 22.5% of those with diabetes. For women requiring ongoing management

and follow-up for health conditions, the lack of coverage exposes them to financial burden.

CHANGES IN COVERAGE BETWEEN 2001 AND 2005

Exhibit 37 shows the changes in women's health insurance coverage between 2001 and 2005. During this four-year period, the proportion of women uninsured for all or part of the year decreased, going from 24.6% in 2001 to 22.3% in 2005. During this time period other coverage sources increased from 3.5% to 4.8%.

The proportion of women with employment-based coverage in their own name (primary coverage) increased from 31.3% in 2001 to 35.3% in 2005, while the proportion with dependent coverage (also referred to as family coverage) declined during this period from 23.2% to 20.4%.

EXHIBIT 35: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS BY HEALTH STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005

HEALTH STATUS	Uninsured All or Part Year	Employment-Based All Year	Medi-Cal All Year	Privately Purchased All Year	Other All Year	Total
EXCELLENT, VERY GOOD OR GOOD HEALTH	20.0%	60.4%	8.2%	7.2%	4.3%	100%
FAIR OR POOR HEALTH	33.1%	34.2%	22.9%	2.7%	7.1%	100%

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add to 100% due to rounding.

Source: 2005 California Health Interview Survey

EXHIBIT 36: UNINSURED ALL OR PART YEAR BY HEALTH CONDITION, WOMEN AGES 18-64, CALIFORNIA, 2005

DIAGNOSED HEALTH CONDITION*	Uninsured All or Part Year
ARTHRITIS	14.8%
ASTHMA	17.6%
CANCER	16.4%
DIABETES**	22.5%
HEART DISEASE	21.0%
HIGH BLOOD PRESSURE	18.2%

*Health condition is based on women reporting they have ever been diagnosed with the condition.

**Diabetes rate excludes gestational diabetes.

Source: 2005 California Health Interview Survey

The increase in employment-based primary coverage between 2001 and 2005 was significant only for women with family incomes at 300% of the Federal Poverty Level and above. Their primary employment-based coverage went from 45.8% to 49.4%. However, the decline in family coverage cut across all income groups.

UNINSURED WOMEN

This section looks specifically at uninsured women and their demographic and work characteristics to better understand their coverage expansion needs. As previously seen in Exhibit 26, 22.3% of California nonelderly women were uninsured for all or part of 2005. This represents approximately 2.5 million women. Of these women, 39.5% are between the ages of 18-29 and another one-third are 30-44 years old (Exhibit 38). Thus, three-fourths of uninsured women are in the primary reproductive age range. An additional 16.9% are ages 45-54, and 9% are ages 55-64.

The majority of uninsured women are low-income and would likely have limited resources to cover medical expenses. Three in ten uninsured women live in

EXHIBIT 37: HEALTH INSURANCE COVERAGE DURING PAST 12 MONTHS, WOMEN AGES 18-64, CALIFORNIA, 2001 AND 2005

COVERAGE STATUS	2001	2005	p-value
UNINSURED ALL OR PART YEAR	24.6%	22.3%	<0.001
EMPLOYMENT-BASED COVERAGE ALL YEAR			
PRIMARY	31.3%	35.3%	<.0001
FAMILY	23.2%	20.4%	<.0001
MEDI-CAL ALL YEAR	11.1%	10.8%	NS
PRIVATELY PURCHASED ALL YEAR	6.3%	6.4%	NS
OTHER ALL YEAR	3.5%	4.8%	<.0001

Notes: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

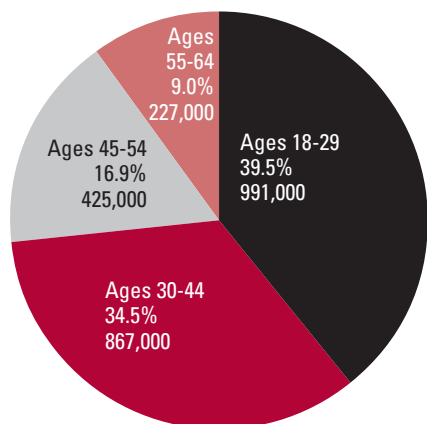
NS = The difference between the estimates for 2001 and 2005 not statistically significant.

Source: 2001 and 2005 California Health Interview Surveys

families with incomes below the Federal Poverty Level (Exhibit 39). An additional one-third are near-poor with family incomes of 100-199% FPL. Thus, nearly two-thirds of uninsured women (62.6%) live in families with incomes below 200% FPL. Another 13.6% are in families at 200-299% FPL. Yet, the reach of lack of coverage extends across income groups. Nearly one-quarter of women uninsured for all or part of 2005 (23.9%) had family incomes at or over 300% FPL.

As Exhibit 40 shows, the majority of uninsured women—approximately six in ten—are workers. One-third work 40 or more hours per week, an additional 26.7% work fewer than 40 hours per week, and 1.4% are employed but not currently working. The large proportion of uninsured women who are in the labor force highlights the difficulty with access to affordable coverage for many working women.

EXHIBIT 38: AGE GROUP DISTRIBUTION AMONG THOSE UNINSURED ALL OR PART YEAR, WOMEN AGES 18-64, CALIFORNIA, 2005

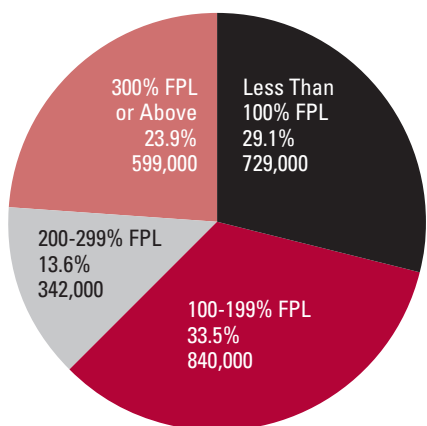


Note: Numbers may not add to 100% due to rounding.
Source: 2005 California Health Interview Survey

COUNTY-LEVEL UNINSURED RATES

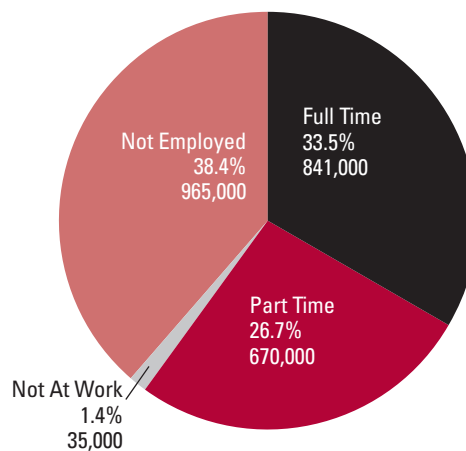
Exhibit 41 shows the proportion of nonelderly women uninsured all or part year in California counties and county groups. The San Francisco Bay area (16.9%) and the Sacramento area (14.6%) have the lowest rates of lack of coverage. In several counties across the state, including Los Angeles, one-quarter or more of women were uninsured for all or part of 2005.

