Women's Health Issues in California:

Findings from the 2001 California Health Interview Survey

Roberta Wyn, PhD

Victoria D. Ojeda, PhD, MPH

Funded by a grant from

The California Wellness Foundation

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Executive Summary

Women are major users of health care throughout their lives. Their need for reproductive and preventive health services, their role as health care decision makers for their families, and their longevity often result in complex relationships with the health care system. Yet changes in health-related public policies and rising health care costs often affect women disproportionately because of their greater use of public programs and their lower incomes relative to men. The costs of health care services and insurance – and other barriers – can affect women's abilities to obtain the medical care they need to safeguard their health.

Using data from the recently released 2001 California Health Interview Survey (CHIS 2001), this report examines important health concerns of nonelderly women in California, including their health status, insurance coverage, and access to care issues.[1] We especially focus on low-income women and women of color, who are often disproportionately affected by the lack of consistent policies that promote affordable access to health care.

CHIS 2001 data points to the poorer health status experienced by lower-income women of all ages, including the prevalence of chronic health conditions. The analyses also found that among women age 45-64, several groups of women of color were disproportionately affected by chronic health conditions, including arthritis and high blood pressure.

Access to the health care system is mediated in part by a woman's health insurance status. However in California a substantial number of nonelderly women, approximately 1.7 million, lack any form of health insurance and low-income women are over-represented among the uninsured. For many women lack of affordability limits them from obtaining health care coverage. CHIS 2001 data suggests that while Medi-Cal – California's Medicaid program – remains a critical source of insurance for many low-income women, those with Medi-Cal coverage are more likely than privately-insured women to experience gaps in coverage, potentially limiting their relationship with the health care system. Differences in health coverage by race and ethnic group are also evident, with Latinas especially disadvantaged in their sources of coverage and at high risk for being uninsured.

Utilization of health services depends not only on a woman's insurance status, but also other indicators, such as whether she has a place where she receives health care. Uninsured and low-income women are more likely to lack a usual source of care as compared to privately- or publicly-insured and higher-income women. Uninsured and low-income women are also less likely to obtain screening tests for detecting emerging health conditions. Notably, across groups of insured women, many lack coverage for other health services such as eye exams or prescription drugs, services which may help them protect their health.

These and other CHIS 2001 data findings suggest a need for policy solutions. The persistence of health status disparities calls for targeted outreach for the prevention and detection of chronic conditions among low-income women and those in communities of color. Additionally, continued public and private efforts are necessary to increase health insurance coverage and continuity of that coverage among nonelderly women. The majority of California's uninsured women have low incomes, requiring solutions that account for their limited resources.

1 This report provides information on women age 18-64. See Wallace S, Pourat N, Enriquez-Haass V, Sripipatana A, *Health of Older Californians: County Data Book*, UCLA Center for Health Policy Research. Los Angeles, CA. October 2003.

Acknowledgements acknowledgements

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Women's Health in California

CALIFORNIA'S WOMEN: A DIVERSE POPULATION

There are approximately 10.2 million women who are between 18 and 64 years of age in California; 27% are age 18-29, 39% are 30-44, 21% are 45-54, and 13% are 55-64. Thirty-six percent – 3.7 million – are low-income, with family incomes below 200% of the Federal Poverty Level (FPL).[2] This includes 17% of women with family incomes below the poverty level. The state's racial/ethnic diversity is reflected in the composition of the female population. Approximately half of all nonelderly women are non-Latino white, Latinas comprise the next largest group (26%), Asian Americans comprise 11% of women, 6% are African-American, and American Indian/Alaska Native and Pacific Islanders each represent under 1% of all nonelderly women.

HEALTH STATUS

Information on women's health status and how it varies by age, poverty level, and race/ethnicity provides a backdrop for discussions focused on health insurance coverage, access to care issues, and health disparities among women. Women's perceived health status and the lifetime prevalence of selected health conditions are examined. Some key highlights of the findings are:

- Seventeen percent of nonelderly women report their health as fair or poor.
- The prevalence of several chronic health conditions increases with age, with four in ten women age 55-64 ever diagnosed with arthritis or high blood pressure.
- Low-income women are three times more likely than those with higher incomes to report fair or poor health.
- Most of the chronic conditions measured – arthritis, diabetes, heart disease, and high blood pressure – have a higher lifetime prevalence in low-income versus higher-income women age 45-64.
- Women of color are more likely than white women to report their health status as fair or poor.

Nonelderly women in California face several health issues, with differences in health status by age, income, and race/ethnic group. Overall, one in six nonelderly women (17%) reports her health as fair or poor (Exhibit 1).

EXHIBIT 1: HEALTH STATUS INDICATORS BY AGE GROUP, WOMEN AGE 18-64, CALIFORNIA, 2001

	ALL WOMEN AGE 18-64	WOMEN AGE 18-29	WOMEN AGE 30-44	WOMEN AGE 45-54	WOMEN AGE 55-64
HEALTH INDICATOR					
FAIR OR POOR HEALTH	17%	14%	16%	20%	24%
DIAGNOSED HEALTH CONDITIONS*					
ARTHRITIS	16%	4%	11%	26%	43%
ASTHMA	13%	14%	12%	14%	15%
DIABETES	4%	1%	3%	7%	11%
HEART DISEASE	4%	1%	3%	6%	11%
HIGH BLOOD PRESSURE	16%	5%	11%	23%	38%

* Conditions diagnosed in lifetime

Source: 2001 California Health Interview Survey

2 The Federal Poverty Level (FPL) is based on household income and household size. In 2001, the poverty threshold (100% FPL) was $9,044 for one person, $11,559 for a family of two, and $14,129 for a family of three.

