



Women in the Health Care System:
Health Status, Insurance, and Access to Care

MEPS

Research #17 Findings

U.S. Department of Health and Human Services
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Abstract

This report from the Agency for Healthcare Research and Quality (AHRQ) focuses on adult noninstitutionalized women in the United States in 1996. In terms of health status, the report shows perceived health, mental health, and the presence of a number of different limitations. Health insurance status is examined in terms of whether women are publicly insured, privately insured, or uninsured, and whether insured women are policyholders or dependents. Data on women's usual source of health care, use of ambulatory care services, and use of selected preventive services are used to examine access to care. The report does not compare women's health to men's health but instead looks at the health status of women by various demographic and health characteristics that may be associated with disparities in access to care or other

The estimates in this report are based on the most recent data available at the time the report was written. However, selected elements of MEPS data may be revised on the basis of additional analyses, which could result in slightly different estimates from those shown here. Please check the MEPS Web site for the most current file releases.

disadvantages in the health care system, including a measure that combines marital status, presence of children in the household, and age of children. The estimates shown come from the Household Component of AHRQ's Medical Expenditure Panel Survey (MEPS).

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The Medical Expenditure Panel Survey (MEPS)

Background

The Medical Expenditure Panel Survey (MEPS) is conducted to provide nationally representative estimates of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. MEPS also includes a nationally representative survey of nursing homes and their residents. MEPS is cosponsored by the Agency for Healthcare Research and Quality (AHRQ), formerly the Agency for Health Care Policy and Research, and the National Center for Health Statistics (NCHS).

MEPS comprises four component surveys: the Household Component (HC), the Medical Provider Component (MPC), the Insurance Component (IC), and the Nursing Home Component (NHC). The HC is the core survey, and it forms the basis for the MPC sample and part of the IC sample. The separate NHC sample supplements the other MEPS components. Together these surveys yield comprehensive data that provide national estimates of the level and distribution of health care use and expenditures, support health services research, and can be used to assess health care policy implications.

MEPS is the third in a series of national probability surveys conducted by AHRQ on the financing and use of medical care in the United States. The National Medical Care Expenditure Survey (NMCES) was conducted in 1977, the National Medical Expenditure Survey (NMES) in 1987. Beginning in 1996, MEPS continues this series with design enhancements and efficiencies that provide a more current data resource to capture the changing dynamics of the health care delivery and insurance system.

The design efficiencies incorporated into MEPS are in accordance with the Department of Health and Human Services (DHHS) Survey Integration Plan of June 1995, which focused on consolidating DHHS surveys, achieving cost efficiencies, reducing respondent burden, and enhancing analytical capacities. To accommodate these goals, new MEPS design features include linkage with the National Health Interview Survey (NHIS), from which the sample for the MEPS

HC is drawn, and enhanced longitudinal data collection for core survey components. The MEPS HC augments NHIS by selecting a sample of NHIS respondents, collecting additional data on their health care expenditures, and linking these data with additional information collected from the respondents' medical providers, employers, and insurance providers.

Household Component

The MEPS HC, a nationally representative survey of the U.S. civilian noninstitutionalized population, collects medical expenditure data at both the person and household levels. The HC collects detailed data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment.

The HC uses an overlapping panel design in which data are collected through a preliminary contact followed by a series of five rounds of interviews over a 2½-year period. Using computer-assisted personal interviewing (CAPI) technology, data on medical expenditures and use for 2 calendar years are collected from each household. This series of data collection rounds is launched each subsequent year on a new sample of households to provide overlapping panels of survey data and, when combined with other ongoing panels, will provide continuous and current estimates of health care expenditures.

The sampling frame for the MEPS HC is drawn from respondents to NHIS, conducted by NCHS. NHIS provides a nationally representative sample of the U.S. civilian noninstitutionalized population, with oversampling of Hispanics and blacks.

Medical Provider Component

The MEPS MPC supplements and validates information on medical care events reported in the MEPS HC by contacting medical providers and pharmacies identified by household respondents. The MPC sample includes all hospitals, hospital physicians, home health agencies, and pharmacies reported in the HC. Also included in the MPC are all office-based physicians:

- Providing care for HC respondents receiving Medicaid.
- Associated with a 75-percent sample of households receiving care through an HMO (health maintenance organization) or managed care plan.
- Associated with a 25-percent sample of the remaining households.

Data are collected on medical and financial characteristics of medical and pharmacy events reported by HC respondents, including:

- Diagnoses coded according to ICD-9 (9th Revision, International Classification of Diseases) and DSM-IV (Fourth Edition, *Diagnostic and Statistical Manual of Mental Disorders*).
- Physician procedure codes classified by CPT-4 (Current Procedural Terminology, Version 4).
- Inpatient stay codes classified by DRG (diagnosis-related group).
- Prescriptions coded by national drug code (NDC), medication names, strength, and quantity dispensed.
- Charges, payments, and the reasons for any difference between charges and payments.

The MPC is conducted through telephone interviews and mailed survey materials.

Insurance Component

The MEPS IC collects data on health insurance plans obtained through private and public-sector employers. Data obtained in the IC include the number and types of private insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, and employer characteristics.

Establishments participating in the MEPS IC are selected through three sampling frames:

- A list of employers or other insurance providers identified by MEPS HC respondents who report having private health insurance at the Round 1 interview.
- A Bureau of the Census list frame of private-sector business establishments.
- The Census of Governments from the Bureau of the Census.

To provide an integrated picture of health insurance, data collected from the first sampling frame (employers and other insurance providers) are linked back to data

provided by the MEPS HC respondents. Data from the other three sampling frames are collected to provide annual national and State estimates of the supply of private health insurance available to American workers and to evaluate policy issues pertaining to health insurance. Since 2000, national estimates of employer contributions to group health insurance from the MEPS IC have been used in the computation of Gross Domestic Product (GDP) by the Bureau of Economic Analysis.

The MEPS IC is an annual panel survey. Data are collected from the selected organizations through a prescreening telephone interview, a mailed questionnaire, and a telephone followup for nonrespondents.

Nursing Home Component

The 1996 MEPS NHC was a survey of nursing homes and persons residing in or admitted to nursing homes at any time during calendar year 1996. The NHC gathered information on the demographic characteristics, residence history, health and functional status, use of services, use of prescription medications, and health care expenditures of nursing home residents. Nursing home administrators and designated staff also provided information on facility size, ownership, certification status, services provided, revenues and expenses, and other facility characteristics. Data on the income, assets, family relationships, and caregiving services for sampled nursing home residents were obtained from next-of-kin or other knowledgeable persons in the community.

The 1996 MEPS NHC sample was selected using a two-stage stratified probability design. In the first stage, facilities were selected; in the second stage, facility residents were sampled, selecting both persons in residence on January 1, 1996, and those admitted during the period January 1 through December 31.

The sampling frame for facilities was derived from the National Health Provider Inventory, which is updated periodically by NCHS. The MEPS NHC data were collected in person in three rounds of data collection over a 1½-year period using the CAPI system. Community data were collected by telephone using computer-assisted telephone interviewing (CATI) technology. At the end of three rounds of data collection,

the sample consisted of 815 responding facilities, 3,209 residents in the facility on January 1, and 2,690 eligible residents admitted during 1996.

Survey Management

MEPS data are collected under the authority of the Public Health Service Act. They are edited and published in accordance with the confidentiality provisions of this act and the Privacy Act. NCHS provides consultation and technical assistance.

As soon as data collection and editing are completed, the MEPS survey data are released to the public in staged releases of summary reports and microdata files. Summary reports are released as printed documents and electronic files. Microdata files are released on CD-ROM and/or as electronic files.

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Additional information on MEPS is available from the MEPS project manager or the MEPS public use data manager at the Center for Cost and Financing Studies, Agency for Healthcare Research and Quality, 2101 East Jefferson Street, Suite 500, Rockville, MD 20852 (301-594-1406).

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Women in the Health Care System: Health Status, Insurance, and Access to Care

by Barbara M. Altman, Ph.D., Centers for Disease Control and Prevention, National Center for Health Statistics,¹ and Amy K. Taylor, Ph.D., Agency for Healthcare Research and Quality

Introduction

Women make up more than half of the U.S. population, but it is only lately that their political, economic, and health situations have been closely examined and brought to the attention of policymakers. With this increased concern about women's health, it is important to monitor their health status, as well as their access to health insurance, health care services, and prevention services. Earlier chartbooks and compilations of survey data have given valuable information about women's health in the late 1980s and early 1990s, including health-related behaviors (Brown, Wyn, Cumberland, et al., 1995), reproductive health issues and incidence and risk factors for chronic disease (Jacobs Institute of Women's Health, 1993; Leiman, Meyer, Rothschild, et al., 1997), factors affecting the health of minority women (Leigh and Lindquist, 1998), and health issues for aging women (Guralnik, Fried, Simonsick, et al., 1995). A recent publication by the Commonwealth Fund (Collins, Schoen, Joseph, et al., 1999) reports on women's use of hormone replacement therapy, experience with violence and abuse, risk for depressive symptoms, and insurance status.

This report focuses on adult noninstitutionalized women and describes their health status, access to health care, and insurance status during calendar year 1996. The report does not compare women's health to men's health. Instead, it looks at the health status of different groups of women who may, because of their circumstances, experience disparities in access to care or other disadvantages in the health care system. Perceived physical and mental health status and disability, health insurance status, and health care access and the source of that access are examined. Specific comparisons are made by age, race/ethnicity, income, employment status, education, and the combined effect of marital status and presence of children in the home.

This report provides a basis for comparison with future data to describe trends in women's health status, insurance status, and access to care and preventive services in the United States.

The estimates of health status, insurance status, and access to care reported here are derived from data collected from respondents in the Household Component (HC) of the Medical Expenditure Panel Survey (MEPS). The estimates represent the civilian noninstitutionalized population of women age 18 and over in the United States during calendar year 1996. A technical appendix at the end of this report provides definitions of the variables used in this report. It also gives a detailed description of the MEPS HC, including data collection methods, sample size, variable construction, and statistical procedures for deriving estimates. Table A in the technical appendix provides comparison information on men's health status, also derived from the 1996 MEPS. Tables B-F give the standard errors associated with Tables 1-5, discussed in the text of this report. Only differences between estimates that are statistically significant at the 0.05 level are discussed in the text unless otherwise specified.

Health and Disability Status

An examination of women's physical and mental health as perceived by the MEPS household respondent (Table 1) shows that approximately 60 percent were in excellent or very good general health and about 70 percent had excellent or very good mental health. Table 2 shows that only 14.3 percent of all women had a functional limitation, 10.4 percent had activity limitations, and 6.8 percent needed help with an activity of daily living (ADL) or an instrumental activity of daily living (IADL). An examination of different sociodemographic characteristics shows that some groups of women experience higher levels of poor health and disability than others.

¹Formerly with the Agency for Healthcare Research and Quality.

