

effectiveness.<sup>18, 19</sup> For example, clinical interventions that focus on appropriate and timely medical care can be equally accessible for people with and without disabilities. Mammography screening is recommended every 1 to 2 years, with or without an annual clinical breast examination, for able-bodied women aged 50 to 69 years.<sup>20</sup> This recommendation also can be adapted for women with disabilities. Clinical providers, however, must first recognize the reasons women with disabilities often refrain from seeking mammography services, such as the lack of adaptive equipment on mammography screening machines or unfamiliarity with the needs of people with disabilities expressed by clinicians. Counseling to prevent injuries among all adults also is recommended. For example, men and women with disabilities, especially those with skeletal insufficiencies or calcium deficits, are at increased risk for fractures. Adding bone mineral screening and fitness counseling during clinical encounters may be beneficial in preventing injuries. In these ways, evidence-based health promotion and disease prevention programs can be developed, implemented, and evaluated to target the health and injury disparities between people with and without disabilities. p.6-6 to 6-7

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## **7. Educational and Community-Based Programs**

very little here for seniors, and nothing specifically for older women

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## **8. Environmental Health**

n/a

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## **9. Family Planning**

### **9-12. Reduce the proportion of married couples whose ability to conceive or maintain a pregnancy is impaired.**

**Target:** 10 percent.

**Baseline:** 13 percent of married couples with wives aged 15 to 44 years had impaired ability to conceive or maintain a pregnancy in 1995.

**Target setting method:** 23 percent improvement. p.9-28

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## **10. Food Safety**

Older people, like infants, are more susceptible but nothing specifically for women.

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## **11. Health Communication**

Public information campaigns are used to promote increased fruit and vegetable consumption (5-A-Day for Better Health!), higher rates of preventive screening (mammogram and colonoscopy),

higher rates of clinical preventive services (immunization), and greater rates of adoption of risk-reducing behaviors (Back to Sleep and Buckle Up for Safety). p.11-5

## 12. Heart Disease and Stroke

Coronary heart disease (CHD) accounts for the largest proportion of heart disease. About 12 million people in the United States have CHD.<sup>1</sup> The CHD death rate peaked in the mid-1960s and has declined in the general population over the past 35 years. This decline began in females in the 1950s and in males in the 1960s. Although absolute declines have been much greater in males than in females, rates of decline also have been greater in males, but in recent years they have been greater in females. p.12-3

Because females have a longer life expectancy than males, the actual number of cases [of Atrial fibrillation (AF)] in elderly females (older than 75 years) is greater than in elderly males. p.12-5

Representing a research and data collection agenda for the coming decade, the topics are related to provider counseling and increasing awareness of cardiovascular disease (CVD) as the leading cause of death for all females. p.12-5

Disparities also exist in treatment outcomes for patients who have heart attacks. Females, in general, have poorer outcomes following a heart attack than do males: 44 percent of females who have a heart attack die within a year, compared with 27 percent of males. At older ages, females who have a heart attack are twice as likely as males to die within a few weeks.<sup>12</sup> These differences are explained, in part, by the presence of coexisting conditions such as high blood pressure, diabetes, and congestive heart failure. After controlling for such factors, however, studies indicate an association remains between female gender and death following a heart attack. Complications are more frequent in females than in males after coronary intervention procedures, such as angioplasty or bypass surgery, are performed. Additional studies are needed to evaluate specific interventions and determine whether gender-specific interventions may be beneficial. In general, factors such as age (older), gender (female), race or ethnicity, low socioeconomic status, and prior medical conditions (previous heart attack, history of angina or diabetes) have been associated with longer prehospital delays in seeking care for symptoms of a heart attack.<sup>13</sup>

The male-female disparity in stroke deaths widened from the 1970s until the 1980s and then narrowed. Although stroke death rates have been decreasing, the decline among African Americans has not been as substantial as the decline in the total population. The racial differences in the number of new cases of stroke and deaths due to stroke are even greater than those found in CHD. Stroke deaths are highest in African American females born before 1950 and in African American males born after 1950. p.12-5 to12-6

Nonetheless, increasing the level of physical activity remains a challenge. Furthermore, according to the 1996 surgeon general's report on physical activity and health,<sup>27</sup> the percentage of people who say they engage in no leisure-time physical activity is higher among females than males... p.12-7

