HEALTH CONCERNS ACROSS A WOMAN'S LIFESPAN:
The Commonwealth Fund 1998 Survey of Women's Health

Karen Scott Collins, Cathy Schoen, Susan Joseph, Lisa Duchon,
Elisabeth Simantov, and Michele Yellowitz

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PREFACE

Fueled by recognition of health issues unique to women and differences in health and health care experiences between women and men, many groups—researchers, health professionals, policymakers, and women themselves—are working together to develop strategies for improved care and quality of life. The emphasis on women's health stems from a concern that it has been an important social issue often hidden by popular misconceptions, research neglect, or women's own silence.

In 1993, The Commonwealth Fund established the Commission on Women's Health, a five-year initiative charged with increasing public awareness of women's health issues and identifying opportunities for improving their health and quality of life. The Fund began the Commission work with a national survey on women's health, which yielded baseline data and new information about significant health concerns.[1] To assess progress to date and challenges for the future, the Fund commissioned Louis Harris and Associates, Inc., to conduct a follow-up survey, *The Commonwealth Fund 1998 Survey of Women's Health*.

This report highlights key survey findings and serves as an update on women's health. Overall, women's voices reveal a mixed story. Over the past five years they and their physicians appear to have greater awareness of steps that can be taken to assure healthy and productive lives, yet progress toward promoting various health behaviors has been uneven. Disturbingly high rates of violence and abuse; increased numbers of uninsured women; and serious health problems and lack of access to health care among lower-income women combine to underscore a need for continued efforts to improve all women's access to high-quality health services and health education.

Given the challenges ahead, The Commonwealth Fund plans to continue work on women's health under the direction of Karen Scott Collins, M.D., M.P.H. The Fund will join others to ensure that the voices of women are heard and that steps are taken toward improved women's health care.

Karen Davis
President
The Commonwealth Fund

[1] M.M. Falik and K.S. Collins, M.D., eds., *Women's Health: The Commonwealth Fund Survey,* Johns Hopkins University Press, Baltimore, Maryland, 1996.

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OVERVIEW OF SURVEY FINDINGS

Overall, *The Commonwealth Fund 1998 Survey of Women's Health* finds a mixed story with respect to progress in health care over the past five years. Women today are more knowledgeable about some health issues and are taking steps to stay healthy. Progress has been uneven across various aspects of health care, however, and significant gaps remain in access to essential care. Violence persists as a significant factor in the lives of women—lifetime rates of violent or abusive events are disturbingly high. Strikingly, more women are uninsured today than five years ago—despite an improved economy—creating access barriers to health care.

The survey findings are based on telephone interviews with 2,850 women and 1,500 men, including oversamples of African American, Hispanic, and Asian American women. (See appendix 2 for methodology.) Conducted by Louis Harris and Associates, Inc., from May through November 1998, the interviews provide a current look at access to care, health knowledge, health-related behaviors, violence, depression, use of hormone replacement therapy, and informal caregiving roles. The 1998 survey generated findings in several major areas, including:

Preventive care. Although breast and cervical cancer screening are central health care procedures, overall receipt of these clinical preventive services has changed little since 1993—despite the potential for increased emphasis on prevention through the growth of managed care. Notably, lower-income and less-educated women appear less likely than higher-income, more educated women to receive regular preventive services and counseling on choices of hormone replace therapy. In addition, smoking rates among women have remained at 1993 levels, with rates notably higher among lower-income women.

The good news is that mammography rates are moving in the right direction: among women age 50 and older, they have increased from 55 to 61 percent. Women's exercise rates are also up, and familiarity with osteoporosis and use of calcium supplements has increased since 1993. This progress, however, has been greatest among upper-income and college-educated women, and lower-income women lag far behind.

Violence and abuse. The 1998 survey found disturbingly high rates of violence and abuse rates among women, crossing income, ethnic, and geographic lines. Nearly two of five women (39%) report violence or abuse in their lifetime. Contrasts of health status among those with any experiences of violence and abuse reveal their corrosive effects, including

significantly worse physical and mental health status across an array of indicators. Gaps in the extent of physician counseling on violence and abuse indicate that physicians are missing opportunities to discuss such sensitive topics. In general, the survey finds low rates of physician counseling across an array of topics related to women's health.

Caregiving. Nine percent, or more than nine million women, are currently caring for a sick or disabled family member, often devoting 20 hours or more to provide supportive care. More needs to be done to support this important social role. Today, time burdens and lack of paid help weigh especially heavily on women with below-average family incomes.

Health and economic security. The tie between overall health and economic security is telling. Good health and access to health care often depend on having a good job, while keeping a job depends on staying healthy. Poor health or family caregiving responsibilities can reduce opportunities to work, adding to economic stress. Half of all non-working women with incomes of $16,000 or less have a disability limiting their capacity to work or are caring for a sick or disabled child, spouse, parent, or other family member.

Insurance status and access to care. Despite a robust economy in 1998, more women are uninsured today than in 1993. Uninsured rates are up significantly among women with below-average incomes, perhaps reflecting welfare reform as well as continued erosion of employer-sponsored coverage. Although the vast majority of uninsured women were working full time or married to a full-time worker, half of women with family incomes of $16,000 or less—the bottom fourth of the income distribution of working age women—were uninsured when surveyed or had spent a time uninsured in 1998. Lack of insurance greatly increases the likelihood that lower-income and minority women will not obtain needed health care and will fail to receive regular preventive care.

The survey findings point to the challenge ahead in supporting women's efforts to lead healthy, productive lives while meeting family health concerns. Taking steps forward in women's health is likely to require the concerted efforts of health researchers, professionals, policymakers, and women as patients and advocates to ensure greater progress in the future.

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SURVEY FINDINGS

NO MAJOR IMPROVEMENTS MADE IN PREVENTIVE CARE

Although improving breast and cervical cancer screening rates have been central goals for women's health care over the past five years, overall receipt of clinical preventive services has changed little from 1993 to 1998. Mammography rates for women age 50 and older, however, did increase from 55 to 61 percent.

One-half to two-thirds of women received preventive care in the past year. For example, 61 percent of women received a physical exam, 66 percent received a clinical breast exam, 64 percent received a Pap test, and 55 percent received a blood cholesterol test in the past year. These rates are virtually the same as those for 1993. (See appendix table 1.)

For certain services, nearly one of five women had not received preventive care in the past three years. National guidelines for cervical cancer screening allow that Pap tests be performed less frequently than once a year for women at very low risk. Nevertheless, 18 percent of all women did not have a Pap test during the last three years.

Receipt of preventive care was lowest among Asian American women. Less than half of Asian American women had received the preventive services asked about in the survey. For Hispanic women, rates for physical exams, blood cholesterol tests, and clinical breast exams were below those for white and African American women: one of two Hispanic women had received these services in the past year. For women age 50 and older, mammography rates varied little among white, African American, or Hispanic women surveyed. (See appendix table 2.)

More should be done to screen older women for colon cancer. Only 25 percent of women age 50 and older had been screened for colon cancer in the past year. More than one-half (53%) of women in this age group who had not been screened for colon cancer in the past year had also not been screened in the past five years. Rates for colon cancer screening were not markedly different when broken down by income or race. Men had higher rates; nonetheless, only 38 percent reported they had been screened.

Higher use of preventive services was associated with increasing income and educational levels. The proportion of women age 50 and older, for example, who had received a mammogram in the past year ranged from 49 percent of those with incomes of $16,000 or less to 83 percent with incomes above $50,000. Preventive care rates among

different income groups were unchanged since 1993, except for the highest income group, for which rates increased. The association with educational level was similar: one-half of women with less than a high school education had received a physical exam or breast or cervical cancer screening in the past year, compared with two-thirds to three-quarters of women with a college education or more. (See appendix tables 3 and 4.)

African American and Hispanic women appear to have gained ground in breast cancer screening. Among African American women age 50 and older, mammography rates increased from 37 percent in 1993 to 66 percent in 1998; for Hispanic women, they rose from 54 to 64 percent.[2]

Uninsured women remained at greatest risk for not receiving preventive care. Nearly one of three women without health insurance (30%) did not receive preventive care in the past year, compared with one of seven insured women. Less than half of uninsured women had a physical exam or breast cancer screening during this time, and just over half of uninsured women had a Pap test. Uninsured women age 50 and older had the lowest rates of colon cancer screening (9%), another indication that having any type of insurance, private or public, makes a difference in whether a woman receives preventive care. Variations in rates of preventive care among different groups of insured women are generally not as great as variations between the insured and uninsured (See appendix table 5.)

MANAGED CARE IS WIDESPREAD BUT NOT YET DELIVERING FULLY ON IMPROVED ACCESS TO PRIMARY AND PREVENTIVE CARE

As of 1998, three of four (76%) insured women under age 65 were in a health maintenance organization (HMO) or preferred provider organization (PPO), or in a health plan having some type of managed care feature, such as a primary care referral requirement for specialist services.[3] Enrollment in managed care is now high across all income groups and among women of all racial and ethnic backgrounds.

The survey finds that managed care has not yet yielded significant improvements in women's access to care or preventive care. Compared with women who had traditional fee-for-service (FFS) coverage, women in managed care were more likely to receive some but not all preventive care. They were more likely to report having a regular source of care. Comparisons of the care experiences of women ages 18 to 64 in managed care versus FFS

[2] The trend for African American women is consistent with recent National Health Interview Survey analysis findings that the greatest increase in mammography screening from 1991 to 1994 occurred among low-income, African American women. D. Makuc et al., "Low Income, Race, and the Use of Mammography," *Health Services Research* 34 (April 1999):part II, pp. 229–239.

[3] Coverage was classified as managed care for insured women who answered yes to at least one of three questions: Is your health plan an HMO or a PPO? Does your health plan require you to get a referral from your primary care physician in order to receive specialty care? Does your plan require you to get a referral from your primary care physician in order to visit an OB-GYN (obstetrician-gynecologist)?

indicated similar levels of access difficulties and low levels of physician counseling on a range of health topics. (See appendix table 7.)

Managed care rates are now high among all insured women under age 65. Rates were high across income groups, ranging from 69 percent of insured women with incomes of $16,000 or less to 81 percent of insured women with incomes above $50,000.

Reflecting the spread of managed care, women frequently needed the permission of their primary care physician before seeing a specialist or an obstetrician-gynecologist (OB-GYN). Three of four women ages 18 to 64 in managed care (75%) reported that they needed a primary care physician referral prior to seeing a specialist. Although referral requirements for OB-GYN care are less restrictive than those for other specialist services, one of four women (23%) said they needed such referrals.

By some, but not all, measures, managed care plans have been more successful than FFS plans in making sure women receive regular preventive care. For example, 74 percent of women in managed care reported having a Pap test in the past year, compared with 67 percent of women in FFS. In contrast, mammography rates for women age 50 and older were not significantly different: 72 percent of women ages 50 to 64 in managed care, compared with 70 percent of women in FFS, reported receiving a mammogram in the past year. While women in managed care had slightly higher rates of preventive care, one of four women still did not receive screening for cervical or breast cancer in the past year. (See appendix table 7.)

Women in managed care were more likely to identify a particular doctor as their regular source of care. The vast majority of insured women said they had a particular doctor who is their regular source of care. Rates for women in managed care plans were higher than those for women with traditional insurance: nearly nine of 10 of women in managed care (87%) reported they had a regular doctor, compared with 78 percent of women in FFS.

Health plans have been making some outreach efforts to ensure preventive care services. Just over one of four women (27%) enrolled in managed care reported that their health plan sends them reminders for preventive care services, compared with slightly fewer than one of five women (18%) with traditional insurance.

Regardless of insurance type, insured women reported similar rates of health care access problems and ratings of physician care. Women in managed care were as likely as those in FFS to report problems getting needed care, filling a prescription because of cost, or seeing a specialist for needed care. One of five insured women under age 65, in both managed care and FFS, reported at least one of these access problems. On average,

women gave similar ratings to their physician care, whether judged by the likelihood of a strongly positive (excellent) or negative (fair or poor) rating. (See appendix table 8.)

WOMEN REPORT IMPROVEMENTS IN KNOWLEDGE ABOUT SELECTED HEALTH CONDITIONS AND BEHAVIORS

In the past five years, federal agencies and state and local groups concerned with women's health have mounted public campaigns to increase women's awareness of the benefits of behaviors likely to enhance long-term health. The survey finds evidence of pay-off for some—but not all—of these public health campaigns.

Contrasts of the 1993 and 1998 surveys find a sharp increase in the proportion of women who are aware of osteoporosis and that women are taking the steps to prevent health problems later in life, including taking calcium supplements. The percentage of women exercising three or more times per week has also risen since 1993, although this activity is concentrated among higher-income women. Smoking rates among women, however, have remained high and are virtually unchanged since 1993.

Women, particularly those age 65 and older, had increased familiarity with osteoporosis. By 1998, 36 percent of women said they were "very familiar" with osteoporosis, compared with 30 percent in 1993. Familiarity was greatest among older women: 47 percent of women age 65 and older were "very familiar" with osteoporosis, compared with 27 percent of women ages 18 to 44. Familiarity has also increased the most among older women since 1993.

More women were taking calcium supplements. Thirty-nine percent of women in 1998 were taking calcium supplements, compared with 28 percent in 1993. The rise in use was most marked among older women, whose use increased from 39 to 57 percent, compared with a rise from 38 to 52 percent for women ages 45 to 64. In contrast, the proportion of younger women (ages 18 to 44) who were taking calcium supplements in 1998 was 26 percent, up from 20 percent in 1993. Supplement use was also greatest among women with higher incomes and higher education.

