Health Disparities Among U.S. Women of Color: An Overview

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Introduction

This paper was prepared for the Margaret E. Mahoney Annual Symposium Health Disparities Among Women of Color convened in Washington, DC on April 16, 2002, by the Jacobs Institute of Women's Health and The Commonwealth Fund. It is designed to give meeting attendees a general overview of the key health disparities that exist among different subgroups of women of color in the U.S. today.

The term "women of color" is used to encompass women of racial and/or ethnic minority groups in the United States. Only recently has the U.S. begun collecting health data that includes detailed information on the race/ethnicity of the population studied. Many earlier studies were limited to information on white and black populations only or white and non-white populations. Newer studies include more detailed data on race and ethnicity, with designations such as non-Hispanic white, non-Hispanic black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native. These terms encompass subgroups with substantially different languages, culture, degrees of acculturation, and social and behavioral norms. For example, the term Asian encompasses Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Cambodian, Hmong, Laotian, and Thai women. In the most recent U.S. census, for the first time, individuals were given the opportunity to select more than one racial or ethnic group. Approximately 2 million women identified themselves as belonging to two or more categories.

Demographic Characteristics

Women and girls made up 50.9% of the total U.S. population in 2000.[i] Of the 108.1 million women aged 18 and older, 27.9% were from one or more racial/ethnic minority group.[ii] Among women of color, non-Hispanic black women constituted the largest racial/ethnic group in 2000 (Table 1).[2] Women of color are expected to comprise almost half of all U.S. women by

2050.[iii] The greatest increase will be in the number of Hispanic women, who are estimated to make up almost a quarter of U.S. women in 2050 compared to just over 10% in 2000.[iv] Asian women have the highest population growth rate among women of color and are expected to constitute approximately 9% of the total population by 2050.[4]

Table 1 - Percent of U.S. women and median age by race/ethnicity, 2000

Race/ethnicity	Percent*	Median age (in years)
Black	11.9	31.7
Hispanic**	10.3	26.3
Asian/Pacific Islander	3.9	33.8
American Indian/Alaska Native	0.8	28.1
Non-Hispanic white	72.1	39.8

*Includes only women aged 18 and older.
**Persons of Hispanic origin may be of any race.
Note: Column may not equal 100% due to rounding.
Source: U.S. Bureau of the Census. Population by age, sex, race, and Hispanic or Latino origin: 2000. Washington: The Bureau; 2001.

The median age is lower for women of color than for non-Hispanic white women (Table 1).[2] Thirty-five percent of Hispanic women are under 18 years of age compared to 21.5% of non-Hispanic white women. Although the percentage of women aged 18 to 64 is similar across all racial/ethnic groups, the percentage of non-Hispanic white women over the age of 65 is nearly double that of any other racial/ethnic group.[2]

Women of color are more likely than white women to experience poverty and low educational attainment. These indicators of socio-economic status are related to poorer health. Higher rates of poverty among women of color persist even though the overall poverty rate dropped to its lowest level in 20 years (11.8%) in 1999 and declined in every racial and ethnic group as well.[v] More than a quarter of non-Hispanic black and Hispanic women aged 18 and older lived below the federal poverty level in 1998 as compared to only 9% of non-Hispanic white women (Table 2).[4]

Table 2 - U.S. women aged 18 and older by race/ethnicity and poverty level, 1998

Race/ethnicity	% Poor (<100% FPL*)	% Near-poor (100-199% FPL)	% Non-poor (≥ 200% FPL)
Black, non-Hispanic	27	24	49
Hispanic	26	28	46
Asian/Pacific Islander	13	15	71
American Indian/Alaska Native	21	19	60
White, non-Hispanic	9	16	75

Note: Columns may not add up to 100% due to rounding.
*FPL is the federal poverty level, which was $16,660 for a family of four in 1998.
Source: Misra, D, ed., Women's Health Data Book: A Profile of Women's Health in the United States, 3rd edition. Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation. 2001.

Women of color also tend to have lower educational attainment. Although over a third of Asian/Pacific Islander women have a bachelor's degree or higher, only 14.0% of non-Hispanic black and 8.5% of Hispanic women have attained that same status (Table 3).

Table 3 - U.S. women with a bachelor's degree or higher by race/ethnicity, 2000

Race/ethnicity	Percent
Black, non-Hispanic	14.0
Hispanic*	8.5
Asian/Pacific Islander	35.2
White, non-Hispanic	22.8

*Persons of Hispanic origin may be of any race.
Source: U.S. Bureau of the Census. Educational attainment of the population 15 years and over, by age, sex, race and Hispanic Origin: March 2000. Washington: The Bureau; 2000.

