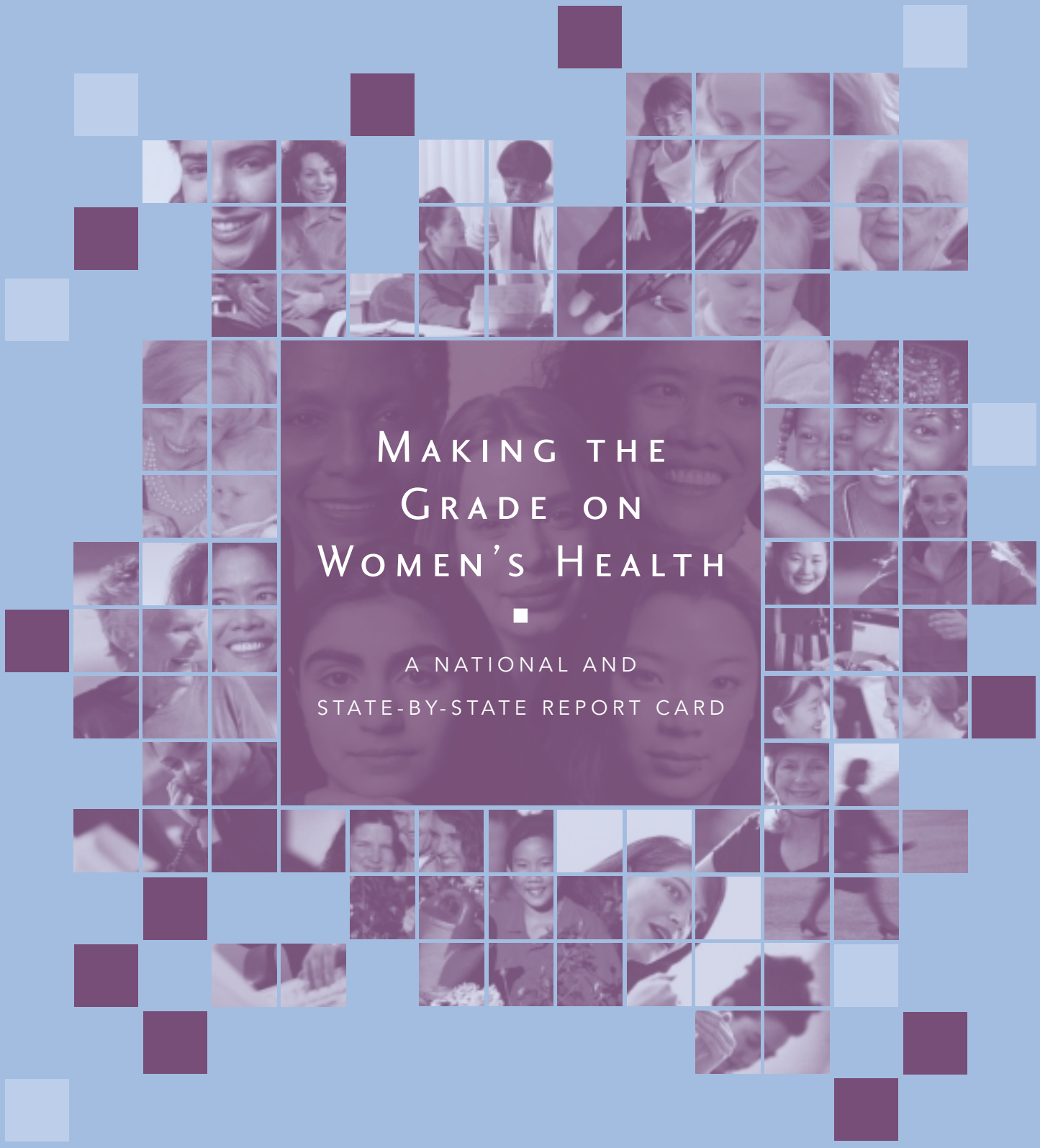
Executive Summary



Making the Grade on Women's Health

A National and State-by-State Report Card

National Women's Law Center • FOCUS/University of Pennsylvania • The Lewin Group

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Disclaimer

While text, citations and data for the indicators were, to the best of the authors' knowledge, current as the *Report Card* was drafted, there may well have been subsequent developments, including recent legislative actions, that could alter the information provided herein. This report does not constitute legal advice; individuals and organizations considering legal action should consult with their own counsel before deciding on a course of action. In addition, this report does not constitute medical advice. Individuals with health problems should consult an appropriate health care provider.

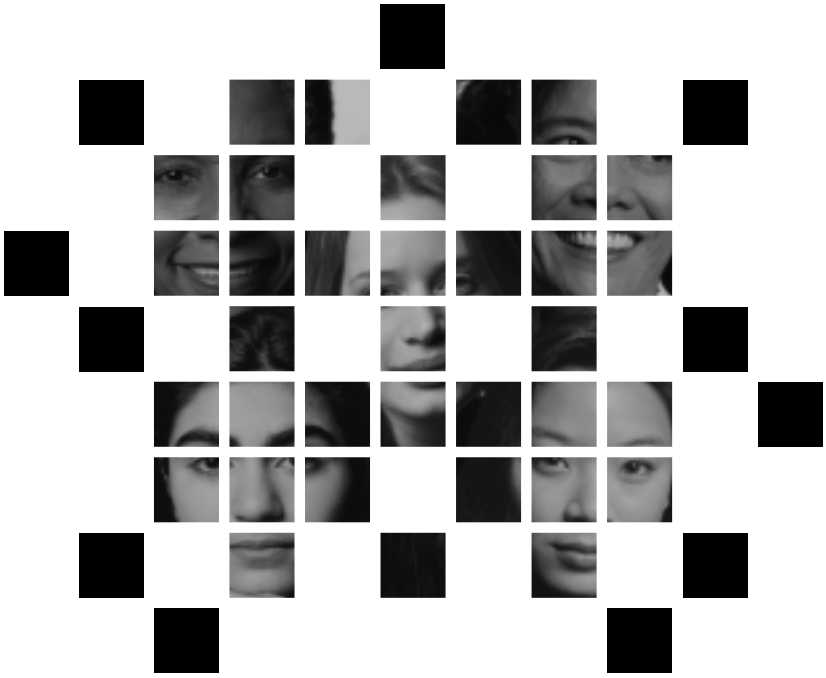
August 2000

Making the Grade on Women's Health: A National and State-by-State Report Card was developed jointly by the National Women's Law Center, FOCUS on Health & Leadership for Women at the Center for Clinical Epidemiology and Biostatistics at the University of Pennsylvania School of Medicine and The Lewin Group:

The **National Women's Law Center** is a Washington-based non-profit organization working to expand opportunities and eliminate barriers for women and their families, with a major emphasis on women's health, education, employment opportunities and family economic security.