Women were drinking milk and/or eating other foods to get extra calcium. Seventy-seven percent of women who were not taking calcium supplements said they were consuming milk and/or other calcium-rich foods to get enough of the nutrient in their diet.

Overall, more women were exercising frequently in 1998 than 1993; yet, increases were concentrated among higher-income women. Thirty-nine percent of women in 1998 reported exercising three or more times per week, compared with 31 percent of women in 1993. Improvements in rates of frequent exercise were greatest among women

with higher incomes: in 1998, 48 percent of women with incomes above $50,000 exercised three or more days per week, compared with 33 percent in 1993. In contrast, the proportion of lower-income women who exercised three or more days per week changed little, rising from 29 to 32 percent over the five-year period for women with incomes of $16,000 or less.

Minority women may not be receiving health information that could improve their quality of life, or may experience more barriers to following through on health-promoting behaviors. Familiarity with osteoporosis and use of calcium supplements was markedly lower among minority women: 25 percent of African American women, 19 percent of Hispanic women, and 17 percent of Asian American women said they were "very familiar" with osteoporosis, compared with 41 percent of white women. African American and Hispanic women were less likely to be taking calcium supplements (21% and 29%, respectively) than white women (44%). Thirty-two percent of African American and Hispanic women, and only 16 percent of Asian American women, exercised three or more times per week, versus 42 percent of white women.

Anti-smoking campaigns appeared to have had little impact among women, as smoking rates were for the most part unchanged. Rates in both 1993 and 1998 were highest among low-income women. One-quarter of women (23%) were smokers in 1998. Low-income women were more than twice as likely to smoke cigarettes as higher-income women: 32 percent of women with incomes of $16,000 or less were smokers, compared with 13 percent of women with incomes above $50,000.

Perhaps reflecting the increased attention to women's health concerns over the past five years, women were more likely to give excellent ratings to their physicians in 1998 than they were in 1993. In 1998, 54 percent of all women rated their physicians excellent in providing good overall health care, compared with 44 percent of women in 1993. In addition, 57 percent of women in 1998 gave their physicians excellent ratings in really caring about them and their health, versus 44 percent in 1993.

MORE WOMEN ARE USING HORMONE REPLACEMENT THERAPY AT MENOPAUSE

Whether to use hormone replacement therapy (HRT) at menopause for the prevention of heart disease, osteoporosis, or menopausal symptoms has become a central health care issue for women at midlife. The survey finds that one of three women in this age group was using hormone replacement therapy in 1998, up from one of four women in 1993. Use of HRT is heavily concentrated among higher-income and more educated women.

Physician counseling and recommendations are likely to figure strongly in women's decisions to begin hormone replacement therapy. Yet, just over one-third of women age 50 and older had physician counseling on this issue in the past year. Women with low incomes or

less than a college education were the least likely to report physician counseling on hormone therapy options.

Use of HRT has increased significantly over the past five years. Thirty-four percent of women age 50 and older said they were using HRT in 1998, compared with 23 percent in 1993. Sixty-five percent of women using HRT said they had been doing so for five years or more.

Increases in HRT use were most pronounced among higher-income women. Among women age 50 and older, 57 percent with incomes above $50,000 were using HRT in 1998, compared with 41 percent in 1993. A more modest rise in HRT use has occurred among women in this age group with incomes of $16,000 or less—from 17 to 21 percent. A similar relationship holds between increased HRT use and level of education. (See appendix tables 3 and 4.)

Use of HRT varied by race. Among women age 50 and older, African Americans were least likely to be using HRT (16%) in 1998, compared with Hispanic women (23%) and white women (37%).

Women's decisions for starting hormone replacement therapy were related to their physician's counseling. Among women age 50 and older who were using HRT, 64 percent reported they decided to do so based on a physician's recommendation. Counseling rates varied significantly by race and ethnicity. African American women were least likely to report they had been counseled by their physician about HRT. Furthermore, of those women not using HRT, African American women were most likely to report they had never heard of it.

The women most likely to be using HRT—those who are college-educated and those who have higher incomes—were also most likely to receive physician counseling on the subject. Women with higher levels of income and education were most likely to receive counseling on hormone replacement therapy. Just over one-third of women age 50 and older said their doctors discussed HRT with them in the past year, though discussion of the topic varied strongly with income and education. Among women age 50 and older, only 22 percent with less than a high school education reported being counseled on the use of hormone replacement therapy, compared with 58 percent of women with a college education or more. Nearly two of three (61%) women with incomes above $50,000 reported that their physicians had discussed HRT with them in the past year, compared with one-quarter of women with incomes of $16,000 or less.

MISSED OPPORTUNITIES FOR PHYSICIAN COUNSELING

The role of physicians and other health providers in influencing their patients' health behaviors through counseling is an important component of prevention. Physician counseling that could promote health in most areas is limited. Although one-half of women had received counseling on diet and exercise in the past year, other important health issues and behaviors were less frequently discussed.

Women reported they had received limited physician counseling on health behaviors. Less than one-half of women reported that their doctors discussed such issues as exercise (49%), diet (46%), calcium intake (41%), smoking (29%), and alcohol and drug use (23%) with them in the past year. These rates did not vary significantly for women with different levels of income or education. (See appendix tables 7 and 9.) Low-income women, however, were more likely to say they had been counseled on smoking (37%), which is consistent with the higher rates of smoking found for this group of women.

Physicians discussed violence at home and sexually transmitted diseases (STDs) most often with low-income and less-educated women. The health topics least often discussed by physicians with their female patients were STDs (16%) and safety and violence at home (8%). Women with low incomes and less education, however, were more likely to have had discussions with their physicians on these topics: among women with incomes of $16,000 or less, 25 percent had discussed STDs, and 12 percent said a doctor had discussed violence at home. Similar variations occurred across educational levels. (See appendix tables 3 and 4.)

VIOLENCE AND ABUSE RATES DURING WOMEN'S LIFETIMES REMAIN HIGH, WITH NEGATIVE LONG-TERM HEALTH EFFECTS

The survey finds that many American women experience violence or abuse in their lifetimes. Nearly two of five women (39%) had at some point been physically or sexually assaulted or abused, or had been a victim of domestic violence. While low-income women were at somewhat higher risk, violence cut across economic, racial, and other demographic characteristics. Comparisons of health status indicators for those who did and did not report violence or abuse strongly suggest that violence and abuse have lasting negative effects on women's physical and psychological well-being. Women with any type of violence or abuse in their history were significantly more likely to report they were in fair or poor health and nearly twice as likely to have depressive symptoms or to have been diagnosed with depression or anxiety.

Lifetime exposure to violence is high among women. Two of five women reported having experienced at least one type of abuse or violence in their lifetime, including physical or sexual abuse as a child, rape or assault, or domestic violence.

Lifetime exposure to domestic abuse is disturbingly high, affecting nearly one-third of all women.[4] Thirty-one percent of women reported having experienced domestic violence by a spouse or boyfriend. Although rates of domestic violence were somewhat higher among lower-income women, they remained high regardless of socioeconomic status. One of four women with incomes above $50,000 (26%) reported domestic abuse in her lifetime by a spouse or boyfriend, as did 37 percent of women with incomes of $16,000 or less. Rates varied little for women when comparing by race/ethnicity, educational level, or geographic location. (See appendix tables 9 and 10.)

One of five women said she had been raped or assaulted in her lifetime. Nine percent of women report being raped in their lifetime. Low-income women ($16,000 or less) were at a higher risk of being raped or assaulted. Nearly one of three low-income women (29%) experienced either, compared with 15 percent of women with incomes above $50,000, and 21 percent of all women.

Childhood abuse affected one of six women. Sixteen percent of women experienced physical and/or sexual abuse during childhood. Eleven percent of women were physically abused and 10 percent were sexually abused as children. Women with incomes of $16,000 or less were twice as likely to have experienced childhood physical or sexual abuse than women with incomes above $50,000 (21% vs. 12%).

Women with a history of childhood abuse were at higher risk of experiencing domestic violence later in life. Nearly two-thirds (62%) of women reporting childhood abuse had experienced domestic violence as an adult, compared with one-quarter of women without a history of childhood abuse.

Abused women were at high risk for psychological problems. Half of women with a history of any type of violence or abuse reported high levels of depressive symptoms, compared with a third of women with no history of abuse. Thirty-six percent of women with a history of childhood abuse and 34 percent of those who have been raped or assaulted had received a diagnosis of anxiety or depression from a physician within the past 5 years, compared with 14 percent and 13 percent, respectively, of women without such a history.

Abused women also had more physical health problems. Women who had been exposed to violence in their lifetime were more likely to report they were in fair or poor health and had higher rates of disability. Twenty-one percent of women with a history of violence or abuse rated their health as fair or poor, compared with 15 percent of women

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[4] Domestic violence is defined in the survey as having responded yes to any of the following items: spouse or boyfriend has ever thrown something at you; pushed, grabbed, shoved, or slapped you; kicked, bit, or hit you with a fist or some other object; beaten you up; choked you; forced you to have sex against your will.

without such a history. Additionally, one fifth of women with a history of violence or abuse reported having a disability or illness that limits their work or daily activities, compared with 15 percent of women without a history of violence. (See appendix table 11.)

Women may engage in unhealthy behaviors to cope with violence. Women who had experienced any type of violence in their lifetime, for example, were twice as likely as other women to smoke (32% vs. 16%).

One of three women with a history of violence or abuse faced problems with access to health care in the past year. Women who had been victims of rape, physical or sexual assault, childhood abuse, or domestic violence were twice as likely to have access problems as those who had never been abused (32% vs. 15%). These problems included not getting needed medical care, not filling a prescription because of cost, or not being able to see a specialist when needed. In addition, abused women were nearly three times as likely not to see a mental health professional when needed, compared with women without a history of violence or abuse (14% vs. 5%).

While three-quarters of women exposed to domestic abuse had discussed these incidents with a friend or relative, only 29 percent had discussed them with a physician or health care professional. Among abused women who discussed their abuse with a doctor, only one of five reported that the doctor raised the subject. Similarly, 30 percent of women who had experienced childhood abuse disclosed this information to a physician, and 28 percent of women who had been raped or assaulted sought medical attention.

The health care system may not be adequately responding to abused women's needs for referrals and support. Of women who discussed their abuse with a doctor, less than half were referred to a support service (44%) and less than one-quarter were referred to the police (23%).

MANY WOMEN AT RISK FOR HIGH DEPRESSIVE SYMPTOMS

Consistent with many studies, the survey finds that women are more likely than men to have problems with depression and anxiety. Two of five women reported having a high level of depressive symptoms in the past week.[5] Several types of circumstances put women at higher risk for depressive symptoms, including having low incomes and economic stress, caregiving responsibilities, lack of social support, and physical illness or disability. A history of violence or

[5] The depression scale was based on a series of questions concerning how frequently the respondent felt a certain way in the previous week. Responses to statements such as "I felt depressed," "My sleep was restless," "I had crying spells," "I enjoyed life," "I felt sad," or "I felt that people disliked me" were summed up for a total score on depression. Three categories of depression were created that were based on the distribution of scores for all respondents: Low (0–2), Moderate (3–5), and High (6–18).

abuse also markedly diminished psychological well-being as measured by depressive symptoms or a diagnosis of depression. In addition, the survey finds that women may be receiving only limited help for their problems.

Women were more likely than men to report feeling depressed in the past week. Thirty-nine percent of women reported having high levels of depressive symptoms in the past week, compared with 26 percent of men. Furthermore, 17 percent of women reported having been diagnosed with anxiety or depression by a physician in the past five years, compared with 8 percent of men.

Younger women were more likely to have depressive symptoms. Forty-four percent of women ages 18 to 44 reported a high level of depressive symptoms in the previous week, compared with 34 percent of women ages 45 to 64 and 33 percent of women age 65 and older. Across age groups, women had higher rates of depressive symptoms, compared with men. (See appendix table 12.)

African American women reported somewhat higher levels of depressive symptoms. Forty-six percent of African American women had a high level of depressive symptoms, compared with 37 percent of white women, 43 percent of Hispanic women, and 41 percent of Asian American women. African American and white women reported comparable rates of physician-diagnosed depression or anxiety. (See appendix tables 13 and 14.)

More than one-half of women under economic stress had high levels of depressive symptoms. Among women with incomes of $16,000 or less, 52 percent reported having a high level of depressive symptoms, compared with 29 percent of women with incomes above $50,000. Women who reported experiencing a lot of difficulty paying for basic needs such as food, telephone service, gas, and electricity were more than twice as likely (68%) to experience high depressive symptoms as women who reported no such difficulty (32%).

Single women with children experienced higher rates of depressive symptoms. Single women with children—including never married, widowed, divorced, and separated women with children under age 18—were more likely to suffer from high depressive symptoms than were married women with children (51% vs. 38%).

Two-thirds of women without social support had high levels of depressive symptoms. Women who lack a source of support when feeling stressed, overwhelmed, or depressed were nearly twice as likely as those who had support to report high levels of depressive symptoms (68% vs. 36%).

Women who had general health problems were also more likely to have high depressive symptoms. Three of five women who rated their health as fair or poor (60%) reported high depressive symptoms, compared with one of three women who rated her health as excellent or good (35%). Women who said that a disability, handicap, or chronic disease kept them from participating fully in school, work, or other activities were more likely than women with no disability to report high depressive symptoms (56% vs. 36%).

One of five women (19%) thought she had a time in the past year when she needed to see a health professional because she felt depressed or anxious. Only one of 10 (11%), however, saw a professional when she needed mental health services. Among women with high depressive symptoms, more than one of three (37%) thought she needed to see a mental health professional in the past year, yet only one of five (20%) actually did.