Health Status

Among the key indicators of the health status of a population are self-reported health status, life expectancy, and morbidity and mortality rates. Women of color generally report being in poorer health. According to the Medical Expenditure Panel Survey (MEPS), 20.5% of black women and 19.6% of Hispanic women perceived themselves to be in fair or poor health compared to 13.4% of white women.[vi]

Table 4 - Ten leading causes of death* for U.S. women by race/ethnicity, 1999

Rank	Race/ethnicity				
	Black	Hispanic	Asian/Pacific Islander	American Indian/ Alaska	White

				Native	
1	Heart disease	Heart disease	Malignant neoplasms	Heart disease	Heart disease
2	Malignant neoplasms	Malignant neoplasms	Heart disease	Malignant neoplasms	Malignant neoplasms
3	Cerebro-vascular diseases	Cerebro-vascular diseases	Cerebro-vascular diseases	Unintentional injuries	Cerebro-vascular diseases
4	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	Diabetes mellitus	Chronic lower respiratory diseases
5	Unintentional injuries	Unintentional injuries	Unintentional injuries	Cerebro-vascular diseases	Influenza and pneumonia
6	Nephritis, nephrotic syndrome and nephrosis	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Chronic liver disease and cirrhosis	Unintentional injuries
7	Chronic lower respiratory diseases	Influenza and pneumonia	Influenza and pneumonia	Chronic lower respiratory diseases	Alzheimer's disease
8	Septicemia	Certain conditions originating in the perinatal period	Nephritis, nephrotic syndrome and nephrosis	Influenza and pneumonia	Diabetes mellitus
9	Influenza and pneumonia	Chronic liver disease and cirrhosis	Essential (primary) hypertension and hypertensive renal disease	Nephritis, nephrotic syndrome and nephrosis	Nephritis, nephrotic syndrome and nephrosis
10	HIV disease	Nephritis, nephrotic syndrome and nephrosis	Septicemia	Septicemia	Septicemia

*Rankings based on total number of deaths for all ages.
Source: Eberhardt MS, Ingram DD, Makuc DM, et al. Urban and Rural Health Chartbook. Health, United States, 2001. Hyattsville, Maryland: National Center for Health Statistics. 2001.

Heart disease and cancer are among the leading causes of death for all women (Table 4). Despite this similarity, age-adjusted mortality rates for these diseases vary greatly by race/ethnicity (Table 5). The mortality rate from heart disease is 33% higher among black women than among non-Hispanic white women, and age-adjusted mortality rates for all cancers, and for breast cancer specifically, are also higher for black women.

Table 5 - Age-adjusted* mortality rates for selected causes of death for U.S. women by race/ethnicity, 1999**

Cause of death	Race/ethnicity				
	Black	Hispanic	Asian/Pacific Islander	American Indian/ Alaska Native	White, non-Hispanic
Heart disease	290.5	146.5	121.5	138.3	218.1
Cancer (all)	200.2	101.4	104.0	109.1	172.1
Breast cancer	35.6	15.4	13.1	15.4	27.0
Lung cancer ***	40.5	13.1	19.6	26.9	43.4
Cerebrovascular diseases	78.1	36.3	48.2	38.5	59.6
Chronic lower respiratory diseases	23.9	15.3	12.0	27.3	41.5
HIV disease	13.4	3.1	--	--	0.7

* Mortality rates are age-adjusted to the 2000 U.S. standard population.
** Rates are per 100,000.
***Lung cancer rates include cancers of the trachea, bronchus, and lung.
-- Based on fewer than 20 deaths.
Source: Eberhardt MS, Ingram DD, Makuc DM, et al. Urban and Rural Health Chartbook. Health, United States, 2001. Hyattsville, Maryland: National Center for Health Statistics. 2001.

Life expectancy is greater for women than men in every racial/ethnic group. On average, women outlive men by six years.[3] Table 6 illustrates the variation in life expectancy among U.S. women by race/ethnicity. Non-Hispanic black women have the lowest life expectancy of all women of color, 74.3 years, compared to 80.0 years for non-Hispanic white women and 85.0 years for Asian/Pacific Islander women.

Table 6 - Life expectancy in years for U.S. women by race/ethnicity, 1995

Race/ethnicity	Years
Black, non-Hispanic	74.3
Hispanic*	82.2
Asian/Pacific Islander	85.0
American Indian, Eskimo, Aleut	80.2
White, non-Hispanic	80.0

*Persons of Hispanic origin may be of any race.
Source: Day, Jennifer Cheeseman. Population projections of the United States by age, sex, race, and Hispanic origin: 1995 to 2050, U.S. Bureau of the Census, Current Population Reports, P25-1130, U.S. Government Printing Office, Washington, DC, 1996.