FOCUS on Health & Leadership for Women at the Center for Clinical Epidemiology and Biostatistics, University of Pennsylvania School of Medicine was launched in response to the need for a comprehensive approach to women's health concerns and experiences, and is part of a National Center of Excellence in Women's Health, designated by the U.S. Department of Health and Human Services' Office on Women's Health.

The Lewin Group is a national health research and policy consulting firm.



Executive Summary

Making the Grade on Women's Health: A National and State-by-State Report Card is the first-ever report card to assess the overall health of women at the national and state levels. The *Report Card* is designed to promote the health and well-being of women in the United States by providing the most comprehensive assessment to date of women's health. It was prepared for policy makers, health care planners and providers, educators, researchers, elected officials, advocates and the public by the National Women's Law Center, FOCUS on Health & Leadership for Women at the University of Pennsylvania School of Medicine and The Lewin Group. An Advisory Committee of health experts from around the nation—including researchers in varied disciplines, health care providers, government officials and public policy advocates—provided invaluable assistance.

Despite recent progress in addressing the health care needs of women, serious problems remain. Our nation lacks a comprehensive and reliable set of accepted benchmarks on women's health. The nation has not focused consistently and comprehensively on improving women's overall health and well-being, and public policy is primarily focused—and even then inadequately—on only a few diseases and health conditions affecting women. There are critical gaps in research on women's health, and even when such research has been done, often only limited results are publicly available. These problems are compounded for specific populations of women by our nation's failure to focus on health disparities based on race, ethnicity, sexual orientation, disability, and socioeconomic status. The *Report Card* was developed to encourage the nation and the states to address and overcome these very serious problems.

The *Report Card* provides "status" indicators that measure women's access to health care services, the degree to which they receive preventive health care and engage in health-promoting activities, the occurrence of key women's health conditions, and the extent to which the communities in which women live enhance their health and well-being. The *Report Card* also provides a set of "policy" indicators, which are based on state statutes, regulations, policies and programs that address the problems identified by the health status indicators.

For the indicators presented, the *Report Card* assesses women's health in each of the 50 states and the District of Columbia. It also contains information on women's health issues and innovative programs in the states beyond the indicators themselves. And it provides information on: women's health status nationally; federal government policies and programs important to advancing women's health and well-being; serious gaps in health research and data collection; and health disparities based on race, ethnicity, sexual orientation and disability.

The *Report Card* recognizes the strong relationship between health and income, which is especially important for women, who represent the majority of the poor. It also has a broad focus on women's well-being, which follows the approach urged by the 1995 United Nations Fourth World Conference on Women held in Beijing. The *Report Card* defines well-being as occurring when a woman's mental, physical, social, economic, political, educational and environmental quality of life allows her to pursue her full potential.

The Report Card Indicators

The *Report Card* includes 32 status indicators and 32 policy indicators. Since many of the state policy indicators are composites of multiple health policies, more than 70 policies are reviewed. The status and policy indicators address a broad range of women's health issues, allowing the national and state report cards to provide a detailed assessment of government performance in promoting and advancing women's health. An array of demographic information (e.g., the number of women in the state by age, by race, by ethnicity, in linguistic isolation, in prison) is included to place the status and policy indicators in context, in recognition of the many factors that can affect women's health.

Health status indicators were selected primarily based on whether they had a significant impact on women's quality of life, functioning and well-being, and whether they affected a large number of women generally or in a specific population and/or age group. Additional criteria were: whether the women's health issue addressed by the indicator could be improved; was measurable across the states; and was commonly accepted as a measure or reflected an important emerging issue where a problem was increasing in prevalence, incidence, or severity.

Similar criteria were applied in selecting the indicators for health policies. Most importantly, the policy indicators were selected based on whether they addressed and could significantly improve the women's health issues reflected in the status indicators, whether they were measurable and allowed for comparisons among the states, and whether they had been adopted by at least one state.

The *Report Card* reviews both status and policy indicators in the following four categories:

1) Women's Access to Health Care Services: Numerous factors affect women's access to health care services, including the affordability and availability of such services, and whether patients have information about how and why it is important to secure access to them. The *Report Card* examines status indicators that reflect the percentage of women who are uninsured, the percentage of persons who live in medically underserved areas, the percentage of women who receive prenatal care in their first trimester of pregnancy, and the percentage of women who do not have access to abortion health care services. The policy indicators reflect state support for Medicaid and other publicly funded health insurance programs, and for services that help remove barriers to obtaining health care, such as family and medical leave, managed care patient protections, language assistance and the absence of special restrictions on reproductive health care.

2) Addressing Wellness and Prevention: Recognizing the importance of promoting wellness and preventing illness, the *Report Card* focuses on status indicators that reflect the extent to which women have access to critical screening tests, such as Pap smears, mammograms and colorectal cancer detection examinations. These screening tests are important both because they help detect key conditions and they reflect women's access to preventive care more broadly. The *Report Card* also addresses other prevention, management and public education measures that can influence good health, related to factors such as physical activity, diet, and smoking. The policy indicators review state policies and programs that facilitate access to preventive health screening tests and programs that help women prevent or manage specific diseases and conditions, such as diabetes, arthritis, osteoporosis, unintended pregnancy and sexually transmitted diseases.

3) Key Health Conditions, Diseases and Causes of Death for Women: The *Report Card* includes five groups of status indicators reflecting significant health conditions, diseases and causes of death for women: key causes of death; chronic conditions; reproductive health; mental health; and violence against women. Policy indicators relating to the five groups of status indicators are identified for each condition, disease and cause of death. They are described in the other three sections of the *Report Card*, because these health policies—while important to the key conditions, diseases and causes of death—also relate more broadly to women's access to health care, preventive services and the communities in which they live.