### 13. HIV

*no explicit data or recommendations for women (or men) over 44 years of age*

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### 14. Immunization and Infectious Diseases

Vaccination rates among persons aged 65 years and older continued to increase over the decade. Influenza vaccine coverage rates were up from 33 percent in 1989 to 64 percent in 1998, and pneumococcal vaccine coverage rates were up from 15 percent to 46 percent. Despite these increases, coverage rates for certain racial and ethnic groups remain substantially below the general population.<sup>16</sup>  
p.14-5

*greater disparities by race/ethnicity than gender here*

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### 15. Injury and Violence Prevention

Elderly persons, females, and children continue to be targets of both physical and sexual assaults, which are frequently perpetrated by individuals they know. p.15-5

Because national data systems will not be available in the first half of the decade for tracking progress, one subject of interest, maltreatment of elderly persons, is not addressed in this focus area's objectives. The maltreatment of persons aged 60 years and older is a topic for research and data collection for the coming decade. p.15-5

There were six objectives with no progress or movement away from the Healthy People 2000 targets. In unintentional injury, the hospitalization rate for hip fractures remains above baseline levels, indicating no progress toward the year 2000 target. p.15-8

The motor vehicle death rate per 100,000 persons is especially high among persons aged 16 to 24 years and persons aged 75 years and older... In 1998, persons aged 70 years and older made up 9 percent of the population but accounted for 14 percent of all traffic fatalities and 18 percent of all pedestrian fatalities. Compared with the fatality rate for drivers aged 25 through 69 years, the rate for drivers in the oldest group is nine times higher.<sup>36</sup>

Older persons also are more susceptible than younger persons to medical complications following motor vehicle crash injuries. Thus, they are more likely to die from their injuries.<sup>36</sup>

Fewer persons aged 70 years and older are licensed to drive, compared to younger persons, and they drive fewer miles per licensed driver. Persons in this older age group, however, have higher rates of fatal crashes per mile driven, per 100,000 persons, and per licensed driver than any other group except young drivers (aged 16 to 24 years).p.15-32

Total Population, 1998	Deaths From Falls
	Rate per 100,000
<b>Select populations</b>	
Persons aged 65 to 84 years (not age adjusted)	17.2
Persons aged 85 years and older (not age adjusted)	107.9

p.15-38

**15-28. Reduce hip fractures among older adults.**

**Target and baseline:**

1998 Baseline 2010 Target Objective Reduction in Hip Fractures  
Rate per 100,000

**15-28a.** Females aged 65 years and older 1,055.8 416

**15-28b.** Males aged 65 years and older 592.7 474

**Target setting method:** Better than the best for 15-28a; 20 percent improvement for 15-28b.  
(Better than the best will be used when data are available.)

**Data source:** National Hospital Discharge Survey (NHDS), CDC, NCHS.

**16. Maternal, Infant, and Child Health**

Maternal age also is a risk factor for infant death. Mortality rates are highest among infants born to young teenagers (aged 16 years and under) and to mothers aged 44 years and older. p.16-4

The risk of ectopic pregnancy increases with age; women of all races aged 35 to 44 years are at more than three times the risk of ectopic pregnancy than are women aged 15 to 24 years.<sup>17</sup>  
p.16-6

For both African American and white women, the proportion entering prenatal care in the first trimester rises with maternal age until the late thirties, then begins to decline.p.16-8

Live Births Plus Fetal Deaths, 1997	16-1a. Fetal Deaths at 20 or More Weeks of Gestation	16-1b. Fetal and Infant Deaths During Perinatal Period
	Rate per 1,000	

<b>Select populations</b>		
Mother's age groups		
Under 15 years	14.2	DNA
15 to 19 years	7.8	DNA
20 to 24 years	6.4	DNA
25 to 29 years	6.0	DNA
30 to 34 years	6.3	DNA
35 years and older	8.9	DNA