Women were more likely to seek help for mental health concerns from a general physician than from a mental health specialist. Of those women who consulted a health professional for mental health services, 42 percent saw a general physician, 18 percent saw a social worker/mental health counselor, 16 percent saw a psychiatrist, and 17 percent saw a psychologist.

Women with high depressive symptoms reported more health care access problems. One of three women with high depressive symptoms reported she could not get needed care, see a specialist, or fill a prescription because of cost, compared with 12 percent of women with no or few symptoms. Women with high depressive symptoms also reported that they had an extremely, very, or somewhat, difficult time getting care (26%), compared with 9 percent of women with no or few symptoms.

WOMEN'S CAREGIVING ROLES

Women, more than men, fill the role of caring for sick or disabled relatives—in addition to fulfilling work and child-rearing responsibilities. Caregiving responsibilities appear to fall on women uniformly, regardless of income, race, or even marital status. The extent of their responsibilities, however, does vary with family resources. In addition, women providing this care often have their own health problems.

Overall, 6 percent of adults surveyed said they were caring for a sick or disabled relative. In 1998, 9 percent of women were caring for a sick family member, compared with 4 percent of men. Women with annual incomes below the national median of $35,000 were as likely as women above the median to be caregivers (11% vs. 9%).

Most women caregivers were in their prime years of employment and child rearing. Caregiving responsibilities may take a particular toll on women who are already balancing work and family demands. Women of all ages were providing caregiving to sick or

disabled family members, although a somewhat higher percentage of women ages 45 to 64 (13%) were fulfilling a caregiving role than were women ages 18 to 29 (7%), 30 to 44 (10%), and 65 and older (7%).

Although women in different income groups were equally likely to fulfill a caregiving role, lower-income women faced a greater time commitment and economic toll. Heavy time burdens are associated with caregiving. Forty-three percent of all women with caregiving responsibilities in 1998 were providing 20 hours or more of care per week. Time burdens were most intense for lower-income women: 52 percent of women with incomes below $35,000 were providing 20 hours or more of care per week, compared with 29 percent of women with incomes above $35,000.

Low-income women were nearly twice as likely as wealthier women to live with the relative for whom they were providing care. Lower-income women were less likely to have opportunities for a respite from their caregiving responsibilities. Among women caring for a sick relative, 62 percent of those with incomes below $35,000 indicated the relative was living at the respondent's home, compared with 36 percent of women with incomes above $35,000.

Only limited assistance was available for informal caregivers through paid home health aides. Only 24 percent of women providing informal caregiving said that their family member was receiving some paid care. Upper-income women were more likely to have paid assistance. Among women with caregiving responsibilities, eighteen percent of women with incomes below $35,000 have paid assistance, compared with 35 percent of women with incomes above $35,000.

The demands of caregiving may take a toll on caregivers' health and well-being. Often the caregiver herself is in need of care. One of four women caring for sick or disabled family members rated herself as being in poor or fair health, compared with one-sixth of other women (17%). More than half (54%) of women caregivers had one or more chronic health conditions, compared with two-fifths (41%) of other women. Caregivers also reported higher rates of mental health concerns: 51 percent reported high depressive symptoms—a far higher proportion than the 38 percent of women not currently caring for sick or disabled relatives who reported these symptoms.

Women caregivers were also twice as likely to report problems getting the health care they need for themselves. Compared with other women, women who were caring for sick or disabled family members were twice as likely not to receive needed care (16% vs. 8%) and not to fill a prescription because of cost (26% vs. 13%). One of four

caregivers also reported difficulty getting needed care, compared with one-sixth of other women (16%).

One of two employed women (52%) reported they would lose pay if they took time off to provide care for a sick relative. Regardless of the threat of lost pay, 31 percent of employed women reported they missed work in the past year to care for a sick relative, compared with 16 percent of men. Low-income women were at greater risk of losing pay: 68 percent of employed women with incomes of $16,000 or less reported they would lose pay if they took time off to care for a sick family member, compared with 40 percent of working women with incomes above $50,000.

Women also had a substantial responsibility for family health care decisions. Seventy-nine percent of women with children selected their children's doctor, and 84 percent attended their children's doctor visits. Two-thirds of women selected their families' health plan. Fifty-three percent of women were the sole decision-makers, and 12 percent made decisions jointly with their spouse.

THE LINK BETWEEN HEALTH AND ECONOMIC SECURITY FOR WORKING-AGE WOMEN

Overall, a strong, negative pattern emerges when comparing women's health status across income groups: the lower a woman's family income, the greater her risk for physical and mental health problems. Among working-age women (ages 18–64), those with family incomes in the bottom half of the income distribution are significantly more likely than higher-income women to have a chronic health condition or disability, depressive symptoms, a diagnosis of depression, and to be in generally poor health.[6]

At the same time, lower-income women have the most difficulty gaining access to needed health care. Women in the bottom fourth of the household income distribution ($16,000 or less) are three times more likely to experience problems getting care when needed and not to have a regular doctor than are women with incomes in the top quarter of the income distribution (above $50,000).

Low-income women were at particularly high risk for chronic health problems. Based on reports of physician diagnoses of four health conditions—hypertension, heart disease, diabetes, and arthritis—low-income women were at notably greater risk for chronic disease than higher-income women. Two of five women ages 18 to 64 with incomes of $16,000 or less reported a physician diagnosis of at least one of these four chronic diseases,

[6] This section of the report focuses on working-age women (18–64) to control for the impact of aging on declining health and income. However, the negative relationship of income and health persists among women age 65 and older as well. See appendix table 16.

or of having cancer in the past five years—a rate 50 percent higher than that for women with incomes above $50,000 (42% vs. 27%).

Low-income women were also at high risk for having a disability that limited their participation in routine activities. Among women ages 18 to 64, one of four (25%) with incomes of $16,000 or less had a disability or handicap preventing them from participating fully in school, work, or other activities, compared with 14 percent of all women and 9 percent of women with incomes above $50,000. This steep gradient of disability and income indicates the negative impact that restrictions on work can have on family standards of living.

As with physical health indicators, low-income women were at higher risk for having depressive symptoms and a diagnosis of depression or anxiety. More than half of low-income women ages 18 to 64 (55%) exhibited high levels of depressive symptoms, compared with 30 percent of women with incomes above $50,000. Similarly, low-income women were more than twice as likely to report a physician diagnosis of depression or anxiety than were upper-income women (26% vs. 12%).

Self-rated health status reflects women's underlying health concerns. Overall, women with incomes at the bottom of the income distribution ($16,000 or less) were six times more likely to report their health as fair or poor than women in the top fourth of the income distribution (above $50,000). Thirty-two percent of low-income women ages 18 to 64 rated their health as fair or poor, compared with 5 percent of high-income women.

Reflecting their generally lower incomes, African American, Hispanic, and Asian American women were also at relatively high risk for health problems. One of four minority women ages 18 to 64—including 21 percent of African American, 28 percent of Hispanic, and 23 percent of Asian American women—rated her health as fair or poor, compared with 12 percent of white women. Although some measures of chronic disease rates are fairly consistent across racial groups, African American women were more likely to report a physician diagnosis in the past 5 years of hypertension or diabetes than did women in other racial or ethnic groups. (See appendix tables 14 and 15.)

Lower-income women were more likely to have problems getting health care when needed and to lack basic primary care. The survey asked women to indicate whether there had a been a time in the past year when they had been unable to get care they needed, see a specialist, or have a prescription filled because of cost. Lower-income women ages 18 to 64 were more than twice as likely to indicate at least one of these three access barriers in the past year as women with incomes above $50,000 (37% vs. 15%). (See appendix table 17.)

Health care access barriers were notable for minority women under age 65 across an array of indicators. Nearly one-third of African American and Hispanic women under age 65 had an access problem in the past year, and 43 percent of Hispanic women did not have a regular doctor. One-third of Asian American women said it was extremely, very, or somewhat difficult for them to get care when needed. (See appendix table 17.)

AN INCREASING PROPORTION OF LOW- AND MODEST-INCOME WORKING-AGE WOMEN ARE UNINSURED

Health insurance is critical to facilitate access to health care and protect the financial security of women and their families. Among all women ages 18 to 64, nearly one of four is either uninsured (18%) or spent a time without health insurance in the past year (8%). Despite a strong economy, uninsured rates for 1998 have increased since 1993, with the steepest rises concentrated among lower-income and Hispanic women.

Analysis of women's health care experiences by insurance status found that gaps in coverage, as well as being uninsured, contributes to access difficulties and barriers to needed care. Women who are insured now but have had a gap in coverage in the past year encounter difficulties in getting needed health care at rates remarkably similar to those for currently uninsured women.

Uninsured rates increased in the past five years, particularly for low- and modest-income women. In 1998, 18 percent of women ages 18 to 64 were uninsured when surveyed. The proportion of working-age women without insurance was up from the rate of 14 percent reported in 1993, despite five years of economic growth. Increases were concentrated among low- and modest-wage women. As of 1998, 35 percent of women under age 65 with incomes of $16,000 or less were uninsured—up from 29 percent in 1993. A similar increase—from 15 percent in 1993 to 21 percent in 1998—occurred for women with incomes from $16,001 to $35,000. (See appendix table 18.)

The largest increases in uninsured rates occurred among Hispanic women under age 65. In 1998, two of five (42%) Hispanic women ages 18 to 64 were uninsured, compared with one of three (33%) in 1993. Hispanic women were three times as likely to be uninsured as white women (13%); African American (23%) and Asian American (25%) women were nearly twice as likely to be uninsured as white women.

Erosion of job-based health insurance accounted for some of the increase in the uninsured. Working-age women were heavily dependent on employer-based health insurance coverage, including coverage through their husband's job. By 1998, 64 percent of women ages 18 to 64 reported being insured through an employer, a decline from 66 percent in 1993. In total, 34 percent of working-age women reported having insurance through their

own employer and 21 percent through their spouse's employer; 9 percent had double coverage through both their job and their husband's job—down from 15 percent in 1993.

Including those who had a gap in health insurance coverage, one of four women were uninsured for a time during 1998. A significant majority of women who were uninsured at some point in that year were full-time workers or married to full-time workers and living on below-median incomes. In addition to the 18 percent who were uninsured when surveyed, 8 percent of women ages 18 to 64 reported a time when they did not have insurance during the past year—bringing to 26 percent the total proportion of working-age women who were uninsured for a time during 1998. Eight of 10 women who were uninsured for a period in 1998 worked or were married to a worker: most were in full-time working families (68%). Seven of 10 women who had a time uninsured (70%) were living on incomes of $16,000 or less (39%) or from $16,001 to $35,000 (31%).

The risk of being uninsured for a period of time in the past year was greatest among women in the bottom half of the income distribution. Nearly half (48%) of women ages 18 to 64 with incomes of $16,000 or less had been uninsured for a time, as had one-third of women with incomes from $16,001 to $35,000.

Being uninsured for a period of time in the past year steeply increased the risk of going without needed health care or having difficulties obtaining health care when needed. Currently uninsured women ages 18 to 64 were three times more likely than women who had been continuously insured to have gone without needed care during the year (22% vs. 6%) or not to have filled a prescription because of cost (31% vs. 10%). Women who were currently insured but had had a gap in health insurance coverage during the past year were also at high risk for going without needed care during the year. Indeed, rates of health care access problems among women with a gap in coverage were remarkably similar to rates of access difficulties reported by currently uninsured women. Both groups of women were at high overall risk for difficulties getting care when needed: 29 percent of women with a gap in coverage and 50 percent of currently uninsured women said it was extremely, very, or somewhat difficult to get care when needed. (See appendix table 19.)

SUMMARY

Women's health has received increased attention since the early 1990s. Federal health agencies now have offices of women's health, and women's health concerns have become a focus of major biomedical and clinical research funded by the National Institutes of Health. Many states and localities have established task forces on women's health as well. While these efforts have great benefits, *The Commonwealth Fund 1998 Survey of Women's Health* points to the need for a continued, concerted, and more concentrated focus on ensuring that women's unique needs are understood and addressed.

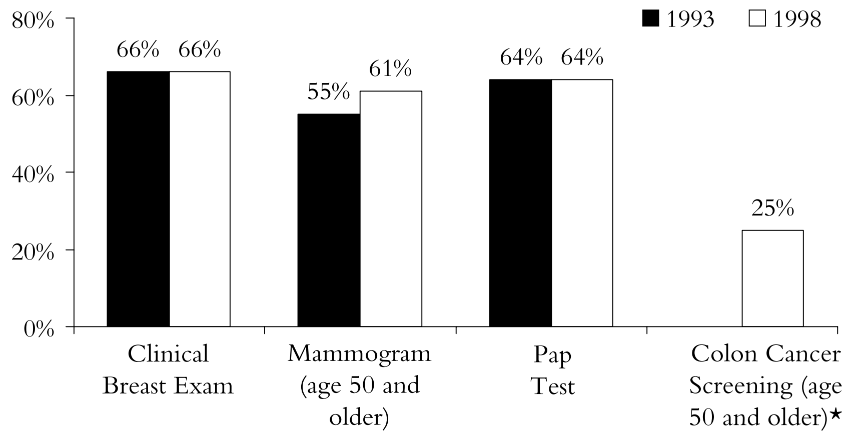
The increase in uninsured women, lack of progress in raising preventive care rates, low rates of physician counseling on healthy behaviors, and women's strong caregiving roles all underscore this need. In addition, high rates of reported violence and abuse and the strong link between violence and negative health consequences call for better efforts and awareness on the part of health care professionals to identify women who are victims of violence, provide them with adequate support services, and improve their access to necessary physical and psychological health services.