Table 1. Physical and mental health status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996

Population characteristic	Total population of women in thousands	Perceived health ^a			Perceived mental health ^b		
		Excellent/very good	Good	Fair/poor	Excellent/very good	Good	Fair/poor
Total in thousands	101,000	59,906	25,585	14,828	70,043	23,622	6,641
		Percent					
Percent of all women	—	59.7	25.5	14.8	69.8	23.6	6.6
Age in years							
18-29	21,071	67.1	25.8	7.1	77.1	18.6	4.3
30-44	32,755	65.2	24.1	10.7	71.9	22.2	5.9
45-64	27,953	56.6	25.9	17.5	67.8	25.9	6.3
65-74	10,142	49.5	27.0	23.5	65.5	27.0	7.5
75-84	6,850	43.5	26.7	29.9	56.6	29.9	13.5
85 and over	2,225	42.1	28.6	29.2	54.6	26.1	19.3
Race/ethnicity							
White	75,247	62.7	23.9	13.4	71.8	22.2	6.0
Black	12,229	50.7	28.8	20.5	61.6	28.2	10.2
Hispanic	9,273	48.6	31.7	19.6	64.1	28.2	7.7
Other	4,247	57.4	29.9	12.7	70.7	23.4	5.9
Education							
Less than 12 years	19,830	37.1	30.9	32.0	49.8	35.2	14.9
12 years	35,645	58.2	28.8	13.0	68.7	25.7	5.6
More than 12 years	45,402	70.8	20.6	8.6	79.4	16.8	3.8
Marital status and children^c							
Married without children	29,973	58.5	25.7	15.8	71.7	23.4	4.9
Married with children 5 and under	11,722	69.7	22.8	7.5	77.1	19.4	3.5
Married with children 6-18	13,844	62.6	26.9	10.5	71.6	23.1	5.3
Single without children	35,320	57.5	23.7	18.8	67.4	23.0	9.6
Single with children 5 and under	4,480	53.0	34.5	12.5	61.4	31.5	7.1
Single with children 6-18	5,657	57.6	30.6	11.9	62.4	31.1	6.5
Income							
Poor/near-poor	20,591	41.8	31.9	26.4	54.5	32.5	13.1
Low income	14,431	52.0	28.5	19.5	63.5	27.6	9.0
Middle income	30,390	63.7	24.0	12.3	72.2	22.5	5.3
High income	35,584	69.7	21.9	8.4	79.2	17.7	3.1
Insurance status^d							
Under age 65:							
Private	62,852	68.0	23.9	8.1	76.6	19.7	3.7
Public only	8,149	36.3	28.9	34.8	46.2	35.1	18.6
Uninsured	10,778	51.9	29.5	18.6	63.3	29.8	6.9

Continued

Table 1. Physical and mental health status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)

Population characteristics	Total population of women in thousands	Perceived health ^a			Perceived mental health ^b		
		Excellent very good/	Good	Fair/poor	Excellent very good/	Good	Fair/poor
Percent							
Age 65 and over:^c							
Medicare only	4,187	49.3	27.9	22.7	63.4	24.2	12.3
Medicare and private	12,347	49.2	27.0	23.8	63.9	27.9	8.2
Medicare and other public	2,593	28.4	25.9	45.6	43.9	34.3	21.7
Employment^f							
Employed full year	54,066	67.1	25.2	7.7	75.9	20.7	3.3
Employed part year	9,710	55.8	29.2	15.0	67.3	27.1	5.5
Not employed	17,970	43.8	28.3	27.8	56.8	30.2	13.1
Metropolitan statistical area (MSA)							
MSA	81,138	61.1	24.8	14.1	71.1	22.4	6.5
Non-MSA	19,858	54.2	28.4	17.4	64.5	28.4	7.1

^aPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^bPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^dHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^eHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^fEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Note: Percents may not add to 100 because of rounding.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Age

As women age, their general health and mental health status show signs of deterioration. Table 1 shows that women ages 18-29 were the most likely to have excellent or very good perceived general health (67.1 percent). By ages 45-64, only 56.6 percent had excellent or very good general health—a significant drop. The percent of women in fair or poor general health increased with age up to age 85. Less than one-quarter of women ages 65-74 had fair or poor general health, but by age 75 the proportion in fair or poor health had leveled off at nearly 30 percent.

Over three-quarters (77.1 percent) of women ages 18-29 had excellent or very good mental health. This

proportion dropped to 67.8 percent by ages 45-64. The deterioration in mental health continues as women age, with women age 75 and over having higher proportions with fair or poor mental health—13.5 percent of women 75-84 and 19.3 percent of those age 85 and over.

Only 5.4 percent of women ages 18-29 had any type of limitation or impairment, but the proportion with limitations increased with age, so that by ages 65-74 almost one-third of women had a limitation of some kind, more than half of women 75-84 (53.7 percent) had a limitation, and more than three-quarters of women age 85 and over had some limitation (Table 2). Although only about 30 percent of women 75 and over had fair or poor health, about 43 percent of women 75-84 and 67 percent of those 85 and over had a functional limitation.

Table 2. Functional and activity limitation status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996

Population characteristic	Total population in thousands	ADLs or IADLs ^a	Activity limitations	Physical activity limitations	Any limitations ^b
Total in thousands	101,000	6,802	10,510	14,455	20,044
		Percent			
Percent of all women	—	6.8	10.4	14.3	19.8
Age in years					
18-29	21,071	1.5	2.6	2.1	5.4
30-44	32,755	2.8	6.4	7.9	13.2
45-64	27,953	5.5	12.1	15.6	21.3
65-74	10,142	10.9	15.9	25.7	32.2
75-84	6,850	24.9	26.8	43.1	53.7
85 and over	2,225	55.3	48.3	67.1	76.6
Race/ethnicity					
White	75,247	7.0	11.1	15.2	20.9
Black	12,229	7.8	10.7	14.4	18.9
Hispanic	9,273	5.4	7.1	10.0	16.2
Other	4,247	2.0	4.8	8.4	12.5
Perceived health^c					
Excellent/very good	59,906	1.8	3.0	5.3	8.4
Good	25,585	5.6	10.0	15.9	23.0
Fair/poor	14,828	27.1	39.8	46.8	59.3
Perceived mental health^d					
Excellent/very good	70,043	3.2	5.7	9.3	13.0
Good	23,622	9.1	15.1	20.0	27.9
Fair/poor	6,641	32.8	40.8	44.1	60.8
Education					
Less than 12 years	19,830	14.6	20.3	26.3	35.3
12 years	35,645	6.4	9.9	14.1	19.1
More than 12 years	45,402	3.6	6.5	9.3	13.6
Marital status and children^e					
Married without children	29,973	5.1	10.3	15.1	20.4
Married with children					
5 and under	11,722	*0.9	3.1	2.4	6.1
Married with children					
6-18	13,844	2.2	5.7	8.2	11.5
Single without children	35,320	13.4	16.4	22.1	29.8
Single with children					
5 and under	4,488	*1.5	4.5	4.5	8.3
Single with children 6-18	5,657	*1.6	5.5	8.8	13.1
Income					
Poor/near-poor	20,591	13.0	18.5	22.3	30.7
Low income	14,431	9.4	14.5	18.9	26.1
Middle income	30,390	5.2	7.8	12.6	17.0
High income	35,584	3.4	6.3	9.3	13.4

Continued

Table 2. Functional and activity limitation status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)

Population characteristic	Total population in thousands	ADLs or IADLs ^a	Activity limitations	Physical activity limitations	Any limitations ^b
Percent					
Insurance status^f					
Under age 65:					
Private	62,852	2.0	5.0	7.1	11.0
Public only	8,149	15.9	26.1	23.9	36.7
Uninsured	10,778	2.3	6.9	9.0	13.8
Age 65 and over: ^g					
Medicare only	4,187	24.2	21.3	31.3	41.9
Medicare and private	12,347	15.8	21.0	35.9	42.4
Medicare and other public	2,593	41.8	40.0	50.4	63.3
Employment^h					
Employed full year	54,066	1.0	2.7	5.4	8.7
Employed part year	9,710	2.7	6.5	7.3	13.2
Not employed	17,970	11.3	22.0	20.9	30.2
Metropolitan statistical area (MSA)					
MSA	81,138	6.4	9.7	13.5	19.0
Non-MSA	19,858	8.2	13.3	17.6	23.3

^aActivities of daily living (ADLs) include activities such as bathing and dressing. Instrumental activities of daily living (IADLs) include activities such as shopping and paying bills.

^bThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with ADLs or IADLs. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^cPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^dPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^eMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^fHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^gHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^hEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

*Relative standard error greater than 30 percent.

Note: Percents may not add to 100 because of rounding.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Nearly one-quarter of women ages 75-84 and more than half of women 85 and over required assistance with an ADL or IADL.

Race/Ethnicity

The racial and ethnic differences in women's self-reported health that have been noted elsewhere (Weigers and Drilea, 1999) are also seen in these data on general health status and mental health status. In this analysis, we

White and black women had higher levels of physical limitations than Hispanic women and women of other races.

have used a measure of race/ethnicity that specifically identifies whites, blacks, and Hispanics but groups all other races, including Asians and Pacific Islanders, Native Americans, and other small groups, into one category

identified as "other." White women were more likely to have excellent or very good health (62.7 percent) than either black women (50.7 percent) or Hispanic women (48.6 percent), although they did not differ significantly from the "other" racial and ethnic group. Following the same pattern, Hispanics and blacks were more likely to have fair or poor health than either white women or women of other races.

White women were also more likely to have excellent or very good perceived mental health (71.8 percent) than black women (61.6 percent) or Hispanic women (64.1 percent). They were less likely to have fair or poor perceived mental health than black women (6.0 percent vs. 10.2 percent), but there were no significant differences in fair/poor mental health status among white women, Hispanic women, and women in the other racial/ethnic group

Despite the differences between white and black women in perceived health and mental health status, there were no significant differences in the proportions of black and white women with functional limitations, activity limitations, or need for assistance with ADLs and IADLs. Women in the other race/ethnicity category were the least likely to have any limitations (12.5 percent, compared to 20.9 percent for whites, 18.9 percent for blacks, and 16.2 percent for Hispanics) and also the least likely to need assistance with ADLs and IADLs.

Marital Status and Children

The results of this analysis show that a woman's marital status, combined with the ages of children, if she has any at home, is associated with her perceived health status. Among women with children age 5 and under, married women were significantly more likely than single women to report excellent or very good general health (69.7 percent vs. 53.0 percent) and less likely to report fair or poor health (7.5 percent vs. 12.5 percent). However, there were no differences in reports of general health between married and single women with children ages 6-18. For women without children at home, there were no differences between the proportion of married and single women with excellent or very good health, but single women were more likely than married women to be in fair or poor health (18.8 percent compared to 15.8 percent).

Among women with children age 5 and under, married women were less likely than single women to have fair or poor perceived mental health (3.5 percent compared to 7.1 percent) and more likely to have excellent or very good reported mental health (77.1 percent compared to 61.4 percent). Women with children ages 6-18 were more likely to have excellent or very good perceived mental health if they were married than if they were single (71.6 percent compared to 62.4 percent), but there was no difference between them in the report of fair or poor mental health. Married women without children were more likely than single women without children to have excellent or very good perceived mental health (71.7 percent compared to 67.4 percent).

There are no differences in the proportions of married women with children and single women with children who had activity limitations, had functional limitations, or needed assistance with ADLs or IADLs, regardless of the age of the children. However, single women without children were more likely than married women without children to have activity limitations, functional limitations, and need for assistance with ADLs and IADLs.