Chronic Conditions

Heart and Cerebrovascular Diseases

Heart disease is the leading cause of death for all women except for Asian/Pacific Islander women for whom it is the second leading cause of death. Black women have the highest age-adjusted mortality rate from heart disease (290.5 per 100,000), followed by non-Hispanic white women (218.1 per 100,000) (Table 5). Rates are lower for Hispanic, Asian/Pacific Islander and American Indian/Alaska Native women. Although cancer is the second leading cause of death among women, age-adjusted mortality rates for cerebrovascular diseases (including stroke) are higher than mortality rates for either lung or breast cancer. The mortality rate from cerebrovascular disease for black women (78.1 per 100,000) is more than twice the rate for Hispanic women (36.3 per 100,000), who have the lowest mortality rate from cerebrovascular diseases of all women.

The higher mortality rates of heart and cerebrovascular diseases in black women seem to be the result of a higher proportion of women with standard risk factors rather than any risk factors unique to black women. The risk factors associated with increased mortality from heart and cerebrovascular diseases are cigarette smoking, hypertension, diabetes, high blood cholesterol, inadequate physical activity, and obesity. Black women are more likely to have at

least one risk factor for heart or cerebrovascular disease. Winkleby et al. examined data from the National Health and Nutrition Examination Survey III (NHANES III) and found that black and Mexican American women had a higher prevalence of heart disease risk factors such as high blood pressure and physical inactivity even after controlling for age and socioeconomic status (SES).[vii] Over 60% of American Indian/Alaska Native women had at least one risk factor (hypertension, current cigarette smoking, high blood cholesterol, obesity, and diabetes) for cardiovascular disease in 1997.[viii]

Cigarette smoking is a preventable risk factor for both heart disease and stroke. American Indian/Alaska Native women have the highest prevalence of cigarette smoking (40.8%) while Hispanic (12.3%) and Asian/Pacific Islander women (7.1%) have the lowest.[ix] Among women aged 20 to 74, hypertension is most prevalent in non-Hispanic black women (36.4%), who are almost twice as likely to be hypertensive than non-Hispanic white women (19.7%).[x] Women who have diabetes are approximately three times more likely to develop heart disease than those who do not.[4] The prevalence of diabetes is at least 2 to 4 times higher among black, Hispanic, American Indian, and Asian/Pacific Islander women than among white women.[xi]

There are no substantial differences by race/ethnicity among women in the percentage with high cholesterol (defined as above 240 mg/dL) based on NHANES data.[4] Among women aged 20 to 74, 20.7% of non-Hispanic whites, 19.9% of non-Hispanic blacks, and 17.7% of Mexican Americans have high cholesterol levels.[10] According to the 1996 Surgeon General's Report on Physical Activity and Health, nearly 43% of non-Hispanic black women and 39% of Hispanic women reported no participation in leisure-time physical activity. This compares to approximately 28% of non-Hispanic white women who reported no participation in leisure-time physical activity.[xii]

Treatment disparities also may contribute to higher mortality rates for heart and cerebrovascular disease in women of color, especially for black women. Evidence has suggested that a patient's race affects her referral for treatment. Schulman et al. examined the effect of patients' race and sex on physicians' recommendations for cardiac catheterization and found that black women were significantly less likely than white women to be referred for this procedure.[xiii] A study exploring the use of reperfusion therapy in Medicare beneficiaries with acute myocardial infarction found similar results. Black women were less likely than white women to receive this potentially lifesaving therapy.[xiv]

Diabetes

Diabetes is a chronic disease caused by the body's inability to produce or use insulin properly. Type I diabetes is an autoimmune disease characterized by onset and diagnosis in childhood or adolescence and requires insulin injections for survival. Type II diabetes develops in adults and is often controlled through nutrition and exercise but may require insulin or oral medications.[4] Approximately 7.8% of women aged 20 and older in the U.S. have diabetes. The prevalence of diabetes is higher for women of color in all age groups but is more pronounced among older women of color.[4]