EXHIBIT 39: FEDERAL POVERTY LEVEL AMONG THOSE UNINSURED ALL OR PART YEAR, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: Numbers may not add to 100% due to rounding.
The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.
Source: 2005 California Health Interview Survey

EXHIBIT 40: WORK STATUS AMONG THOSE UNINSURED ALL OR PART YEAR, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: Numbers may not add to 100% due to rounding.
Source: 2005 California Health Interview Survey

EXHIBIT 41: UNINSURED ALL OR PART YEAR BY COUNTY, WOMEN AGES 18-64, CALIFORNIA, 2005

UNINSURED ALL OR PART YEAR	% UNINSURED	95% Confidence Interval
NORTHERN AND SIERRA COUNTIES	23.8%	(21.2%-26.3%)
BUTTE	21.3%	(13.8%-28.8%)
SHASTA	33.9%	(24.5%-43.4%)
HUMBOLDT	23.5%	(17.7%-29.2%)
DEL NORTE, SISKIYOU, LASSEN, TRINITY, MODOC, PLUMAS, SIERRA	21.8%	(14.0%-29.7%)
MENDOCINO	25.4%	(17.9%-32.8%)
LAKE	23.7%	(15.1%-32.3%)
TEHAMA, GLENN, COLUSA	30.2%	(21.5%-38.9%)
SUTTER	16.5%	(9.1%-23.8%)
YUBA	23.1%	(14.3%-31.8%)
NEVADA	19.7%	(12.4%-26.9%)
TUOLUMNE, INYO, CALAVERAS, AMADOR, MARIPOSA, MONO, ALPINE	20.9%	(12.9%-28.9%)
GREATER BAY AREA	16.9%	(14.9%-18.9%)
SANTA CLARA	14.6%	(10.5%-18.6%)
ALAMEDA	19.4%	(14.7%-24.1%)
CONTRA COSTA	19.6%	(13.4%-25.8%)
SAN FRANCISCO	17.5%	(11.8%-23.2%)
SAN MATEO	14.0%	(7.4%-20.6%)
SONOMA	18.9%	(11.4%-26.4%)
SOLANO	14.0%	(9.9%-18.1%)
MARIN	11.0%	(8.7%-13.2%)
NAPA	22.8%	(15.2%-30.4%)
SACRAMENTO AREA	14.6%	(11.6%-17.6%)
SACRAMENTO	16.8%	(12.6%-21.1%)
PLACER	9.1%	(4.8%-13.3%)
YOLO	13.0%	(7.8%-18.2%)
EL DORADO	9.0%	(4.8%-13.3%)
SAN JOAQUIN VALLEY	26.5%	(23.4%-29.7%)
FRESNO	31.4%	(22.9%-40.0%)
KERN	28.8%	(21.8%-35.8%)
SAN JOAQUIN	21.8%	(14.8%-28.7%)
STANISLAUS	20.9%	(13.9%-27.8%)
TULARE	28.1%	(20.8%-35.3%)
MERCED	23.0%	(16.0%-30.0%)
KINGS	22.1%	(15.1%-29.1%)
MADERA	32.6%	(23.6%-41.6%)
CENTRAL COAST	22.1%	(18.6%-25.6%)
VENTURA	23.1%	(16.2%-29.9%)
SANTA BARBARA	22.3%	(13.0%-31.5%)
SANTA CRUZ	18.6%	(12.1%-25.0%)
SAN LUIS OBISPO	20.0%	(11.8%-28.2%)
MONTEREY	23.6%	(17.0%-30.3%)
SAN BENITO	22.5%	(12.7%-32.3%)
LOS ANGELES	25.9%	(24.0%-27.8%)
LOS ANGELES	25.9%	(24.0%-27.8%)
OTHER SOUTHERN CALIFORNIA	22.5%	(20.7%-24.3%)
ORANGE	19.7%	(16.2%-23.3%)
SAN DIEGO	21.0%	(18.4%-23.6%)
SAN BERNARDINO	25.7%	(21.3%-30.0%)
RIVERSIDE	25.6%	(20.7%-30.5%)
IMPERIAL	30.7%	(22.2%-39.1%)

Notes: The confidence interval (CI) shows the range where the actual value may lie. The 95%CI means that you can assume with 95% confidence that the actual value lies between the lower and upper CI range.

Source: 2005 California Health Interview Survey

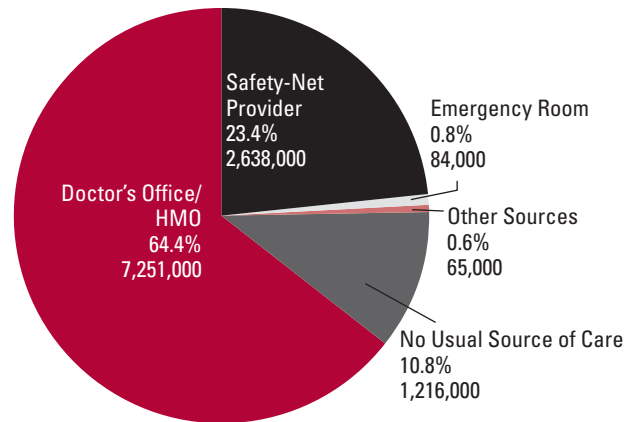
care and utilization

Source of Care and Utilization of Selected Services

This section examines where women obtain their health care—including use of safety-net providers, and their access to physician services and selected screening services. Key findings include:

- Most women have a usual place where they obtain medical care: for the majority it is a doctor’s office or HMO-setting, and a sizeable percent of women use safety-net providers. But one in ten women lacks a usual source of care.
- Safety-net providers serve as a primary source of care for 23.4% of women, approximately 2.6 million.
- 85% of nonelderly women had a Pap test within the past three years. Pap test rates are lower for young women, Asian/Pacific Islander women, and those with family incomes below 300% of the FPL.
- Pap test screening rates are lower for women receiving Medi-Cal and for uninsured women than for those with employment-based insurance.
- 77.4% of women ages 40-64 had a mammogram within the past two years. Mammography screening prevalence was lower for women ages 40-49, women with family incomes below 300% FPL, Asian/Pacific Islander women, Latinas and American Indian/Alaska Native women.
- Slightly under half of women ages 40-64 with no usual source of care (48.1%) had a mammogram in the past two years and women with Medi-Cal and the uninsured had lower screening rates than women with employment-based coverage.