4) Living in a Healthy Community: The community in which a woman lives affects virtually all aspects of her health and well-being. The *Report Card* includes key measures of whether a community fosters good health. The status indicators review: overall health including women's life expectancy, limited activity days and infant mortality; women's education levels; and economic security measures of women in poverty and the gap between men's and women's wages. The policy indicators address state efforts to bolster the economic security of women, to address the discrimination they face, to reduce gun deaths and injuries and to improve the environment in which they live.

The Report Card Grades and Ranking

The state is given a total grade and overall rank based on the status indicators. (A chart listing the state grades and ranks is on

page 12.) In addition, for each status indicator on the state report cards, each state is ranked against the other 49 states and the District of Columbia, and given a grade where a benchmark was available. Twenty-five state indicators are graded, based on overall benchmarks for both men and women that were primarily drawn from the ten-year health objectives set for the nation by the U.S. Department of Health and Human Services' Healthy People 2000. Healthy People 2010 objectives were used when no Healthy People 2000 objective was available. Because most benchmarks reflect desirable progress rather than measures of where women's health should ultimately be, the *Report Card* sets **"Satisfactory" ("S")** as the highest grade a state may receive. States falling below this standard are graded **"Unsatisfactory" ("U")** if they came within ten percent of the benchmark, and **"Fail" ("F")** if they fell short by an even greater margin. The grades and ranks are based on the data available for women across the states. Data for women by race, ethnicity and age are also provided when available, but such data were not consistently available. The nation is graded on the same indicators, using the same benchmarks.

Nation's Performance

Nation's Grade	U
Number of Benchmarks Met	5
Number of Benchmarks Missed	22

In this first *Report Card*, states are compared, but not graded, on the policy indicators. In contrast to the status indicators—where basic data were available, although with serious gaps—the absence of consistently collected policy data precluded meaningful comparisons of the states in key policy areas, such as health program budget expenditures. This made grading very problematic. Working with the National Conference of State Legislatures, some important state policies on Medicaid coverage and private insurance requirements were collected for the *Report Card*, and the *Report Card* used other policy data from government agencies and private organizations. There is a need for greater attention to state policies of great concern to women and far more extensive data on state policies and programs should be routinely collected and made publicly available in the future.

Report Card Findings and Recommendations

The *Report Card* demonstrates that far more national and state attention and resources are needed to address the health of the nation's women. While states and the nation met some of the *Report Card* goals, the results were inconsistent at best. There are substantial disparities in women's health by state and nationally, and by race, ethnicity, socioeconomic status, disability and sexual orientation. Moreover, there is great disparity among the states in adopting policies and programs to improve the health of all women. The *Report Card* found that:

Women's access to health care services is seriously compromised by inadequate health insurance coverage.

- A growing number of women in this country lack health insurance. Nationwide, approximately 14 percent of women are uninsured, falling seriously short of the national goal that every person should have health insurance. No state met this national goal, and only eight came within ten percent of meeting it. Moreover, the variation among the states was substantial. Hawaii ranked first, with 7.5 percent of women age 18 to 64 without health insurance. Texas ranked last, with 28 percent of women age 18 to 64 without health insurance.

- State policy makers should do much more to extend health insurance to a greater number of their residents, even in the absence of a nationwide policy to provide insurance coverage for all. To date, for instance, no state has adequately raised the income levels beyond federal minimum requirements at which pregnant women, single parents and the aged and disabled qualify for Medicaid coverage. Only 11 states and the District of Columbia came close to those levels for all three eligibility categories. Six states did not raise income eligibility levels at all, even though five of those six ranked in the bottom third of states in the number of female residents insured. Only seven states provided comprehensive health coverage to otherwise uninsured adults at or below 100% of the Federal Poverty Level. Finally, states are not doing all they should to streamline the Medicaid application process and conduct outreach efforts, which is especially necessary given that many low-income women leaving welfare do not know that they still may be Medicaid-eligible. Only four states have adopted all four key programs identified in the *Report Card* to reach a greater number of eligible individuals.

- The federal government has not adopted comprehensive policies to provide insurance coverage for prescription drugs, and only New Jersey has adopted the four pharmaceutical policies considered by the *Report Card*. Only 19 states have provided significant prescription drug support beyond that provided by the federal government for Medicaid recipients, and also provided low-income pharmacy assistance programs and programs that provide treatment to people with HIV/AIDS. Thirty states and the District of Columbia have adopted so few prescription drug policies, or their policies are so weak, that they have minimal effect.

- Coverage for specific conditions affecting women is often excluded from general insurance plans. For example, only four states have required mental health insurance parity to provide coverage of mental disorders on the same basis as physical disorders. Twenty-three states and the District of Columbia had no parity protections at all. Only eight states require

adequate insurance coverage for both reconstructive surgery after mastectomies and post-mastectomy hospital stays. Only two states require both private insurance plans to provide comprehensive contraceptive coverage and have applied for federal Medicaid waivers to expand family planning coverage for low-income women. Only six states require comprehensive insurance coverage for hospital stays after childbirth for the period of time deemed necessary by the woman's physician. Only 15 states fund abortion services as they do other medically necessary procedures under Medicaid. Only 15 states broadly prohibit insurance discrimination against domestic violence victims.

Neither the nation nor the states have met the challenge of helping women secure better access to key health care services and increasing the availability of needed health care providers.

- Nationally, nearly one in ten people live in a "medically underserved area," with reduced access to primary care physicians. There are large disparities among states in providing access: in Maryland, 2.2 percent of the population live in medically underserved areas, while in Louisiana, 24 percent of the population live in these areas. The *Report Card* indicators regarding access to specific health care services targeted to women also highlight this serious problem. No state met the national goal that 90.0 percent of all pregnant women receive prenatal care in the first trimester of pregnancy. Here too, disparities among the states are great. In Maine, 89.9 percent of women received prenatal care in the first trimester, while in New Mexico, just 69.7 percent of women received such care. The District of Columbia fell even further short of the goal, with just 64.6 percent of women receiving prenatal care in the first trimester. There has been a 30 percent decline in the number of abortion providers nationwide since 1982; almost one-third of women—including those who need abortions to address medical emergencies—reside in a county with no provider available. Only two states and the District of Columbia met the benchmark for the availability of abortion providers.