Hispanic women aged 50 and older have the highest prevalence of Type II diabetes, with more than one quarter of the population having been diagnosed with diabetes. Hispanic women with diabetes are three to four times more likely to have heart disease or a stroke.[xv] Thirty-two percent of non-Hispanic black women aged 60 to 74 have diabetes; this rate is twice that of non-Hispanic white women the same age.[4] Black women are also more likely to have undiagnosed diabetes at older ages. Undiagnosed diabetes can lead to complications such as retinopathy, kidney disease and amputations. According to NHANES III data, non-Hispanic black women

aged 45 to 64 had more than twice the rate of undiagnosed diabetes as did non-Hispanic white women the same age.[11] This may be a serious health risk for these women since black women are already more likely to become blind, require amputation, and develop end-stage renal impairment from diabetes.[xvi]

Non-Hispanic black women had the highest age-adjusted mortality rate (51.7 per 100,000) from diabetes in 1999. This compares to a rate of 32.6 per 100,000 for Hispanic women and 19.5 per 100,000 for non-Hispanic white women.[xvii] The mortality rate for the American Indian/Alaska Native population is approximately 2.7 times the rate for the general U.S. population, and the mortality rate for American Indian/Alaska Native women has increased 550% over a 30-year period.[xviii]

Obesity (defined as Body Mass Index (BMI) of 30.0 kg/m^2 or greater) and being overweight (defined as BMI between 25.0 and 29.9 kg/m^2) are risk factors for diabetes. The percentage of women who are overweight or obese has been increasing over the past 25 years.[4] Data from NHANES III indicate that non-Hispanic white women are the least likely to be overweight or obese. Although Mexican Americans are slightly more likely to be overweight than black women (32% and 30% respectively), non-Hispanic black women are more likely to be obese (40% compared to 31%).[4] The prevalence of being overweight or obese among Asian women ranges from 12.8% in Chinese women to 25.5% in Filipino women. Overweight and obesity are more prevalent among Pacific Islanders, especially Samoans and Native Hawaiians, than other racial/ethnic groups.[xix] Obesity and being overweight are also problems for American Indian/Alaska Native women. It is estimated that 40% of American Indian women are overweight and another 17% are obese. In certain populations of American Indians/Alaska

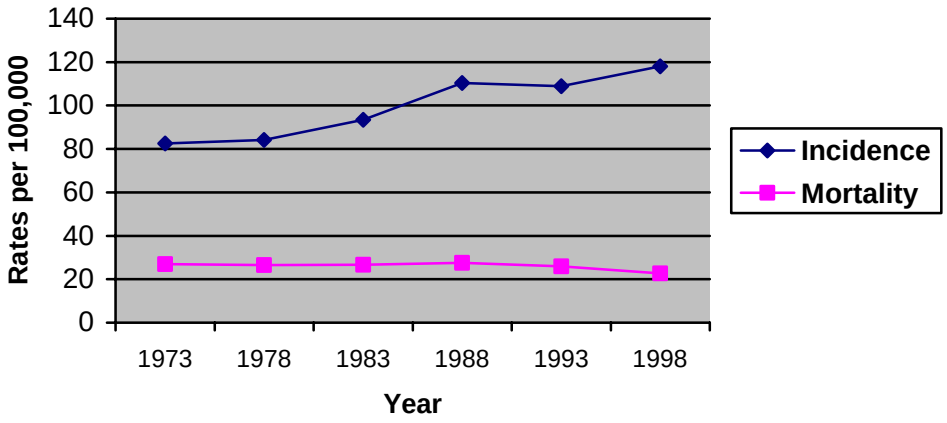
Natives, the prevalence is even higher. Eighty percent of Arizona Indian women are overweight or obese.[xx]

Breast Cancer

Excluding cancers of the skin, breast cancer is the most common form of cancer among women. It is estimated that over 190,000 new cases of invasive breast cancer were diagnosed and over 40,000 women died of breast cancer in 2001.[xxi] Incidence, survival and mortality rates for breast cancer vary substantially by race/ethnicity. Incidence rates for breast cancer have increased over the past twenty years, due in part to better screening (Figure 1). Among women of color, black women have the highest incidence rates for breast cancer (Table 7). They also have lower five-year survival rates; only 72% of black women are alive five years after the diagnosis of breast cancer, compared to more than 87% of white women.[xxii] American Indian/Alaska Native women have the lowest incidence of breast cancer yet have the poorest five-year survival rates.[xxiii] Later stage of diagnosis may contribute to lower survival rates among women of color. Although breast cancer is diagnosed approximately 30% less often among women of Hispanic origin, it is more frequently diagnosed at a later stage than in non-Hispanic white women.[xxiv]

Breast cancer mortality has decreased in the past ten years after remaining stable for twenty years (Figure 1). However, the rate of decline in mortality was not equal among all women. Mortality rates for white women declined annually by 2.7% from 1992 to 1998, but there was no statistically significant decrease for black women during that same time period.[xxv]

Figure 1 - Age-adjusted* incidence and mortality rates for invasive breast cancer for women, 1973-1998



*Incidence and mortality rates are age-adjusted to the 1970 U.S. standard population.
Source: Ries LAG, Eisner MP, Kosary CL, Hankey BF, Miller BA, Clegg L, Edwards BK (eds). SEER Cancer Statistics Review, 1973-1998, National Cancer Institute. Bethesda, MD, 2001.