EXHIBIT 42: USUAL SOURCE OF CARE SETTING, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: Numbers may not add to 100% due to rounding.
Source: 2005 California Health Interview Survey

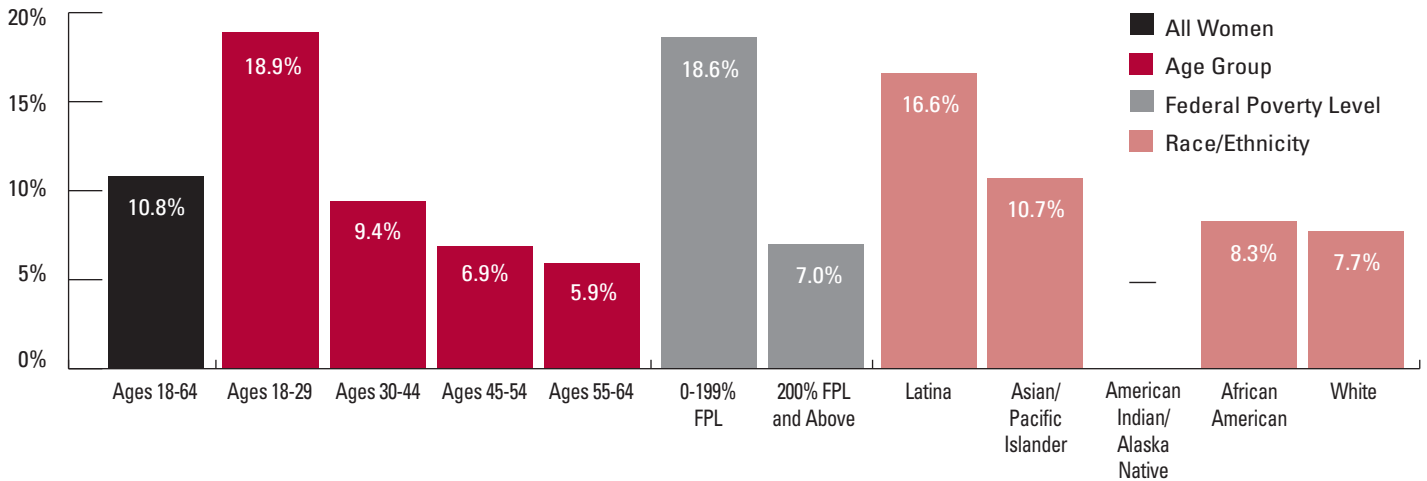
USUAL SOURCE OF CARE

A usual source of care facilitates the timely receipt and the continuity of care.¹⁹ The majority of nonelderly women have a regular place where they seek care and for most it is a doctor’s office or HMO (64.4%; Exhibit 42). An additional one-quarter of women (23.4%) report a community health center, public hospital or clinic as their usual source of care, while a small portion (<1%) use an emergency room as their regular source. However, 10.8% of women lack a usual source of health care; this overall rate masks the considerable variation among women with access to a “medical home.”

Young women (ages 18-29) are two to three times more likely to lack a regular source of care than women in the other age groups (18.9% vs. 5.9-9.4%; Exhibit 43). Access to a usual source of care also varies by family income level. Low-income women are nearly three times as likely to lack a usual source of care as women

19 Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. National Academies Press. Washington, DC, 2002.

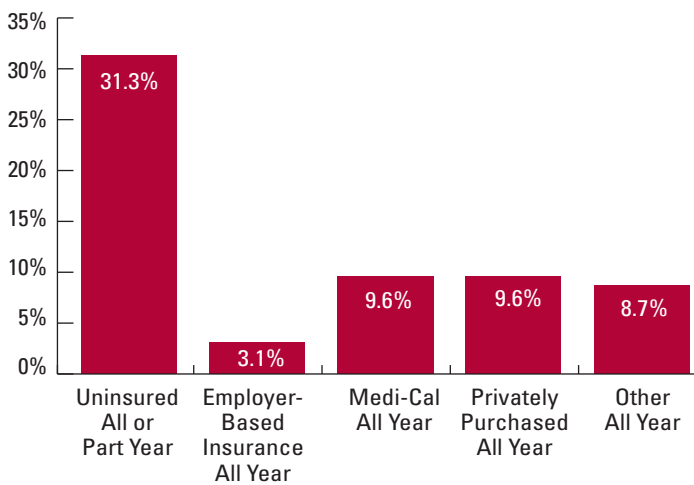
EXHIBIT 43: NO USUAL SOURCE OF CARE BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.
 “—” = Estimate not reliable due to small sample size.

Source: 2005 California Health Interview Survey

EXHIBIT 44: NO USUAL SOURCE OF CARE BY HEALTH INSURANCE STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005



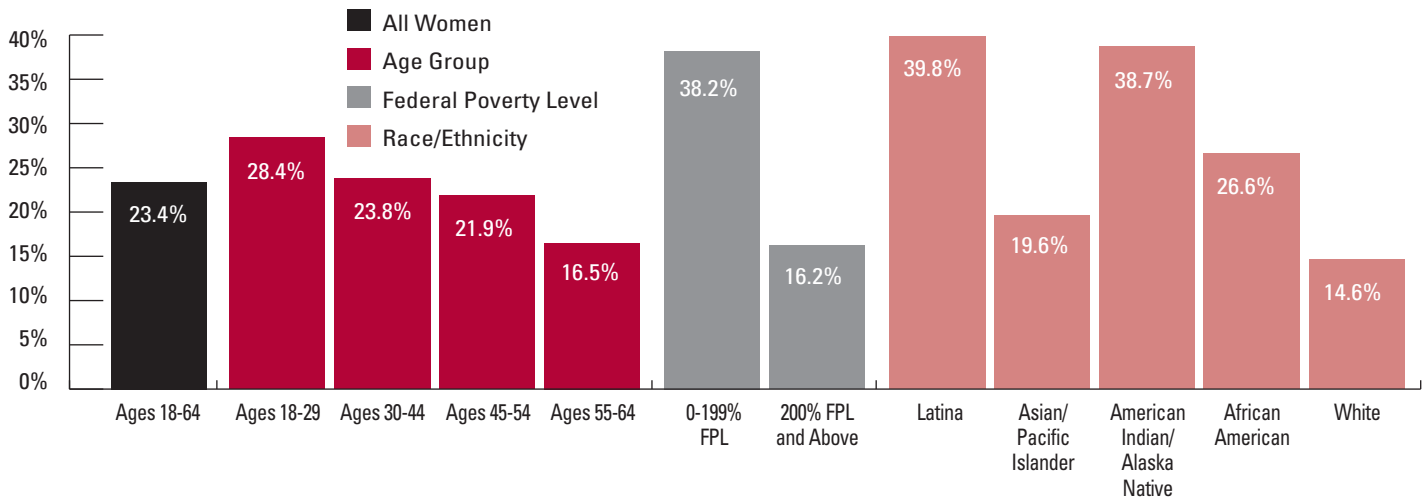
Note: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.
 Source: 2005 California Health Interview Survey

above 200% of the Federal Poverty Level (18.6% vs. 7%). There also is variation across racial/ethnic groups. Latinas and Asian/Pacific Islander women are more likely than white women to lack a usual source of care. And non-citizen women are more likely to lack a usual source of care (22.3%) than either U.S.-born women (8.3%) or women who are naturalized citizens (8%; data not shown).