National Benchmarks Met and Missed by All the States and the District of Columbia

Benchmarks Met	Benchmarks Missed
1. Mammograms for Women Age 50 and Over	1. Women Without Health Insurance
	2. First Trimester Prenatal Care
	3. No Leisure-Time Physical Activity
	4. Overweight
	5. Eating Five Fruits and Vegetables a Day
	6. High Blood Pressure
	7. Diabetes
	8. Life Expectancy
	9. Poverty
	10. Wage Gap

- Only 12 states have both continued full Medicaid reimbursement policies to maintain Federally Qualified Health Centers that provide primary and preventive health care for low-income individuals, and funded the operation of "comprehensive primary medical care practice" programs.
- The federal government has not adopted comprehensive policies to ensure quality, affordable long-term care. Medicare does not cover most long-term care services, and there are serious limitations on coverage available through private insurance or Medicaid. Even with the limited state policies and programs that begin to address the problem, only 10 states and the District of Columbia adopted the highest levels of protection under federal Medicaid rules to prevent impoverishment of spouses of long-term care recipients. Twenty-one states have opted for no expansion at all. In a range of state Medicaid programs supporting home and community-based long-term care options for disabled and older women, Oregon provides services for 11 recipients per 1,000 adults in the state, in contrast to Tennessee, which provides services for just .07 recipients per 1,000 of its adult residents. Regarding participation in a federal ombudsman program to improve quality by providing advocates to assist long-term care recipients and their families, only 20 states and the District of Columbia met the Institute of Medicine standard for advocate-per-facility-bed ratios.
- States can also help women secure access to health care for themselves and their family members through family and medical leave; managed care patient protections; and interpretation and translation services for patients with limited English proficiency. Only three states have provided both family and medical leave expansions beyond federal law and paid temporary disability leave policies; 31 states have adopted neither. Thirteen states and the District of Columbia have adopted at least three of four essential managed care patient protections, while seven have adopted none. Only four states have comprehensive legal requirements to ensure that the language needs of those seeking health care are met, while 23 states have no such legal requirements at all.

The nation and the states are just beginning to address the challenge to enhance women's health and well-being through preventive and health-promoting measures.

- Despite the importance of promoting wellness and preventing illness, no state has met the national goals for increasing physical activity, reducing overweight, and improving diet. Only one state (Utah) met the national goal for reducing the percentage of adults who smoke, and just 18 states met the national goal for reducing binge drinking. State and federal policies and programs to help women adopt these preventive behaviors are limited in scope and are only beginning to be

developed and implemented. Few comprehensive and measurable programs could be identified to encourage exercise and healthy diet and reduce overweight and binge drinking, and few states have put them in place. In contrast, effective and comprehensive smoking prevention and cessation policies and programs have been identified, but still only a handful of states have adopted them. Many states have not yet allocated funds available from their tobacco litigation settlements, which may support more such programs in the future. But not a single state has required private insurers to fully cover smoking cessation treatments, and only six cover comprehensive treatment programs under Medicaid. Twenty-one states met the federal government's target for reducing tobacco sales to minors, but only three of those states met a higher target set by many health experts. Only four states have comprehensive bans on indoor smoking, and only three place an excise tax of one dollar or more per pack of cigarettes, a target that yields substantial reductions in teenage and overall smoking.

- Although more states met the *Report Card* goals for screening for key diseases, much work remains to be done. All states and the District of Columbia met the national goal for mammograms for women age 50 and over. However, specific populations of women, particularly women who are uninsured, older and members of certain racial and ethnic groups do not yet receive mammograms at the overall national rate. Moreover, there is now a new and higher national goal for women age 40 and over. Twenty-four states and the District of Columbia met the national goal for Pap smears—the primary screening test to help prevent cervical cancer. Nineteen states and the District of Columbia met the national goal for colorectal cancer screening. States varied significantly in adopting policies on screening. Only two states require private insurers to cover colorectal cancer screening, and only 14 states and the District of Columbia require insurers to cover annual mammograms for women age 40 and over. Twenty-two states and the District of Columbia require private insurers to cover Pap smears and cervical cancer screenings, but only three states require insurers to cover recommended screening for chlamydia, the most common bacterial sexually transmitted disease.

Ranges Among States and the District of Columbia for Selected Indicators

Women Without Health Insurance (%):	
Hawaii	7.5
Texas	28.0
Life Expectancy for Women (years):	
Hawaii	81.3
Louisiana	76.9
District of Columbia	74.2
Women Living in Poverty (%):	
Utah	8.2
New Mexico	21.4
District of Columbia	21.6
Heart Disease Death Rate (per 100,000):	
Minnesota	65.4
Mississippi	141.2
Women Who Smoke (%):	
Utah	12.6
Kentucky	28.5
Women 50 and Over Who Had a Mammogram Within the Past Two Years (%):	
District of Columbia	89.4
Massachusetts	84.2
Minnesota	64.9
Women Who Are Overweight (%):	
Arizona	21.9
Mississippi	38.4

The key health conditions, diseases and causes of death faced by women present a mixed picture of satisfactory results in some areas, but very poor results in others.

- The nation and individual states met many of the *Report Card* goals addressing key causes of death for women. Thirty states met the national goal for the number of women dying from heart disease, the leading cause of death for women. But here, disparities among the states are instructive. In the state with the best rank on heart disease, Minnesota, 65.4 per 100,000 women died of coronary heart disease, in contrast to Mississippi, where 141.2 per 100,000 women died of heart disease. The new national goal approximates Minnesota's performance as the standard for the country. Only four states met the national goal for deaths from strokes, the third leading cause of death for women. Twenty-five states and the District of Columbia met the national goal for the number of women dying from lung cancer, the second most common cause of death for women. Thirty-six states met the goal for the number of deaths from breast cancer, the most common type of cancer for women and the second leading cause of cancer death for women.
- Chronic conditions can be debilitating and contribute to key causes of death. Controlling high blood pressure helps decrease the risk of developing heart disease and stroke. Yet no state met the national goal for reducing the percentage of women with high blood pressure. Despite the fact that more than five percent of women suffer from diabetes, no state met the national goal for reducing the number of cases. Arthritis is the leading cause of limited activity for women age 40 and over, yet there are no adequately reported state-level data on occurrence. Nor are such data available for osteoporosis—a disease affecting 20 percent of women nationally. There were

no nationwide benchmarks adopted for arthritis. In the case of osteoporosis, the nation failed to meet by substantially more than ten percent the current goal of reducing the number of cases to eight percent of adults age 50 and over. In just over a decade, the percentage of all AIDS cases reported that are adult and adolescent women has more than tripled, with the most dramatic increases among women of color. Forty-three states met the national goal, but overall statistics mask the fact that African American and Hispanic women suffer disproportionately from AIDS. In the top-ranked state, North Dakota, 0.4 women per 100,000 were reported to have AIDS, while in the bottom-ranked state, New York, 33.6 per 100,000 women were so reported. In the District of Columbia, 120.2 women per 100,000 were reported to have AIDS.