HEALTH CONCERNS ACROSS A WOMAN'S LIFESPAN:
The Commonwealth Fund 1998 Survey of Women's Health

CHARTS

Preventive Health Trends, 1993–98

Percent of women who received service in past year

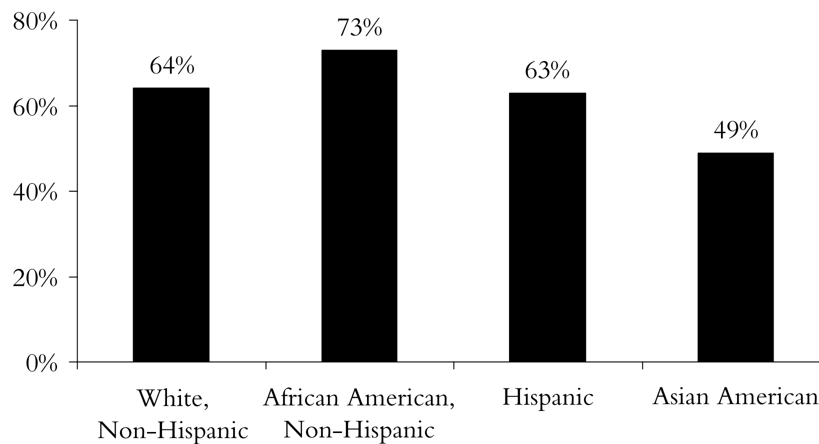


*Not asked in 1993.

The Commonwealth Fund 1993 and 1998 Surveys of Women's Health

Pap Test by Race/Ethnicity, 1998

Percent of women who received a Pap test in past year

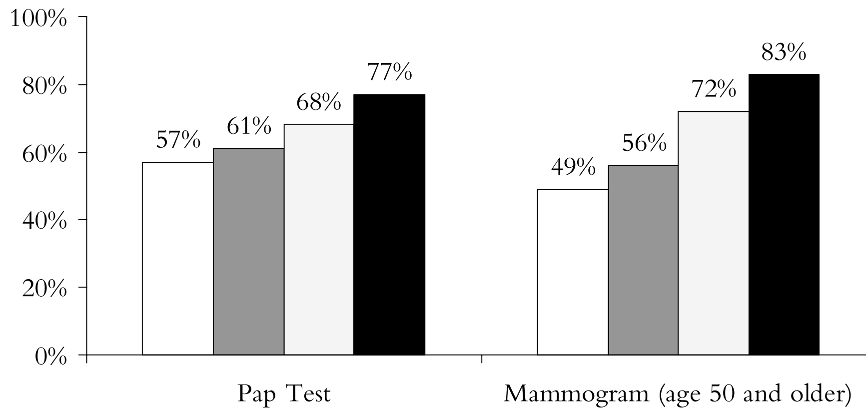


The Commonwealth Fund 1998 Survey of Women's Health

Women's Preventive Care by Income, 1998

Percent of women who received preventive care in past year

□ $16,000 or Less ■ $16,001–$35,000 □ $35,001–$50,000 ■ More than $50,000

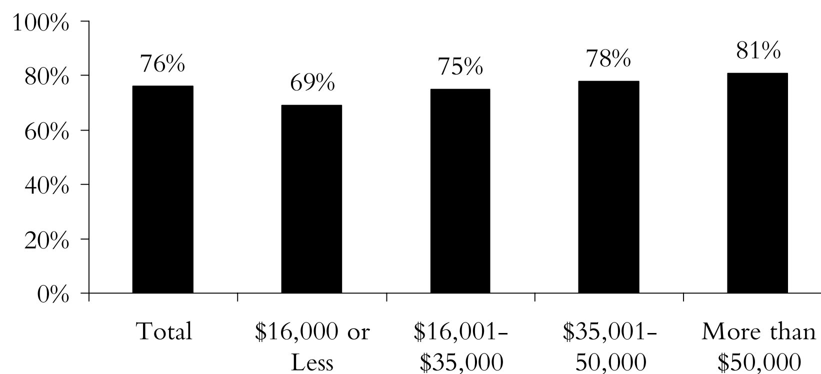


The Commonwealth Fund 1998 Survey of Women's Health

High Rates of Managed Care, 1998*

Women Ages 18–64

Percent of insured women enrolled in managed care

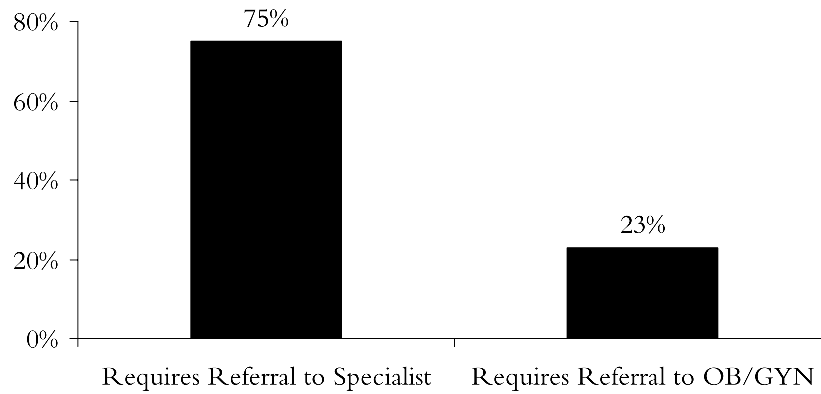


*Respondent reported plan was an HMO or PPO or plan requires a referral for specialist care.

The Commonwealth Fund 1998 Survey of Women's Health

Managed Care Referral Requirements, 1998
Women Ages 18–64

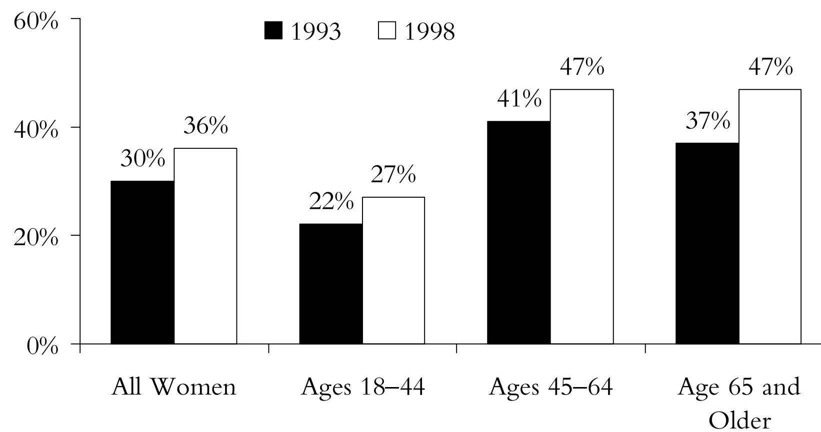
Percent of women in managed care plans whose plan requires referrals



The Commonwealth Fund 1998 Survey of Women's Health

Familiarity with Osteoporosis, 1993–98

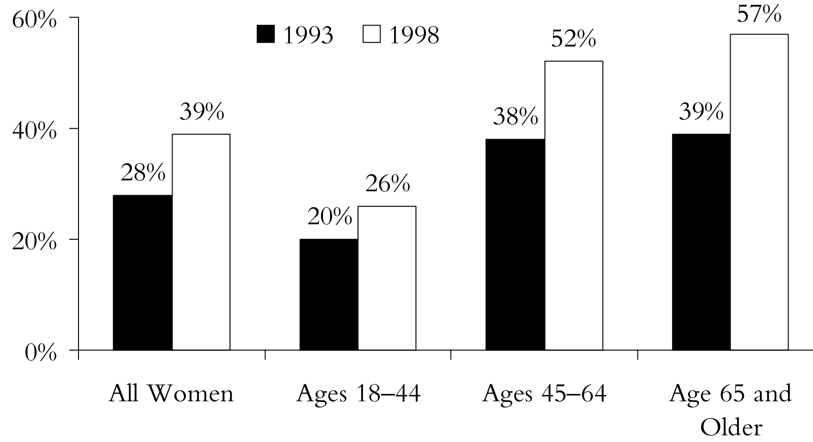
Percent of women who reported being "very familiar" with osteoporosis



The Commonwealth Fund 1993 and 1998 Surveys of Women's Health

Women Taking Calcium Supplements, 1993–98

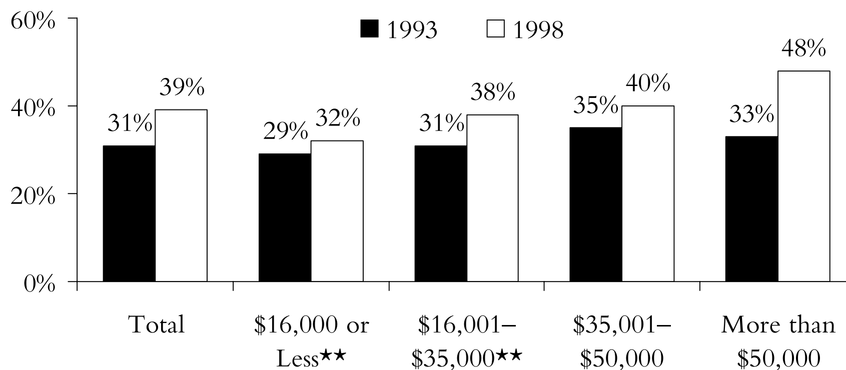
Percent of women taking calcium supplements



The Commonwealth Fund 1993 and 1998 Surveys of Women's Health

Women and Frequent Exercise, 1993–98

Percent of women who exercise three or more days per week*



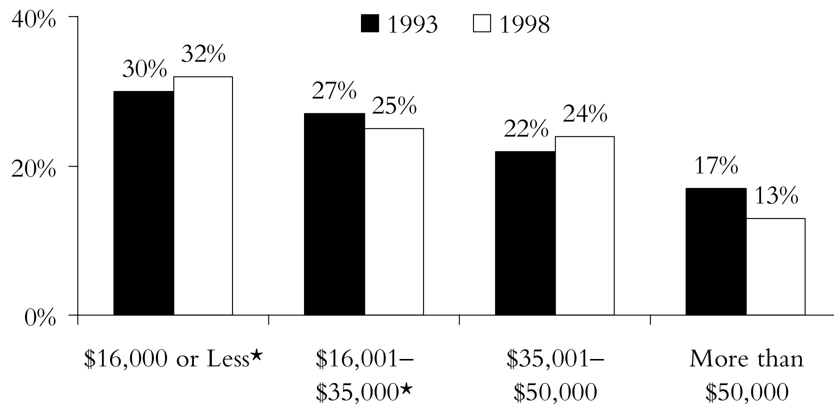
*Exercise is defined as physical activity that entails heavy breathing and acceleration of the heart and pulse rates for at least 20 minutes.

**The income breakdowns for the 1993 survey were $15,000 or less, and $15,001–$35,000.

The Commonwealth Fund 1993 and 1998 Surveys of Women's Health

Cigarette Smoking by Income, 1993–98

Percent of women who smoke

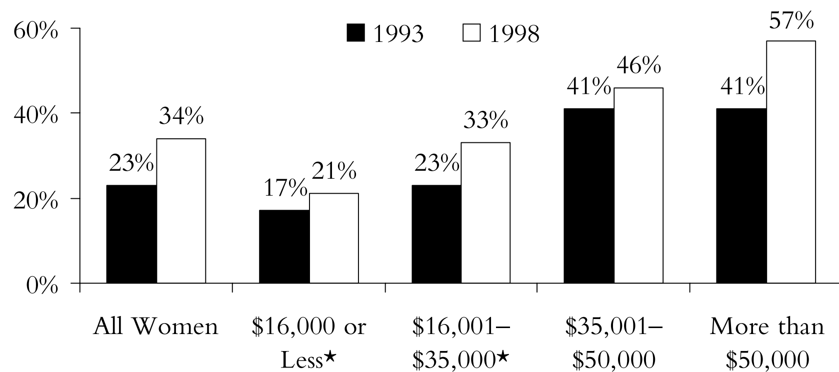


*The income breakdowns for the 1993 survey were $15,000 or less, and $15,001–$35,000.

The Commonwealth Fund 1993 and 1998 Surveys of Women's Health

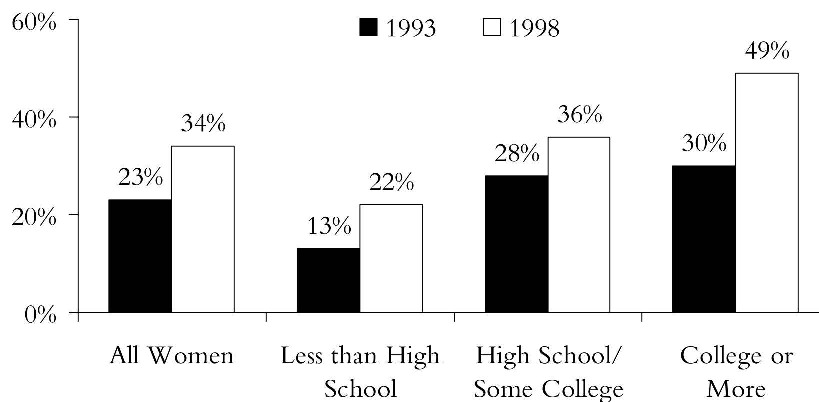
Hormone Replacement Therapy by Income, 1993–98

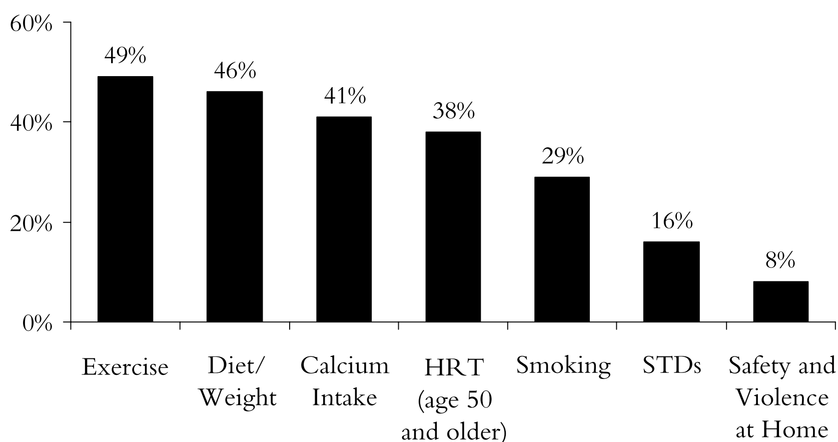
Percent of women age 50 or older using HRT



*The income breakdowns for the 1993 survey were $15,000 or less, and $15,001–$35,000.