Three in ten uninsured women (31.3%) do not have a usual source of care in comparison to just 3.1% of women with employment-based coverage, a 10-fold difference (Exhibit 44). Women on Medi-Cal fare much better—9.6% are without a usual source of care—than uninsured women, but not as well as women with employment-based coverage. And women with privately-purchased coverage have a rate similar to women on Medi-Cal.

Safety-net providers, which include community health centers, public hospitals and public clinics, provide regular care to 23.4% of nonelderly women in the state,

EXHIBIT 45: USE OF SAFETY-NET PROVIDERS AS USUAL SOURCE OF CARE BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

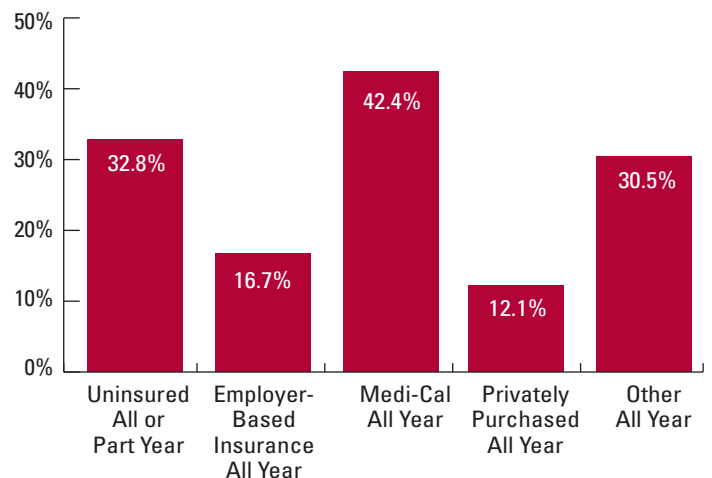
Source: 2005 California Health Interview Survey

approximately 2.6 million women (Exhibit 45). Women ages 18-29 are more likely to use community clinics or other safety-net providers as their usual source of health care (28.4%) than women in other age groups. Use of these safety-net services extends well beyond young adult women: nearly one-quarter of women ages 30-44; 21.9% of women ages 45-54; and 16.5% of women ages 55-64 report these providers as their main source of care.

Women with family incomes below 200% FPL are more reliant on safety-net services than higher income women—there is a two-fold difference in use (38.2% vs. 16.2%). There is also variation in the proportion of women who use safety-net providers among racial/ethnic groups, ranging from 14.6% of white women to nearly four in ten Latinas and American Indian/Alaska Native women. Furthermore, safety-net providers are an important source of care for non-citizen women: four in ten use safety-net providers as their regular source of care (data not shown).

Use of safety-net providers varies by insurance status (Exhibit 46). Among women receiving Medi-Cal, 42.4% report their main source of care as safety-net clinics and

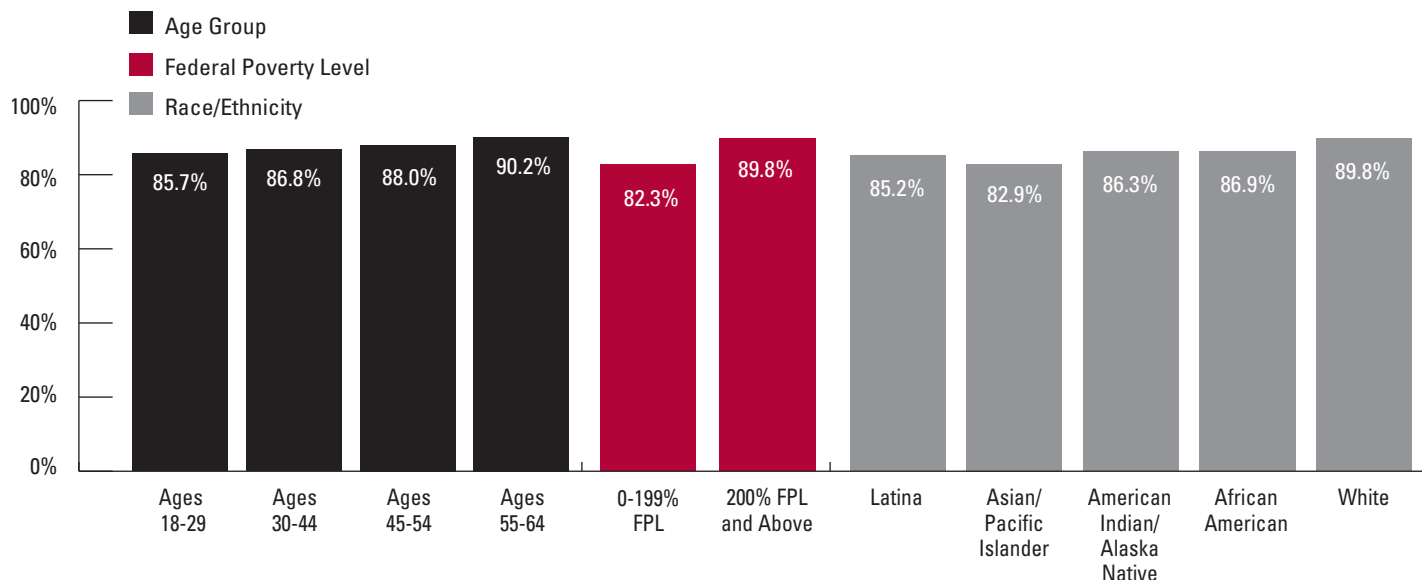
EXHIBIT 46: USE OF SAFETY-NET PROVIDERS AS USUAL SOURCE OF CARE BY HEALTH INSURANCE STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Source: 2005 California Health Interview Survey