Live Births, 1998	16-1c. All Infant Deaths (<1 year)	16-1d. Neonatal Deaths (<28 days)	16-1e. Postneona- tal Deaths (28 to 364 days)
	Rate per 1,000		
30 to 34 years	6.0	4.4	1.6
35 years and older	7.1	5.2	1.9

p.16-14 to 16-15

Live Births, 1998	Maternal Deaths
	Rate per 100,000
<b>Select populations</b>	
Mother's age groups	
Under 20 years	DSU
20 to 24 years	5.0
25 to 29 years	6.7
30 to 34 years	7.5
35 years and older	14.5

p.16-24

*each of these tables illustrates a goal, such as reducing maternal death*

Deliveries, 1998	16-5a. Maternal Complications During Hospitalized Labor and Delivery
	Rate per 100 Deliveries
<b>Select populations</b>	
Mother's age group	
Under 15 years	DSU
15 to 19 years	34.4
20 to 24 years	30.4
25 to 29 years	29.7
30 to 34 years	31.1
35 years and older	32.7

p.16-25

**16-9. Reduce cesarean births among low-risk (full term, singleton, vertex presentation) women.**

Cesarean Births to Low-Risk Women, 1998	Cesarean Birth	
	16-9a. Women Giving Birth for the First Time	16-9b. Prior Cesarean Birth
	Percent	

<b>Select populations</b>		
Mother's age groups		
Under 15 years old	13	DSU
15 to 19 years	12	67
20 to 24 years	16	70
25 to 29 years	20	71
30 to 34 years	24	72
35 years and older	32	75

p.16-31

Live Births, 1998 (unless noted)	16-10a. Low Birth Weight	16-10b. Very Low Birth Weight
	Percent	
<b>Select populations</b>		
Mother's age groups		
Under 15 years	13.1	3.3
15 to 19 years	9.5	1.8
20 to 24 years	7.5	1.4
25 to 29 years	6.7	1.3
30 to 34 years	7.0	1.4
35 years and older	8.7	1.7

p.16-33

Live Births, 1998	16-11a. Total Preterm Births	16-11b. 32 to 36 Weeks of Gestation	16-11c. Less Than 32 Weeks of Gestation
	Percent		

<b>Select populations</b>			
Mother's age groups			
Under 15 years	22.0	16.2	5.8
15 to 19 years	13.8	11.1	2.7
20 to 24 years	11.5	9.6	1.9
25 to 29 years	10.6	8.9	1.7
30 to 34 years	10.8	9.1	1.8
35 years and older	12.9	10.8	2.2

p.16-35

Rates of breastfeeding are highest among college-educated women and women aged 35 years and older.p.16-47

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### 17. Medical Product Safety

Certain groups are particularly vulnerable to poor health outcomes because they are exposed to both socioeconomic and age-related physiological stress factors that interact synergistically. People aged 65 years and older, for example, take the greatest number and quantity of medications.<sup>8</sup> Of elderly patients taking three or more prescription drugs for chronic conditions, more than one-third are rehospitalized within 6 months of discharge from a hospital, with 20 percent of those readmissions due to drug problems.<sup>9</sup> Twenty-eight percent of hospitalizations of older people are due to noncompliance with drug therapy and adverse events.<sup>10</sup> Adverse drug events rank fifth among the top preventable threats to the health of older people in the United States, after congestive heart failure, breast cancer, hypertension, and pneumonia.<sup>11</sup> Moreover, 32,000 adults aged 65 years and older suffer hip fractures each year as a result of falls associated with the use of psychotropic drugs, which are used to treat the patients' underlying medical condition.<sup>12</sup> A growth in these numbers is expected, given the increasing number and potency of drug products being marketed and the increasing percentage of the population that are elderly.p.17-8

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### 18. Mental Health and Mental Disorders

In later life, the majority of people aged 65 years and older cope constructively with the changes associated with aging and maintain mental health, yet an estimated 25 percent of older people (8.6 million) experience specific mental disorders, such as depression, anxiety, substance abuse, and dementia, that are not part of normal aging. Alzheimer's disease strikes 8 to 15 percent of people over age 65 years,<sup>10</sup> with the number of cases in the population doubling every 5 years of age after age 60 years. Alzheimer's disease is thought to be responsible for 60 to 70 percent of all cases of dementia and is one of the leading causes of nursing home placements.<sup>11</sup>

p.18-3



*Affective disorders*, which encompass major depression and manic depressive illness, constitute a second category of severe mental illness. The World Health Organization found major depression to be the leading cause of disability among adults in developed nations such as the United States.<sup>1</sup> About 6.5 percent of women and 3.3 percent of men will have major depression in any year. Manic depressive illness affects around 1 percent of adults, with comparable rates of occurrence in men and women. A high rate of suicide is associated with such mood disorders.<sup>12</sup>  
p.18-4 to 18-5