While non-Hispanic white women have the highest breast cancer incidence rates, black women are more likely to die from breast cancer (Table 7). Asian/Pacific Islander women have the lowest mortality rate from breast cancer. However, certain populations of Asian/Pacific Islander women have higher rates, such as Hawaiian women, who have mortality rates comparable to non-Hispanic white women.[xxvi]

Table 7 - Age-adjusted incidence and mortality rates* for invasive breast cancer in women by race/ethnicity, 1992-1998

	Race/ethnicity				
	Black	**Hispanic**	**Asian/Pacific Islander**	**American Indian/ Alaska Native**	**White, non-Hispanic**
Incidence	101.5	68.5	78.1	50.5	120.5
Mortality	31.0	14.8	11.0	12.4	24.7

*Rates are per 100,000.
Source: Ries LAG, Eisner MP, Kosary CL, Hankey BF, Miller BA, Clegg L, Edwards BK (eds). SEER Cancer Statistics Review, 1973-1998, National Cancer Institute. Bethesda, MD, 2001.

Mental Health Disorders

Approximately one in five women will experience an episode of major depression during her lifetime, while slightly more than one-third of women will experience an anxiety disorder.[4] Mental health disorders are a significant women's health issue, especially for women of color. Women of color are less likely to report excellent or very good perceived mental health status. Black women are the most likely to report having fair or poor mental health.[6]

Certain social factors are also risk factors for mental health disorders. Low socioeconomic status is a risk factor for depression, presumably as a result of the psychological impact of having limited access to economic and social resources. Women of color are at an increased risk of having mental health disorders due to the fact that a disproportionate number live below the federal poverty level. Thirty-two percent of women living below the federal poverty level reported being currently distressed in 1998.[xxvii]

The 1998 Commonwealth Fund Survey of Women's Health examined women's perceived need for help for mental health disorders. Perceived need was assessed by identifying women who in the past 12 months thought they needed to consult with a health professional because they felt depressed or anxious. While women of color are more likely to be classified as distressed (based on questions asking respondents how frequently in the past week they felt sad, enjoyed life, had crying spells, felt people disliked them, and had restless sleep), white women are more likely to perceive a need for care. Asian women in particular reported low perceived need (8%) in relation to other racial/ethnic groups, even though 20% of Asian women were classified as being currently distressed in the survey (current psychological distress was based on exceeding a cut-point on a depression symptom scale). There were also large disparities by race/ethnicity among women with a perceived need to see a mental health professional. Almost

two thirds of black, Hispanic, and Asian women who perceived a need to see a mental health professional did not see one in the past year compared to 35% of white women.[27]

Among women of color, mortality rates from suicide are highest for American Indian/Alaska Native women (4.7 per 100,000) who have rates similar to those of non-Hispanic white women. Asian/Pacific Islander women also have a higher mortality rate from suicide (3.6 per 100,000), nearly twice the rate of Hispanic or black women (1.9 per 100,000 and 1.6 per 100,000 respectively). In general, mortality rates from suicide increase with age in every racial/ethnic group but decrease after age 65. An exception occurs among Asian/Pacific Islander women over age 65, who have the highest suicide rate (6.5 per 100,000) of all women in that age group.[10]

HIV/AIDS

HIV and AIDS continue to severely impact the health of women of color. Although black women represent only 13% of U.S. women, they accounted for almost two thirds (63%) of new AIDS cases reported among women in 1999.[xxviii] Among women aged 25 to 34, HIV disease was the leading cause of death for non-Hispanic black women, the fourth leading cause for Hispanic women and the eighth leading cause for American Indian/Alaska Native and non-Hispanic white women in 1999.[xxix] As of December 2000, non-Hispanic black and Hispanic women represented over three quarters (77.5%) of all reported AIDS cases in women in the United States.[xxx] Non-Hispanic black women have the highest prevalence of AIDS cases of any other group of women. The AIDS case rate (new cases per 100,000 population) for black women is 20 times higher than for non-Hispanic white women (45.9 per 100,000 compared to 2.2 per 100,000), and Hispanic women have a rate (13.8 per 100,000) more than six times that for non-Hispanic white women.