Income and Insurance Status

Over one-quarter of women living at or near poverty level were reported to be in fair or poor health (26.4 percent). That is twice the level for women in families with middle-level incomes (12.3 percent) and three times

the proportion for women with high family incomes (8.4 percent). The pattern is repeated with perceived mental health. Thirteen percent of women in families with poor or near-poor levels of income had fair or poor perceived mental health. This is more than four times the proportion among women in families with high incomes (3.1 percent). Women in poor or near-poor as well as low-income families also were more likely than women with higher incomes to have functional limitations, activity limitations, and need for assistance with ADLs or IADLs. Women in families with incomes at or near the poverty level were more than twice as likely as women in high-income families to have some form of physical limitation (30.7 percent compared to 13.4 percent) and more than three times as likely to need assistance with ADLs or IADLs (13.0 percent compared to 3.4 percent).

Among women under age 65, those covered only by public insurance were the least likely to have excellent or very good perceived physical health (only 36.3 percent). Over a third of them were reported to be in fair or poor health (34.8 percent)—almost twice the proportion for uninsured women under 65 (18.6 percent) and four times the proportion for those with private insurance (8.1 percent). Approximately 13 percent of women under age 65 were uninsured. Among those who were uninsured, 18.6 percent were in fair or poor health. As with self-reported physical health, women under age 65 who had only public insurance were more likely to have fair or poor perceived mental health (18.6 percent) than women who had private insurance (3.7 percent) or who were uninsured (6.9 percent).

Among women 65 and over, about half of those with Medicare only or Medicare plus private insurance were in excellent or very good general health. Among women 65 and over, 45.6 percent of those with Medicare along with Medicaid or other public insurance had fair or poor general health, a higher proportion than for women with Medicare alone or Medicare and private insurance. Similarly, reports of excellent or very good mental health were more common for women over 65 with Medicare only (63.4 percent) or Medicare and private insurance (63.9 percent), while those with Medicare and Medicaid or other public insurance had much higher proportions with fair or poor mental health (21.7 percent).

Among women under age 65, those with only public health insurance were the most likely to have any physical limitation: over one-third had a limitation, almost 16 percent required assistance with an ADL or

IADL, and close to one-quarter had activity limitations and/or functional limitations. The highest proportion of elderly women with limitations was for those with Medicare and other public insurance: more than 40 percent of these women needed assistance with ADLs or IADLs and more than 60 percent had some type of limitation.

Employment

The examination of employment and health status is limited to women ages 18-64. Women who were employed all year were the most likely to be in excellent or very good health (67.1 percent) and mental health (75.9 percent). Women who were not employed at all during the year had the highest levels of fair or poor general health (27.8 percent) and fair or poor mental health (13.1 percent), and they also were the most likely to have some type of limitation (30.2 percent).

Education

Women with less than 12 years of education were much more likely to have fair or poor perceived health (32.0 percent) than those with a high school education (13.0 percent) or those with education beyond high school (8.6 percent). The same is true for perceived mental health status. Women with less than 12 years of education were more likely to have fair or poor mental health (14.9 percent) than women with 12 years of education (5.6 percent) or more than 12 years of education (3.8 percent).

Area of Residence

Women living in metropolitan areas were more likely than women living outside of metropolitan areas to be in excellent or very good health (61.1 percent vs. 54.2 percent). The reverse relationship also held, with a higher proportion of women in nonmetropolitan areas having fair or poor health (17.4 percent). The proportion of women with excellent or very good reported mental health was higher in metropolitan areas (71.1 percent), but there was no metropolitan-nonmetropolitan difference in the proportion with fair or poor mental health. Consistent with higher levels of fair or poor health, women in nonmetropolitan areas were also more

Table 3. Health insurance status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996

Population characteristic	Total population in thousands	Private insurance ^a			Public only	Uninsured
		Total	Policyholder	Dependent		
Total in thousand	101,000	75,198	46,610	28,588	14,928	10,778
		Percent				
Percent of all women	—	74.5	46.2	28.3	14.8	10.7
Age in years						
18-29	21,071	68.3	38.3	30.0	13.6	18.1
30-44	32,755	78.7	49.4	29.3	9.4	11.9
45-64	27,953	81.2	48.5	32.7	7.9	11.9
65-74	10,142	66.8	43.8	23.1	33.2	0.0
75-84	6,850	63.9	47.4	16.5	36.1	0.0
85 and over	2,225	56.4	51.8	4.6	43.6	0.0
Race/ethnicity						
White	75,247	80.4	48.5	31.9	11.4	8.2
Black	12,229	58.2	44.5	13.8	26.6	15.2
Hispanic	9,273	52.9	33.4	19.5	25.0	22.1
Other	4,247	64.2	38.0	26.2	18.2	17.6
Perceived health^b						
Excellent/very good	59,906	81.3	49.7	31.5	9.4	9.3
Good	25,585	71.5	45.7	25.9	16.1	12.4
Fair/poor	14,828	53.7	33.1	20.6	32.9	13.4
Perceived mental health^c						
Excellent/very good	70,043	79.8	49.5	30.3	10.6	9.7
Good	23,622	66.7	41.4	25.3	19.8	13.5
Fair/poor	6,641	50.3	29.6	20.8	38.5	11.2
Any limitation^d						
No	80,982	77.9	47.7	30.2	10.6	11.5
Yes	20,044	60.7	40.0	20.8	31.9	7.4
Education						
Less than 12 years	19,830	47.6	29.1	18.5	36.0	16.4
12 years	35,645	74.3	43.6	30.7	14.5	11.1
More than 12 years	45,402	86.6	55.7	30.8	5.7	7.8
Marital status and children^e						
Married without children	29,973	83.8	44.3	39.4	9.5	6.7
Married with children						
5 and under	11,722	81.6	36.5	45.1	7.9	10.5
Married with children						
6-18	13,844	83.7	38.0	45.7	4.9	11.3
Single without children	35,320	67.6	54.4	13.2	20.3	12.2
Single with children						
5 and under	4,480	39.0	31.8	7.2	43.6	17.4
Single with children 6-18	5,657	59.7	56.4	3.3	24.2	16.1

Continued

Table 3. Health insurance status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)

Population characteristic	Total population in thousands	Private insurance ^a			Public only	Uninsured
		Total	Policyholder	Dependent		
		Percent				
Income						
Poor/near-poor	20,591	37.7	24.4	13.3	41.4	21.0
Low income	14,431	66.1	43.0	23.2	17.5	16.4
Middle income	30,390	83.9	52.2	31.7	7.2	8.9
High income	38,584	91.3	55.0	36.2	4.8	4.0
Employment^f						
Employed full year	54,066	86.6	61.7	25.0	3.1	10.2
Employed part year	9,710	63.5	23.9	39.6	16.9	19.6
Not employed	17,970	54.8	12.0	42.8	26.9	18.4
Metropolitan statistical area (MSA)						
MSA	81,138	75.4	46.7	28.7	14.7	9.9
Non-MSA	19,858	70.8	44.0	26.8	15.1	14.1

^aHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^bPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cPerceived mental health status was collected during Round 1 and refer to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^dThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with activities of daily living and instrumental activities of daily living. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^eMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^fEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Note: Percents may not add to 100 because of rounding.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

likely to have limitations, including ADLs or IADLs, activity limitations, and functional limitations.

Insurance Status and Source of Care

In Table 3, the insurance status of women in the United States is described. The data on private insurance not only show the percent of women with and without insurance but also indicate the proportions of women who were policyholders of their insurance or dependents

on someone else's policy. Policyholders can have access to insurance through their employment, including self-employment, or through union programs, or they could purchase the insurance independently of those employment mechanisms. About 75 million, or 75 percent of all women, were covered by private insurance in 1996. Over half of these women (about 62 percent, calculated from Table 3) were covered by policies that they held themselves. The remainder were covered by private insurance as a dependent. Another 14.8 percent of women were covered by public health insurance only, leaving 10.7 percent without any coverage to facilitate

Table 4. Usual source of care for civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996

Population characteristic	Total population in thousands	No usual source of health care	Usual source of health care		
			Office based	Hospital outpatient	Emergency room
Total in thousands	101,000	16,186	73,560	9,516	530
			Percent		
Percent of all women	—	16.2	73.7	9.5	0.5
Age in years					
18-29	21,071	26.4	62.9	9.6	*1.0
30-44	32,755	17.2	72.9	9.6	*0.3
45-64	27,953	12.3	77.7	9.3	0.6
65-74	10,142	9.7	80.4	9.5	*0.3
75-84	6,850	8.8	78.6	11.8	*0.9
85 and over	2,225	3.9	93.6	2.4	*0.0
Race/ethnicity					
White	75,247	14.5	77.5	7.6	0.4
Black	12,229	17.1	65.5	16.1	*1.3
Hispanic	9,273	26.3	59.7	13.3	*0.6
Other	4,247	21.8	61.4	16.8	0.0
Perceived health^a					
Excellent/very good	59,906	18.0	72.9	8.7	*0.4
Good	25,585	15.8	73.7	10.1	0.5
Fair/poor	14,828	9.7	77.4	11.9	*1.1
Perceived mental health^b					
Excellent/very good	70,043	17.1	73.2	9.2	0.4
Good	23,622	14.3	75.0	9.8	0.9
Fair/poor	6,641	13.0	74.3	12.0	*0.6
Any limitation^c					
No	80,952	18.0	72.4	9.3	0.4
Yes	20,044	9.0	79.3	10.7	1.0
Education					
Less than 12 years	19,830	19.1	68.3	11.5	1.1
12 years	35,645	15.6	74.6	9.2	0.6
More than 12 years	45,402	15.4	75.4	8.9	*0.3
Marital status and children^d					
Married without children	29,973	12.7	78.2	8.8	*0.3
Married with children					
5 and under	11,722	19.3	71.7	8.5	*0.5
Married with children 6-18	13,844	13.0	77.3	9.3	*0.4
Single without children	35,320	17.8	71.7	9.9	*0.6
Single with children					
5 and under	4,480	25.0	58.8	14.9	*1.2
Single with children 6-18	5,657	19.6	69.5	9.8	*1.0
Income					
Poor/near-poor	20,591	21.1	64.5	12.9	1.5
Low income	14,431	20.6	68.4	10.3	*0.7
Middle income	30,390	15.9	75.2	8.5	*0.4
High income	38,584	11.9	79.9	8.2	*0.1

Continued

Table 4. Usual source of care for civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)

Population characteristic	Total population in thousands	No usual source of health care	Usual source of health care		
			Office based	Hospital outpatient	Emergency room
Percent					
Insurance status^e					
Under age 65:					
Any private	62,852	15.1	76.2	8.5	0.2
Public only	8,149	15.6	65.5	17.0	*2.0
Uninsured	10,778	36.6	52.0	10.1	*1.2
Age 65 and over ^f					
Medicare only	4,187	13.6	73.8	12.6	*0.0
Medicare and private	12,347	6.6	84.6	8.1	*0.7
Medicare and other public	2,593	9.1	78.1	12.3	*0.6
Employment^g					
Employed full year	54,066	17.0	74.0	8.6	0.4
Employed part year	9,710	24.0	64.0	11.6	*0.4
Not employed	17,970	17.5	70.3	11.1	1.1
Metropolitan statistical area (MSA)					
MSA	81,138	16.9	73.0	9.7	0.5
Non-MSA	19,858	13.6	76.5	9.0	*0.9

^aPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^bPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with activities of daily living and instrumental activities of daily living. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^dMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^eHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^fHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^gEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

*Relative standard error is greater than 30 percent.