Differences between men and women are evident in the number of cases of particular mental disorders. For example, major depression affects approximately twice as many women as men.<sup>23</sup> Women who are poor, have little formal schooling, and are on welfare or are unemployed are more likely to experience depression than women in the general population. Anxiety, panic, and phobic disorders affect two to three times as many women as men.<sup>24, 25, 26</sup>  
p.18-8

Women attempt suicide more often than men,<sup>29</sup> but men's risk of completed suicide is on average four and one half times higher than women's.<sup>30</sup> This suicide gender gap begins in adolescence and grows through middle and later life.<sup>31</sup>  
p.18-8

Alzheimer's disease affects equal numbers of women and men, although women's longer average life spans mean that more women than men have Alzheimer's disease at any point in time.<sup>33</sup>  
p.18-8

### **18-9. Increase the proportion of adults with mental disorders who receive treatment.**

#### **Target and baseline:**

1997 Baseline(unless noted) 2010Target Objective Increase in Adults With Mental Disorders Receiving Treatment  
*Percent*

**18-9a.** Adults aged 18 to 54 years with serious mental illness 47 (1991) 55

p.18-17

Depression also can result in suicide and has an especially severe impact on women.<sup>12, 23</sup>  
p.18-20

The Nation is growing older; the number and proportion of the population aged 65 years and older will grow rapidly after 2010. As the Nation ages, the mental health needs of elderly persons must be addressed because their needs will continue to grow. Mood disorders affect between 2 and 4 percent of community-living elderly persons.<sup>37</sup> Elderly persons with clinically significant depressive symptoms range from 10 to 15 percent of the U.S. population.<sup>95</sup> State mental health authorities and localities should become increasingly engaged in meeting the mental health needs of this growing population.  
p.18-23

Related Objectives From Other Focus Areas.

References:

33 CDC. *Priorities for Women's Health*. Atlanta, GA: CDC, 1993.

**19. Nutrition and Overweight**

Adults Aged 20 Years and Older, 1988-94 (unless noted)	Healthy Weight		
	19-1. Both Genders	Females*	Males*
	Percent		
<b>Age</b>			
20 to 39 years	51	55	48
40 to 59 years	36	40	31
60 years and older	36	37	33

p.19-11

Adults Aged 20 Years and Older, 1988-94 (unless noted)	Obesity		
	19-2. Both Genders	Females*	Males*
	Percent		
<b>Age (not age adjusted)</b>			
20 to 39 years	18	21	15
40 to 59 years	28	30	25
60 years and older	24	26	21

p.19-12

Persons Aged 2 Years and Older, 1994-96	Two or More Daily Servings of Fruit
	Percent

<b>Gender and age</b>	
Female	
2 years and older	26
2 to 5 years (not age adjusted)	43
6 to 11 years (not age adjusted)	26
12 to 19 years (not age adjusted)	23
20 to 39 years (not age adjusted)	20
40 to 59 years (not age adjusted)	26
60 years and older (not age adjusted)	35

p.19-19

<b>Persons Aged 2 Years and Older, 1994–96</b>	<b>Servings of Vegetables</b>		
	<b>19-6. Meet Both Recommendations</b>	<b>3 or More Daily Servings*</b>	<b>One-Third or More Servings From Dark Green or Orange Vegetables*</b>
	Percent		
<b>Gender and age</b>			
Female			
2 years and older	4	41	10
2 to 5 years (not age adjusted)	DSU	23	9
6 to 11 years (not age adjusted)	DSU	24	7
12 to 19 years (not age adjusted)	2	38	7
20 to 39 years (not age adjusted)	4	43	10
40 to 59 years (not age adjusted)	4	49	11
60 years and older (not age adjusted)	6	43	13

p.19-21

To help clarify the relationship between total dietary fat and the risk of cancer, a randomized clinical trial called the Women's Health Initiative has been started. Set to conclude in 2003, it is a multicenter trial designed to test several risk factors for chronic disease in U.S. females.<sup>44</sup> A major emphasis is to reduce fat to 25 percent of dietary calories to determine whether a low-fat diet has any effect on breast cancer risk.<sup>p.19-29 to 19-30</sup>