- State policies and programs to address these specific conditions affecting women are too few in scope and size. For example, given the high rate of diabetes, and the fact that no state met the national goal for reducing the occurrence of cases, it is especially troubling that only six states both qualified for the highest level of funding from the Centers for Disease Control and Prevention (CDC) State Diabetes Control Program and supplemented these CDC funds with state funds. Similarly, the CDC provides two levels of funding for the Community Based Arthritis Program, but only eight states received the highest level of funding in that program. Just 26 states have any state-funded osteoporosis public education programs, and the funding levels range from $2,500 to $750,000. And in the case of STD and HIV prevention, only five states require both comprehensive sexuality education and comprehensive STD/HIV education in schools.

Women's health suffers because reproductive health, mental health and the violence women confront are not given sufficient attention by the nation or the states.

- Reproductive health affects every stage of a woman's life, yet because family planning, prevention of sexually transmitted diseases and abortion services in particular are subject to controversy, women's health suffers. Nationally, almost half of all pregnancies are unintended, thereby missing by a substantial margin the national goal to reduce unintended pregnancies to 30 percent or less of all pregnancies. Women under age 18 and over age 40 have the highest rates of unintended pregnancy. Nor has the nation as a whole reached its goal to reduce maternal mortality levels, and the World Health Organization ranks 20 countries ahead of the United States on this key marker of public health. In addition, the maternal mortality ratio among African American women is almost four times greater than that for white women. Only three states have met the national goal for maternal mortality, with top-ranked New Hampshire at 1.9 maternal deaths per 100,000 live births, and the bottom-ranked state, Mississippi, at 12.3 maternal deaths. The District of Columbia ranks even lower, at 22.8 maternal deaths per 100,000 live births. For chlamydia, the most common bacterial sexually transmitted disease, 21 states met the national goal. The states' adoption of policies and programs to improve women's reproductive health varies widely. Some states actively block women's access to full reproductive health care services through policies such as waiting periods, bans on medically approved procedures and funding restrictions for abortion services. Other states provide public funding for and broad access to reproductive health care services.

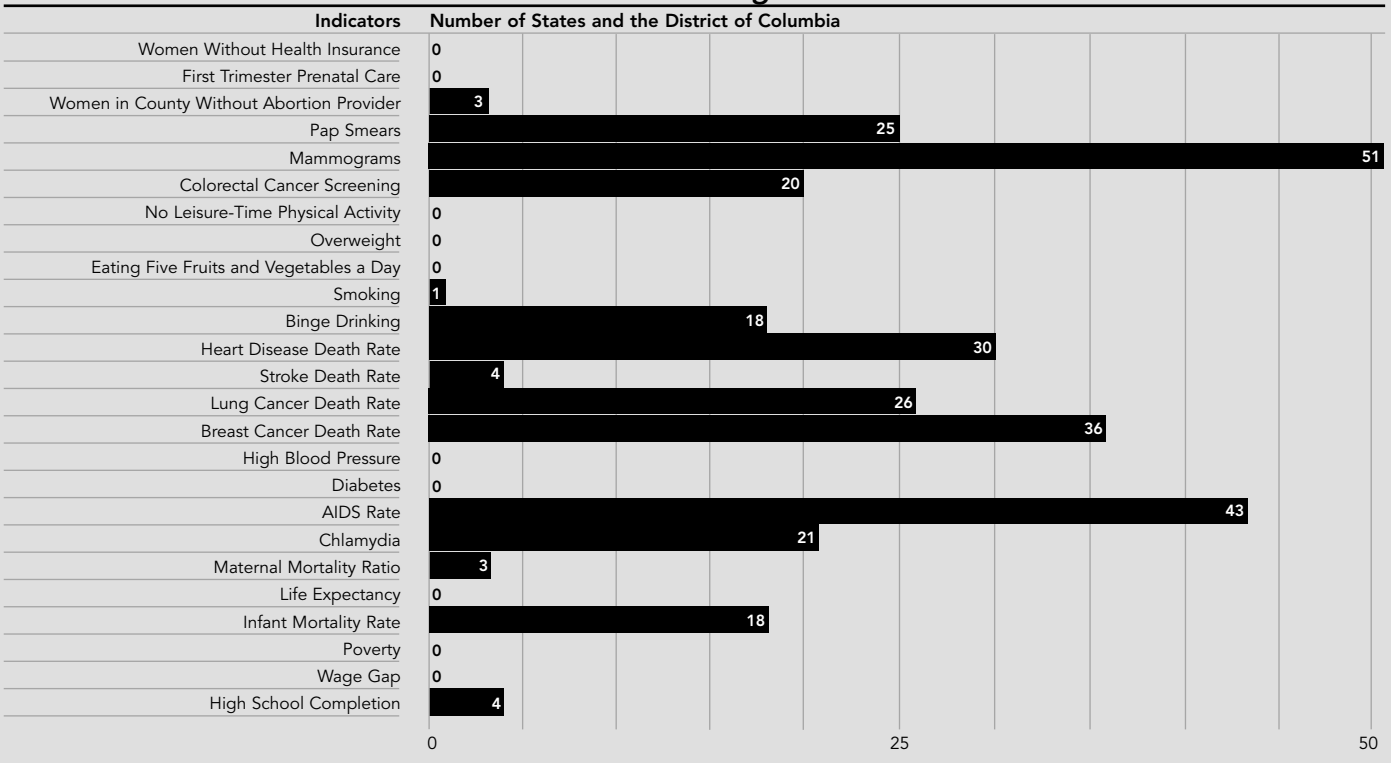
- The first Surgeon General's report on mental health, issued in 1999, underscores the close relationship between mental and physical health. But the generally limited state-level data, and the absence of a concrete national objective to improve mental health with data to measure progress, illustrate the nation's lack of attention to mental health. The number of days in the past 30 that women reported that their mental health was "not good" varied substantially: from Arizona, where women reported on average 1.2 such days, to Kentucky, where women reported on average 5.5 such days. Only four states currently require mental health disorders to be covered by insurance on the same basis as physical disorders.