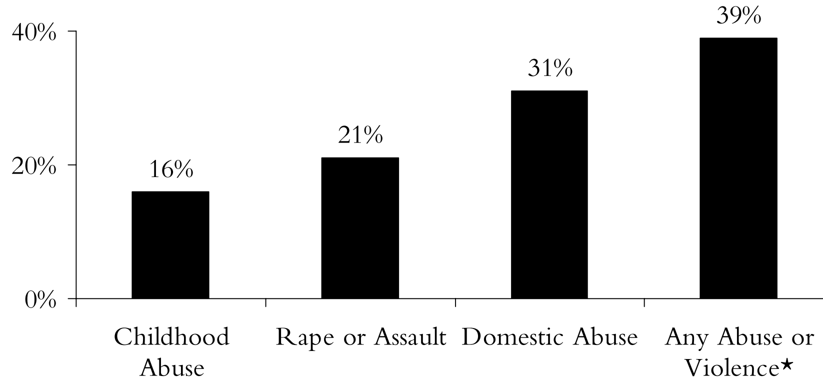
The Commonwealth Fund 1993 and 1998 Surveys of Women's Health


Hormone Replacement Therapy by Level of Education, 1993–98
Percent of women age 50 or older receiving HRT
60%
40%
20%
0%
1993
1998
23%
34%
13%
22%
28%
36%
30%
49%
All Women
Less than High School
High School/ Some College
College or More
The Commonwealth Fund 1993 and 1998 Surveys of Women's Health


Physician Counseling on Health, 1998
Percent of women whose doctor discussed health issue in past year
60%
40%
20%
0%
49%
46%
41%
38%
29%
16%
8%
Exercise
Diet/ Weight
Calcium Intake
HRT (age 50 and older)
Smoking
STDs
Safety and Violence at Home
The Commonwealth Fund 1998 Survey of Women's Health

Women's Lifetime Experience with Violence and Abuse, 1998

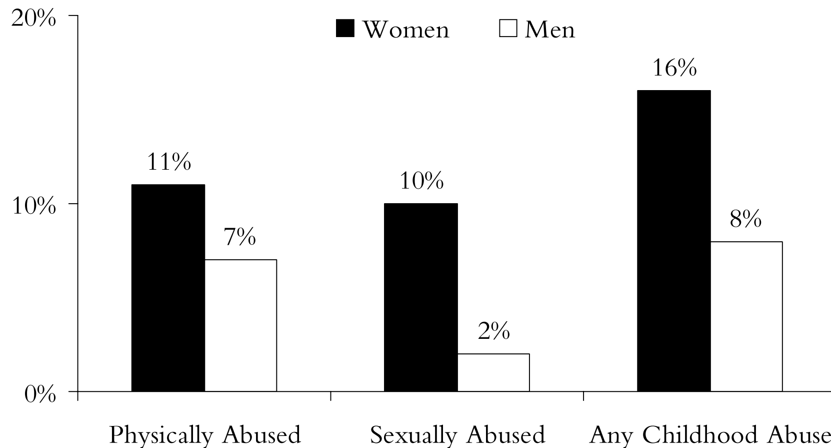
Percent of women exposed



*Includes assault, battery, or rape by a spouse or partner, or physical/sexual assault or rape by anyone else, or physical or sexual abuse that occurred in childhood.

The Commonwealth Fund 1998 Survey of Women's Health

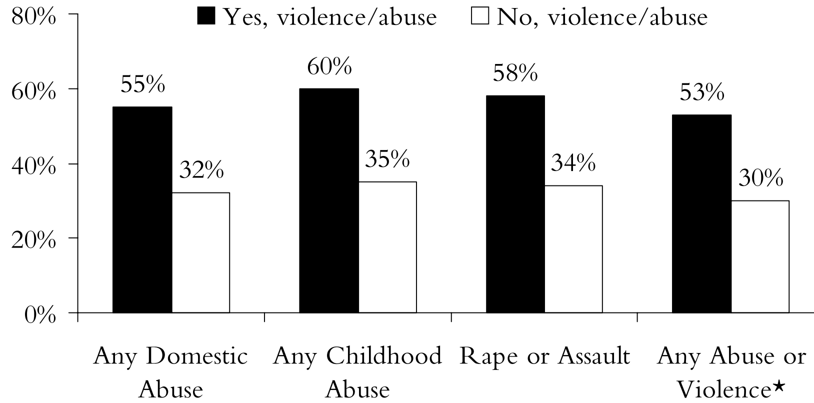
Childhood Physical or Sexual Abuse, 1998



The Commonwealth Fund 1998 Survey of Women's Health

Violence, Abuse, and Mental Health, 1998

Percent of women with high levels of depressive symptoms

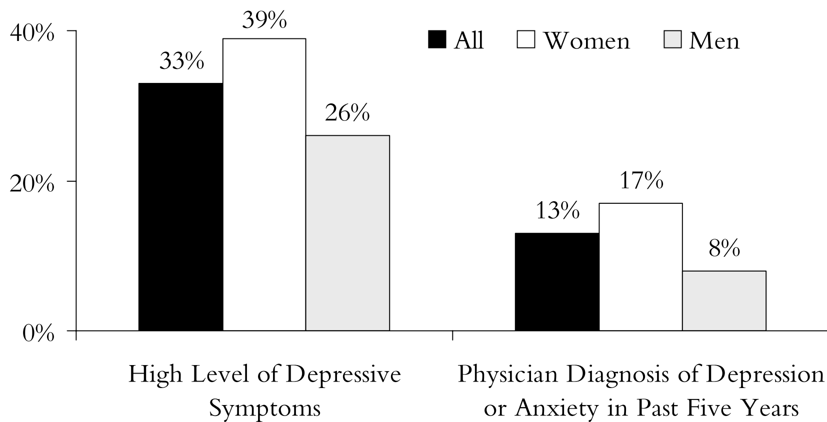


*Includes assault, battery, or rape by a spouse or partner, or physical/sexual assault or rape by anyone else, or physical or sexual abuse that occurred in childhood.

The Commonwealth Fund 1998 Survey of Women's Health

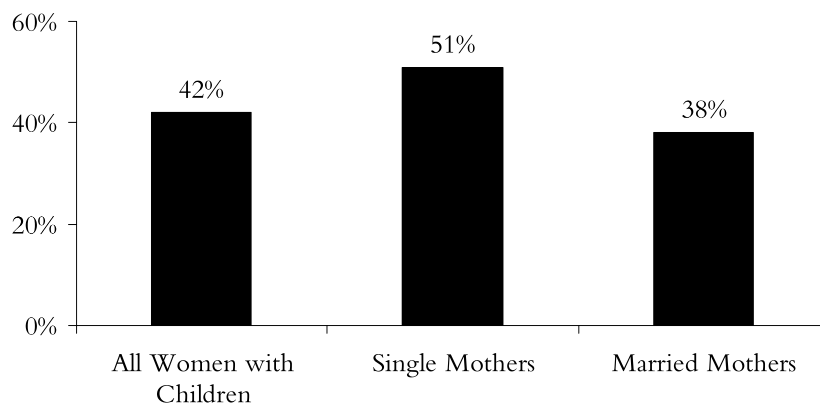
Mental Health Status: Women Compared with Men, 1998

Percent with depressive symptoms or diagnosis of depression



The Commonwealth Fund 1998 Survey of Women's Health

Depressive Symptoms Among Women with Children, 1998

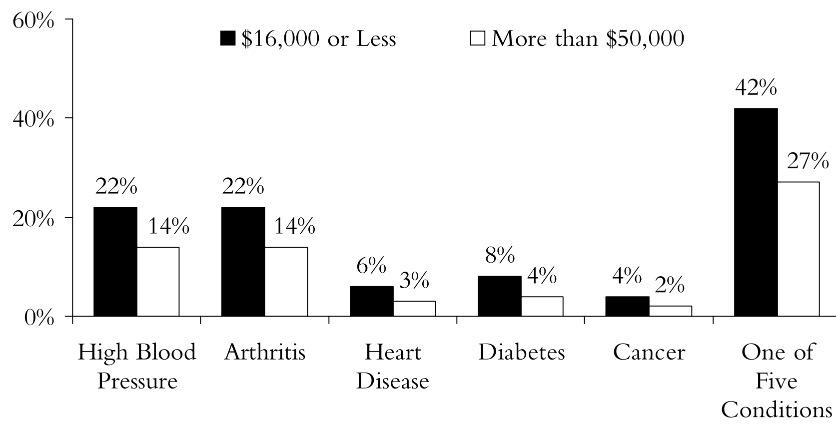


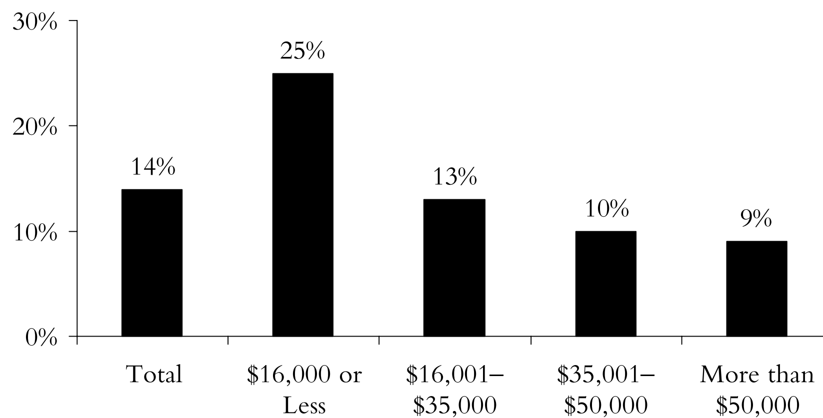
The Commonwealth Fund 1998 Survey of Women's Health

Women Caring for Sick or Disabled Family Member, 1998

	All Women	Income of $35,000 or Less	Income Above $35,000
Percent of women who are currently caregivers	9%	11%	9%
Percent of women caregivers who:			
Provide more than 20 hours of care per week	43%	52%	29%
Provide care to a relative living with them	51%	62%	36%
Have some paid home health care or assistance	24%	18%	35%

The Commonwealth Fund 1998 Survey of Women's Health


Chronic Disease by Income, 1998
Women Ages 18–64
Percent of women with physician diagnosis in past five years of...
60%
40%
20%
0%
$16,000 or Less
More than $50,000
22%
14%
22%
14%
6%
3%
8%
4%
4%
2%
42%
27%
High Blood Pressure
Arthritis
Heart Disease
Diabetes
Cancer
One of Five Conditions
The Commonwealth Fund 1998 Survey of Women's Health

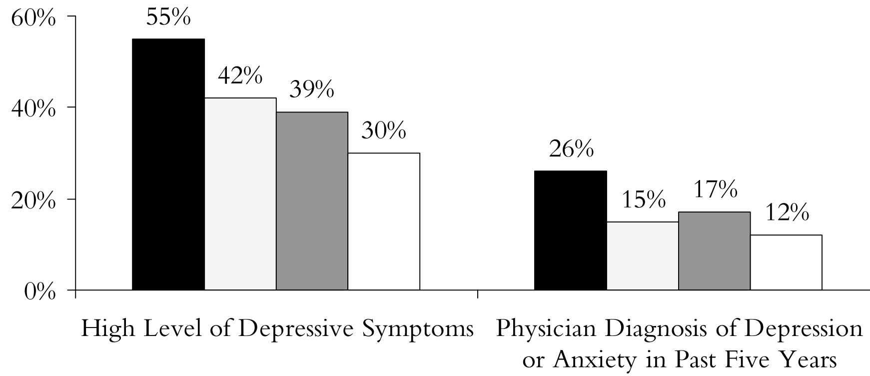

Disability by Income, 1998
Women Ages 18–64
Percent of women with disability limiting work or daily activities
30%
20%
10%
0%
14%
25%
13%
10%
9%
Total
$16,000 or Less
$16,001–$35,000
$35,001–$50,000
More than $50,000
The Commonwealth Fund 1998 Survey of Women's Health