Although American Indian/Alaska Native women have a lower annual rate of AIDS cases (8.3 per 100,000), it is still almost four times the rate for non-Hispanic white women.[30]

Preventive Health Services

Preventive health services include both screening for early detection of disease and counseling regarding health behaviors related to diet, smoking, exercise, injuries, pregnancy, and sexually transmitted diseases. These services can be effective in reducing premature deaths, injuries, and chronic conditions. Results from the 1998 Commonwealth Fund Survey indicate that the overall receipt of clinical preventive services has changed very little since 1993 and lower-income and less-educated women are still receiving fewer regular preventive services. Asian American and Hispanic women were most likely to lack preventive care, with 29% of Asian American and 21% of Hispanic women receiving no preventive services in the past year. Mammography screening rates increased for women over 50 between 1993 and 1998, with black and Hispanic women experiencing the greatest improvement. Although mammography screening rates for Hispanic and black women were higher than those for white women, less than two thirds (61%) of U.S. women aged 50 or older have had a mammogram in the past year.[xxxi]

Almost two thirds (64%) of women received Pap tests in the past year.[31] Black women were more likely to receive Pap tests than either white or Hispanic women. The percent of Asian American women getting Pap tests was significantly lower than all other groups of women with only about half (49%) reporting receiving a Pap test in the past year (Table 8). Pap tests may be especially important for this group of women because certain subgroups of Asian women, such as Vietnamese women, have higher rates of cervical cancer.[26]

Table 8 - Percent of women receiving selected preventive services in the past year by race/ethnicity, 1998

Preventive service	Race/ethnicity			
	Black	Hispanic	Asian American	White
Mammogram (age 50 and older)	66	64	--	60
Pap test	73	63	49	64
Colon cancer screening (age 50 and older)	25	22	--	26
Blood cholesterol test	63	45	41	55

-- Sample size was too small for a reliable estimate.
Source: Collins K, Schoen C, Joseph S, Duchon L, Simantov E, Yellowitz M. Health concerns across a woman's lifespan: The Commonwealth Fund 1998 Survey of Women's Health. New York: The Commonwealth Fund; 1999.

Colorectal cancer ranked among the top four cancers in all major racial/ethnic populations in the United States from 1992 through 1998.[25] The United States Preventive Services Task Force (USPSTF) recommends that all people aged 50 and older be screened for colorectal cancer.[xxxii] According to the 1998 Commonwealth Fund Survey, only a quarter of women aged 50 and older received colorectal screening in the past year. Screening is especially crucial for black women, as they experience the highest mortality rates from colorectal cancer.[22]

Counseling by health care providers to promote healthy behaviors is considered an integral component of prevention, as it gives providers the opportunity to influence patients' health behaviors. The 1998 Commonwealth Fund Survey illustrates that counseling is underutilized in women. A majority of women had not been counseled on several of the topics asked about in the survey, including smoking and violence at home. Diet/weight and exercise were the two topics discussed most often with women (Table 9).[31] Hispanic women were most often counseled about these topics. Counseling on these topics may be crucial given the high rates of heart disease and obesity in the Hispanic population. Black women had higher rates of

counseling for almost all topics, while Asian women had significantly lower rates of physician counseling on topics such as diet/weight and sexually transmitted diseases.

Table 9 - Percent of women who had physician counseling on selected topics in the past year by race/ethnicity, 1998

Counseling topic	Race/ethnicity			
	Black	Hispanic	Asian American	White
Smoking	42	31	13	28
Diet and weight	65	42	27	44
Exercise	60	43	40	48
Hormone replacement therapy age 50 and older	27	35	--	40
Importance of calcium intake	41	39	31	41
Use of alcohol/drugs	33	22	8	21
Concerns about safety/violence at home	19	16	5	5
Sexually transmitted diseases	37	29	9	10

-- Sample size was too small for a reliable estimate.
Source: Collins K, Schoen C, Joseph S, Duchon L, Simantov E, Yellowitz M. Health concerns across a woman's lifespan: The Commonwealth Fund 1998 Survey of Women's Health. New York: The Commonwealth Fund; 1999.