- Despite estimates that nationally, 55 percent of women have been physically assaulted and/or raped in their lifetime, there is a serious lack of consistent and reliable data collected over time at the national and state levels, particularly in measuring the nature and prevalence of domestic violence. Generally, state policies and programs targeting domestic violence and sexual assault have been piecemeal and inadequate. Only four states have adopted requirements addressing health care protocols, training and screening for and about domestic violence and sexual assault victims, and prohibit insurance discrimination against domestic violence victims. Twelve states and the District of Columbia have none of these policies.

To achieve healthy communities, the nation and the states must address the serious disparities and gaps in economic security and educational attainment that underlie key disparities in women's health.

- While women live longer than men, the United States ranks only 19th in life expectancy for women worldwide. In Japan, which ranks first, women's life expectancy is 82.9 years. In the United States, it is four years less—78.9 years. There is also a significant disparity among states. Women living in Hawaii, the highest ranking state, have a life expectancy of 81.3 years; in the lowest ranking state, Louisiana, women's life expectancy is 76.9 years. In the District of Columbia, women's life expectancy is 74.2 years. The disparities for women nationally based on race or ethnicity are even greater than those by state. White women have a life expectancy of 79.5 years, as compared to black women, who have a life expectancy of just 73.7 years.

Number of States and the District of Columbia Meeting Status Indicator Benchmarks



- Women's quality of life is affected by their ability to carry out daily activities at work, at home and in the community. Substantial variation exists among the states regarding the average number of days out of the past 30 that women report having to limit their usual activities due to poor physical or mental health, ranging from a low of 2.6 days in Alaska to a high of 6.7 days in Kentucky.

- Infant mortality rates reflect not only the health of infants, but of women and of the community as a whole. Although the nation missed the goal by less than ten percent, 18 states did meet the goal to reduce infant mortality. But the states range from top-ranked Massachusetts with 5.2 infant deaths per 1,000 live births, to Mississippi, with 10.4 infant deaths per 1,000 live births. The District of Columbia had a rate of 15.9 infant deaths per 1,000 live births. The infant death rate among African Americans is more than double that of whites or Hispanics.

- Disparities in income levels and educational attainment are strongly associated with disparities in the occurrence of illness and death. Nationwide, 13.3 percent of women live in poverty, ranging from top-ranked Utah, where 8.2 percent of women live in poverty, to bottom-ranked New Mexico, where 21.4 percent of women live in poverty. In the District of Columbia, 21.6 percent of women live in poverty. The gap between wages of men and women also reflects the particular economic hurdles facing women even when not living in poverty. Nationwide, women earn 72.3 percent of what men earn, and the states vary widely. The state with the highest percentage of earnings for women as compared to men is Vermont, where women earn 81.9 percent of what men earn. The District of Columbia's wage gap is even smaller at 87.5 percent. The states with the largest wage gap are Alabama and Oklahoma, both at 63.3 percent. Nor is the country as a whole or the great majority of states meeting the nation's goal of a 90 percent high school graduation rate. A high school degree improves a woman's health and well-being, both by opening the doors to greater economic security which is central to good health, and by providing the literacy skills necessary to navigate the health care system. But only four states met this goal. No state has done all it can do to increase women's economic security by adopting strong policies in all of the following areas: child support payment and collection efforts; supplemental security income for the aged, blind and disabled (60 percent of whom are women); state and local tax rate burdens on the poor; and minimum wage levels. Only 19 states have taken significant steps to do so. The rest had minimal policies in place.

- Discriminatory practices can affect women's health by creating barriers to securing health care services and health insurance, by creating stress that contributes to physical and mental health problems, and by creating barriers to financial and educational achievement. In reviewing two discriminatory

practices where new legal protections are especially important, employment discrimination based on sexual orientation and genetic discrimination, only eight states have adopted strong legal prohibitions against both forms of discrimination, and ten states have no policies at all.

- In 1996, almost 5,000 women in the United States were killed and many others were injured with guns. States can require licensing and waiting periods, safe storage rules and the prohibition of concealed handguns. No state fully adopted all of these restrictions, although the District of Columbia banned handguns entirely. Twenty-three states have none of these restrictions.

- Exposure to hazardous agents in the air, water and soil contribute to illness, disability and death. A national priority has been placed on states monitoring conditions such as asthma and poisoning by lead, mercury, pesticides, carbon monoxide and acute chemicals, but only four states monitor at least five of these conditions. Thirteen states and the District of Columbia do not require any monitoring at all. In addition, support for public transportation not only helps people reach their health care providers, jobs, markets and other destinations important to their health, but also reduces toxic pollution caused by cars. Yet state average annual per capita spending on public transportation ranged from approximately $675 per urban resident in New Jersey to less than two dollars per urban resident in Mississippi.

More research into women's health, better data collection and data systems, and a greater focus on emerging issues affecting women's health and well-being are needed.

- There is a major need for more research on women's health, and more female enrollment (with data analyzed and reported by sex) in clinical trials, to better understand the causes, symptoms, prevention and treatment of conditions and diseases that especially affect women.

- More research with a particular focus on racial, ethnic and socioeconomic disparities in health conditions important to women is needed.

- More research is needed on specific health concerns for women such as non-financial barriers to access to care, mental health, substance abuse, violence against women, homelessness, the health of disabled women and lesbians, the impact of discrimination and occupational health.