Mental Health Status by Income, 1998

Women Ages 18–64

Mental health status of women

■ $16,000 or Less □ $16,001–$35,000 ■ $35,001–$50,000 □ More than $50,000

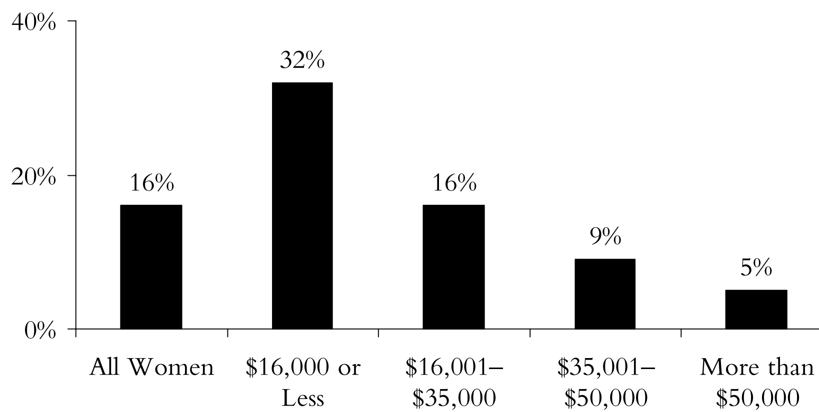


The Commonwealth Fund 1998 Survey of Women's Health

Self-Rated Health Status by Income, 1998

Women Ages 18–64

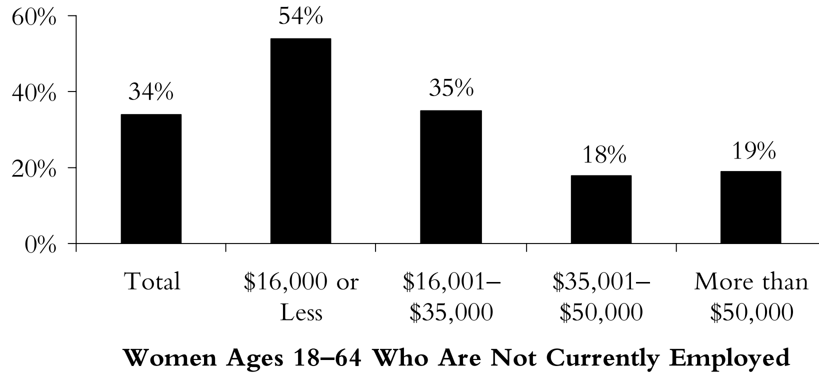
Percent of women who rate their health as fair or poor



The Commonwealth Fund 1998 Survey of Women's Health

Disability and Caregiving Among Nonworking Women Ages 18–64, 1998

Percent of women not currently employed who are disabled or caring for a sick or disabled family member

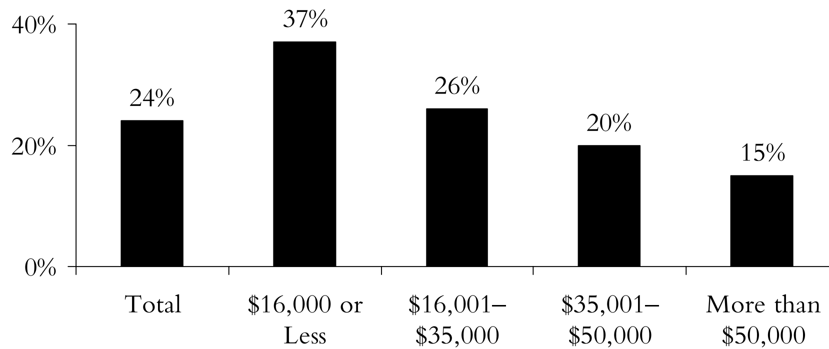


The Commonwealth Fund 1998 Survey of Women's Health

Health Care Access Problems by Income, 1998

Women Ages 18–64

Percent of women with at least one of three access problems in past year*

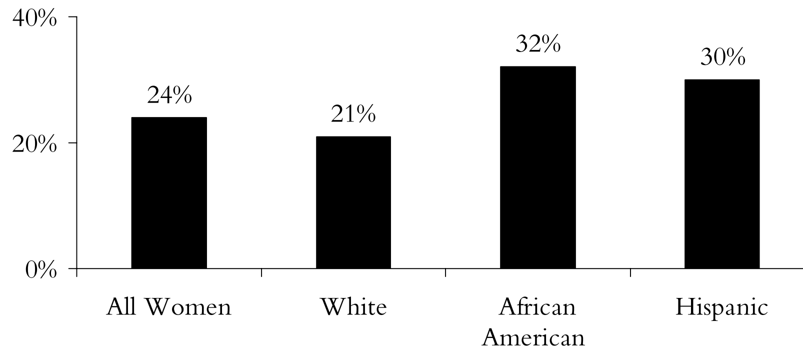


*Reported a time they did not get needed care or specialty care or did not fill a prescription because of costs.

The Commonwealth Fund 1998 Survey of Women's Health

Health Care Access Problems by Race/Ethnicity, 1998
Women Ages 18–64

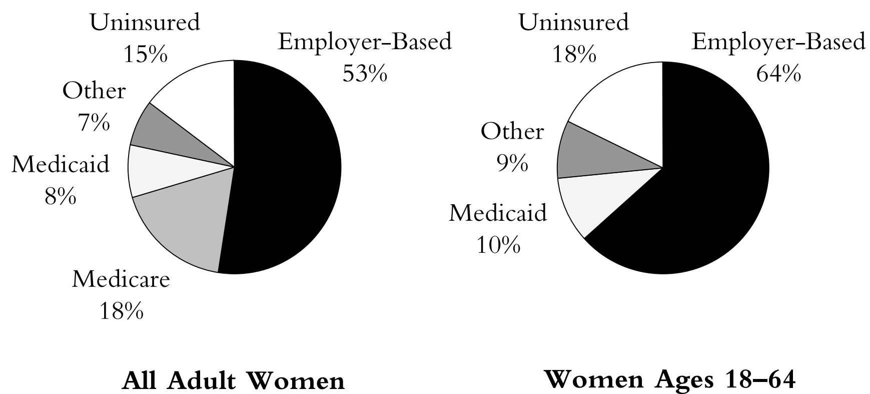
Percent of women with at least one of three access problems in past year*



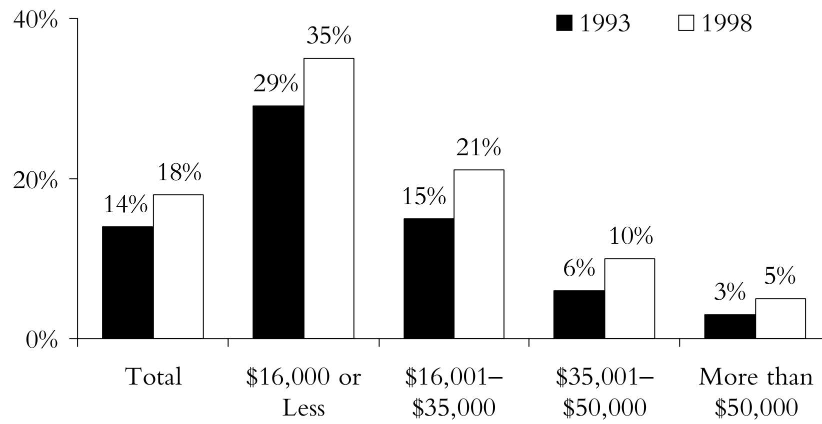
*Reported a time they did not get needed care or specialty care or did not fill a prescription because of costs.

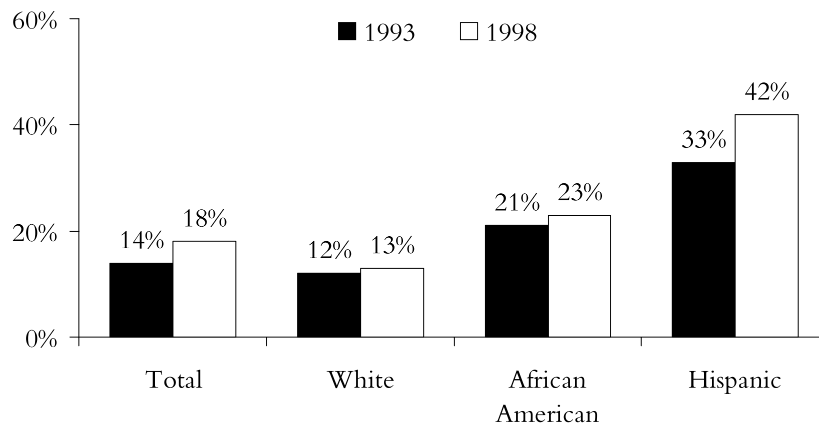
The Commonwealth Fund 1998 Survey of Women's Health

Sources of Health Insurance for Women, 1998

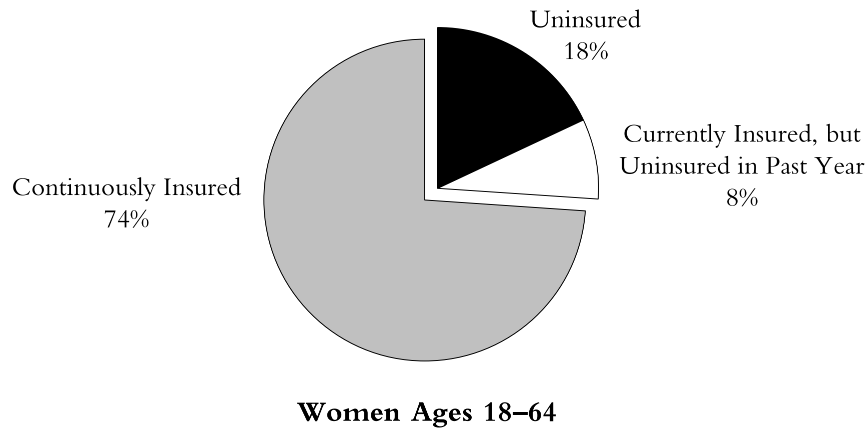


The Commonwealth Fund 1998 Survey of Women's Health


Uninsured Trends by Income, 1993–98
Women Ages 18–64
Percent of women who are uninsured
40%
20%
0%
1993
1998
14%
18%
29%
35%
15%
21%
6%
10%
3%
5%
Total
$16,000 or Less
$16,001–$35,000
$35,001–$50,000
More than $50,000
The Commonwealth Fund 1993 and 1998 Surveys of Women's Health


Uninsured Trends by Race/Ethnicity, 1993–98
Women Ages 18–64
Percent of women who are uninsured
60%
40%
20%
0%
1993
1998
14%
18%
12%
13%
21%
23%
33%
42%
Total
White
African American
Hispanic
The Commonwealth Fund 1993 and 1998 Surveys of Women's Health

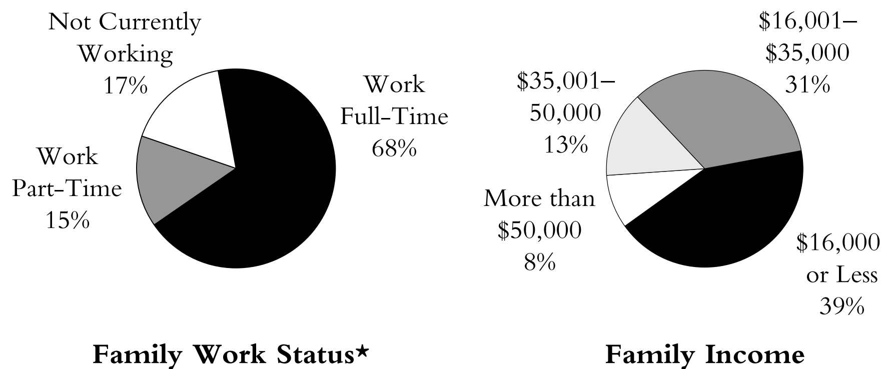
Time Uninsured, 1998



The Commonwealth Fund 1998 Survey of Women's Health

Uninsured Women: Work Status and Income, 1998

Women Ages 18–64 Who Had a Time Uninsured in Past Year



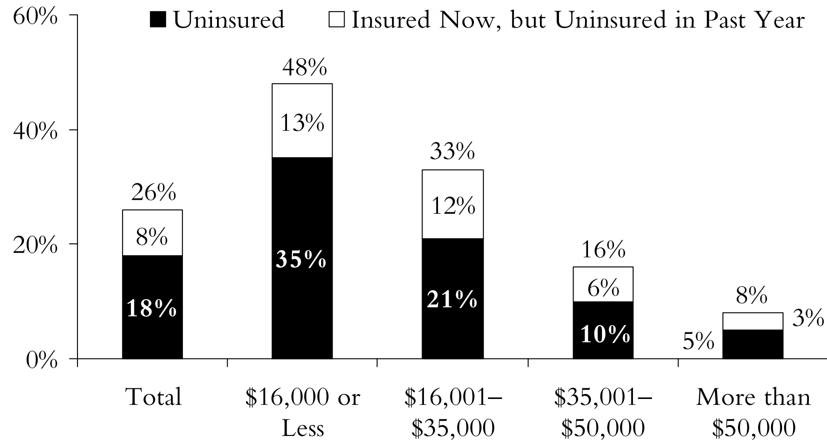
*Full-time: either woman, spouse, or both work full-time.
Part-time: no full-time worker.

The Commonwealth Fund 1998 Survey of Women's Health

Uninsured Women by Income, 1998

Women Ages 18–64

Percent uninsured

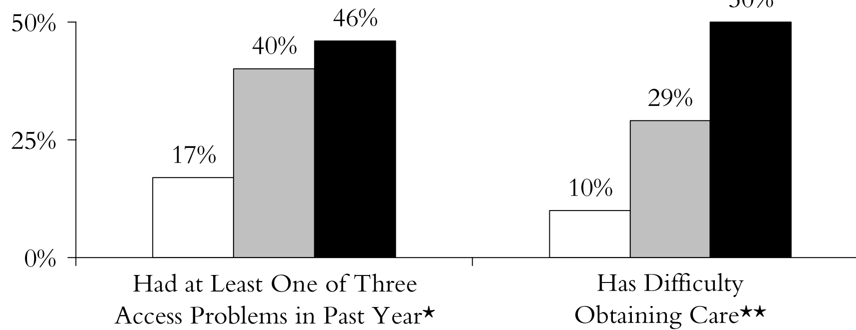


The Commonwealth Fund 1998 Survey of Women's Health

Access to Health Care by Insurance Status, 1998

Women Ages 18–64

☐ Insured All Year ▒ Insured Now, but Spent Time Uninsured ■ Uninsured



*Reported a time they did not get needed care or specialty care or did not fill a prescription because of costs.