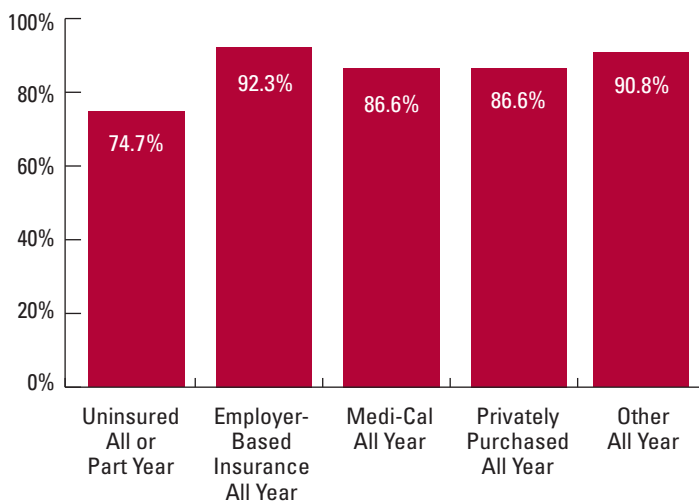
EXHIBIT 47: PHYSICIAN VISIT PAST YEAR BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

EXHIBIT 48: PHYSICIAN VISIT PAST YEAR BY HEALTH INSURANCE STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Source: 2005 California Health Interview Survey

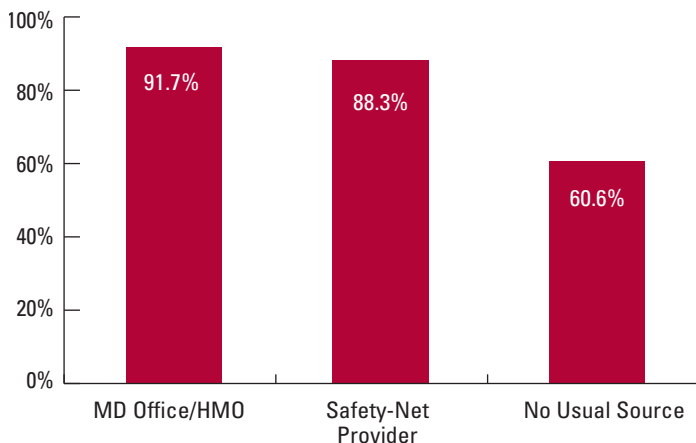
hospitals. One-third of uninsured women rely on safety-net providers as do a similar proportion of women who are covered by “other” sources. A portion of women covered by employment-based coverage (16.7%) use safety-net providers as do 12.1% of women with privately-purchased insurance.

PHYSICIAN VISITS

Most nonelderly women have had at least one visit to a physician in the past year (Exhibit 47). While there is no specific recommendation on how frequently to see a physician, this measure provides a general indicator of access to the health care system.

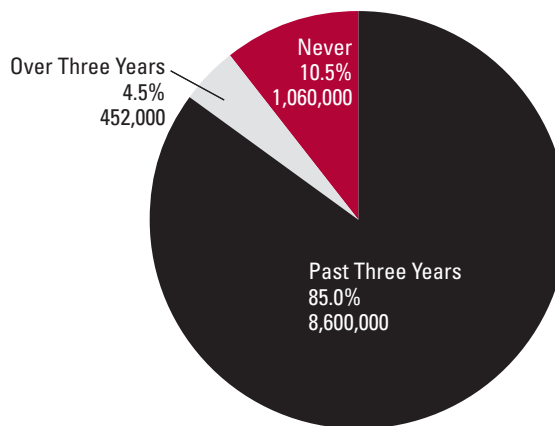
Women who were uninsured all or part year were less likely to see a physician in the past year (74.7%), compared to women in the other insurance status groups (86.6-92.3%; Exhibit 48).

EXHIBIT 49: PHYSICIAN VISIT PAST YEAR BY TYPE OF USUAL SOURCE OF CARE, WOMEN AGES 18-64, CALIFORNIA, 2005



Source: 2005 California Health Interview Survey

EXHIBIT 50: PAP TEST SCREENING, WOMEN AGES 18-64, CALIFORNIA, 2005



Notes: Numbers may not add to 100% due to rounding. Estimates exclude women who have had a hysterectomy.
Source: 2005 California Health Interview Survey

Women without a usual source of care were also less likely to have seen a physician in the past year (60.6%) than those with a usual source—whether the usual source was a physician office or HMO (91.7%) or a safety-net provider (88.3%; Exhibit 49).

PAP TEST SCREENING RATES

Overall, the majority of women in California ages 18-64 received a Pap test in the past three years (85%; Exhibit 50).²⁰ An additional 4.5% had their last screening over three years ago, and one in ten have never had a Pap test.

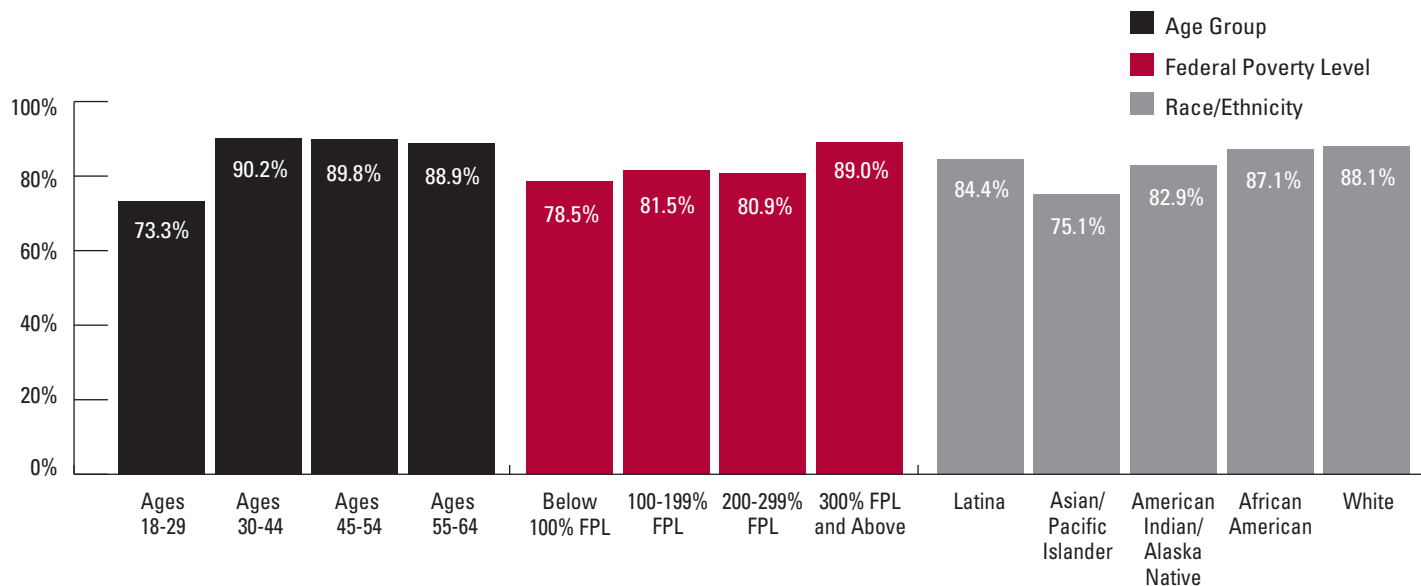
Women ages 18-29 are less likely to have had a Pap test (73.3%) than women age 30 and over (approximately 90% screened; Exhibit 51). Differences in the income level of women also affected their access to cervical