EXHIBIT 2: HEALTH STATUS INDICATORS BY FEDERAL POVERTY LEVEL (FPL) AND RACE/ETHNIC GROUP, WOMEN AGE 18-64, CALIFORNIA, 2001

	PERCEIVED HEALTH STATUS AGE 18-64	DIAGNOSED HEALTH CONDITIONS* AGE 45-64				
	FAIR OR POOR HEALTH	ARTHRITIS	ASTHMA	DIABETES	HEART DISEASE	HIGH BLOOD PRESSURE
POVERTY LEVEL						
LESS THAN 200% FPL	30%	39%	14%	15%	13%	35%
200% FPL AND OVER	10%	30%	14%	6%	6%	26%
RACE/ETHNIC GROUP						
AFRICAN AMERICAN	21%	40%	21%	18%	17%	50%
AMERICAN INDIAN/ ALASKA NATIVE	28%	47%	29%	NA	14%	32%
ASIAN	15%	18%	6%	6%	7%	29%
LATINA	29%	31%	9%	13%	8%	27%
WHITE	11%	34%	16%	6%	7%	27%
OTHER SINGLE/MULTIPLE RACE	19%	32%	18%	15%	9%	28%

* Conditions diagnosed in lifetime

Note: Estimates with small sample sizes are Not Available (NA)

Source: 2001 California Health Interview Survey

As women get older they are more likely to report fair or poor health – 24% of women age 55-64 compared with 14% of women age 18-29. Among the measured chronic conditions, the prevalence of arthritis, asthma, and high blood pressure among women age 18-64 ranges from 13% to 16%, whereas the prevalence of diabetes and heart disease is lower, at 4% each.[3] Most of these health conditions increase with age. Compared to women age 18-29, arthritis and high blood pressure are at least eight times more prevalent among women age 55-64, affecting approximately four in ten women in this age group. Diabetes and heart disease affect 11% of women age 55-64, but are less prevalent among younger women. Asthma rates remain similar across all age groups.

Socioeconomic status is widely recognized as influencing health status.[4] Disparities in women's reported health status are seen by income level, with a pattern of poorer reported health status among women with lower incomes (Exhibit 2). Thirty percent of low-income women (family incomes below 200% FPL) report being in fair or poor health and very few of these women report their health as excellent (12%). In contrast, among women with family incomes at 200% or over the poverty level, 10% report fair or poor health.

Among women age 45-64, the prevalence of nearly all the health conditions varies by income status.[5] Arthritis, diabetes, heart disease, and high blood pressure are all

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

4 National Institutes of Health, Office of Research on Women's Health. *Women of Color Data Book*. Washington DC, Department of Health and Human Services: 1998.

5 We examined health conditions for women age 45-64 only, since rates of these health conditions are relatively low among women age 18-44.

more prevalent in low-income women. Asthma is the exception, with rates the same for low- and higher-income women.

There is also variation in reported health status among women by race/ethnic group, with women of color more likely to report fair or poor health than white women (Exhibit 2). Rates of fair or poor health range from 15% of Asian women to a high of 29% of Latinas, in comparison to 11% of white women. The lifetime prevalence of health conditions among women age 45-64 also varies across race/ethnic group. American Indian/Alaska Native women and African-American women have among the highest rates of arthritis, a condition that affects one-third or more of women in most race/ethnic groups. American Indian/Alaska Native women and African-American women also have among the highest rates of asthma, which ranges from 29% of American Indian/Alaska Native women to 6% of Asian women age 45-64. Diabetes has a three-fold range, from 6% of Asian and white women to 18% of African-American women. Heart disease shows a similar range, from 7% of Asian and white women to 17% of African-American women. High blood pressure has been ever-diagnosed in at least one in four women in each race/ethnic group, with the highest rate of 50% among African-American women.

HEALTH INSURANCE COVERAGE

Health insurance coverage is a critical resource that facilitates access to the health care system. Being uninsured can affect patient-provider relationships and also can have adverse repercussions on health status.[6]

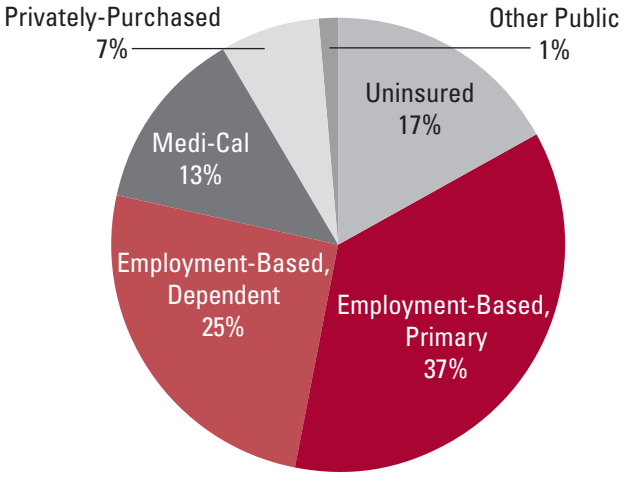
6 Hadley J, *Sicker and Poorer – The Consequences of Being Uninsured.* Medical Research and Review. Supp. Vol. 60:2. June 2003. Kaiser Commission on Medicaid and the Uninsured. *The Uninsured and Their Access to Health Care.* Washington DC. January, 2003. Collins KS, Hughes DL, Doty MM, et al. Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans. Findings from the Commonwealth Fund 2001 Health Care Quality Survey. New York, NY. March 2002. Committee on the Consequences of Uninsurance Board on Health Care Services, Institute of Medicine. *Care Without Coverage: Too Little Too Late.* National Academy Press, Washington DC. 2002.

A significant portion of women lack health insurance coverage, and many uninsured women have low incomes.

- 1.7 million California nonelderly women (17%) were uninsured in 2001 at the time of the CHIS 2001 survey.
- 69% of uninsured nonelderly women have family incomes below 200% FPL.
- One-fourth of nonelderly women, 2.4 million, were uninsured for some period in the past 12 months.