**Reported getting care when needed is "extremely," "very," or "somewhat" difficult.

The Commonwealth Fund 1998 Survey of Women's Health

HEALTH CONCERNS ACROSS A WOMAN'S LIFESPAN:
The Commonwealth Fund 1998 Survey of Women's Health

APPENDIX 1. TABLES

Table 1
Trends in Preventive Care, Physician Counseling, and Health Behaviors, 1998 vs. 1993

	% TOTAL WOMEN	
	1998	**1993**
Preventive Care		
Received in the past year:		
Physical exam	61	62
Blood cholesterol test	55	54
Clinical breast exam	66	66
Pap test	64	64
Mammogram age 50 and older	61	55
Colon cancer screening age 50 and older	25	*
No preventive services in past year	16	15
Physician Counseling		
In past year physician discussed:		
Smoking	29	*
Diet and weight	46	*
Exercise	49	*
HRT age 50 and older	38	*
Importance of calcium intake	41	*
Use of alcohol/drugs	23	*
Concerns about safety/violence at home	8	*
STDs	16	*
Health Habits/Behaviors		
Smoke cigarettes	23	25
Drink at least once a week	18	*
Very familiar with osteoporosis	36	30
Currently taking calcium supplements	39	28
Consuming milk/dairy for calcium Base: women currently not taking calcium supplements	77	*
Exercise three or more days/week	39	31
Currently taking HRT age 50 and older	34	23

*Not asked in 1993.

Table 2
Preventive Care, Physician Counseling, and Health Behaviors by Race/Ethnicity

	% Total Women	% RACE/ETHNICITY White	African American	Hispanic	Asian American
Preventive Care					
Received in the past year:					
Physical exam	61	60	72	55	45
Blood cholesterol test	55	55	63	45	41
Clinical breast exam	66	68	70	53	44
Pap test	64	64	73	63	49
Mammogram age 50 and older	61	60	66	64	*
Colon cancer screening age 50 and older	25	26	25	22	*
No preventive services in past year	16	16	7	21	29
Physician Counseling					
In past year physician discussed:					
Smoking	29	28	42	31	13
Diet and weight	46	44	65	42	27
Exercise	49	48	60	43	40
HRT age 50 and older	38	40	27	35	*
Importance of calcium intake	41	41	41	39	31
Use of alcohol/drugs	23	21	33	22	8
Concerns about safety/violence at home	8	5	19	16	5
STDs	16	10	37	29	9
Health Habits/Behaviors					
Smoke cigarettes	23	25	22	11	4
Drink at least once a week	18	21	13	11	8
Very familiar with osteoporosis	36	41	25	19	17
Currently taking calcium supplements	39	44	21	29	38
Consuming milk/dairy for calcium Base: women currently not taking calcium supplements	77	80	72	77	62
Exercise three or more days/week	39	42	32	32	16
Currently taking HRT age 50 and older	34	37	16	23	*

*Sample size too small for a reliable estimate.

Table 3
Preventive Care, Physician Counseling, and Health Behaviors by Income

	% Total Women	% INCOME $16,000 or Less	$16,001–$35,000	$35,001–$50,000	More than $50,000
Preventive Care					
Received in the past year:					
Physical exam	61	58	60	63	65
Blood cholesterol test	55	49	54	53	62
Clinical breast exam	66	56	63	68	80
Pap test	64	57	61	68	77
Mammogram age 50 and older	61	49	56	72	83
Colon cancer screening age 50 and older	25	19	28	22	31
No preventive services in past year	16	19	17	15	10
Physician Counseling					
In past year physician discussed:					
Smoking	29	37	31	31	22
Diet and weight	46	46	49	46	45
Exercise	49	48	48	49	52
HRT age 50 and older	38	25	42	47	61
Importance of calcium intake	41	39	38	42	44
Use of alcohol/drugs	23	27	23	23	22
Concerns about safety/violence at home	8	12	7	8	5
STDs	16	25	18	12	9
Health Habits/Behaviors					
Smoke cigarettes	23	32	25	24	13
Drink at least once a week	18	14	17	19	28
Very familiar with osteoporosis	36	28	35	36	47
Currently taking calcium supplements	39	29	37	42	46
Consuming milk/dairy for calcium	77	75	78	75	83
Base: women currently not taking calcium supplements					
Exercise three or more days/week	39	32	38	40	48
Currently taking HRT age 50 and older	34	21	33	46	57

Table 4
Preventive Care, Physician Counseling, and Health Behaviors by Education

	% Total Women	% EDUCATION		
		Less than High School	High School/ Some College	College or More
Preventive Care				
Received in the past year:				
Physical exam	61	56	61	64
Blood cholesterol test	55	55	53	58
Clinical breast exam	66	52	66	77
Pap test	64	52	64	76
Mammogram age 50 and older	61	52	63	73
Colon cancer screening age 50 and older	25	22	25	33
No preventive services in past year	16	20	16	11
Physician Counseling				
In past year physician discussed:				
Smoking	29	34	31	22
Diet and weight	46	46	46	47
Exercise	49	50	48	51
HRT age 50 and older	38	22	42	58
Importance of calcium intake	41	40	41	41
Use of alcohol/drugs	23	25	23	21
Concerns about safety/violence at home	8	13	8	5
STDs	16	23	15	11
Health Habits/Behaviors				
Smoke cigarettes	23	28	25	11
Drink at least once a week	18	10	18	27
Very familiar with osteoporosis	36	22	36	51
Currently taking calcium supplements	39	31	38	49
Consuming milk/dairy for calcium Base: women currently not taking calcium supplements	77	73	76	87
Exercise three or more days/week	39	26	41	47
Currently taking HRT age 50 and older	34	22	36	49

Table 5
Preventive Care, Physician Counseling, and Health Behaviors by Insurance Type

	% Total Women	Uninsured	% INSURANCE TYPE Medicaid	Employer-Sponsored	Other Private	Medicare
Preventive Care						
Received in the past year:						
Physical exam	61	44	66	63	60	67
Blood cholesterol test	55	33	49	57	47	71
Clinical breast exam	66	45	63	73	66	61
Pap test	64	55	66	73	71	42
Mammogram age 50 and older	61	41	59	75	63	53
Colon cancer screening age 50 and older	25	9	26	26	29	26
No preventive services in past year	16	30	12	13	13	14
Physician Counseling						
In past year physician discussed:						
Smoking	29	30	48	30	28	20
Diet and weight	46	35	55	47	37	51
Exercise	49	36	53	51	39	57
HRT age 50 and older	38	21	36	58	40	26
Importance of calcium intake	41	29	40	42	37	48
Use of alcohol/drugs	23	22	39	24	19	15
Concerns about safety/violence at home	8	11	20	6	3	7
STDs	16	21	30	15	12	8
Health Habits/Behaviors						
Smoke cigarettes	23	31	36	23	16	13
Drink at least once a week	18	17	11	22	24	12
Very familiar with osteoporosis	36	23	26	38	33	46
Currently taking calcium supplements	39	24	21	39	43	56
Consuming milk/dairy for calcium Base: women currently not taking calcium supplements	77	73	73	80	75	77
Exercise three or more days/week	39	38	33	41	44	35
Currently taking HRT age 50 and older	34	12	37	49	45	23

Table 6
Preventive Care, Physician Counseling, and Health Behaviors by Region

	% Total Women	% REGION OF THE COUNTRY			
		Northeast	Midwest	South	Mountain/ Pacific
Preventive Care					
Received in the past year:					
Physical exam	61	65	63	61	55
Blood cholesterol test	55	59	53	55	52
Clinical breast exam	66	72	69	63	61
Pap test	64	68	66	63	61
Mammogram age 50 and older	61	72	61	56	61
Colon cancer screening age 50 and older	25	30	28	23	22
No preventive services in past year	16	11	15	16	20
Physician Counseling					
In past year physician discussed:					
Smoking	29	31	31	30	26
Diet and weight	46	50	42	49	42
Exercise	49	52	47	51	46
HRT age 50 and older	38	45	34	37	40
Importance of calcium intake	41	43	37	43	39
Use of alcohol/drugs	23	26	25	23	18
Concerns about safety/violence at home	8	12	7	8	7
STDs	16	19	14	16	14
Health Habits/Behaviors					
Smoke cigarettes	23	21	24	24	20
Drink at least once a week	18	21	19	15	21
Very familiar with osteoporosis	36	39	37	34	36
Currently taking calcium supplements	39	38	36	38	43
Consuming milk/dairy for calcium Base: women currently not taking calcium supplements	77	78	80	75	77
Exercise three or more days/week	39	41	40	40	36
Currently taking HRT age 50 and older	34	26	30	35	43

Table 7
Preventive Care, Physician Counseling, and Access by Insurance Plan Type, Insured Women Ages 18–64

	INSURED WOMEN		
	% Total N=1508	% INSURANCE PLAN Managed Care N=1140	Traditional Insurance N=351
Has regular doctor	84	87	78
Sees an OB-GYN as primary care physician/other	65	66	61
Plan requires referral to see specialist	57	75	NA
Plan requires referral to see OB-GYN	17	23	NA
Health plan sends reminder for preventive care	25	27	18
Preventive Care			
Received in the past year:			
Physical exam	63	64	62
Blood cholesterol test	55	56	53
Clinical breast exam	71	73	69
Pap test	72	74	67
Mammogram age 50 and older	71	72	70
Colon cancer screening age 50 and older	26	29	20
No preventive services in past year	13	12	14
Physician Counseling			
In past year physician discussed:			
Smoking	32	32	32
Diet and weight	47	48	45
Exercise	50	50	50
HRT age 50 and older	54	56	50
Importance of calcium intake	41	40	45
Use of alcohol/drugs	26	25	26
Concerns about safety/violence at home	8	7	10
STDs	17	16	21
Access Barriers to Care			
In the past year did not:			
Get needed care	8	8	7
See a specialist when needed	8	9	8
Fill a prescription because of cost	12	12	11
At least one of the three problems	19	20	17
Difficulty getting needed care*	12	12	12

*Woman reported that it is "extremely," "very," or "somewhat" difficult to get needed care.

Table 8
Physician Satisfaction Ratings by Insurance Plan Type, Insured Women Ages 18–64

Physician Ratings	% Total Insured	% INSURANCE PLAN TYPE Managed Care	Traditional Insurance
Rated Physician Excellent on:			
Provides good health care overall	45	45	45
Cares about your health	46	46	46
Spends enough time with you	40	41	40
Answers all your questions	47	48	47
Makes sure you understand what you've been told	45	45	46
Treats you with dignity and respect	57	55	58
Rated Physician Fair/Poor on:			
Provides good health care overall	7	7	5
Cares about your health	7	8	4
Spends enough time with you	14	14	11
Answers all your questions	8	8	6
Makes sure you understand what you've been told	8	9	6
Treats you with dignity and respect	3	3	2

Table 9
Violence and Abuse by Income, Race/Ethnicity, and Education

	%	% INCOME				% RACE/ETHNICITY			% EDUCATION		
	Total Women	$16,000 or Less	$16,001–$35,000	$35,001–$50,000	More than $50,000	White	African American	Hispanic	Less than High School	High School/ Some College	College or More
Ever a victim of:											
Physical assault	17	24	18	16	11	18	16	13	16	18	14
Rape	9	14	9	8	5	9	10	5	11	8	7
Sexual assault	12	16	12	12	9	12	11	7	15	11	10
Any rape or assault	21	29	23	21	15	22	22	16	22	22	19
Domestic abuse*	31	37	34	30	26	32	33	26	30	32	25
Childhood abuse											
Physical	11	15	10	11	9	11	8	11	12	11	10
Sexual	10	13	11	11	8	11	7	7	11	11	6
Physical or sexual	16	21	16	16	12	17	12	14	17	16	13
Any type of abuse or violence in lifetime**	39	47	44	39	34	41	40	37	40	41	35

*Responded yes to any of the following items. Spouse or boyfriend has ever: thrown something at you; pushed, grabbed, shoved, or slapped you; kicked, bit, or hit you with a fist or some other object; beaten you up; choked you; forced you to have sex against your will.

**Includes assault, battery, or rape by a spouse or partner, or physical/sexual assault or rape by anyone else, or physical or sexual abuse that occurred in childhood.

Table 10
Violence and Abuse by Urbanicity and Region

	%	% URBANICITY			% REGION			
	Total Women	Urban	Suburban	Rural	Northeast	Midwest	South	Mountain/ Pacific
Ever a victim of:								
Physical assault	17	18	16	17	12	18	18	18
Rape	9	9	8	9	7	9	9	9
Sexual assault	12	12	11	12	8	12	12	14
Any rape or assault	21	22	21	21	16	23	21	24
Domestic abuse*	31	29	31	32	28	34	30	31
Childhood abuse								
Physical	11	12	11	10	10	11	10	13
Sexual	10	8	11	12	8	10	11	10
Physical or sexual	16	16	16	16	14	16	15	17
Any type of abuse or violence in lifetime**	39	38	40	39	35	43	38	40

*Responded yes to any of the following items. Spouse or boyfriend has ever: thrown something at you; pushed, grabbed, shoved, or slapped you; kicked, bit, or hit you with a fist or some other object; beaten you up; choked you; forced you to have sex against your will.