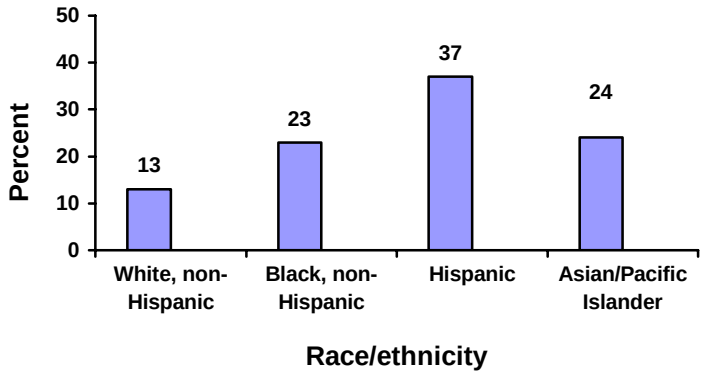
Lack of Health Insurance Coverage

Access to health care services is important for improving the health status among women of color, who tend to have poorer access to health care services than their white counterparts. Twice as many Hispanic and Asian women aged 18 to 64 report having difficulty getting needed care in the past year as do white women of the same age.[31] According to MEPS data, 26.3% of Hispanic women had no usual source of care compared to 14.5% of white women.[6]

The number of uninsured women has steadily increased over the last decade.[4] In 1999, among women aged 18 to 64, 15.1 million women, or 18%, were uninsured.[4] Of those, 84% were women of color.[xxxiii] Hispanic women are most likely to be uninsured with over a third (37%) lacking coverage (Figure 2). Considerably less data exist regarding the number of American Indian/Alaska Native women without health insurance. Although the Indian Health Service (IHS) offers health care services for American Indians/Alaska Natives who belong to a federally

recognized tribe, approximately 23% of American Indian/Alaska Natives were uninsured in 1997.[xxxiv]

Figure 2 - Percent of uninsured women aged 18 to 64 by race/ethnicity, 1999



Source: Misra, D, ed., Women's Health Data Book: A Profile of Women's Health in the United States, 3rd edition. Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation. 2001.

Low-income women, defined as those women with incomes below 200% of the federal poverty level, are especially vulnerable to being without health insurance. Slightly over a third of low-income women (35%) were uninsured in 1998.[xxxv] Low-income women are disproportionately women of color; they are twice as likely to be black and three times more likely to be Hispanic.[35] Low-income Hispanic women have the highest uninsured rate with 51% lacking coverage, followed by 42% of Asian/Pacific Islander women without health insurance coverage.[35]

Conclusion

Women of color make up a growing proportion of all women in the United States and are expected to comprise almost half of U.S. women by 2050. Unfortunately, they bear a disproportionate burden of disease and mortality. Some of the demographic factors that contribute to poorer health status and increased mortality among women of color are less education and higher rates of poverty. A greater proportion of women of color lack health

insurance coverage, which results in limited access to health services, including preventive health services and counseling. These issues must be addressed if the Healthy People 2010 goal of eliminating health disparities among different segments of the population is to be met.