The leading source of coverage for women age 18-64 is employment-based insurance. Approximately six in ten nonelderly women (62%) have this form of coverage, obtained either through their own (37%) or a family member's employer (25%). Among working women, nearly three-fourths (72%) have job-based coverage. Medi-Cal, California's Medicaid program, also plays an important role for women in California, covering 1.3 million, or 13%. Privately purchased insurance, often an expensive coverage option, covers 7% of women. Other government programs, such as Medicare or CHAMPUS/VA, cover 1% of nonelderly women (Exhibit 3).

EXHIBIT 3: CURRENT HEALTH INSURANCE COVERAGE, WOMEN AGE 18-64, CALIFORNIA, 2001

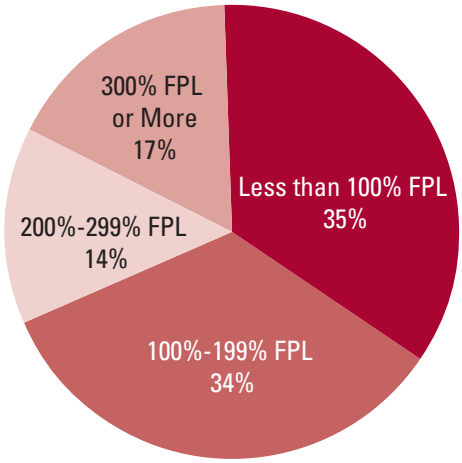


Note: Other public coverage includes CHAMPUS, VA, and Medicare.
Source: 2001 California Health Interview Survey

The various public and private sources of coverage make up a patchwork of options for women, but fail to cover all women. An estimated 17% of California women age 18-64 – 1.7 million – were uninsured in 2001 at the time of the CHIS 2001 survey. Despite being active in the labor market, approximately one in eight working women are uninsured.

The vast majority of California's uninsured nonelderly female population is low-income, with 69% living in families with incomes below 200% FPL (Exhibit 4). Yet, 17% of uninsured women have family incomes over 300% FPL, illustrating the reach of lack of coverage across income groups.

EXHIBIT 4: UNINSURED WOMEN BY FEDERAL POVERTY LEVEL (FPL), WOMEN AGE 18-64, CALIFORNIA, 2001



Source: 2001 California Health Interview Survey

Past Year Uninsurance

New data in the California Health Interview Survey offers information about women's experiences with coverage over the course of the previous year. This perspective is important since women's coverage status can change throughout the year due to changes in income, work, family situation, or public policies.[7] As Exhibit 5 illustrates, in addition to the 17% of women uninsured at the time of the survey (which is a point-in-time estimate), an additional 7% were insured at the time of the survey, but uninsured at some point in the previous 12 months. Thus, over a 12-month period, one-fourth (24%) of California women age 18-64 – 2.4 million – experienced some time without coverage. While this report focuses on currently uninsured women (those uninsured at the time of the survey) this longer past-year perspective highlights issues with health care coverage stability.

Main Reason for Lack of Coverage

The CHIS 2001 survey asked currently uninsured women why they lacked coverage. The most frequently mentioned reason was that they could not afford it. Nearly one-half of nonelderly uninsured women (46%) cited lack of affordability as their main reason for having no coverage. Among other reasons, which are mentioned much less often, are a change in employment situation (8%), not eligible due to citizenship or immigration status (8%), not eligible because of work status (6%), healthy so there is no need (6%), and employer did not offer (5%).

7 For other information about coverage stability see also Brown ER, Ponce N, Rice T, and Lavarreda SA. The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey. UCLA Center for Health Policy Research. Los Angeles, CA. 2002.

EXHIBIT 5: PERCENT AND NUMBER OF UNINSURED WOMEN, AGE 18-64, CALIFORNIA, 2001

	UNINSURED AT TIME OF INTERVIEW	CURRENTLY INSURED, BUT UNINSURED SOME TIME DURING PAST 12 MONTHS	TOTAL UNINSURED AT TIME OF INTERVIEW OR SOME TIME DURING PAST 12 MONTHS
ALL WOMEN	17% (1,726,000)	7% (686,000)	24% (2,412,000)

Source: 2001 California Health Interview Survey

Variation in Access to Health Insurance by Age, Income Status, and Race/Ethnic Group

Health insurance coverage is intricately connected to such factors as employment opportunities, family situation, income level, and public policies.[8] It is this backdrop of factors that often determine whether or not a woman has health insurance coverage. This section examines how women of different age groups, income levels, and race/ethnic groups fare in the current insurance system. Some highlights of this section are:

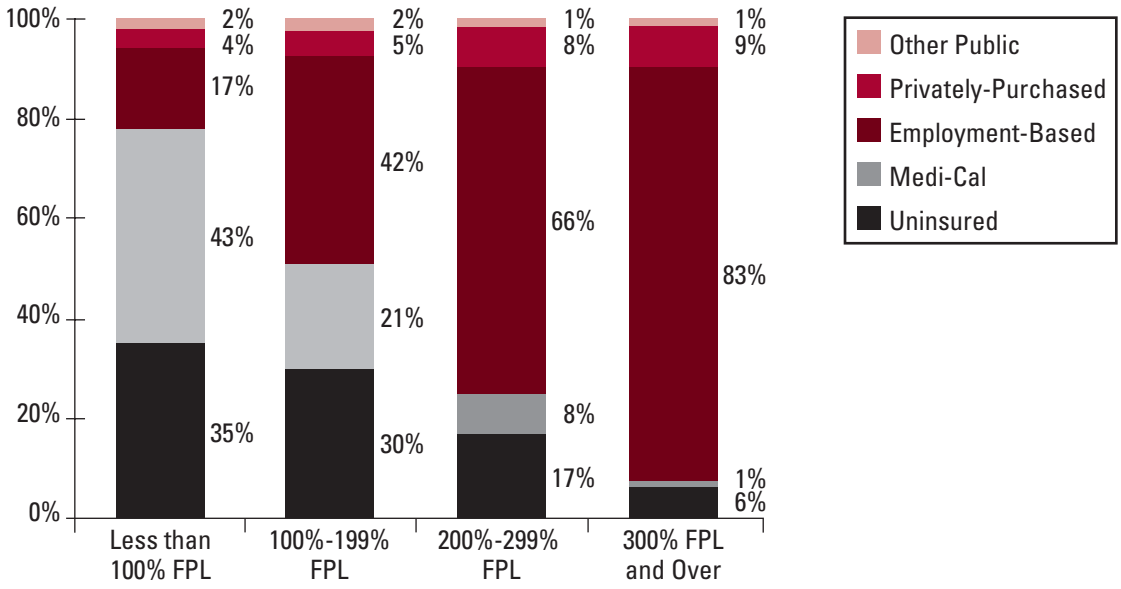
- Young women age 18-29 are the least likely to have job-based coverage and are the most likely to be uninsured.
- Women with incomes below 100% FPL are six times more likely to lack coverage than women with family incomes at or over 300% FPL.
- Latinas have the highest rate of uninsurance (34%), followed by Asian and American Indian/Alaska Native women (17% and 16%, respectively).
- Rates of job-based coverage range from a high of 72% among white women to the lowest rates for Latinas of 42%.
- Women who are non-citizens have very limited access to job-based coverage, leaving nearly four in ten uninsured.