**Includes assault, battery, or rape by a spouse or partner, or physical/sexual assault or rape by anyone else, or physical or sexual abuse that occurred in childhood.

Table 11
Health Indicators and Access to Health Care by Violence and Abuse

	Childhood Abuse: Physical or Sexual		Rape or Assault		Domestic Abuse by Spouse or Partner		Any Type of Violence or Abuse During Lifetime	
	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
Health Indicators								
Self-reported health status is fair/poor	27	16	25	15	22	15	21	15
Disability or illness limits work or daily activities	25	16	26	15	21	15	21	15
High level of depressive symptoms	60	35	58	34	55	32	53	30
Diagnosis of anxiety or depression in past five years	36	14	34	13	28	12	27	10
Access Barriers								
Access problem*	36	19	38	18	35	16	32	15
Difficulty getting needed care**	24	15	25	14	23	14	22	13
Time too embarrassed to discuss issues with doctor	14	6	13	6	12	5	11	5
Needed to see mental health professional	38	16	37	15	33	13	31	12
Did not see a mental health professional when needed	14	7	15	7	13	5	14	5

*Defined as experiencing any one of the following: did not get needed care, did not fill a prescription because of cost, or could not see a specialist when needed.

**Woman reported that it is "extremely," "very," or "somewhat" difficult to get needed care.

Table 12
Depressive Symptoms by Gender and Age

	% WOMEN				% MEN			
		AGE				AGE		
Rates of Depressive Symptoms	Total	18–44	45–64	65 and Older	Total	18–44	45–64	65 and Older
Low	28	26	32	30	40	39	42	41
Moderate	32	30	34	37	34	34	31	40
High	39	44	34	33	26	27	27	19

*The depression scale was created based on a series of questions on how frequently the respondent felt a certain way in the previous week. Each respondent's answers to statements such as "I felt depressed," "My sleep was restless," "I had crying spells," "I enjoyed life," "I felt sad," or "I felt that people disliked me" were summed up for a total score of depression. Categories of depression were created based on the distribution of scores for all the respondents: Low (0–2), Moderate (3–5), and High (6–18).

Table 13
Demographic Characteristics by Level of Depressive Symptoms

	% DEPRESSIVE SYMPTOMS*	
	None/Low	High
Total Women	28	39
Income Groups		
Family annual income		
$16,000 or less	20	52
$16,001–$35,000	27	40
$35,001–$50,000	30	37
More than $50,000	35	29
Has trouble paying for basics**		
A lot	14	68
Some	17	55
None	33	32
Insurance Status		
Insured	29	38
Uninsured	28	46
Race/Ethnicity		
White	29	37
African American	27	46
Hispanic	31	43
Asian American	29	41
Employment Status		
Working	28	39
Homemaker	34	39
Unemployed (looking for work)	23	47
Children Less than 18 Years Old in Household	28	42
Single parent	24	51
Two parents	30	38
Marital Status		
Married/living as a couple	31	36
Widowed/divorced/separated	26	44
Single, never married	23	44
Health Indicators		
Self-reported health status		
Excellent/good	31	35
Fair/poor	18	60
Disability or illness limits work or daily activities	15	56
No disability	31	36

*The depression scale was created based on a series of questions on how frequently the respondent felt a certain way in the previous week. Each respondent's answers to statements such as "I felt depressed," "My sleep was restless," "I had crying spells," "I enjoyed life," "I felt sad," or "I felt that people disliked me" were summed up for a total score of depression. Categories of depression were created based on the distribution of scores for all the respondents: Low (0–2), Moderate (3–5), and High (6–18).

**Refers to trouble paying for basic needs, such as food, phone, gas, and electric bills.

Table 14
Health Status by Income and Race/Ethnicity

	%	% INCOME				% RACE/ETHNICITY			
	Total Women	$16,000 or Less	$16,001–$35,000	$35,001–$50,000	More than $50,000	White	African American	Hispanic	Asian American
Self-rated health status is fair or poor	17	32	16	9	6	14	24	29	25
Doctor diagnosis in the past five years:									
Hypertension	24	30	25	18	16	24	32	19	11
Heart disease	7	11	6	5	3	7	7	4	5
Diabetes	7	11	6	5	4	6	11	8	5
Arthritis	24	31	25	20	16	26	27	19	10
Cancer, other than skin cancer	3	4	3	3	3	3	3	2	1
At least one of five chronic conditions*	42	52	43	36	30	43	47	33	23
Disability or illness limits work or daily activities	17	28	15	13	9	18	16	10	6
Mental Health									
High level of depressive symptoms	39	52	40	37	29	37	46	43	41
Physician diagnosis of depression or anxiety in past five years	17	25	15	17	11	18	17	12	5

*Based on physician diagnosis of hypertension, arthritis, heart disease, or cancer in the last five years.

Table 15
Health Status by Income and Race/Ethnicity, Women Ages 18–64

	%	% INCOME				% RACE/ETHNICITY			
	Total Women	$16,000 or Less	$16,001–$35,000	$35,001–$50,000	More than $50,000	White	African American	Hispanic	Asian American
Self-rated health status is fair or poor	16	32	16	9	5	12	21	28	23
Doctor diagnosis in the past five years:									
Hypertension	17	22	20	14	14	17	27	14	9
Heart disease	4	6	4	2	3	4	4	3	4
Diabetes	6	8	6	5	4	5	9	6	4
Arthritis	17	22	18	16	14	18	20	15	7
Cancer, other than skin cancer	3	4	2	2	2	3	3	2	1
At least one of five chronic conditions*	33	42	36	31	27	34	41	28	19
Disability or illness limits work or daily activities	14	25	13	10	9	15	13	10	5
Mental Health									
High level of depressive symptoms	41	55	42	39	30	39	46	44	41
Physician diagnosis of depression or anxiety in past five years	17	26	15	17	12	18	17	12	5

*Based on physician diagnosis of hypertension, arthritis, heart disease, or cancer in the last five years.

Table 16
Health Status by Income, Women Age 65 and Older

	% Total Women	% INCOME $16,000 or Less	$16,001–$35,000	More than $35,000*
Self-rated health status is fair or poor	25	33	17	12
Doctor diagnosis in the past five years:				
Hypertension	51	51	47	44
Heart disease	21	24	19	23
Diabetes	13	20	6	4
Arthritis	58	57	53	56
Cancer, other than skin cancer	6	5	6	8
At least one of five chronic conditions**	20	20	26	26
Disability or illness limits work or daily activities	31	35	25	27
Mental Health				
High level of depressive symptoms	33	42	31	22
Physician diagnosis of depression or anxiety in past five years	17	21	17	10

*Incomes above $50,000 were combined with incomes $35,001 to $50,000 because the sample size of women age 65 and older in the highest income category is too small for reliable estimates.

**Based on physician diagnosis of hypertension, arthritis, heart disease, or cancer in the past five years.

Table 17
Access to Care by Income and Race/Ethnicity, Women Ages 18–64

	%	% INCOME				% RACE/ETHNICITY			
	Total Women	$16,000 or Less	$16,001–$35,000	$35,001–$50,000	More than $50,000	White	African American	Hispanic	Asian American
In the past year:									
Did not get care when needed	10	17	11	8	6	9	14	11	9
Did not see a specialist when needed	12	21	16	6	7	10	18	17	12
Did not fill a prescription due to cost	15	26	17	10	7	13	24	17	8
At least one of the three problems	24	37	26	20	15	21	32	30	19
Difficulty getting needed care*	19	32	22	10	10	15	21	32	33
No regular doctor	22	33	25	14	12	18	26	43	27
In the past year:									
No visits to physician	8	10	10	6	6	7	4	16	22
No Pap test	30	35	35	28	22	29	24	36	47
No clinical breast exam	33	41	38	31	21	30	30	49	58

*Woman reported that it is "extremely," "very," or "somewhat" difficult to get needed care.

Table 18
Health Insurance Status by Income and Race/Ethnicity, Women Ages 18–64

	%	% INCOME				% RACE/ETHNICITY			
	Total Women	$16,000 or Less	$16,001–$35,000	$35,001–$50,000	More than $50,000	White	African American	Hispanic	Asian American
Current Insurance Status									
Employer-based	64	27	61	81	86	71	52	39	51
Own employer only	34	16	42	42	37	36	34	22	30
Own and spouse's employer	9	1	4	13	15	10	7	5	4
Spouse's employer only	21	10	15	25	34	25	10	12	16
Medicaid	10	27	6	3	2	7	18	13	9
Other	9	10	11	6	7	9	7	5	15
Uninsured	18	35	21	10	5	13	23	42	25
Insurance During Past Year									
Continuously insured	74	51	67	84	92	79	67	50	67
Insured now but time uninsured in past year	8	13	12	6	3	8	10	8	8
Currently uninsured	18	35	21	10	5	13	23	42	25

Table 19
Access to Health Care by Insurance Status, Women Ages 18–64

	% Total Women	% INSURANCE STATUS Continuously Insured	Insured Now, but Time Uninsured	Currently Uninsured
In the past year:				
Did not get care when needed	10	6	23	22
Did not see a specialist when needed	12	7	24	31
Did not fill a prescription due to cost	15	10	27	31
At least one of the three problems	24	17	40	46
Difficulty getting needed care*	19	10	29	50
No regular doctor	22	14	29	51
In the past year:				
No visits to physician	8	6	8	20
No Pap test	30	27	35	43
No clinical breast exam	33	27	42	54

*Woman reported that it is "extremely," "very," or "somewhat" difficult to get needed care.

APPENDIX 2. METHODOLOGY

The Commonwealth Fund 1998 Survey of Women's Health was conducted by Louis Harris and Associates, Inc. Interviews were conducted by telephone from their centralized telephone research center in Rochester, New York, from May 7, 1998, to November 10, 1998. Interviews were conducted in English, Spanish, Korean, Cantonese, Mandarin, and Vietnamese.

The survey sample included a national, cross-section of 2,011 women 18 years of age and older, with an additional oversample of African American (n=242), Hispanic (n=229), and Asian American (n=368) women for a total 429 African American, 404 Hispanic, and 400 Asian American women. The study also included a national cross-section of 1,084 men 18 years of age and older, with an additional oversample of African American (n=205) and Hispanic (n=211) men for a total of 305 African American and 309 Hispanic men. The total unweighted sample comprises 2,850 women and 1,500 men. The margin of error for the overall sample of women is 3 percent, and for the overall sample of men, 4 percent.

The survey data were weighted by age, sex, race/ethnicity, education, insurance status, and geographic region, using the *1997 Current Population Survey* from the U.S. Census Bureau to produce representative results for the 104 million women and 97 million men 18 years of age and older in the United States.

DEFINITIONS OF KEY VARIABLES

Health insurance coverage. The survey included questions about current health insurance coverage and about coverage during the past 12 months. From responses to these questions, women were classified into three categories of insurance:

- *continuously insured:* women who were insured when surveyed and had no time without insurance in the past 12 months;
- *insured now, but time uninsured:* women who were insured when surveyed but had a time uninsured in the past 12 months;
- *currently uninsured:* women who were without insurance when surveyed.

Working family. The survey included questions about women's employment and marital status. From responses to these questions, women were classified into three types of working families:

- *full-time working family:* a woman who is single and works full time, or is married and either she or her spouse/partner works full time;

- *part-time working family:* a woman who works part time, or if married, she or her spouse/partner works part time, with neither working full time;

- *no worker in the family:* a woman who is not working, or if married, neither she nor her spouse/partner were working at the time of the survey.

Depressive symptoms. The depression scale was created based on scores of a series of questions taken from the Center for Epidemiologic Studies Depression Scale, from *Applied Psychological Measurement, 1977.* For each of the following statements, "I felt depressed," "My sleep was restless," "I had crying spells," "I enjoyed life," "I felt sad," "I felt that people disliked me," each woman was asked to state how often she felt this way during the past week (never=0, rarely=1, some of the time=2, most of the time=3); the last statement was reverse-coded. Each woman's answers to the statements were summed up for a total score of depression. Categories of depression were created based on the distribution of scores for all the respondents: Low (0–2), Moderate (3–5), and High (6–18).

Violence. The survey included questions about women's experience with violence and abuse. Based on a series of questions, four categories of violence or abuse were defined. These categories are not mutually exclusive.

- *childhood abuse:* women who responded yes to either of the following questions:
  When you were growing up, were you ever:
    physically abused?
    sexually abused?

- *rape or assault:* women who responded yes to any of the following questions:
  Have you ever been a victim of:
    physical assault?
    rape?
    sexual assault?

- *domestic abuse:* women who responded yes to any of the following questions:
  Has a spouse or boyfriend ever:
    thrown something at you?
    pushed, grabbed, shoved, or slapped you?
    kicked, bit, or hit you with a fist or some other object?
    beaten you up?
    choked you?
    forced you to have sex against you will?

- *any abuse or violence:* women who responded yes to any of the questions listed above.

THE COMMONWEALTH FUND

The Commonwealth Fund is a philanthropic foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate through its efforts to help Americans live healthy and productive lives and to assist specific groups with serious and neglected problems. In 1986, the Fund was given the assets of the James Picker Foundation, in support of Picker programs to advance the Fund's mission.

The Fund's current four national program areas are improving health care services, bettering the health of minority Americans, advancing the well-being of elderly people, and developing the capacities of children and young people. In all its national programs, the Fund emphasizes prevention and promoting healthy behavior. The Fund's international program in health policy seeks to build a network of policy-oriented health care researchers whose multinational experience and outlook stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, the Fund makes grants to improve health care services and to make the most of public spaces and services.