cancer screening. Women with family incomes at 300% Federal Poverty Level and over were more likely to be screened than women with family incomes below that level. Approximately eight in ten women with family incomes from 0-299% FPL had a Pap test in the previous three years; in comparison, nine in ten women with family incomes at 300% FPL and over were screened. Just three-quarters of Asian/Pacific Islander women (75.1%) had a Pap test in the past three years, a rate lower than Latinas, African-American and white women. Among non-citizen women, 81% had a Pap test in the past three years, a rate lower than naturalized citizen women (84.4%) and U.S.-born women (86.4%; data not shown).

Both a usual source of care and health insurance coverage were related to receipt of a timely Pap test. Exhibit 52 shows the difference in rates between women

²⁰ The National Cancer Institute recommends a Pap test for cervical cancer at least once every three years. Accessed at www.cancer.gov/cancertopics/factsheet/Detection/Pap-test.

EXHIBIT 51: PAP TEST SCREENING PAST THREE YEARS BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 18-64, CALIFORNIA, 2005

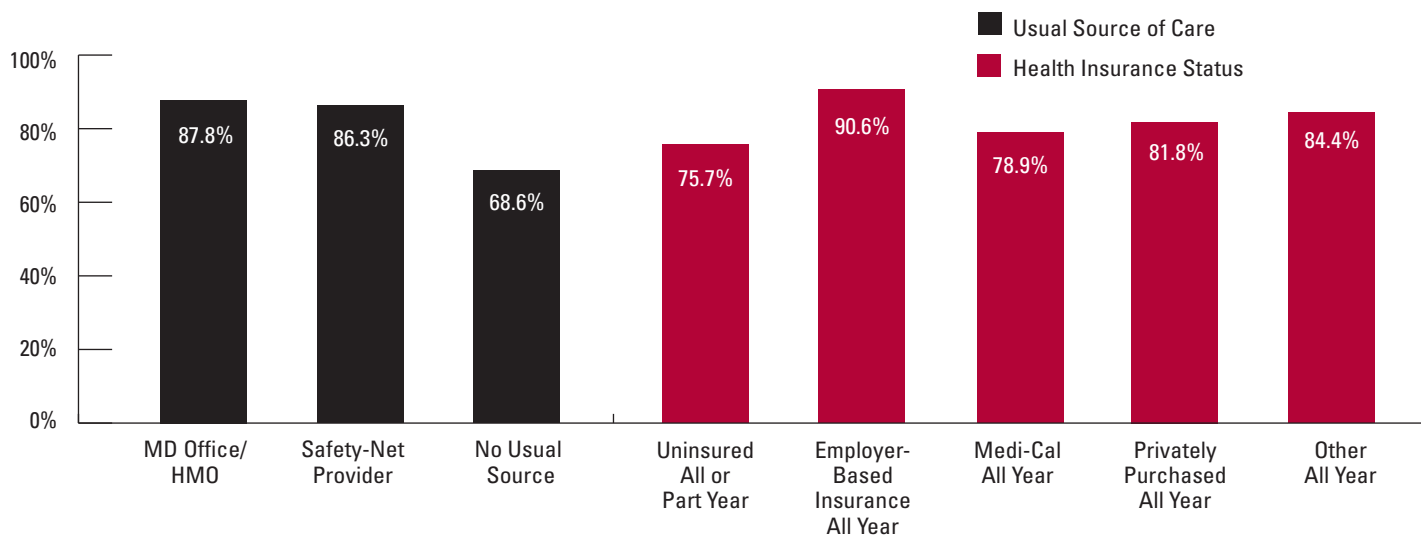


Notes: Estimates exclude women who have had a hysterectomy.

Source: 2005 California Health Interview Survey

The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

EXHIBIT 52: PAP TEST SCREENING PAST THREE YEARS BY USUAL SOURCE OF CARE AND HEALTH INSURANCE STATUS, WOMEN AGES 18-64, CALIFORNIA, 2005



Note: Estimates exclude women who have had a hysterectomy.

Source: 2005 California Health Interview Survey

The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

with no usual source of health care and those with a regular source, either a doctor's office or safety-net provider. Only 68.6% of women with no usual source of care were screened, while nearly nine out of ten women with access to a usual source were screened. There was no difference in screening rates between women whose usual source was an MD office/HMO and those women who received care in community/government clinics or hospitals. Women with employment-based coverage had higher screening rates than women in each of the other health insurance categories. The screening rates for uninsured women and those on Medi-Cal were statistically the same. Uninsured women had lower screening rates than women in each of the other insurance groups except Medi-Cal.

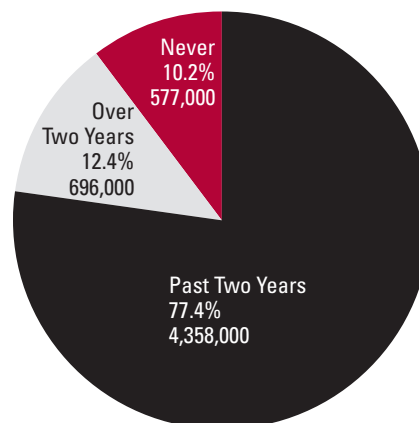
MAMMOGRAPHY SCREENING RATES

Among women ages 40-64, 77.4% have had a mammography screening in the past two years (Exhibit 53).²¹ An additional 12.4% of women had their most recent mammogram over two years ago and 10.2% have never had a mammogram.

Women ages 50-64 are more likely to have had a recent screening than women ages 40-49 (84.4% vs. 70.1%; Exhibit 54), possibly because the recommendations have been less consistent for women ages 40-49. Low-income women have the lowest screening rates: 64.8% of women with family incomes at 0-99% Federal Poverty Level and 67.1% at 100-199% FPL. In contrast, 73.8% of women at 200-299% FPL and 82.8% whose family incomes are 300% FPL and over had a mammography within the previous two years. Screening rates also varied by racial/ethnic group. Two-thirds of American Indian/Alaskan Native women (67.1%) had a mammogram in the past two years and, along with Latinas and Asian/Pacific Islander women, have lower rates than African-American and white women. Nearly

21 The National Cancer Institute recommends a screening mammogram every one to two years for women age 40 and over. Accessed at www.cancer.gov/cancertopics/factsheet/Detection/Screening-mammograms.