Persons Aged 2 Years and Older, 1988–94 (unless noted)	Met Calcium Recommendations
	Percent
<b>Gender and age</b>	
Female	
2 years and older	36
2 to 8 years (not age adjusted)	79
9 to 19 years (not age adjusted)	19
20 to 49 years (not age adjusted)	40
50 years and older (not age adjusted)	27

p.19-33

For the most part, young children appear to meet the approximate calcium requirements. In contrast, the majority of adolescent and adult females do not meet the average requirements. This is in part because of their lower food consumption, as well as the lower consumption of milk products relative to soft drinks in U.S. diets.<sup>54</sup>

p.19-34

In postmenopausal females —the group at highest risk for osteoporosis—estrogen replacement therapy under medical supervision is the most effective means to reduce the rate of bone loss and risk of fractures.<sup>32</sup>

p.19-35

The prevalence of iron deficiency anemia among children aged 1 to 2 years and 3 to 4 years and females aged 12 to 49 years in 1988 to 1994 was 3 percent, less than 1 percent, and 4 percent, respectively.

p.19-38

## 20. Occupational Safety and Health

Little is known about factors such as gender, genetic susceptibility, culture, and literacy that may increase the risk for occupational disease and injury.

p.20-6

## 21. Oral Health

Females tend to have more teeth extracted than males of the same age group.  
p.21-18

## 22. Physical Activity and Fitness

Physical activity also may protect against lower back pain and some forms of cancer (for example, breast cancer), but the evidence is not yet conclusive.<sup>2,3</sup>  
p.22-3

*for each goal, gender is almost always broken down in the data but rarely gender by age groups*

Strength training also has been shown to preserve bone density in postmenopausal women.<sup>9</sup>  
p.22-17

### References:

<sup>3</sup>McTiernan, A.; Stanford, J.L.; Weiss, N.S.; et al. Occurrence of breast cancer in relation to recreational exercise in women age 50-64 years. *Epidemiology* 7(6):598-604, 1996.

Sherman, S.E.; D'Agostino, R.B.; Cobb, J.L.; et al. Physical activity and mortality in women in the Framingham Heart Study. *American Heart Journal* 128(5):879-884, 1994.

<sup>15</sup>Snow-Harter, C.; Shaw, J.M.; and Matkin, C.C. Physical activity and risk of osteoporosis. In: Marcus, R.; Feldman, D.; and Kelsey, J., eds. *Osteoporosis*. San Diego, CA: Academic Press, 1996, 511-528.

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## 23. Public Health Infrastructure

Researchers and research organizations now recognize the value of including diverse populations and communities in their studies. Population-based prevention and clinical research must continue to include specific population groups, such as females, racial and ethnic groups, and persons who are either not served or are underserved. Research should be responsive to National, State, and local public health priorities and needs.  
p.23-20

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## 24. Respiratory Diseases

Among adults, women of all races have higher rates of illness and death from asthma than men.<sup>16</sup>  
p.24-5

COPD occurs most often in older people. As much as 10 percent of the population aged 65 years and older is estimated to have COPD.<sup>2</sup> COPD has a major impact on health care, illness, disability, and death in the older population, and the magnitude of the problem is growing. Since 1980, the prevalence and age adjusted death rate for COPD increased more than 30 percent.<sup>2, 21, 22</sup> Most of the increase occurred in people over age 65 years. Taking into account the expected aging of the U.S. population over the next 10 to 30 years as well as the improved management of other smoking-related diseases, any decline in the proportion of persons with COPD is unlikely

without substantial changes in risk factors, mainly reductions in cigarette smoking. This is important for both men and women, given the modest decline in cigarette smoking rates from 1990 to 1995.<sup>22</sup>

p.24-8

In 1995, the proportion of the population with COPD was 5 percent in men aged 45 to 64 years and 11 percent in men aged 65 years and older. The proportion was 10 percent in women aged 45 to 64 years and 9 percent in women aged 65 to 74 years.