[i] U.S. Bureau of the Census. Profiles of general demographic characteristics: 2000. Washington: The Bureau; 2001.
[ii] U.S. Bureau of the Census. Population by age, sex, race, and Hispanic or Latino origin: 2000. Washington: The Bureau; 2001.
[iii] Day, Jennifer Cheeseman. Population projections of the United States by age, sex, race, and Hispanic origin: 1995 to 2050, U.S. Bureau of the Census, Current Population Reports, P25-1130, U.S. Government Printing Office, Washington, DC, 1996.
[iv] Misra, D, ed., Women's Health Data Book: A Profile of Women's Health in the United States, 3rd edition. Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation. 2001.
[v] U.S. Bureau of the Census. Age, gender, household relationship, race and Hispanic origin – poverty status of people by selected characteristics in 1999: Current Population Survey. Washington: U.S. Department of Labor; 2000.
[vi] Altman BM, Taylor AK. Women in the health care system: health status, insurance, and access to care. Rockville (MD): Agency for Healthcare Research and Quality; 2001.
[vii] Winkleby MA, Kraemer HC, Ahn DK, Varady AN. Ethnic and socioeconomic differences in cardiovascular disease risk factors. JAMA. 1998;280:356-62.
[viii] Centers for Disease Control and Prevention. Prevalence of selected cardiovascular disease risk factors among American Indians and Alaska Natives, United States, 1997. MMWR Morb Mortal Wkly Rpt 2000;49(21):461- 65.
[ix] Centers for Disease Control and Prevention. Cigarette smoking among adults, United States, 1999. MMWR Morb Mortal Wkly Rpt 2001;50(40):869-73.
[x] Eberhardt MS, Ingram DD, Makuc DM, et al. Urban and Rural Health Chartbook. Health, United States, 2001. Hyattsville, Maryland: National Center for Health Statistics. 2001.
[xi] Beckles GLA, Thompson-Reid PE, editors. Diabetes and women's health across the life stages: a public health perspective. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, 2001.
[xii] U.S. Department of Health and Human Services. Physical activity and health: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1996.
[xiii] Schulman KA, Berlin JA, Harless W, Kerner JF, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. New England Journal of Medicine. 1999;340:618-26.
[xiv] Canto JG, Allison JJ, Kiefe CI, Fincher C, et al. Relation of race and sex to the use of reperfusion therapy in Medicare beneficiaries with acute myocardial infarction. New England Journal of Medicine. 2000;342:1094-100.
[xv] The Office on Women's Health, U.S. Department of Health and Human Services. Diabetes and Hispanic American women. April 2001. Available at: www.4woman.gov/faq/diabetes-hispanic.htm. Accessed November 1, 2001.
[xvi] The Office on Women's Health, U.S. Department of Health and Human Services. Diabetes and African American women. December 2000. Available at: www.4woman.gov/faq/diabetesafrc.htm. Accessed November 1, 2001.
[xvii] Hoyert DL, Arias E, Smith BL, Murphy SL, Kochanek KD. Deaths: final data for 1999. Natl Vital Stat Rep 2001;49:1-114.
[xviii] The Office on Women's Health, U.S. Department of Health and Human Services. Diabetes and American Indian/Alaska Native Women. 2001. Available at: www.4woman.gov/faq/diabetes-native-american.htm. Accessed November 1, 2001.
[xix] National Institutes of Health. Addressing cardiovascular health in Asian Americans and Pacific Islanders: a background report. U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 2000.
[xx] National Institutes of Health. Building healthy hearts for American Indians and Alaska Natives: a background report. U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute, 1998.
[xxi] American Cancer Society. Cancer facts and figures, 2001. Atlanta: The Society; 2001.
[xxii] Ries LAG, Eisner MP, Kosary CL, Hankey BF, Miller BA, Clegg L, Edwards BK (eds). SEER Cancer Statistics Review, 1973-1998, National Cancer Institute. Bethesda, MD, 2001.

[xxiii] Committee on Cancer Research Among Minorities and the Medically Underserved, Institute of Medicine. The unequal burden of cancer: an assessment of NIH research and programs for ethnic minorities and the medically underserved. Washington: National Academy Press; 1999.

[xxiv] American Cancer Society. Cancer facts and figures for Hispanics, 2000-2001. Atlanta: The Society; 2001.

[xxv] Howe HL, Wingo PA, Thun MJ, Ries LAG, Rosenberg HM, Feigal EG, Edwards BK. Annual report to the Nation on the status of cancer (1973 through 1998), featuring cancers with recent increasing trends. Journal of the National Cancer Institute. 2001;93:824-42.

[xxvi] Miller BA, Kolonel LN, Bernstein L, Young, Jr. JL, Swanson GM, West D, Key CR, Liff JM, Glover CS, Alexander GA, et al. (eds). Racial/ethnic patterns of cancer in the United States 1988-1992, National Cancer Institute. Bethesda, MD, 1996.

[xxvii] Sherbourne CD, Dwight-Johnson M, Klap R. Psychological distress, unmet need, and barriers to mental health care for women. Women's Health Issues. 2001;11(3):231-43.

[xxviii] Henry J. Kaiser Family Foundation. Key Facts: Women and HIV/AIDS. Washington: The Foundation, 2001.

[xxix] Anderson RN. Deaths: leading causes for 1999. Natl Vital Stat Rep. 2001;49:1-88.

[xxx] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2000;12(No. 2):1-48.

[xxxi] Collins K, Schoen C, Joseph S, Duchon L, Simantov E, Yellowitz M. Health concerns across a woman's lifespan: The Commonwealth Fund 1998 Survey of Women's Health. New York: The Commonwealth Fund; 1999.

[xxxii] U.S. Preventive Services Task Force. Guide to clinical preventive services, 2nd Edition. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 1996.

[xxxiii] Henry J. Kaiser Family Foundation. Women's Health Insurance Coverage. Fact Sheet. Menlo Park (CA): The Foundation; 2001.

[xxxiv] The Office on Women's Health, U.S. Department of Health and Human Services. Health care access and American Indian/Alaska Native women. 2001. Available at: www.4woman.gov/faq/hca-na.htm#2. Accessed November 27, 2001.

[xxxv] Wyn R, Solis B, Ojeda V, Pourat N. Falling through the cracks: health insurance coverage of low-income women. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2001.