EXHIBIT 53: MAMMOGRAPHY SCREENING, WOMEN AGES 40-64, CALIFORNIA, 2005

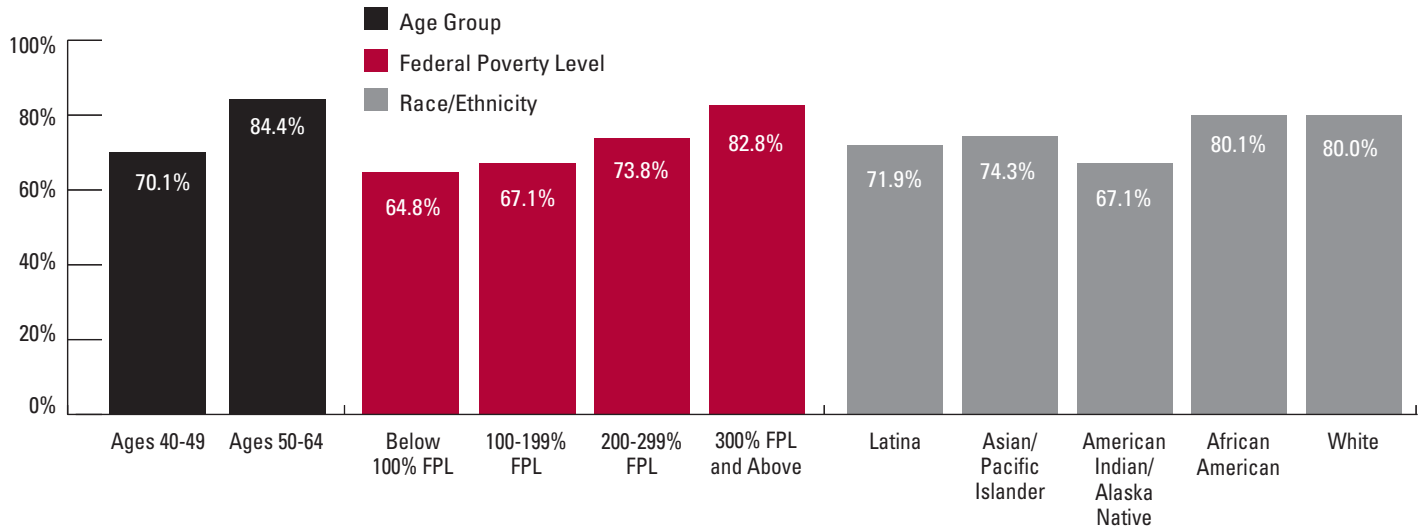


Note: Numbers may not add to 100% due to rounding.
Source: 2005 California Health Interview Survey

eight in ten U.S.-born and naturalized citizen women had a mammogram within the past two years, compared with 64.7% of non-citizen women (data not shown).

Disparities in the utilization of mammography screening by access to health care measures are also apparent (Exhibit 55). Among women with no usual source of care, less than one-half (48.1%) received a mammogram in the past two years. This is in contrast to women whose primary source of care was in doctor's offices or HMOs, 81.4% of whom had a recent mammogram. Women using safety-net providers had better screening rates (74.4%) than those with no usual source, but were still below those of women receiving care in doctor's offices/HMOs. Health insurance coverage also was an important access factor. Women who were uninsured all or part year had the lowest screening rates (57.6%). Women with Medi-Cal had better screening rates (68.6% screened) than uninsured women, but both groups were still under-screened compared to other insurance groups. The highest screening rates were seen among women with employment-based insurance, 83.2% of whom had a mammogram in the past two years.

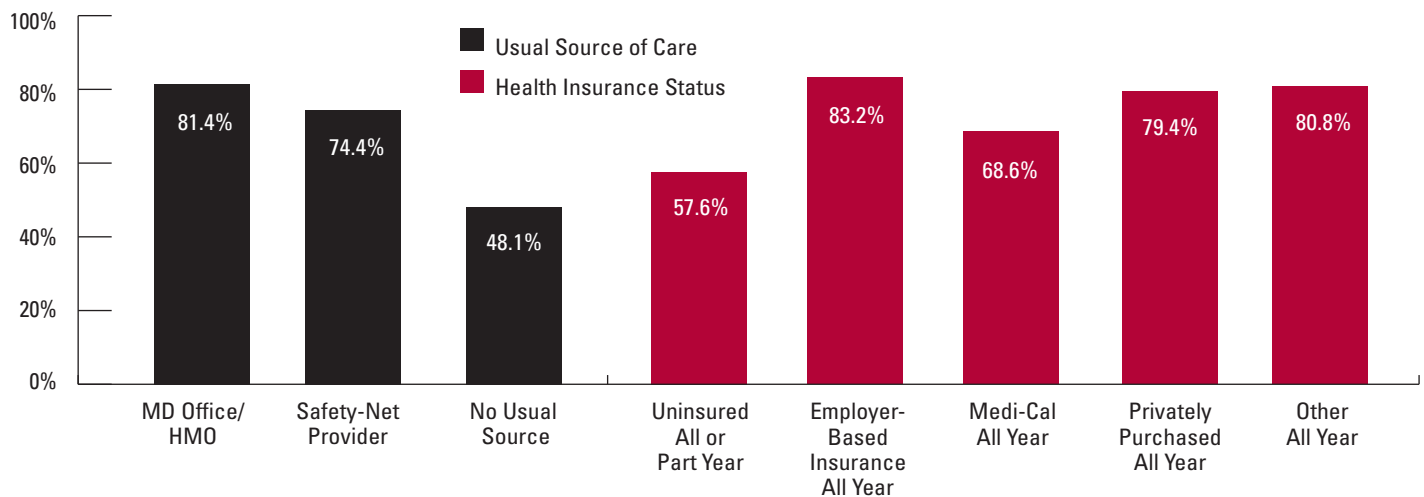
EXHIBIT 54: MAMMOGRAPHY SCREENING PAST TWO YEARS BY AGE GROUP, FEDERAL POVERTY LEVEL AND RACE/ETHNICITY, WOMEN AGES 40-64, CALIFORNIA, 2005



Note: The 2005 federal poverty level was \$9,973 for one person, \$12,755 for a two-person family and \$15,577 for a three-person family.