p.24-9

Women might be more susceptible than men to developing COPD when exposed to risk factors such as tobacco smoke.<sup>38</sup> The beneficial effects of stopping smoking on the rate of lung function decline may be greater for women than men.<sup>39</sup>

p.24-10

Select Age Groups, 1998	Asthma Deaths				
	24-1a. Children Under Age 5 Years	24-1b. Children Aged 5 to 14 Years	24-1c. Adoles- cents and Adults Aged 15 to 34 Years	24-1d. Adults Aged 35 to 64 Years	24-1e. Adults Aged 65 Years and Older
Rate per Million					
<b>Gender</b>					
Female	1.4	2.7	4.3	22.3	99.1
Male	2.8	4.0	5.7	13.0	68.1

p.24-14

Select Age Groups, 1998	Asthma Hospitalizations		
	24-2a. Children Under Age 5 Years	24-2b. Children and Adults Aged 5 to 64 Years*	24-2c. Adults Aged 65 Years and Older*
Rate per 10,000			
<b>Gender</b>			
Female	33.1	15.9	24.6
Male	57.6	9.0	8.5

p.24-15

Select Age Groups, 1995-97	Hospital Emergency Department Visits for Asthma		
	24-3a. Children Under Age 5 Years	24-3b. Children and Adults Aged 5 to 64 Years	24-3c. Adults Aged 65 Years and Older
	Rate per 10,000		
<b>Gender</b>			
Female	103.0	83.6	37.8
Male	195.5	57.9	17.9

p.24-17

Adults Aged 45 Years and Older, 1997	Experienced Activity Limitations Due to Chronic Lung and Breathing Problems
	Percent
<b>Gender</b>	
Female	2.1
Aged 45 to 64 years	1.6
Aged 65 years and older	3.0
Male	2.5
Aged 45 to 64 years	1.6
Aged 65 years and older	4.1

p.24-21

## 25. Sexually Transmitted Diseases

**Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease (PID), ectopic pregnancy, infertility, and chronic pelvic pain.<sup>29</sup> Women are biologically more susceptible to infection when exposed to a sexually transmitted agent. Often, STDs are

transmitted more easily from a man to a woman.<sup>30</sup> Acute STDs (and even some complications) often are very mild or are completely asymptomatic in women. STDs are more difficult to diagnose in women due to the physiology and anatomy of the female reproductive tract. This combination of increased susceptibility and "silent" infection frequently can result in women being unaware of an STD, which results in delayed diagnosis and treatment.

p.25-6 to 25-7

Total Population, 1997	New Gonorrhea Cases		
	25-29 Both Genders	Females*	Males*
	Rate per 100,000		
<b>Age</b>			
15 to 24 years	512	617	414
25 to 34 years	198	161	235
35 to 44 years	71	40	101

p.25-17

Reducing the number of new HPV cases can help to minimize the overall number of cases of high-risk subtypes associated with cervical cancer in females aged 15 to 44 years.

p.25-20

### STD Complications Affecting Females

**25-6. Reduce the proportion of females who have ever required treatment for pelvic inflammatory disease (PID).**

**Target:** 5 percent.

**Baseline:** 8 percent of females aged 15 to 44 years required treatment for PID in 1995.

**25-7. Reduce the proportion of childless females with fertility problems who have had a sexually transmitted disease or who have required treatment for pelvic inflammatory disease (PID).**

**Target:** 15 percent.

**Baseline:** 27 percent of childless females aged 15 to 44 years with fertility problems had a history of STDs or PID treatment in 1995.