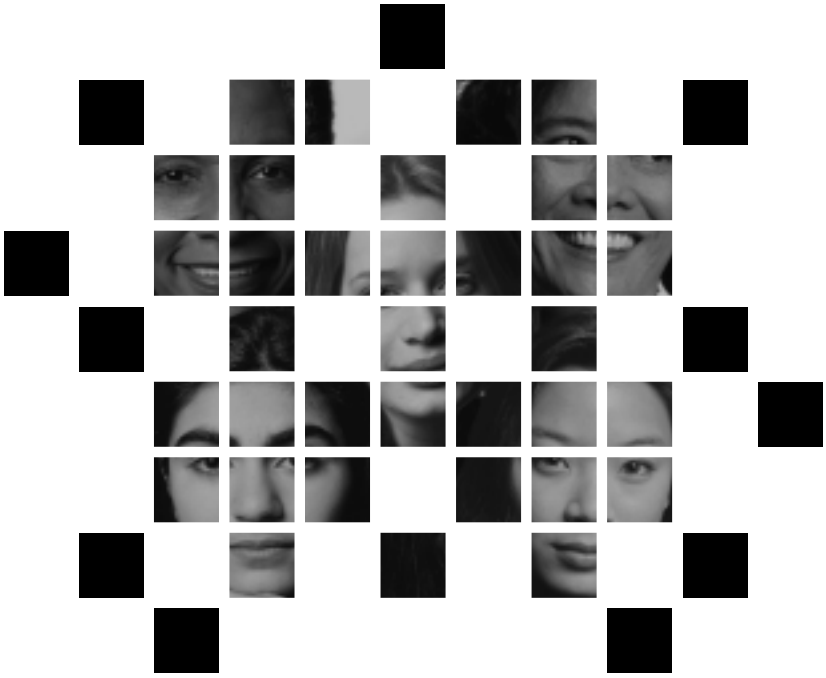
- There is a need for more research and the systemic collection of data on policies and programs that effectively address women's health concerns, and the identification of the specific groups of women for whom they work best. In addition, data are needed on the states' funding and implementation of policies and programs that address women's health and well-being.

- Priority areas for better data collection at the state and national levels include delineation of data by gender and socioeconomic status, and consistent and comprehensive measures by race and ethnicity, sexual orientation, disability, age and geography (by region and urban/rural).

- Data systems and data collection mechanisms should be improved to obtain appropriate data, connect to other relevant data systems, reduce duplication and facilitate information-sharing.

Conclusion

Both the states and the federal government could do much more to ensure that women receive better health care and to improve women's health and well-being. Of the 25 status indicators with benchmarks, only one was met by all of the states and the District of Columbia, as compared to ten that were missed by every state and the District of Columbia. There are a number of policies and programs that states and the federal government could adopt for greater improvement of women's health. For example, millions of women and their families are not covered by health insurance, and while some states have done a far better job than others, neither the states nor the federal government have adopted key policies to complete the task. Similarly, the lack of strong federal and state policies in place to promote wellness and prevent illness through increased physical activity, better diet, and the reduction of overweight corresponds to the failure of all of the states to meet even one of the goals for these key health-promoting activities. The absence of sustained research, or even adequate data collection in such key areas as violence, mental health and unintended pregnancies has a severe negative effect on women's health. Finally, neither the federal government nor the states have adequately recognized in their program priorities, research and data collection, that women are not a monolithic group, and that differences and disparities among women must be addressed. This first *Report Card* shines a light on the challenges to the nation and the states to improve women's health. It is time for the nation and the states to take the steps necessary to earn an "A" for effort, and an "A" for results for all women.



Nation's Report Card
State Rankings and Grades

Status Indicators

I. Women's Access to Health Care Services

	White (Total)	White (Non-Hispanic)	Black (Total)	Hispanic	U.S. Total Data	U.S. Grade
Women Without Health Insurance (%)					14.0	F
People in Medically Underserved Areas (%)					9.6	–
First Trimester Prenatal Care (%)	84.0	87.4	71.4	72.2	81.9	U
Women in County Without Abortion Provider (%)					32	F

II. Addressing Wellness and Prevention

	White	Black	Hispanic	Asian/ Pacific Islander	Am. Indian/ Alaskan Native		
Screening							
Pap Smears (%)	84.4	87.8	78.1	70.9	83.5	84.9	U
Mammograms (%)	67.1	66.7	62.2	69.5	65.6	75.2	S
Colorectal Cancer Screening (%)	21.0	21.2	18.1	20.3	19.8	37.7	U
Prevention							
No Leisure-Time Physical Activity (%)						29.9	F
Overweight (%)	22.7	39.7	26.5	9.6	35.5	31.4	F
Eating Five Fruits and Vegetables a Day (%)	28.5	22.3	27.7	27.1	28.0	27.8	F
Smoking (%)	21.7	20.2	14.3	10.3	30.7	20.8	F
Binge Drinking (%)						6.7	F

III. Key Conditions

	Age 25-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+	White	Black	Hispanic	Asian/ Pacific Islander	Am. Indian/ Alaskan Native		
Key Causes of Death For Women													
Heart Disease Death Rate (per 100,000)	11.5	55.8	189.6	544.1	1670.1	6119.5	92.7	152.4	65.5	51.0	75.3	98.0	S
Stroke Death Rate (per 100,000)	4.0	15.5	39.0	120.9	453.7	1646.0	22.9	38.9	17.3	21.0	20.1	24.5	F
Lung Cancer Death Rate (per 100,000)	3.0	28.1	100.8	204.5	247.2	188.8	27.4	26.9	8.3	11.4	15.9	26.9	S
Breast Cancer Death Rate (per 100,000)	8.8	39.4	67.5	98.8	138.0	202.0	19.7	26.9	12.7	9.6	10.9	20.2	S
Chronic Conditions													
High Blood Pressure (%)												23.6	F
Diabetes (%)							4.7	8.2	6.3	4.6	9.6	5.3	F

	White (Non-Hispanic)	Black (Non-Hispanic)	Hispanic	Asian/ Pacific Islander	Am. Indian/ Alaskan Native		
AIDS Rate (per 100,000)	2.4	49.8	16.6	1.4	3.8	9.6	S

	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+	White	Black	Asian/ Pacific Islander	Am. Indian/ Alaskan Native	Other		
Arthritis (%) (National Only)	3.3	7.7	14.7	27.8	40.2	50.9	60.7	62.0	22.1	23.4	10.8	24.5	18.6	22.7	–

	White (Non-Hispanic)	Black (Non-Hispanic)	Mexican American		
Osteoporosis (%) (National Only)	21	10	16	20	F