Note: Percents may not add to 100 because of rounding.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

their access to medical care. This section discusses the factors associated with whether a woman is insured and the type of insurance she holds, as well as characteristics associated with her usual source of medical care (Tables 3 and 4).

Age

Young women ages 18-29 were the most likely to be uninsured (18.1 percent); among women under age 65, they were also the most likely to have only public insurance (13.6 percent). Once women reach age 65, however, very few are uninsured and the levels of public insurance increase with age. Interestingly, 56.4 percent of women 85 and over, 63.9 percent of women 75-84, and 66.8 percent of women 65-74 had private insurance in addition to Medicare. Women in all age groups were more likely to hold their own policies than to be dependents on another policy.

Younger women were the most likely to lack a usual source of health care (26.4 percent), followed by women ages 30-44 (17.2 percent). Older women were the least likely to lack a usual source of care. About 10 percent of women 65-74 had no usual source of care, and by age 85, that proportion was less than 4 percent. Most women with a usual source of care saw an office-based physician for that care. However, for all ages up to age 85, between 9 and 12 percent of women who had a usual source of care got their care in a hospital outpatient department.

Race/Ethnicity

White women were the most likely to have private insurance; about 80 percent had private insurance as either their main form of insurance or as a supplement to Medicare. Hispanic women were the least likely to have private insurance (only 52.9 percent). Only a little more than 58 percent of black women were covered by private insurance. Like white women, black women were significantly more likely to hold their own policies than to be a dependent on someone else's policy. Black and Hispanic women were the most likely to receive public insurance (26.6 percent and 25.0 percent, respectively). However, public insurance did not compensate for low rates of private insurance among Hispanic women, so they were the most likely to be uninsured (22.1 percent).

Hispanic women (26.3 percent) also were more likely than white women (14.5 percent) or black women (17.1 percent) to lack a regular source of medical care. Among women who had a source of care, white women were the most likely to visit an office-based physician, while blacks, Hispanics, and women of other races were more likely than white women to use hospital outpatient services.

Health and Disability Status

Women in fair or poor general health were much less likely to have private health insurance than women in better health (53.7 percent compared to 81.3 percent for women in excellent or very good health and 71.5 percent for women in good health), and they were much less likely than women in better health to hold their own private policies (33.1 percent). Women in excellent or very good health were less likely to be uninsured (9.3 percent) than women in good health (12.4 percent) or fair to poor health (13.4 percent). Similarly, women reported to be in fair or poor mental health were much less likely to have private insurance than women in better mental health (50.3 percent compared to 79.8 percent for women in excellent or very good health and 66.7 percent for women in good health) and much more likely to be covered by public insurance only (38.5 percent).

Women in fair or poor general health were the most likely to have an office-based physician as a usual source of care. They were the least likely to lack a regular source of care (9.7 percent for women in fair or poor health compared to 18.0 percent for women in excellent or very good health and 15.8 percent for women in good health). These patterns did not necessarily hold for women in fair or poor mental health.

As with women in fair or poor health, women with a limitation were less likely to have private insurance (60.7 percent) than women without a limitation (77.9 percent). Women with limitations were significantly more likely than those without limitations to have public insurance and less likely to be uninsured.

Women with limitations were significantly less likely to lack a usual source of care (9.0 percent compared to 18.0 percent for women without limitations), and their usual source of care was more likely to be a physician's office (79.3 percent compared

to 72.4 percent). There was no difference in the use of hospital outpatient facilities or the emergency room as the usual source of care between women with and without limitations.

Marital Status and Children

There is a marked difference in insurance status between married women with children age 5 and under and single women with children age 5 and under. Among mothers of children age 5 and under:

- Over three-quarters (81.6 percent) of married women but only approximately 39 percent of single women had private insurance.
- Only 7.9 percent of married women had public insurance only, and 10.5 percent were uninsured.
- Over 40 percent of single women (more than eight times the proportion of married women) had public insurance only, and approximately 17 percent were uninsured.

A similar pattern holds for women with older children. Among mothers of children ages 6-18:

- Married women were much more likely to have private insurance (83.7 percent compared to 59.7 percent for single women).
- Single women were more likely than married women to have public insurance only or to be uninsured. More than one-fifth of single women had public insurance and 16 percent were uninsured.
- When they did have private insurance, single women were much more likely (56.4 percent) than married women (38.0 percent) to hold the private insurance coverage themselves.

Among women without children in the household, married women were again more likely than single women to have private insurance (83.8 percent compared to 67.6 percent), while single women were almost twice as likely to be uninsured and twice as likely to be covered by public insurance only.

Of all the groups discussed here, single women with children age 5 and under were the most likely to lack a usual source of care (25.0 percent). They are also the least likely to have an office-based physician as their regular source of care (58.8 percent). Single women with children ages 6-18 were more likely to see an office-based physician (69.5 percent) than single women with children age 5 and under, but they were less likely

to do so than married women with children ages 6-18. Among women without children in the household, single women were more likely than married women to lack a usual source of care.

Income

Women with family incomes at or near the poverty level were the least likely to have private health insurance (37.7 percent). They had the highest proportions of public insurance (41.4 percent), and an additional 21.0 percent of them were uninsured. Only 66.1 percent of low-income women had private insurance, compared to 83.9 percent of middle-income women and 91.3 percent of high-income women. Regardless of income, women with private insurance were more likely to hold the private insurance policies themselves than to be dependents on someone else's policy.

Poor and low-income women were the most likely to lack a regular source of care (21.1 percent and 20.6 percent, respectively, compared to 15.9 percent for middle-income women and 11.9 percent for high-income women). When poor and low-income women had a usual source of care, they were less likely than middle- and high-income women to have an office-based physician as that source of care.

Single women with children 5 and under were much more likely than married women with young children to be uninsured or insured by public programs.

Employment Status

Employment status is an important factor associated with the health insurance coverage of women ages 18-64. Private insurance coverage was significantly more common among women who were employed all year (86.6 percent) than among women who worked only part of the year (63.5 percent) or did not work during the year (54.8 percent). Women who worked all year were also significantly more likely to be policyholders of their insurance (61.7 percent compared to 23.9 percent for women who worked part of the year and 12.0 percent for women who were not employed during the year). Women who were not employed during the year were the most likely to be covered by public

insurance only (26.9 percent), while women who worked for part of the year were the most likely to be uninsured (19.6 percent).

Women who were not employed during the year were about as likely as women who were employed to lack a source of care (17-18 percent). Women who worked for only part of the year were the most likely to lack a regular source of care. Employment is associated with where women get their care. Women employed all year were more likely than other women to have an office-based practitioner as the usual source of care (74.0 percent). The usual source of care was more likely to be hospital based for women employed for part of the year (11.6 percent) and women who were not employed (11.1 percent) than for women employed all year (8.6 percent).

Education

The highest proportion with private insurance (86.6 percent) was for women with more than 12 years of education. In addition, women with the most education were more likely to be the holders of their private insurance policies, less likely to have public insurance (5.7 percent), and less likely to be uninsured (7.8 percent).

Area of Residence

Women living in metropolitan areas were more likely to have private insurance (75.4 percent) than women living outside metropolitan areas. Women in nonmetropolitan areas were about as likely as women in metropolitan areas to have public insurance but were more likely to be uninsured.

Use of Preventive Services

About 81 percent of American women used some form of ambulatory health service in 1996 (Table 5). Approximately 71 percent of women received a Pap smear in the last 2 years, 64 percent of those ages 40 and over received a mammogram in the last 2 years, and about 67 percent of women had a complete physical within the last 2 years. Preventive care has been found to be associated with individual characteristics and with available resources. The discussion below examines the

impact of characteristics and resources on use of preventive services.

Age and Race/Ethnicity

The youngest women (18-29 years) were the least likely to have had an ambulatory health care visit (73.3 percent), and the oldest women (age 85 and over) were the most likely to have had such a visit (93.0 percent). Although older women were more likely to have had a medical care visit, as age increased after age 64, they were less likely to have received a Pap smear (60.9 percent for ages 65-74, 42.4 percent for ages 75-84, and 26.3 percent for age 85 and over). Looking only at women age 40 and over, the data show that after age 65, a similar pattern appears with mammograms; with each increasing 10 years of age, the probability of having received a mammogram within the past 2 years was significantly reduced. There are fewer differences between age groups on receiving a complete physical.

Poor and near-poor women were the least likely to have Pap smears or mammograms.

White women were more likely than women of other racial and ethnic groups to have had an ambulatory health visit in 1996 (84 percent). This racial/ethnic difference does not hold, however, when looking at use of preventive care. White women and Hispanic women were equally likely to have received Pap smears within the past 2 years, but black women were the most likely to have had a Pap smear (76.5 percent for black women compared to 70.6 percent for whites, 69.0 percent for Hispanics, and 58.2 percent for women of other races). Black, white, and Hispanic women age 40 and over were equally likely to have received a mammogram in the past 2 years (63-65 percent), but a smaller percentage of women of other races (50.4 percent) received a mammogram. In addition to receiving Pap smears more often, black women were significantly more likely than women of any other racial or ethnic group to have had a complete physical within the last 2 years.

Health and Disability Status

As one would expect, women in fair or poor health or fair or poor mental health were more likely than other women to have had an ambulatory visit during 1996. However, fair or poor health or mental health appears to be associated with lower probabilities of receiving preventive gynecological screenings, both Pap smears (62.7 percent for women in fair or poor general health and 60.1 percent for women in fair or poor mental health) and mammograms for women 40 and over (58.3 percent for women in fair or poor general health and 50.6 percent for women in fair or poor mental health). On the other hand, women in fair or poor general health were more likely to receive a complete physical (73.6 percent) than women with better health status (64.6 percent for women in excellent or very good health and 68.5 percent for women in good health).

Like women in fair or poor health, women with some form of limitation were significantly more likely to have had an ambulatory health care visit during the year (93.4 percent). However, this increased use of health care does not translate into increased use of gynecological preventive care for women with limitations. They were significantly less likely than women without limitations to have received either a recent Pap smear (58.9 percent compared to 73.5 percent) or a recent mammogram (56.4 percent compared to 67.1 percent). Nonetheless, women with limitations were more likely to have received a physical within the last 2 years (70.2 percent compared to 65.7 percent for women without limitations).

Marital Status and Children

Married women with children, regardless of the ages of the children, were more likely to have an ambulatory health care visit than single women with children (81.6 percent for married women with children 5 and under and 77.5 percent for married women with children 6-18, compared to 72.0 percent for single women with children in either age group). Among women with children age 5 and under, married women were more likely than single women to have had a Pap smear (87.8 percent compared to 81.2 percent), but there was no significant difference in the percent receiving mammograms or complete physicals in the last 2 years. Among women with children ages 6-18, there were no differences by marital status in gynecological

screenings, but single women were more likely to have had a complete physical (70.4 percent compared to 64.0 percent).