Age Differences. Women's access to health insurance coverage changes across their lifespan, with younger women the most likely to lack coverage. One-fourth of women age 18-29 are uninsured and one-half have job-based coverage. Medi-Cal is an important coverage source for these younger women, covering 17%.

Uninsured rates decline with each successive age group and then stabilize at 12% for women age 45 and older. Job-based coverage rates increase by age group, peak among women age 45-54 (70%), then decline for women age 55-64 (65%). This is of concern since this last age group has the highest rates of health conditions and needs. Women age 55-64 privately purchase coverage (10%), possibly to compensate for declining job-based rates.

8 Collins SR, Schoen C, and Tenney K. *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help.* The Commonwealth Fund. New york, NY. 2003. Wyn R, and Ojeda VD. *Health Insurance Coverage of Single Mothers in California.* UCLA Center for Health Policy Research. Los Angeles, CA. 2002. Ellwood M. *The Medicaid Eligibility Maze: Coverage Expands, But Enrollment Problems Persist. Findings From a Five State Study.* The Kaiser Commission on Medicaid and the Uninsured. Washington, DC. September 1999.

EXHIBIT 6: CURRENT HEALTH INSURANCE COVERAGE BY FEDERAL POVERTY LEVEL (FPL), WOMEN AGE 18-64, CALIFORNIA, 2001



Note: Other public coverage includes CHAMPUS, VA, and Medicare.

Source: 2001 California Health Interview Survey

Family Income Differences. Women with the lowest family incomes are the most likely to be uninsured, and as family income rises, so does coverage (Exhibit 6). Thirty-five percent of poor women are uninsured, six times the rate of women with family incomes at or over 300% FPL. This disparity in uninsured rates is explained mainly by the wide difference in job-based coverage rates; just one in six poor women (17%) has this source of coverage compared to 83% of higher-income women.

Medi-Cal plays a critical role for poor women, covering four in ten. Yet, even with Medi-Cal, one-third of poor women are without coverage. Near-poor women (family incomes 100%-199% FPL) also have high uninsured rates (30%), yet their sources of coverage differ from those of poor women. Job-based coverage insures four in ten near-poor women and they are half as likely as poor women to have Medi-Cal, as a result of income-related eligibility criteria.

Over a one-year period, 45% of poor women and 38% of near-poor women experienced some period when they were uninsured. Further, women on Medi-Cal have less stable coverage than those with employment-based coverage. Among insured women age 18-44, one in five currently covered by Medi-Cal (19%) has been uninsured at some time during the previous year in contrast to 8% of those currently insured through job-based coverage. Insurance coverage of women in their middle years is more stable than that of younger women. Approximately one in ten women age 45-64 with Medi-Cal and fewer than one in 20 with employment-based insurance (3%) was uninsured at any time in the previous year.

EXHIBIT 7: CURRENT HEALTH INSURANCE COVERAGE BY RACE/ETHNIC GROUP, WOMEN AGE 18-64, CALIFORNIA, 2001

	UNINSURED	MEDI-CAL	EMPLOYMENT-BASED COVERAGE	PRIVATELY-PURCHASED	OTHER PUBLIC
RACE/ETHNIC GROUP					
AFRICAN AMERICAN	10%	26%	59%	2%	2%
AMERICAN INDIAN/ALASKA NATIVE	16%	21%	58%	NA	NA
ASIAN	17%	10%	64%	8%	1%
LATINA	34%	20%	42%	3%	1%
WHITE	9%	8%	72%	10%	1%
OTHER SINGLE/MULTIPLE RACE	17%	17%	55%	8%	NA

Note: Estimates with small sample sizes are Not Available (NA)

Source: 2001 California Health Interview Survey

Race/Ethnic Group Differences. Differences in access to employment-based coverage, as well as variation in Medi-Cal coverage, lead to disparities in insured rates among women by race/ethnic group (Exhibit 7). Rates of job-based coverage range from a high of 72% among white women to the lowest rate among Latinas of 42%. Job-based coverage rates fall in-between for other racial/ethnic groups – Asian (64%), African American (59%), and American Indian/Alaska Native (58%).

Latinas have the highest uninsured rate, with one-third without coverage. One in seven American Indian/Alaska Native women and one in six Asian women are uninsured (Exhibit 7). Lower uninsured rates are among African-American women (10%) and white women (9%), although patterns of coverage differ among these groups. African-American women are less likely to have job-based coverage than white women.

Medi-Cal provides coverage to women across all race/ethnic groups, but plays more of a role for Latinas, American Indian/Alaska Native women, and African-American women, covering at least one in five in each group. Privately purchased coverage, which is usually costly, is used by a small proportion of women.