Reproductive Health	Less than 15	Age 15-17	Age 18-19	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40+	White	Black	Hispanic	Non-Hispanic	Other		
Chlamydia (%)														5.4	U
Unintended Pregnancies (%) (National Only)	81.7	82.7	75.0	58.5	39.7	33.1	40.8	50.7	42.9	72.3	48.6	49.3	50.0	49.2	F
Maternal Mortality Ratio (per 100,000)									5.3	19.6				7.7	F
Mental Health															
Days Mental Health Was "Not Good" in Past 30 Days														3.5	–

Violence Against Women	White	Black	Hispanic	Non-Hispanic	Asian/ Pacific Islander	Am. Indian/ Alaskan Native	Mixed Race		
Violence Experienced Over Lifetime (%) (National Only)	54.5	55.1	54.9	55.1	51.9	64.8	61.2	55.0	–

Grading Key for Status Indicators S Satisfactory U Unsatisfactory F Fail

Status Indicators, continued

IV. Living in a Healthy Community

	White	Black	Hispanic	Non Hispanic	Other than White	Unknown	U.S. Total Data	U.S. Grade
Overall Health								
Life Expectancy (years)	79.45	73.73			75.39		78.81	U
Days Activities Were Limited in Past 30 Days							3.6	–
Infant Mortality Rate (per 1,000)	6.3	14.7	6.3	7.8		9.2	7.6	U

Economic Security and Education	Age 18-44	Age 45-64	Age 65+	White (Non-Hispanic)	Black (Non-Hispanic)	Hispanic	Asian/ Pacific Islander (Non-Hispanic)	Am. Indian/ Alaskan Native (Non-Hispanic)		
Poverty (%)	15.2	9.7	13.3	9.5	26.1	26.5	12.6	23.8	13.3	F
Wage Gap (%)									72.3	F
High School Completion (%)				87.0	77.4	55.8	83.0	76.4	82.8	U

Demographics

	U.S.
Total Population of Women	136,772,861
Sex Ratio (women to men)	1.08

Percent and Number of Women by Race	***Number (Percent)***
White (non-Hispanic)	97,929,368 (71.6%)
Black (non-Hispanic)	17,917,245 (13.1%)
American Indian/Alaskan Native (non-Hispanic)	1,094,183 (0.8%)
Asian/Pacific Islander (non-Hispanic)	5,197,369 (3.8%)
Hispanic	14,771,469 (10.8%)

Percent and Number of Women by Age	
0-14	29,132,619 (21.3%)
15-25	19,968,838 (14.6%)
26-44	40,484,767 (29.6%)
45-64	28,585,528 (20.9%)
65-84	16,549,516 (12.1%)
85 and over	1,914,820 (1.4%)

	U.S.
Median Age of Women	35 years
Households Headed by Single Women	12,717,810 (12.5%)
Median Earnings for Women	$24,000
Women Prisoners (State Jurisdictions)	66,879 (0.05%)
Disabled Women Receiving Social Security Benefits	5,475,270 (4.0%)
Women Residing in Urban Areas	109,729,378 (80.2%)

Women Living in Linguistic Isolation by Age Group	
5-17	852,018 (3.9%)
18-64	2,349,620 (3.0%)
65 and over	609,391 (3.3%)
Women with 13-15 Years of Education	24,566,965 (26.0%)
Women with 16 or More Years of Education	20,746,519 (21.9%)
Percent of Births Attended by a Midwife	(7.0%)

STATE RANKINGS AND GRADES

Alphabetical By State

Rank*	State	Grade
49	Alabama	U
14	Alaska	U
20	Arizona	U
47	Arkansas	F
21	California	U
5	Colorado	U
6	Connecticut	U
23	Delaware	U
41	District of Columbia	F
29	Florida	U
39	Georgia	U
1	Hawaii	U
22	Idaho	U
37	Illinois	F
40	Indiana	F
18	Iowa	U
10	Kansas	U
47	Kentucky	U
50	Louisiana	F
16	Maine	U
25	Maryland	U
3	Massachusetts	U
31	Michigan	U
4	Minnesota	U
51	Mississippi	F
36	Missouri	U
17	Montana	U
12	Nebraska	U
30	Nevada	U
9	New Hampshire	U
26	New Jersey	U
33	New Mexico	U
34	New York	U
38	North Carolina	U
15	North Dakota	U
35	Ohio	U
44	Oklahoma	F
19	Oregon	U
32	Pennsylvania	F
24	Rhode Island	U
46	South Carolina	F
10	South Dakota	U
43	Tennessee	U
42	Texas	U
8	Utah	U
2	Vermont	U
28	Virginia	U
7	Washington	U
45	West Virginia	U
13	Wisconsin	U
26	Wyoming	U

Rank Order

Rank*	State	Grade
1	Hawaii	U
2	Vermont	U
3	Massachusetts	U
4	Minnesota	U
5	Colorado	U
6	Connecticut	U
7	Washington	U
8	Utah	U
9	New Hampshire	U
10	Kansas	U
10	South Dakota	U
12	Nebraska	U
13	Wisconsin	U
14	Alaska	U
15	North Dakota	U
16	Maine	U
17	Montana	U
18	Iowa	U
19	Oregon	U
20	Arizona	U
21	California	U
22	Idaho	U
23	Delaware	U
24	Rhode Island	U
25	Maryland	U
26	New Jersey	U
26	Wyoming	U
28	Virginia	U
29	Florida	U
30	Nevada	U
31	Michigan	U
32	Pennsylvania	F
33	New Mexico	U
34	New York	U
35	Ohio	U
36	Missouri	U
37	Illinois	F
38	North Carolina	U
39	Georgia	U
40	Indiana	F
41	District of Columbia	F
42	Texas	U
43	Tennessee	U
44	Oklahoma	F
45	West Virginia	U
46	South Carolina	F
47	Arkansas	F
47	Kentucky	U
49	Alabama	U
50	Louisiana	F
51	Mississippi	F

*State rankings are based on 28 state status indicators (25 graded indicators and three indicators that were not graded because benchmarks were unavailable). Therefore state rankings do not neccessarily correspond directly to state grades.

Grading Key for Status Indicators — **S** Satisfactory — **U** Unsatisfactory — **F** Fail

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