Among women without children at home, married women were more likely than single women to have had a Pap smear and, for those age 40 and over, a mammogram in the past 2 years. There was no difference in the proportion that received a physical exam for these two groups.

Income and Insurance Status

Women with high family incomes were more likely than those with lower incomes to have had an ambulatory health care visit in 1996: 84.7 percent of high-income women compared to 76.4 percent of poor or near-poor women, 78.7 percent of low-income women, and 81.7 percent of middle-income women. In addition, income was associated with the receipt of Pap smears and mammograms. While there are no differences between women with poverty-level incomes and those with low incomes, middle-income women were more likely to have had a Pap smear (72.4 percent) than poor or near-poor women (61.7 percent) and low-income women (64.4 percent). Middle-income women were also more likely to have received a mammogram (64.1 percent compared to 51.3 percent for poor and near-poor women and 56.3 percent for low-income women). As with ambulatory visits, high-income women were more likely than any of the other income groups to have had a Pap smear or a mammogram. However, there was little difference among the income groups on receipt of a complete physical.

Among women under age 65, having some form of insurance is associated with having an ambulatory health visit. In 1996, the proportion with an ambulatory visit was higher for women with private insurance (82.2 percent) or public insurance (84.0 percent) than for uninsured women (57.4 percent). The same pattern holds for receipt of the three types of preventive care examined here. A higher proportion of women covered by either private or public insurance than uninsured women had Pap smears, mammograms, and physical examinations. Women under age 65 who had private insurance were more likely than those with public coverage to have received a Pap smear (79.6 percent compared to 72.1 percent) or a mammogram (71.1 percent compared to 58.8 percent) but were less likely to

Table 5. Use of ambulatory and preventive care services by civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996

Population characteristic	Total population in thousands	Any use of ambulatory services	Pap smear in past 2 years	Mammogram ^a in past 2 years	Complete physical in past 2 years
Total in thousands	101,000	82,050	71,316	37,317	67,229
		Percent			
Percent of all women	—	81.2	70.6	^a 64.1	66.6
Age in years					
18-29	21,071	73.3	73.6	—	62.2
30-44	32,755	78.8	79.5	57.1	64.4
45-64	27,953	83.8	71.8	70.7	68.4
65-74	10,142	90.1	60.9	68.9	74.8
75-84	6,850	90.0	42.4	52.0	71.6
85 and over	2,225	93.0	26.3	31.5	63.8
Race/ethnicity					
White	75,247	84.2	70.6	64.9	65.4
Black	12,229	72.1	76.5	63.3	78.5
Hispanic	9,273	73.6	69.0	63.8	65.1
Other	4,247	71.9	58.2	50.4	55.9
Perceived health^b					
Excellent/very good	59,906	78.2	73.5	67.0	64.6
Good	25,585	82.7	70.1	64.5	68.5
Fair/poor	14,828	91.8	62.7	58.3	73.6
Perceived mental health^c					
Excellent/very good	70,043	80.3	73.5	67.8	66.8
Good	23,622	83.1	66.8	61.2	67.8
Fair/poor	6,641	87.3	60.1	50.6	67.1
Any limitation^d					
No	80,952	78.2	73.5	67.1	65.7
Yes	20,044	93.4	58.9	56.4	70.2
Education					
Less than 12 years	19,830	79.3	56.4	52.4	65.1
12 years	35,645	79.6	69.3	64.3	66.5
More than 12 years	45,402	83.5	78.0	70.9	67.4
Marital status and children^e					
Married without children	29,973	85.9	71.1	70.2	68.5
Married with children					
5 and under	11,722	81.6	87.8	59.4	64.9
Married with children 6-18	13,844	77.5	75.9	63.6	64.0
Single without children	35,320	81.3	60.4	57.6	65.8
Single with children					
5 and under	4,480	72.0	81.2	55.0	67.5
Single with children 6-18	5,657	72.0	74.6	61.0	70.4

Continued

Table 5. Use of ambulatory and preventive care services by civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996
(continued)

Population characteristic	Total population in thousands	Any use of ambulatory services	Pap smear in past 2 years	Mammogram ^a in past 2 years	Complete physical in past 2 years
Percent					
Income					
Poor/near-poor	20,591	76.4	61.7	51.3	63.3
Low income	14,431	78.7	64.4	56.3	65.4
Middle income	30,390	81.7	72.4	64.1	66.6
High income	35,584	84.7	76.7	72.6	68.9
Insurance status^f					
Under age 65:					
Private	62,852	82.2	79.6	71.1	67.1
Public only	8,149	84.0	72.1	58.8	72.1
Uninsured	10,778	57.4	60.3	40.4	48.9
Age 65 and over: ^g					
Medicare only	4,187	86.1	40.8	49.3	66.8
Medicare and private	12,347	92.3	54.7	63.7	75.2
Medicare and other public	2,593	90.8	45.4	50.2	67.7
Employment^h					
Employed full year	54,066	79.9	78.1	68.6	65.5
Employed part year	9,710	74.9	71.2	59.9	61.5
Not employed	17,970	79.1	69.6	64.2	66.4
Metropolitan statistical area (MSA)					
MSA	81,139	81.3	72.4	66.0	68.0
Non-MSA	19,857	80.8	63.3	56.8	60.8

^aData on mammograms were limited to women age 40 and over. The population total reflects the number of women this age.

Approximately 37,317,000, or 64.1 percent, of women age 40 and over (37 percent of all women age 18 and over) received a mammogram in the past 2 years.

^bPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^dThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with activities of daily living and instrumental activities of daily living. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^eMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^fHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^gHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^hEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Note: Percents may not add to 100 because of rounding.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

have had a complete physical (67.1 percent compared to 72.1 percent).

Older women with Medicare benefits and private insurance are at an advantage over women with Medicare only and women with Medicare and other public insurance. In 1996, elderly women who had private insurance in addition to Medicare were more likely to have ambulatory visits and all three types of preventive care services than women who had Medicare coverage only or Medicare and other public insurance. There were no differences in use between women with Medicare only and those with Medicare and other public insurance.

Employment

Ambulatory visits were more likely for women ages 18-64 who were employed all year (79.9 percent) or not employed during the year (79.1 percent) than for women who were employed for part of the year (74.9 percent). The proportion receiving a Pap smear was larger for women who were employed throughout the year (78.1 percent) than for women employed part of the year (71.2 percent) or women not employed during the year (69.6 percent). Similarly, the proportion of women getting a mammogram was greater for women employed all year (68.6 percent) than for women employed part of the year (59.9 percent) or not employed (64.2 percent). Women who were either employed all year or not employed at all were more likely to have had a physical exam within the last 2 years than women who had a job at some point in the year.

Education

While women with education levels greater than high school graduation were more likely than women with less education to have an ambulatory visit, women of all levels of education were equally likely to have received a physical examination within the last 2 years. However, that equality did not extend to receipt of gynecological preventive services. Women with more than a high school education were more likely to have received a Pap smear (78.0 percent, compared to 56.4 percent for women with less than 12 years of education and 69.3 percent for high school graduates) and a mammogram (70.9 percent compared to 52.4 percent for women with less than 12 years of education and 64.3

percent for high school graduates) within the past 2 years.

Area of Residence

Where a woman lives also was associated with access to certain services. Although women who lived in metropolitan and nonmetropolitan areas were equally likely to have had an ambulatory health care visit during the year, the women in nonmetropolitan areas were less likely to have had any of the preventive services examined here within the past 2 years (Pap smear, 63.3 percent as opposed to 72.4 percent for women in metropolitan areas; mammogram, 56.8 percent as opposed to 66.0 percent for women in metropolitan areas; or physical exam, 60.8 percent as opposed to 68.0 percent for women in metropolitan areas).

Conclusions

These data give a clear indication that, as the population of women ages, their health status deteriorates slowly until about age 75, when approximately 30 percent are reported to be in fair or poor health. While this is not unexpected, it also should be noted that among older women, limitations in functioning and limitations in activities are more widespread than fair or poor health and should be of equal concern. Although there are still indications of racial/ethnic differences in the proportion of women in fair or poor general health, white and black women, at least, have similar levels of activity limitation, functional limitation, and need for assistance with ADLs and IADLs. Hispanic women and women of other races have lower levels of these limitations than whites and blacks.

Marital status and the presence of children in the family also are associated with women's health. Single women with children age 5 and under have poorer general health status and mental health status than their married counterparts. Moreover, there is a marked difference in the types of insurance coverage between the two groups. Single women with children age 5 and under are much less likely than married women with small children to have private insurance, are much more dependent on public insurance, are much more likely to be uninsured, are much more likely to lack a usual source of medical care, and are less likely to have had an ambulatory health care visit. However, despite the

access problems faced by single women with children age 5 and under, they are receiving some preventive care services at the same level as other women (mammograms and physical exams).

Two other important characteristics that influence women's health and their access to medical care are family income and health insurance status. When compared to women with higher income levels, poor women have much higher levels of perceived fair or poor health and fair or poor mental health. In addition, they have the highest levels of activity limitations and need for help with ADLs or IADLS; along with low-income women, they also have the highest levels of functional limitations. Both women at or near poverty and those with low incomes are significantly more likely than higher income women to lack a usual source of care; when they do have a source of care, it is less likely to be an office-based physician. Poverty is strongly related to women's insurance status, with poor and near-poor women being the income group least likely to have private insurance and most likely to have public coverage or be uninsured. This combination of poverty and insurance status has a significant effect on poor and

near-poor women, and they are less likely than middle-income and high-income women to have an ambulatory visit or to have gynecological screening in the form of a Pap smear or mammogram (for women 40 and over). Access to ambulatory visits or preventive care services is significantly restricted for those poor and near-poor women who are uninsured. Employment for women ages 18-64 significantly improves their access to private health insurance. A high number of women who are not working or who worked only part of the year are uninsured.

Finally, there are some subtle differences in health status and access to health care between women who live in metropolitan areas and those who live in nonmetropolitan areas. Women in nonmetropolitan areas are more likely to need help with ADLs or IADLS and to have activity limitations or functional limitations. At the same time, they are less likely than women in metropolitan areas to have private health insurance, are more likely to be uninsured, and are less likely to receive preventive services.

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Technical Appendix

The data in this report were obtained in the Round 1, 2, and 3 interviews for the Household Component (HC) of the 1996 Medical Expenditure Panel Survey (MEPS). MEPS is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). The MEPS HC is a nationally representative survey of the U.S. civilian noninstitutionalized population that collects medical expenditure data at both the person and household levels. The focus of the MEPS HC is to collect detailed data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. In other components of MEPS, data are collected on residents of licensed or certified nursing homes and from the supply side of the health insurance market.

Survey Design

The sample for the 1996 MEPS HC was selected from respondents to the 1995 National Health Interview Survey (NHIS), which was conducted by NCHS. NHIS provides a nationally representative sample of the U.S. civilian noninstitutionalized population and reflects an oversampling of Hispanics and blacks. The MEPS HC collects data through an overlapping panel design. In this design, data are collected through a precontact interview that is followed by a series of five rounds of interviews over 2-years. Interviews are conducted with one member of each family, who reports on the health care experiences of the entire family. Two calendar years of medical expenditure and utilization data are collected from each household and captured using computer-assisted personal interviewing (CAPI). This series of data collection rounds is launched again each subsequent year on a new sample of households to provide overlapping panels of survey data which that will provide continuous and current estimates of health care expenditures.