Whereas the overall uninsured rate among Latinas is 34%, variation in coverage exists among Latina ethnic groups. Exhibit 8 displays information for selected Latina subgroups, where there was sufficient sample size to report information. Approximately four in ten Salvadoran and Guatemalan women, one-third of

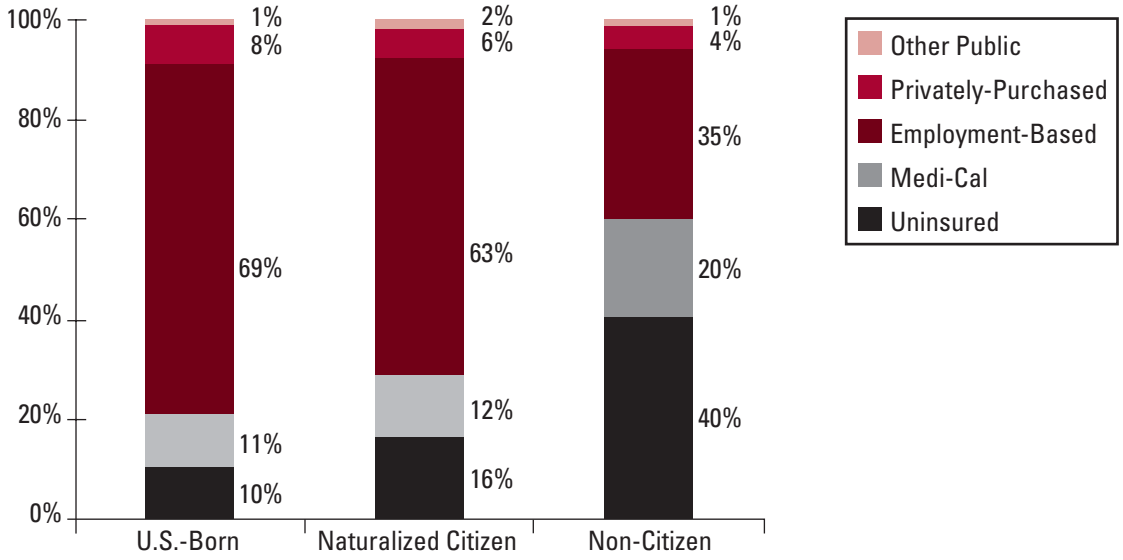
EXHIBIT 8: CURRENT HEALTH INSURANCE COVERAGE OF SELECTED LATINA ETHNIC GROUPS, WOMEN AGE 18-64, CALIFORNIA, 2001

	INSURED	UNINSURED
SELECTED LATINA ETHNIC SUBGROUPS		
GUATEMALAN	61%	39%
MEXICAN	66%	34%
SALVADORAN	56%	44%
SOUTH AMERICAN	76%	24%

Note: Insured women may have any of the following forms of insurance: employment-based, Medi-Cal, privately-purchased, CHAMPUS, VA, or Medicare

Source: 2001 California Health Interview Survey

EXHIBIT 9: CURRENT HEALTH INSURANCE COVERAGE BY CITIZENSHIP STATUS, WOMEN AGE 18-64, CALIFORNIA, 2001



Note: Other public coverage includes CHAMPUS, VA, and Medicare.

Source: 2001 California Health Interview Survey

Mexican-origin Latinas, and one in four South American Latinas are uninsured (Exhibit 8).

California differs from many other states because of its mix of immigrants and natives; one-fifth of nonelderly women (19%) are noncitizens, and 14% are naturalized immigrants, while about two-thirds are native-born. Significantly, women who are non-citizens have a higher uninsured rate and lower job-based coverage rate than women in other citizen groups (Exhibit 9). Four in ten non-citizen women are uninsured, a rate four times that of U.S.-born women and over twice that of women who are naturalized citizens.

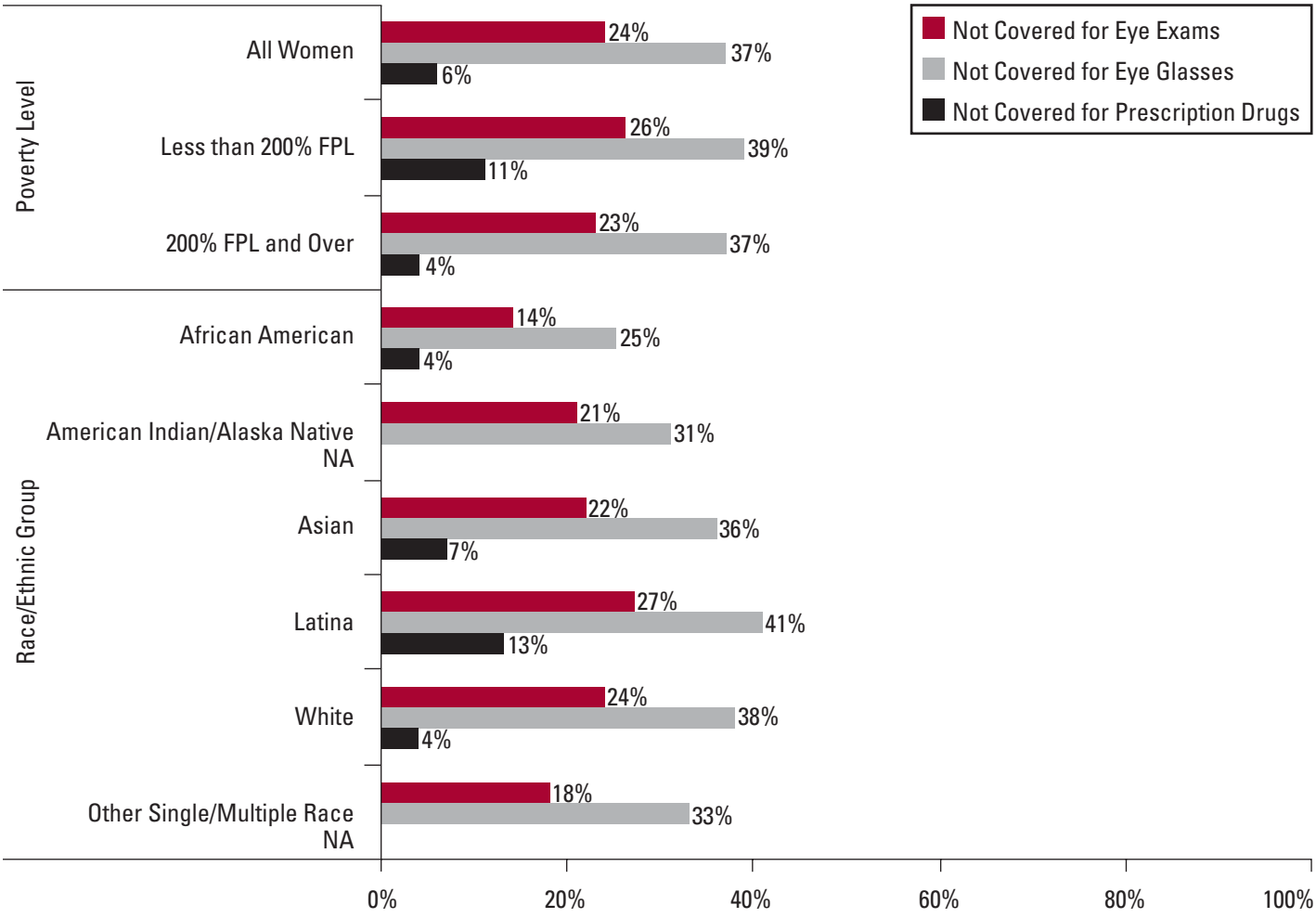
This disparity reflects the limited access of non-citizen women to job-based coverage, with a two-fold difference between their rate and that of U.S.-born women (35% vs. 69%, respectively).