**Target setting method:** 44 percent improvement.



Childless Females Aged 15 to 44 Years With Fertility Problems, 1995	STD History or PID Treatment
	Percent
Age	
15 to 24 years	23
25 to 34 years	26
35 to 44 years	31

p.25-23

**25-16. (Developmental) Increase the proportion of sexually active females aged 25 years and under who are screened annually for genital chlamydia infections.**

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**26. Substance Abuse**

Light-to-moderate drinking can have beneficial effects on the heart, particularly among those at greatest risk for heart attacks, such as men over age 45 years and women after menopause.<sup>9</sup> Moderate drinking generally refers to consuming one or two drinks per day. Moderate drinking, however, cannot be achieved by simply averaging the number of drinks. For example, consuming seven drinks on a single occasion will not have the same effects as consuming one drink each day of the week.

p.26-4

Women's risk of developing breast cancer increases slightly if they drink two or more drinks per day.<sup>13</sup>

p.26-4

Binge drinking among women of childbearing age (defined as 18 to 44 years) also is a problem because of the risk for prenatal alcohol exposures. Approximately half of the pregnancies in the United States are unintended,<sup>88</sup> and most women do not know they are pregnant until after the sixth week of gestation.<sup>89</sup> Such prenatal alcohol exposures can result in fetal alcohol syndrome and other alcohol-related neurodevelopmental disorders.<sup>90</sup>

p.26-33

It is estimated that 5.3 million persons are most in need of treatment.<sup>77</sup> National efforts are under way to estimate better the size of the gap, to develop strategies to expand capacity, and to eliminate barriers to access for those in need. These strategies involve seeking changes in financial barriers created by funding constraints and inadequate health and disability insurance coverage<sup>101</sup> and improvements in **gender-specific** and culturally appropriate treatment methods.<sup>102</sup>

p.26-43

References:

61 Hasin, D.; Grant, B.; and Harford, T. Male and female differences in liver cirrhosis mortality in the United States, 1961–1985. *Journal of Studies on Alcohol* 51:123-129, 1990.

90 CDC. Alcohol consumption among pregnant and childbearing-aged women, United States, 1991 and 1995. *Morbidity and Mortality Weekly Report* 46:346-350, 1997.

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## 27. Tobacco Use

Smoking during pregnancy causes spontaneous abortions, low birth weight, and sudden infant death syndrome.<sup>3</sup>

p.27-3

Men are more likely to smoke than women

### 27-6. Increase smoking cessation during pregnancy.

**Target:** 30 percent.

**Baseline:** 14 percent of females aged 18 to 49 years stopped smoking during the first trimester of their pregnancy in 1998.

**Target setting method:** Better than the best.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS.

p.27-20

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## 28. Vision and Hearing

More than two-thirds of visually impaired adults are over age 65 years. Although no gender differences exist in the number of older adults with vision problems, more women are visually impaired than men are because, on average, women live longer than men do.

#### 4. 年齢・性別・社会階層別 医療費の国際比較

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##### はじめに

わが国では全国民が公的医療保険に加入し、医療サービスの公定料金は低く設定されているため、国民はいつでもどこでも安心して医療を受けることができる。このように平等なアクセスが達成されているにもかかわらず、国民医療費は先進諸国の中では比較的安く抑えられているため、わが国医療システムの効率性は国際的に評価が高い。

しかしながら近年経済が停滞する中で医療費支出が従来同様に伸びた結果、国民医療費の対GDP比率が上昇すると同時に、医療保険財政が逼迫をきたした。これに対処するために国は医療制度改革を急いでいる。改革のひとつに公的医療保険の給付率引き下げがある。患者の側からみればこれは医療費の自己負担率の引き上げである。例えば被用者保険の本人負担は1984年に1割へ、1997年に2割へ引き上げられた。さらに2002年には3歳未満と70歳以上を除く国民すべての自己負担率は3割となる。

自己負担率は医療サービスの需要者価格である。この引き上げは2重の意味で医療保険財政を改善する。ひとつは保険給付を引き下げた分だけ支出が減る効果である。第二の効果は価格上昇による需要減退効果である。医療サービス需要の価格弾力性（価格が1%上昇したときに医療需要が何%減少するかをみる経済学の指標）が十分に大きければ、自己負担率を引き上げで国民医療費を縮小させる効果が期待できる。

しかし医療価格の上昇が国民の中のどの階層の需要を減らすかの議論がなされていない。一般に軽い病気では価格弾力性が大きいことが知られており、軽い疾病に費やされる医療費の一部は自己負担引き上げで売薬などに代替されることになろう。だがより重篤な病気ではどうなのかは明らかでない。国民の中でも男女別、所得階層別、社会階層別、年齢階層別などで医療価格の引き上げによる影響は異なる可能性があるだろう。その結果、わが国医療システムの平等なアクセスが損なわれる危険性が否めない。特定の階層が医療にアクセスできなくなることもあり得る。そもそもわが国の医療アクセスはそれほど平等であったのかどうかも検証する必要がある。