The reference period for Round 1 of the MEPS HC was from January 1, 1996, to the date of the first interview, which occurred during the period from March through July 1996. The reference period for Round 2 of

the MEPS HC was from the date of the first interview (March-July 1996) to the date of the second interview, which took place during the period from August through November 1996. The reference period for Round 3 was from December 1996 through July 1997. However, the only Round 3 data included in this Research Findings represent information collected from the end of Round 2 through December 31, 1996.

Health Status

A questionnaire module on health status was administered in Rounds 1 and 2 of the MEPS HC. The data reported in Tables 1-4 on perceived health, perceived mental health, and functional, ADL (activities of daily living), IADL (instrumental activities of daily living), and activity limitations were collected during Round 1.

Only women ages 18 and over who were assigned a positive person-level weight were included in this analysis. Positive person-level weights were assigned to eligible members of the U.S. civilian noninstitutionalized population for whom data were collected as a means to apply sampling adjustments and reapportion population subgroups that were originally oversampled to their representation in the full population. Of the 24,676 persons surveyed in the first round, 23,612 were assigned a positive person-level weight. Of the 23,767 individuals surveyed in the second round, 22,149 were assigned a positive person-level weight. The estimated population total for the U.S. civilian noninstitutionalized population as of the first half of 1996 was 263,515,813.

Although this report is on women's health, Table A shows data for men for comparison purposes.

Perceived Health and Mental Health Status

The respondent was asked to rate the health and mental health of each person in the family at the time of the Round 1 interview according to the following categories: excellent, very good, good, fair, or poor.

Minimal editing was done to the perceived health status variables reported in Tables 1-5. For this report, the response categories "excellent" and "very good" were collapsed, as were "fair" and "poor." Women with missing data on perceived health or mental health status

were excluded from the estimates. Data for perceived health status were missing for 57 persons in the sample (.70 percent). This left an unweighted sample population of 8,011 women on which the estimates in Table 1 were based. Data for perceived mental health status were missing for 59 persons in the sample (.73 percent), which left an unweighted sample population of 8,009 women on which the estimates in Table 1 were based.

Functional Limitations

Three indicators of functional limitation were used for this analysis: the need for help with IADLs or ADLs; physical activity limitations (such as difficulties walking, bending, or stooping); and work/housework/school limitations. A combined measure of any of those limitations was also used. Questions about functional limitation were asked first at the family level to ascertain if anyone in the household had a particular problem or limitation. These were followed by questions at the person level to determine which household member had each problem or limitation. Logical editing at the person level was performed to insure that family-level and person-level responses were consistent. Particular attention was given to cases where missing values were reported at the family level to ensure that appropriate information was carried to the person level. For variables that pertained only to persons of certain age groups, editing was performed to appropriately code other ages as “inapplicable.”

Physical activity limitations are reported in Table 2 only for women ages 18 and over. In this analysis, women whose physical activity limitation status was unknown were considered to have no physical activity limitations. Data for ADL or IADL limitations were missing for 13 persons in the sample (.16 percent). This left an unweighted sample of 8,055 women on which estimates in Table 2 were based. Data for the activities limitation measure were missing for 19 persons in the sample (.23 percent). This left an unweighed sample population of 8,049 women on which estimates in Table 2 were based. There were no missing data for physical functional limitations.

IADLs and ADLs

Limitations in the ability to perform instrumental activities of daily living were assessed by first asking the respondent whether anyone in the family received help or supervision using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping. If the respondent indicated that someone in the household received help with any of these activities, a followup question was asked to determine which household member received help.

Limitations in the ability to perform activities of daily living were assessed by asking whether anyone in the family received help or supervision with personal care such as bathing, dressing, or getting around the house.

A combined indicator was constructed for this analysis to report whether individuals received help with either IADLs or ADLs.

Physical Activity Limitations

Limitations in physical activities were measured by asking whether anyone in the family had difficulty walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping, or standing for long periods of time. A followup question identified each family member over age 12 who experienced any type of physical limitation.

Activity Limitations

These limitations include both paid work and unpaid housework, as well as limitations in the ability to attend school. The work/housework/school limitation was measured by asking the respondent whether anyone in the family was limited in any way in the ability to work at a job, do housework, or go to school *because of an impairment or a physical or mental health problem*. For all individuals identified as having a work/housework/school limitation, a followup question was asked to clarify if the limitation applied to working at a job, doing housework, going to school, or some combination of the three.

Any Limitation

The measure “any limitations,” reported first in Table 2, is simply a combined measure that indicates

whether an individual had one or more of the limitations previously described: IADLs/ADLs, physical activity limitations, or activity limitations. It also included other limitations in social role behavior and cognitive limitations, measures which were not included in the tables.

Population Characteristics

Age

The respondent was asked to report the age of each family member as of the date of the Round 1 interview. The age at Round 1 was used for the analysis of both Round 1 and Round 2 data.

Race/Ethnicity

Classification by race and ethnicity was based on information reported for each household member. Respondents were asked if the race of the sample person was best described as American Indian, Alaska Native, Asian or Pacific Islander, black, white, or other. Respondents were also asked if the sample person's main national origin or ancestry was Puerto Rican; Cuban; Mexican, Mexicano, Mexican American, or Chicano; other Latin American; or other Spanish. All persons who claimed main national origin or ancestry in one of these Hispanic groups, regardless of racial background, were classified as Hispanic. Since the Hispanic grouping can include black Hispanic, white Hispanic, and other Hispanic, the race categories of black, white, and other do not include Hispanic.

Place of Residence

Individuals were identified as residing either inside or outside a metropolitan statistical area (MSA) as designated by the U.S. Office of Management and Budget, which applied 1990 standards using population counts from the 1990 U.S. census. An MSA is a large population nucleus combined with adjacent communities that have a high degree of economic and social integration within the nucleus. Each MSA has one or more central counties containing the area's main population concentration. In New England, metropolitan areas consist of cities and towns rather than whole counties.

Health Insurance

The household respondent was asked if, between January 1, 1996, and the time of the Round 1 interview, anyone in the family was covered by any of the sources of public and private health insurance coverage discussed in the following paragraphs. For this report, Medicare and CHAMPUS/CHAMPVA coverage represent coverage as of the date of the Round 1 interview. (CHAMPUS and CHAMPVA are the Civilian Health and Medical Programs for the Uniformed Services and Veterans Affairs.) All other sources of insurance represent coverage at any time during the Round 1 reference period. Persons counted as uninsured were uninsured throughout the Round 1 reference period. For additional details on health insurance status measures in MEPS, see Vistnes and Monheit (1997).

Public Coverage

For this report, individuals were considered to have public coverage only if they met both of the following criteria:

- They were not covered by private insurance.
- They were covered by one of the following public programs: Medicare, Medicaid, or other public hospital/physician coverage.

Private Health Insurance

Private health insurance was defined for this report as insurance that provides coverage for hospital and physician care. Insurance that provided coverage for a single service only, such as dental or vision coverage, is not counted. Coverage by CHAMPUS/CHAMPVA was included as private health insurance.

Uninsured

The uninsured were defined as persons not covered by Medicare, CHAMPUS/CHAMPVA, Medicaid, other public hospital/physician programs, or private hospital/physician insurance throughout the entire Round 1 reference period. Individuals covered only by noncomprehensive State-specific programs (e.g., Maryland Kidney Disease Program, Colorado Child Health Plan) or private single-service plans (e.g., coverage for dental or vision care only, coverage for accidents or specific diseases) were not considered to be insured.

Marital Status and Presence of Children

Family composition was a constructed indicator of living arrangements based on the relationship of each person to each of the other people in the household at the time of the Round 1 interview. Separate categories were coded for adults living alone; adults living with a spouse or partner, either with or without children age 18 and under; adults without a spouse or partner living with a child or other nonrelated adults. In addition, the ages of the children were reported in such a way that the presence of *any* children age 5 or under in the household was noted. Otherwise, the children living in the household were considered to be ages 6-18. Women who had at least one child age 5 or under were included in that category even if they had older children as well. Women categorized as having children 6-18 had no children in the household under age 6. This age break was chosen on the assumption that children ages 6 and over were in school full time, while children younger than that probably required some type of daycare arrangements.

Employment

For this report, employment status was determined at any time during Round 1 and Round 2 by asking whether each adult in the household was currently employed for pay. Only employment status for women ages 18-64 is used in this analysis. Women employed for pay throughout Round 1 and Round 2 were considered to be employed. Women employed for pay for some part of the Round 1 or Round 2 reference period and women who were temporarily unemployed throughout the Round 1 or Round 2 reference period but had a paying job to return to were considered employed during the year. Women not employed during Rounds 1 or 2 and without a job to return to were considered not employed.

Poverty Status of Family

Each sample woman was classified according to the total 1996 income of her family. Within a household, all individuals related by blood, marriage, or adoption were considered to be a family. Personal income from all family members was summed to create family income. Possible sources of income included annual earnings from wages, salaries, bonuses, tips, and commissions;

business and farm gains and losses; unemployment and Worker's Compensation; interest and dividends, alimony, child support, and other private cash transfers; private pensions, individual retirement account (IRA) withdrawals, Social Security, and Department of Veterans Affairs payments; Supplemental Security Income and cash welfare payments from public assistance, Aid to Families with Dependent Children and Aid to Dependent Children; gains or losses from estates, trusts, partnerships, S corporations, rent, and royalties; and a small amount of "other" income.

Poverty status is the ratio of family income to the 1996 Federal poverty thresholds, which control for family size and the age of the head of the family. The results are grouped into five categories. Poor indicates family income less than 100 percent of the poverty line; near-poor indicates family income from 100 to less than 125 percent of poverty; low income indicates family income from 125 to less than 200 percent of poverty; middle income indicates family income from 200 to less than 400 percent of poverty; and high income indicates family income 400 percent of poverty or more.

Education

Respondents were asked to report the highest grade or year of schooling ever completed by each family member 18 years of age and over as of the date of the Round 1 interview. There was a small amount of item nonresponse for education (1.40 percent among Hispanics, 1.17 percent among blacks, and .76 percent among whites). Within each racial/ethnic group, a correction was applied to adjust for item nonresponse so that the distribution of educational levels for each group adds to 100.0 percent.

Use of Ambulatory and Preventive Services

Any Use of Ambulatory Services

Office-based ambulatory events include visits to physician and nonphysician providers as well as office-based providers of unknown type. Telephone contacts with office-based providers, regardless of provider type, are not included in the estimates. Examples of nonphysician providers include chiropractors, physical and occupational therapists, nurses and nurse

practitioners, podiatrists, technicians and receptionists, clerks or secretaries.

Hospital-based ambulatory events include visits to physician and nonphysician providers as well as providers of unknown type in hospital outpatient departments and emergency rooms. Same-day hospital discharges (hospital events classified as inpatient that did not result in an overnight stay) also are treated as ambulatory hospital-based events in these estimates. Telephone contact with hospital-based providers is not included in these estimates.