Coverage of Selected Benefits

A critical component of health insurance coverage is the benefits offered. This section examines access to selected health care services – eye exams, glasses, and prescription medications.

Among insured women, one-fourth are not covered for eye examinations and nearly four in ten do not get eye glasses covered as a benefit (Exhibit 10). There are slight differences in coverage of these benefits by income level. Of the race/ethnic groups examined, lack of coverage among insured women for eye examinations ranges from 14% of African-American women to 27% of Latinas. And for eye glass coverage, among insured women, from 25% of African-American women to 41% of Latina women lack coverage of this benefit.

EXHIBIT 10: HEALTH CARE SERVICES NOT COVERED BY HEALTH INSURANCE PLAN, INSURED WOMEN, WOMEN AGE 18-64, CALIFORNIA, 2001



Note: Estimates with small sample sizes are Not Available (NA)

Source: 2001 California Health Interview Survey

As the costs of prescription medications rise, coverage for such medications becomes an important concern for all women. Overall, 6% of insured women report they lack coverage for prescription drugs. Low-income women are nearly three times as likely than their higher-income counterparts to lack coverage for this benefit (Exhibit 10).

ACCESS TO CARE ISSUES

A consistent relationship with a health care provider facilitates women's access to preventive screenings and other health care services. It also facilitates the timely receipt of care and continuity of care.[9] This section looks at which women have a usual source of care and, for low-income women, where they receive that care. Also addressed are new data that shows receipt of care in another country. Finally, this access to care section looks at how many and which women delay needed care. Some key findings include:

- Over one-third of uninsured women lack a usual place where they receive care.
- Low-income women are less likely to have a usual place where they receive care and when they do, it is more likely to be community and hospital clinics.
- About 3% of women obtain medical or dental care outside of the U.S. and a similar proportion obtain prescription medication in another country.
- About one in ten women delayed getting tests/treatments or prescription medications and nearly two in ten delay other types of health care services.

A consistent relationship with the health care system is an important component of health care. While the majority of nonelderly women have a regular place where they seek care, one in eight women (12%) do not. Younger women are less likely than those in older age groups to have a regular connection to the health care system; one in five women age 18-29 lack a usual source of care, two to three times the rate of women in the other age groups (Exhibit 11).

9 Salganicoff A, Beckerman JZ, Wyn R and Ojeda VD. Women's Health in the United States: Health Coverage and Access to Care. The Henry J. Kaiser Family Foundation. Menlo Park, CA. 2002. Misra D, ed. *Women's Health Data Book: A Profile of Women's Health in the United States*, Third edition, Table 8-3. Jacobs Institute of Women's Health and Henry J. Kaiser Family Foundation. Washington DC. 2001

EXHIBIT 11: NO USUAL SOURCE OF CARE BY AGE GROUP, HEALTH INSURANCE STATUS, AND RACE/ETHNIC GROUP, WOMEN AGE 18-64, CALIFORNIA, 2001

AGE GROUP	
18-29	20%
30-44	11%
45-64	7%
HEALTH INSURANCE STATUS	
UNINSURED	36%
MEDI-CAL	13%
EMPLOYMENT-BASED	6%
PRIVATELY PURCHASED	11%
OTHER PUBLIC	9%
RACE/ETHNIC GROUP	
AFRICAN AMERICAN	6%
AMERICAN INDIAN/ALASKA NATIVE	NA
ASIAN	14%
LATINA	19%
WHITE	9%
OTHER SINGLE/MULTIPLE RACE	14%