以上のような問題意識から、わが国の医療費が男女別、所得階層別、社会階層別、年齢階層別にどのように分配されているのかを調べ、それを他の先進諸国と比較することによってわが国の特色を明らかにするのが本論文の目的である。

##### 1. 先進諸国のマクロ医療費

医療費増加は先進各国共通の課題である。医療費は所得向上にともなって増加することが知られているが、Newhouse(1977)を筆頭とした一連の計測によれば所得弾力性（所得が1%増加したときに医療費が何%増加するかをみる経済学の指標）は1より大

大きく、医療費支出は所得の上昇よりも早いスピードで増加する。言い換えれば医療サービスは贅沢財で、所得が高まるとそれ以上にその消費が進む財なのである。これが先進国すなわち1人当たり国民所得の高い国々で、医療費の高騰が共通の悩みとなることの第一の原因といえる。

医療費を増加させる第二の原因として人口の高齢化をあげることができる。一般に高齢者は疾病罹患率が高いため、医療サービスに対する需要が大きいことがその理由である。実際多くの先進諸国で高齢者の平均医療費支出は若年層に比較して大きい。そして人口の高齢化で、平均医療支出が大きい高齢者の割合が高まるため、国民1人当たり医療費が押し上げられる。これが高齢化による医療費高騰である。

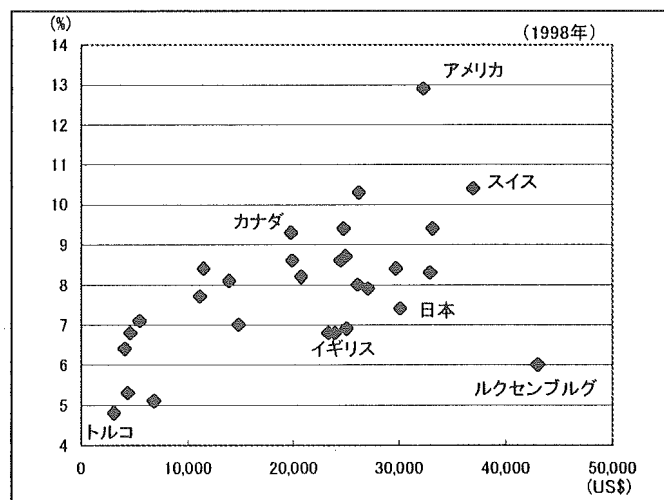
しかしながら、高齢者の潜在的な医療需要がたとえ大きくても、それがそのまま医療サービス消費の実現に直結するとは言い切れない。高齢者の所得が医療需要を実現するのに十分なほど高いか、さもなければ医療保険制度の普及によって平等な医療アクセスが保障されていないければ、医療需要が高くても高齢者の医療サービス消費は小さいままに終わる。言い換えれば、医療支出の大きさは需要の大きさだけでなく、所得や医療制度の制約を強く受けるのである<sup>1</sup>。

### 1) 所得と医療費

図表1はOECD各国の1人当たりGDP(US\$)と対GDP比医療支出の関係を見たものである。ルクセンブルグを例外とすれば、所得が高い国ほど、医療費が経済全体に占めるシェアが大きく、2つの変数の間に強い正の相関がある。

仮にOECD諸国の医療支出の所得弾力性が1であれば(所得が1%増えたときに医療支出が1%増えるならば)、医療支出のGDP比は全ての国で一定になるはずである。ところが図表から明らかなように所得の高い国では所得の中から医療に振り向ける比率が大きい、すなわち所得増加よりも医療支出増加のほうが大きい(所得弾力性が1より大きい)。

図表1 1人当たりGDPと医療支出(対GDP比、%)の関係



資料) OECD Health Data 2001

<sup>1</sup>医療支出に影響を与える要因として、ここであげた所得や医療制度など経済学的な分析の対象となる要因のほかに、罹患率、公衆衛生、予防医療の普及、社会的な習慣などが考えられる。