Preventive Care Use

Data on preventive care are based on a series of questions asked in Round 3 about preventive health care use and when it occurred: within the past year, the past 2 years, the past 5 years, or never. The set of indicators included receipt of a Pap smear, mammogram, breast exam, physical exam, blood pressure reading, and flu shot. Pap smears, mammograms, and physical exams were included in this analysis. Since many preventive services are considered most effective if received within a 1-year to 2-year period, women were identified as having received such services if they had received them within that time period.

Usual Source of Care

For each family member, the MEPS interviewer ascertained whether there was a particular doctor's office, clinic, health center, or other place that the individual usually went when sick or in need of health advice. For those family members who did not have a usual source of health care, the interviewer ascertained the reasons why, but that information is not used in this analysis.

Sample Design and Accuracy of Estimates

The sample selected for the 1996 MEPS, a subsample of the 1995 NHIS, was designed to produce national estimates that are representative of the civilian noninstitutionalized population of the United States. Round 1 data were obtained for approximately 9,400 households in MEPS, resulting in a survey response rate

of 78 percent. This figure reflects participation in both NHIS and MEPS. For Round 2, the response rate was 95 percent, resulting in a response rate of 74 percent overall from the NHIS interview through Round 2 of MEPS.

The statistics presented in this report are affected by both sampling error and sources of nonsampling error, which include nonresponse bias, respondent reporting errors, and interviewer effects. For a detailed description of the MEPS survey design, the adopted sample design, and methods used to minimize sources of nonsampling error, see J. Cohen (1997), S. Cohen (1997) and Cohen, Monheit, Beauregard, et al. (1996).

The MEPS person-level estimation weights include nonresponse adjustments and poststratification adjustments to population estimates derived from the March 1996 Current Population Survey based on cross-classifications by region, age, race/ethnicity, and sex.

Tests of statistical significance were used to determine whether the differences between populations exist at specified levels of confidence or whether they occurred by chance. Differences were tested using Z-scores having asymptotic normal properties at the 0.05 level of significance. Unless otherwise noted, only statistically significant differences between estimates are discussed in the text.

Rounding

Estimates presented in Tables 1-5 were rounded to the nearest 0.1 percent. Standard errors, presented in Tables B-F, were rounded to the nearest 0.01. Some of the estimates for population totals of subgroups presented in the tables will not add exactly to the overall estimated population total as a consequence of rounding.

Comparisons with Other Data Sources

Because of methodological differences, caution should be used when comparing these data with data from other sources. Particularly with questions about limitations in activities, a range of results is frequently found among surveys based on question wording, the sequencing of questions, the placement of questions, and whether or not the respondent was a proxy for the person with the limitation. Benchmarking activities

indicate that the proportions with ADLs and IADLs are very similar to those reported in the National Health Interview Survey. However, the estimates of limitations in work, school, or housework activities are more conservative than those found in NHIS.

Table A. Physical and mental health status of civilian noninstitutionalized men by sociodemographic characteristics: United States, 1996

Population characteristic	Total population of men in thousands	Perceived health ^a			Perceived mental health ^b		
		Excellent/very good	Good	Fair/poor	Excellent/very good	Good	Fair/poor
		Percent					
All men	91,720	63.2	25.3	11.5	72.2	21.5	6.3
Age in years							
18-29	20,000	75.6	20.9	4.5	77.5	17.8	4.7
30-44	31,840	68.8	23.5	7.7	76.1	18.8	5.1
45-64	26,270	57.7	28.1	14.2	69.8	23.8	6.4
65-74	8,185	47.0	29.4	23.6	62.6	28.5	8.9
75-84	4,672	38.5	33.0	28.5	57.7	29.4	12.9
85 and over	753	45.3	24.3	30.4	43.4	33.0	23.7
Race/ethnicity							
White	68,690	64.8	24.6	10.6	73.3	20.7	6.1
Black	9,598	58.5	24.3	17.3	65.8	25.7	8.5
Hispanic	9,416	59.1	28.8	12.2	70.5	23.4	6.1
Other	4,015	56.5	31.7	11.9	73.5	22.0	4.5
Education							
Less than 12 years	17,690	42.2	32.0	25.8	50.8	34.2	15.0
12 years	29,770	61.6	28.0	10.4	71.4	23.3	5.3
More than 12 years	44,190	72.7	20.7	6.6	81.4	15.3	3.4
Income							
Poor/near-poor	13,859	46.7	30.3	23.0	57.1	29.3	13.6
Low income	11,550	51.3	31.3	17.4	61.4	27.7	10.9
Middle income	29,310	65.4	25.0	9.6	73.7	21.6	4.7
High income	37,000	71.3	21.7	6.9	80.1	16.7	3.3
Insurance status^c							
Under age 65:							
Private	55,790	70.6	22.9	6.5	79.2	17.9	2.9
Public	5,184	33.6	30.0	36.4	39.6	34.0	26.4
Uninsured	17,740	62.2	27.7	10.1	68.3	24.7	7.1
Age 65 and over:							
Medicare only	3,205	43.6	32.1	24.3	52.5	36.3	11.2
Medicare and private	8,566	45.9	29.6	24.5	64.0	25.5	10.5
Medicare and other public	933	31.0	27.8	41.2	58.4	19.7	21.9

^aPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^bPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

Note: Percents may not add to 100 because of rounding.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Table B. Standard errors for physical and mental health status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996
Corresponds to Table 1

Population characteristic	Perceived health ^a			Perceived mental health ^b		
	Excellent/ very good	Good	Fair/poor	Excellent/ very good	Good	Fair/poor
	Standard error					
Total	0.77	0.63	0.47	0.67	0.54	0.35
Age in years						
18-29	1.36	1.33	0.71	1.22	1.19	0.60
30-44	1.16	0.96	0.65	1.10	0.94	0.54
45-64	1.20	1.07	0.85	1.15	1.04	0.60
65-74	2.00	1.77	1.67	1.73	1.65	0.99
75-84	2.53	1.91	2.27	2.53	2.14	1.57
85 and over	4.24	3.88	4.22	4.28	3.92	3.23
Race/ethnicity						
White	0.94	0.72	0.52	0.78	0.62	0.37
Black	1.69	1.75	1.62	1.59	1.62	1.29
Hispanic	1.71	1.48	1.25	1.62	1.48	0.85
Other	3.57	3.10	2.10	3.09	2.59	1.70
Education						
Less than 12 years	1.32	1.21	1.26	1.29	1.11	0.99
12 years	1.18	1.01	0.77	1.15	0.99	0.53
More than 12 years	0.94	0.86	0.54	0.77	0.69	0.34
Marital status and children^c						
Married without children	1.21	1.09	0.78	0.99	0.93	0.50
Married with children 5 and under	1.66	1.48	0.85	1.43	1.36	0.76
Married with children 6-18	1.69	1.48	1.01	1.45	1.34	0.66
Single without children	1.22	0.93	1.01	1.13	0.90	0.73
Single with children 5 and under	2.73	2.83	1.69	2.84	2.74	1.4
Single with children 6-18	2.23	2.25	1.36	2.40	2.16	1.26
Income						
Poor/near-poor	1.37	1.38	1.33	1.56	1.33	1.51
Low income	1.75	1.40	1.36	1.64	1.52	1.01
Middle income	1.17	1.03	0.78	1.06	0.95	0.50
High income	1.13	0.96	0.65	0.87	0.80	0.40
Insurance status^d						
Under age 65:						
Private	0.83	0.75	0.43	0.73	0.67	0.31
Public only	2.0	2.06	2.10	2.27	1.93	1.76
Uninsured	1.95	1.84	1.47	1.82	1.77	1.04
Age 65 and over: ^e						
Medicare only	3.18	2.74	2.44	2.67	2.30	1.68
Medicare and private	1.95	1.69	1.72	1.78	1.59	1.04
Medicare and other public	3.47	3.21	3.99	3.67	3.37	2.74

Continued

Table B. Standard errors for physical and mental health status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)
Corresponds to Table 1

Population characteristic	Perceived health ^a			Perceived mental health ^a		
	Excellent/ very good	Good	Fair/poor	Excellent/ very good	Good	Fair/poor
	Standard error					
Employment^f						
Employed full year	0.90	0.83	0.41	0.79	0.74	0.31
Employed part year	2.20	1.84	1.30	1.96	1.87	0.97
Not employed	1.56	1.33	1.33	1.43	1.26	1.02
Metropolitan statistical area (MSA)						
MSA	0.87	0.70	0.52	0.75	0.59	0.37
Non-MSA	1.55	1.41	1.24	1.40	1.36	0.93

^aPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^bPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^dHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^eHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^fEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Table C. Standard errors for functional and activity limitation status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996
Corresponds to Table 2

Population characteristic	ADLs or IADLs ^a	Activity limitations	Physical activity limitations	Any limitations ^b
Standard error				
Total	0.31	0.41	0.48	0.53
Age in years				
18-29	0.34	0.42	0.41	0.64
30-44	0.39	0.60	0.66	0.81
45-64	0.48	0.72	0.78	0.93
65-74	1.09	1.45	1.69	1.77
75-84	1.92	2.06	2.33	2.22
85 and over	4.60	4.69	3.95	3.67
Race/ethnicity				
White	0.39	0.51	0.59	0.65
Black	0.97	1.12	1.29	1.39
Hispanic	0.79	0.79	0.83	1.29
Other	0.78	1.32	1.82	2.08
Perceived health^c				
Excellent/very good	0.22	0.29	0.36	0.48
Good	0.55	0.69	0.94	1.06
Fair/poor	1.34	1.56	1.57	1.56
Perceived mental health^d				
Excellent/very good	0.24	0.35	0.42	0.50
Good	0.65	0.90	1.04	1.20
Fair/poor	2.26	2.16	2.24	2.26
Education				
Less than 12 years	0.82	1.12	1.19	1.24
12 years	0.51	0.62	0.72	0.82
More than 12 years	0.34	0.45	0.63	0.72
Marital status and children^e				
Married without children	0.48	0.70	0.77	0.88
Married with children 5 and under	0.31	0.62	0.62	0.90
Married with children 6-18	0.46	0.69	0.87	1.05
Single without children	0.78	0.92	0.98	1.11
Single with children 5 and under	0.69	1.29	1.49	1.79
Single with children 6-18	0.52	1.10	1.47	1.61
Income				
Poor/near-poor	0.90	1.10	1.21	1.40
Low income	0.96	1.08	1.29	1.32
Middle income	0.48	0.64	0.74	0.91
High income	0.42	0.55	0.64	0.71
Insurance status^f				
Under age 65:				
Private	0.21	0.32	0.41	0.50
Public only	1.53	2.00	1.88	2.26
Uninsured	0.50	0.91	0.92	1.27

Continued

Table C. Standard errors for functional and activity limitation status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)
Corresponds to Table 2

Population characteristic	ADLs or IADLs ^a	Activity limitations	Physical activity limitations	Any limitations ^b
Standard error				
Insurance status^f (continued)				
Age 65 and over: ^g				
Medicare only	2.48	2.33	2.56	2.68
Medicare and private	1.24	1.56	1.88	1.84
Medicare and other public	3.66	4.04	4.03	3.92
Employment^h				
Employed full year	—	0.28	0.43	0.52
Employed part year	—	0.93	1.05	1.40
Not employed	0.95	1.26	1.23	1.45
Metropolitan statistical area (MSA)				
MSA	0.34	0.43	0.52	0.57
Non-MSA	0.69	1.09	1.16	1.31

^aActivities of daily living (ADLs) include activities such as bathing and dressing. Instrumental activities of daily living (IADLs) include activities such as shopping and paying bills.

^bThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with ADLs or IADLs. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^cPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^dPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^eMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^fHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^gHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^hEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Table D. Standard errors for health insurance status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996
Corresponds to Table 3

Population characteristic	Private insurance ^a			Public only	Uninsured
	Total	Policyholder	Dependent		
	Standard error				
Total	0.72	0.73	0.72	0.56	0.44
Age in years					
18-29	1.51	.51	1.51	1.05	1.19
30-44	1.08	1.33	1.10	0.74	0.71
45-64	1.02	1.21	1.26	0.67	0.71
65-74	1.76	1.87	1.70	1.76	—
75-84	2.25	2.40	1.73	2.25	—
85 and over	4.24	4.28	1.69	4.24	—
Race/ethnicity					
White	0.75	0.86	0.87	0.59	0.44
Black	1.84	1.55	1.17	1.87	1.25
Hispanic	2.23	1.85	1.50	1.73	1.74
Other	3.78	3.09	3.56	3.15	2.58
Perceived health^b					
Excellent/very good	0.67	0.92	0.87	0.49	0.50
Good	1.36	1.32	1.18	1.06	0.86
Fair/poor	1.84	1.55	1.49	1.45	1.16
Perceived mental health^c					
Excellent/very good	0.68	0.86	0.81	0.54	0.46
Good	1.41	1.37	1.17	1.05	0.96
Fair/poor	2.34	2.05	2.08	2.33	1.60
Any limitation^d					
No	0.73	0.84	0.78	0.52	0.51
Yes	1.53	1.43	1.16	1.39	0.71
Education					
Less than 12 years	1.41	1.22	1.16	1.30	1.15
12 years	1.06	1.03	0.97	0.96	0.69
More than 12 years	0.66	1.05	1.05	0.42	0.52
Marital status and children^e					
Married without children	0.85	1.08	1.28	0.66	0.52
Married with children 5 and under	1.44	1.68	1.80	0.85	1.12
Married with children 6-18	1.19	1.62	1.72	0.65	1.01
Single without children	1.13	1.25	0.91	0.95	0.76
Single with children 5 and under	2.65	2.65	1.53	3.11	2.31
Single with children 6-18	2.54	2.58	0.90	2.10	1.92

Continued

Table D. Standard errors for health insurance status of civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)
Corresponds to Table 3

Population characteristic	Private insurance ^a			Public only	Uninsured
	Total	Policyholder	Dependent		
	Standard error				
Income					
Poor/near-poor	1.41	1.16	0.96	1.46	1.27
Low income	1.62	1.58	1.45	1.23	1.13
Middle income	0.83	1.11	1.10	0.55	0.65
High income	0.61	1.20	1.18	0.42	0.41
Employment^f					
Employed full year	0.68	0.98	0.89	0.36	0.56
Employed part year	2.35	1.59	2.08	1.70	1.62
Not employed	1.65	1.08	1.68	1.39	1.20
Metropolitan statistical area (MSA)					
MSA	0.79	0.83	0.80	0.65	0.48
Non-MSA	1.81	1.65	1.57	1.11	1.12

^aHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^bPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^dThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with activities of daily living and instrumental activities of daily living. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^eMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^fEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Table E. Standard errors for usual source of care for civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996
Corresponds to Table 4

Population characteristic	No usual source of health care	Usual source of health care		
		Office based	Hospital outpatient	Emergency room
Standard error				
Total	0.52	0.68	0.54	0.10
Age in years				
18-29	1.39	1.60	1.03	0.35
30-44	0.80	1.03	0.76	0.09
45-64	0.77	0.97	0.82	0.15
65-74	1.24	1.66	1.24	0.24
75-84	1.33	1.86	1.43	0.53
85 and over	1.80	2.24	1.42	—
Race/ethnicity				
White	0.61	0.75	0.58	0.11
Black	1.30	1.65	1.30	0.49
Hispanic	1.49	1.67	1.23	0.29
Other	2.74	3.50	2.98	—
Perceived health^a				
Excellent/very good	0.66	0.82	0.58	0.13
Good	0.97	1.25	0.89	0.14
Fair/poor	0.92	1.35	1.11	0.33
Perceived mental health^b				
Excellent/very good	0.61	0.77	0.59	0.10
Good	0.85	1.07	0.88	0.25
Fair/poor	1.58	2.13	1.53	0.40
Education				
Less than 12 years	1.18	1.29	0.94	0.30
12 years	0.90	1.12	0.74	0.16
More than 12 years	0.74	0.87	0.65	0.12
Any limitation^c				
No	0.59	0.77	0.58	0.10
Yes	0.91	1.23	0.86	0.29
Marital status and children^d				
Married without children	0.84	1.03	0.74	0.12
Married with children 5 and under	1.42	1.65	1.01	0.26
Married with children 6-18	1.02	1.30	0.97	0.16
Single without children	0.84	1.03	0.81	0.21
Single with children 5 and under	2.54	2.84	2.26	0.60
Single with children 6-18	1.98	2.15	1.28	0.73
Income				
Poor/near-poor	1.28	1.42	1.03	0.35
Low income	1.41	1.71	1.25	0.36
Middle income	0.86	1.06	0.79	0.14
High income	0.70	0.92	0.66	0.04

Continued

Table E. Standard errors for usual source of care for civilian noninstitutionalized women by sociodemographic characteristics: United States, 1996 (continued)
Corresponds to Table 4

Population characteristic	No usual source of health care	Usual source of health care		
		Office based	Hospital outpatient	Emergency room
Standard error				
Insurance status^e				
Under age 65:				
Any private	0.66	0.76	0.62	0.06
Public only	1.65	2.10	1.56	0.68
Uninsured	1.83	2.00	1.33	0.42
Age 65 and over: ^f				
Medicare only	1.88	2.54	2.23	—
Medicare and private	0.94	1.39	0.99	0.34
Medicare and other public	2.05	3.04	2.21	0.54
Employment^g				
Employed full year	0.71	0.87	0.66	—
Employed part year	1.70	1.80	1.35	—
Not employed	1.13	1.90	0.88	—
Metropolitan statistical area (MSA)				
MSA	0.61	0.75	0.57	0.10
Non-MSA	1.12	1.57	1.44	0.27

^aPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^bPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with activities of daily living and instrumental activities of daily living. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^dMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^eHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^fHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^gEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

Table F. Standard errors for use of preventive care services by civilian non-institutionalized women by sociodemographic characteristics: United States, 1996
Corresponds to Table 5

Population characteristic	Any use of ambulatory services	Pap smear in past 2 years	Mammogram ^a in past 2 years	Complete physical in past 2 years
	Standard error			
Total	0.51	0.64	0.87	0.74
Age in years				
18-29	1.34	1.50	—	1.61
30-44	0.84	0.86	1.82	1.12
45-64	0.83	1.08	1.16	1.03
65-74	1.12	1.74	1.84	1.57
75-84	1.29	2.29	2.49	2.25
85 and over	1.95	3.71	4.10	4.24
Race/ethnicity				
White	0.58	0.73	0.95	0.90
Black	1.50	1.60	2.18	1.56
Hispanic	1.40	1.64	2.69	1.72
Other	3.00	3.08	3.93	3.26
Perceived health^b				
Excellent/very good	0.70	0.79	1.10	0.94
Good	1.04	1.29	1.52	1.28
Fair/poor	0.84	1.57	1.90	1.33
Perceived mental health^c				
Excellent/very good	0.61	0.73	1.01	0.85
Good	1.00	1.47	1.64	1.30
Fair/poor	1.58	2.50	2.89	2.19
Any limitation^d				
No	0.61	0.72	0.99	0.83
Yes	0.68	1.42	1.55	1.27
Education				
Less than 12 years	1.18	1.51	1.95	1.40
12 years	0.82	0.95	1.24	1.11
More than 12 years	0.68	0.83	1.20	1.00
Marital status and children^e				
Married without children	0.78	1.03	1.19	1.14
Married with children 5 and under	1.37	1.20	5.14	1.61
Married with children 6-18	1.35	1.48	2.25	1.41
Single without children	0.92	1.16	1.44	1.25
Single with children 5 and under	2.56	2.25	12.09	3.21
Single with children 6-18	2.27	2.36	3.68	2.46
Income				
Poor/near-poor	1.13	1.47	1.99	1.26
Low income	1.39	1.60	2.25	1.61
Middle income	0.85	1.00	1.35	1.22
High income	0.82	0.93	1.24	1.11

Table F. Standard errors for use of preventive care services by civilian non-institutionalized women by sociodemographic characteristics: United States, 1996 (continued)
Corresponds to Table 5

Population characteristic	Any use of ambulatory services	Pap smear in past 2 years	Mammogram ^a in past 2 years	Complete physical in past 2 years
Standard error				
Insurance status^f				
Under age 65:				
Private	0.61	0.69	1.03	0.94
Public only	1.33	1.76	3.47	2.11
Uninsured	1.96	1.87	2.98	1.96
Age 65 and over: ^g				
Medicare only	1.92	2.94	3.04	2.91
Medicare and private	0.94	1.73	1.79	1.40
Medicare and other public	2.02	3.45	3.65	3.19
Employment^h				
Employed full year	0.68	0.69	1.11	0.98
Employed part year	1.77	1.92	3.29	1.95
Not employed	1.15	1.34	1.90	1.39
Metropolitan statistical area (MSA)				
MSA	0.55	0.67	0.95	0.86
Non-MSA	1.46	1.80	1.97	1.54

^aData on mammograms were limited to women age 40 and over. The population total reflects the number of women this age. Approximately 37,317,000, or 64.1 percent, of women age 40 and over (37 percent of all women age 18 and over) received a mammogram in the past 2 years.

^bPerceived health status was collected during Round 1 and refers to health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^cPerceived mental health status was collected during Round 1 and refers to mental health status during the first half of 1996. The estimated population excludes less than 0.7 percent missing data resulting from item nonresponse.

^dThe measure of any limitations combines indicators of any activity limitations, functional limitations, and problems with activities of daily living and instrumental activities of daily living. In addition, it includes social role limitations and cognitive limitations not reported here. Measures of limitations were collected in Round 1.

^eMarital status and number of parents in the home were collected during Round 1 and refer to the first half of 1996.

^fHealth insurance status was collected during Round 1 and refers to health insurance status during the first half of 1996. Public and private insurance categories refer to individuals with public or private insurance at any time during this period; individuals under age 65 with both public and private insurance are considered privately insured.

^gHealth insurance for persons age 65 and over excludes less than 1.0 percent missing data resulting from item nonresponse.

^hEmployment reflects the employment status over Rounds 1 and 2 and indicates if the person worked throughout those two periods, worked for only a portion of those two periods, or did not work at all during those two periods. Employment is measured only for women ages 18-64. The estimated population of women ages 18-64 is 81,745,971.

Source: Center for Cost and Financing Studies, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey Household Component, 1996.

U.S. Department of Health and Human Services

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