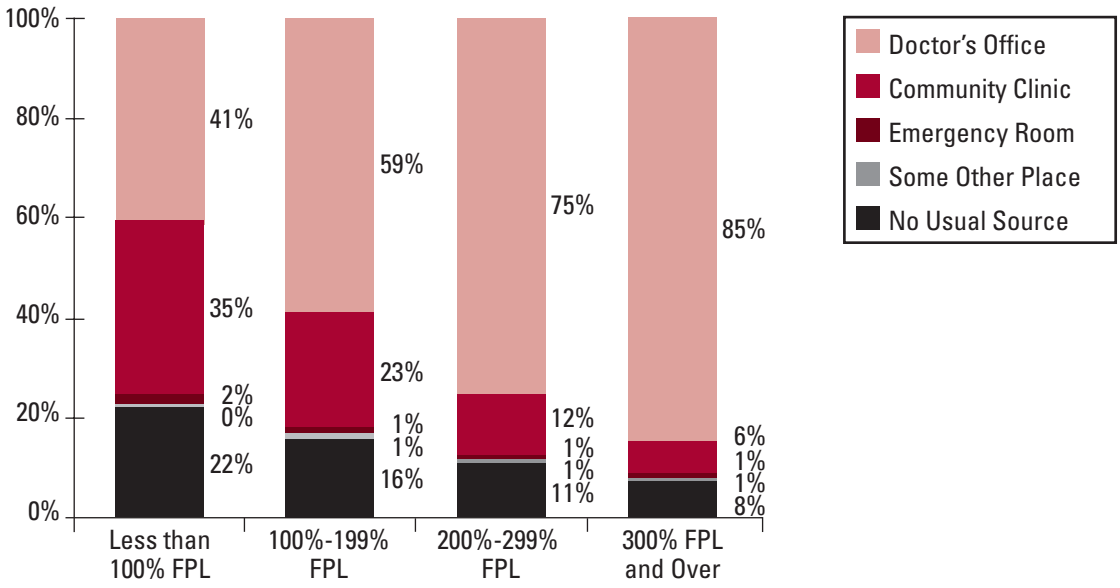
Note: Estimates with small sample sizes are Not Available (NA)
Source: 2001 California Health Interview Survey

Usual Source of Care

Lack of insurance coverage reduces women's access to a regular source of care (Exhibit 11). Over one-third of uninsured women (36%) lack a usual source of care, a rate approximately three times higher than for insured women, including those with Medi-Cal.

Even though Medi-Cal provides an important bridge for poor women to the health care system, there are striking income-related differences in access to a usual source of care and to where care is received (Exhibit 12). There is nearly a three-fold difference in lack of a usual source

EXHIBIT 12: USUAL SOURCE OF CARE BY FEDERAL POVERTY LEVEL (FPL), WOMEN AGE 18-64, CALIFORNIA, 2001



Source: 2001 California Health Interview Survey

of care between women with family incomes below the poverty level and those with incomes at or above 300% FPL (22% vs. 8%). Further, low-income women are more likely than higher-income women to rely on community clinics or hospitals as their primary source of care.

Use of Selected Services

Exhibit 13 shows the differences in doctor visit, receipt of a Pap test and mammogram by income level and insurance status. While there are differences in use by income level, the greater differences are seen by

EXHIBIT 13: USE OF SELECTED HEALTH SERVICES BY FEDERAL POVERTY LEVEL (FPL) AND HEALTH INSURANCE STATUS, WOMEN AGE 18-64, CALIFORNIA, 2001

	DOCTOR VISIT PAST YEAR	PAP TEST PAST THREE YEARS	MAMMOGRAPHY PAST TWO YEARS (WOMEN AGE 40-64)
ALL WOMEN	87%	87%	74%
POVERTY LEVEL			
LESS THAN 200% FPL	83%	82%	66%
200% FPL AND OVER	89%	89%	78%
HEALTH INSURANCE STATUS			
INSURED	90%	89%	78%
UNINSURED	70%	75%	50%

Source: 2001 California Health Interview Survey

EXHIBIT 14: DELAYS IN HEALTH CARE SERVICES BY FEDERAL POVERTY LEVEL (FPL), WOMEN AGE 18-64, CALIFORNIA, 2001

	DELAYED/DID NOT GET DOCTOR RECOMMENDED TEST OR TREATMENT IN PAST 12 MONTHS	DELAYED/DID NOT GET PRESCRIPTION MEDICATION IN PAST 12 MONTHS`	DELAYED/DID NOT GET OTHER MEDICAL CARE THOUGHT NEEDED IN PAST 12 MONTHS*
ALL WOMEN	10%	12%	17%
POVERTY LEVEL			
LESS THAN 200% FPL	8%	11%	17%
200% FPL AND OVER	11%	12%	17%

* Other medical care includes seeing a doctor, specialist, or other health professional

Source: 2001 California Health Interview Survey

insurance status. Across the three indicators measured, uninsured women are less likely to have seen a physician in the past year, had a Pap test in the past three years, and among women age 40-64, had a mammogram in the past two years.

Delays in Care

Exhibit 14 shows delays in receipt of (or forgone) health care. Approximately one in ten women report delays in getting tests/treatments (10%) or prescribed medications (12%) in the previous year. Nearly two in ten report delay in another kind of care (such as a referral to another doctor or specialist).

Out of Country Care

The 2001 California Health Interview Survey provides new data on the use of foreign medical services and purchase of prescription drugs by California's residents. A limited number of nonelderly women obtain medical or dental care outside of the United States; approximately 270,000 or 3% of all women do so. The group of women who purchase either medical or dental services outside the U.S. are mainly Latinas (72%), low-income (66%), and 71% are age 18-44. Additionally, more than one-half of women who obtain medical or dental care outside the U.S. are uninsured (52%), while approximately one-third (30%) have employment-based coverage.

In addition to health services, women were also asked about purchasing prescription medications outside the U.S.; approximately 329,000 or 3% of all nonelderly women do so. Of women who report purchasing prescription medications outside the U.S., about 45% are low-income, about one-half are Latinas (46%), 40% are white, about three in ten are age 18-29, and 39% are 30-44 years of age. Among women who purchase prescription drugs outside the U.S., one-third lack health insurance coverage, 46% have job-based coverage, and one in ten (11%) have coverage through Medi-Cal.