Source: 2005 California Health Interview Survey

EXHIBIT 55: MAMMOGRAPHY SCREENING PAST TWO YEARS BY USUAL SOURCE OF CARE AND HEALTH INSURANCE STATUS, WOMEN AGES 40-64, CALIFORNIA, 2005



Note: The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Source: 2005 California Health Interview Survey

Discussion

The findings in this report highlight the considerable variation among California nonelderly women in their health conditions and health activities, health insurance coverage and measures of access to care. A sizeable portion of women face serious disparities—which persist across the indicators measured.

Disparities in health status and physical limitations persist for women in California requiring targeted outreach for prevention and detection of chronic conditions.

Low-income women and many women of color experience poorer health status and more physical limitations related to their health conditions. Among middle-age women, the prevalence rates of most of the health conditions examined were higher for those with low incomes. Rates of specific health conditions vary by racial/ethnic group and provide information about where targeted prevention efforts and regular monitoring by health care providers are especially needed. Generally, American Indian/Alaska Native and African-American women have the highest prevalence of the health conditions examined. Further, a sizable portion of women (from 14.8% to 22.5%) with diagnosed health conditions, such as asthma, diabetes, and hypertension, lack health insurance coverage, increasing the financial burden for these women and possibly jeopardizing access to care and chronic disease management.

The majority of uninsured nonelderly women have low incomes, requiring solutions that consider their limited resources.

The majority of uninsured women (62.6%) are low income. Proposals to extend health insurance coverage to the uninsured need to consider the affordability of such proposals for the individuals and families involved. A recent California affordability analysis that examined the costs of basic necessities and health care expenses concluded that families with incomes below 200% of the Federal Poverty Level have few or no resources available to contribute to premiums or out-of-pocket costs.²² Given their assessment of health costs and basic necessities, the authors recommend that health care proposals consider full subsidies for medical expenses for those with low incomes (below 200% FPL) and partial subsidies for families above this level.

Erosion of employment-based family coverage affects nonelderly women's coverage options.

One in five women rely on employment-based coverage through a spouse or parent (family coverage), but this source of coverage is declining as premium and worker share of costs increase.²³ The average share of premiums paid by workers for family coverage was 25% in 2001 and 29% in 2005.²⁴ Women rely on a patchwork of coverage options, and employment-based insurance through a family member is an important component. The decline in this form of coverage affects all family income groups and leaves a small proportion of women with family incomes under 100% FPL covered through this source. Women not in the labor force and those who work part time would be particularly affected by

22 Carroll D, Roby DH, Ross J, Snaveley M, Brown ER, Kominski GF. *What Does It Take for a Family to Afford to Pay for Health Care?* Los Angeles, CA: UCLA Center for Health Policy Research, 2007.

23 Brown ER, Lavarreda SA, Ponce N, Yoon J, Cummings J, Rice T. *The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey.* Los Angeles, CA: UCLA Center for Health Policy Research, 2007.

24 California HealthCare Foundation (CHCF)/The Center for Studying Health System Change (HSC) California Employer Health Benefits Survey, Oakland, CA: California HealthCare Foundation, 2005.

decreases in this coverage source. The erosion of employment-based family coverage emphasizes the need for broad-based solutions that stabilize coverage.

There is considerable variation in the practice of health-promoting behaviors among nonelderly women.

The practice of health-promoting behaviors can have a significant effect on health and play an important role in disease prevention. This report addresses differences among women in their practice of both health-promoting and unhealthy behaviors based on individual demographic and socioeconomic characteristics. By identifying specific groups at increased risk of chronic disease based on their health behaviors, interventions can be targeted specifically to those groups at highest risk.

While differences in individual health behaviors are important to address, often these health behaviors are shaped or constrained by social and physical environments.²⁵ Information about differences in health behaviors among women provide an opportunity for targeted interventions that consider the broader social, economic, and physical environments that influence health.²⁶ Community environments can promote or impede health and influence the onset of disease.²⁷ Proactive policies and programs are necessary to equalize access to resources and promote healthy environments.

Nearly one-quarter of women use safety-net providers as their usual source of care.

Safety-net providers are the usual source of care for nearly one-quarter of California women (23.4%). Four

in ten Latinas, American Indian/Alaska Native women, and low-income women rely on the safety net, as do a high proportion of the uninsured and those on Medi-Cal. Deficit-driven proposals that affect support for the safety net will have a negative effect on women's access to care in California.

Women who are uninsured have serious access to care problems.

Uninsured women experience more barriers to care than insured women for nearly all the access measures examined in the report. Compared to insured women, uninsured women are less likely to have a usual source of care, to have seen a physician within the past year or to have timely mammograms. The only exception was for Pap tests, where screening rates between uninsured women and those on Medi-Cal are comparable. The relatively poorer health status of uninsured women and their lower incomes combine to create formidable obstacles for these women to get basic health care needs met. The importance of coverage and access to health care underscores the urgency of continued efforts on all fronts to expand health insurance coverage to California women—and all Californians. The persistence and consequences of lack of coverage require effective and bold solutions to this problem.

25 Adler N, Newman K. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*. 2002; 21:60-76.

26 PolicyLink and Joint Center Health Policy Institute. *A Place for Living: Improving Access to Physical Activity*. Oakland, CA: PolicyLink, 2004.

27 Babey H, Diamant A, Hastert T, Goldstein H, Harvey S, Banthia R, Flournoy R, Rubin V, Treuhaft S. *Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes*. California Center for Public Health Advocacy, PolicyLink, and the UCLA Center for Health Policy Research, 2008.

Methods

This report is based on data from the 2005 California Health Interview Survey (CHIS 2005), augmented with data from CHIS 2001 to ascertain trends. The California Health Interview Survey is a biennial telephone survey of the California population living in households. CHIS 2005 interviewed 45,649 households between July 2005 and April 2006, and includes information on 43,649 adults. CHIS 2001 includes information on 56,720 adults.

CHIS is based at the UCLA Center for Health Policy Research and is conducted in collaboration with the California Department of Health Services and the Public Health Institute.

The data in the report were analyzed using SAS. Sampling tolerances at the 95% confidence interval were used to calculate statistically significant differences between proportions. All differences between groups that are reported in the narrative are based on statistical testing.

The determination of adequate sample size was based on an analysis of the coefficient of variation (CV) using a criterion of 30%. Because the estimates for Pacific Islander women were based on sample sizes too small to report, they were combined with Asian women.

For more information on CHIS, please visit www.chis.ucla.edu.

UCLA CENTER FOR
HEALTH POLICY RESEARCH



10960 Wilshire Boulevard, Suite 1550
Los Angeles, CA 90024
www.healthpolicy.ucla.edu