DISCUSSION AND POLICY IMPLICATIONS

The findings of this report show the variation among California's nonelderly women in their health status, health insurance coverage, and measures of access to health care. The study found patterns of problems with access among women of color and low-income women. As one would expect, the data illustrates that chronic health conditions are more common among women age 45-64 and there are important differences by income. Access to the health care system can facilitate detection and management of health conditions, yet nearly one-fourth of all women has lacked medical insurance at some time in the previous year. Even among those with coverage, many lack vision, and to a lesser extent, prescription coverage. Being uninsured is a serious barrier to establishing or maintaining a relationship with the health care system, and can influence the source and type of care women obtain.

The persistence of health status disparities requires targeted outreach for prevention and detection of chronic conditions for low-income women and those in communities of color. Reinforcing findings from other studies, CHIS 2001 data demonstrates that the health status of low-income women is worse than their higher-income counterparts. Low-income women have poorer health status than higher income women. And among women age 45-64, the lifetime rates of such chronic conditions as arthritis, diabetes, and high blood pressure are higher among women with low incomes. Rates of these chronic conditions among women vary by race/ethnic group and provide information about where targeted prevention and the need for regular monitoring by a health care provider are especially important.

Continued public and private efforts are necessary to increase health insurance coverage and continuity of that coverage among nonelderly women. About one-quarter of all women age 18-64 are either currently uninsured or have been uninsured at some time in the previous year; for many women, barriers to coverage are financial. Being uninsured or having gaps in coverage can have important consequences for women's health status if they delay or forgo care for acute or chronic health conditions. The current patchwork of insurance options for women leaves many without coverage, and low-income, Latinas, and noncitizen women are especially predominant among the uninsured. Women with Medi-Cal are at risk for gaps in their coverage, which can be an important barrier to regular access and use of health services. California's financial crises may result in restrictions to public programs that serve lower-income, single mothers, or women with chronic health concerns; such actions may further compromise women's access to and use of necessary health services.

The majority of California's uninsured women have low incomes, requiring solutions that account for their limited resources. The limited resources of many of California's uninsured women translates to few options to cover health care costs given their other competing necessities. Sixty-nine percent of uninsured nonelderly women have incomes below 200% of the Federal Poverty Level. Delays in expansion of Healthy Families to eligible parents adds to the health care uncertainty of low-income women.

Many women experience difficulties maintaining a stable relationship with the health care system. Lack of coverage or gaps in coverage can reduce women's ongoing connection to the health care system. Uninsured women are the least likely to have a regular provider. Women's connections to coverage, primarily the workplace (one's own or a spouse's) and public programs are vulnerable, especially during difficult economic times. Women on Medi-Cal especially are less likely to have continuous coverage over a year than privately insured women. This can disrupt connections with the health care system and create uncertainties about health care.

It is important to promote parity in scope and type of health benefits. To better protect their health, women also require access to vision care and prescription medications. Lack of benefits for these services may make women delay or forgo vision screenings or prescription medications for ongoing health conditions, negatively affecting their health status.

In conclusion, there are numerous groups of women who experience important barriers to maintaining their health. Additional efforts are necessary to reduce the impact of financial and health system obstacles for these women. The eroding economic situation further jeopardizes women's access to needed care, affecting all women, but particularly those already experiencing access difficulties, low-income women and women from different racial and ethnic groups.

METHODS

Data Source

This report is based on data from public use and source files of the 2001 California Health Interview Survey (CHIS 2001). CHIS 2001 randomly selected 55,428 households drawn from every county in California for its random-digit dial (RDD) telephone survey, providing a sample that is representative of the state's noninstitutionalized population living in households. Data was weighted to the 2000 Census at both the stratum and statewide levels. CHIS 2001 interviewed one sample adult in each household. In households with children, CHIS 2001 interviewed one adolescent age 12-17 and obtained information for one child under age 12 by interviewing the adult who was most knowledgeable about the child. This report is based on data from 25,588 women age 18-64.

CHIS 2001 interviews were conducted between November 2000 and September 2001. CHIS 2001 questionnaires were translated and interviews were conducted in six languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, Korean, and Khmer.

Definitions of Selected Variables

Race/ethnicity. CHIS 2001 respondents were first asked about their Latino origin. Subsequently, respondents identified which racial group they would use to describe themselves, with the option of selecting one or more groups from this list: Native Hawaiian and other Pacific Islander, American Indian and Alaska Native, Asian, African American, or white. Respondents who selected more than one racial group, or who said they were Latino and selected a racial group, were asked to identify which group they most identified with. Responses to this question were used to categorize

respondents who identified more than one race or ethnicity into the following categories: Latino, white, African American, Asian, Native Hawaiian and other Pacific Islander (NHOPI), American Indian and Alaska Native (AIAN), or multiple race. The sample sizes for Native Hawaiian and other Pacific Islander were too small to report.

Health insurance coverage. The categories of the health insurance variable are mutually exclusive and were assigned using a hierarchical process. Where respondents reported more than one source of coverage, the following hierarchical assignment order was used: Medi-Cal, Healthy Families, employer-based insurance, privately-purchased coverage, other public coverage, and uninsured.

Poverty Level. The Federal Poverty Level (FPL) varies by household income and household size. In 2001, the poverty threshold (100% FPL) was $9,044 for one person, $11,559 for a family of two, and $14,129 for a family of three. The poverty thresholds are available from the Census Bureau at: *http://www.census.gov/hhes/poverty/threshld/thresh01.html*

Data Methods

The data in this report was analyzed using SAS and SUDAAN, statistical packages frequently used in analyses of survey data. Sampling tolerances at the 95 percent confidence interval were used to evaluate 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 25%, the cell size of the estimate, and confidence intervals to determine the reportability of an estimate.

For more information on CHIS or detailed survey methodologies, please visit: *www.chis.ucla.edu*

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