

CONCLUSION

This report finds racial and ethnic disparities in health status and health care in every state in the nation, often disparities that are quite stark. It not only adds to the chorus of research that documents the disparities faced by women of color, particularly African American, Hispanic, and American Indian and Alaska Native women, it also documents the magnitude of these disparities for a broad range of indicators in all 50 states.

Several crosscutting themes emerge from the findings of this report. The first is that women of color fare consistently less well than White women across a broad range of measures in almost every state, and in some states these disparities are striking. African American women and American Indian and Alaska Native women in particular face many challenges, but Hispanic women also fare considerably more poorly than White women in almost all states. Second, there is considerable variation across the nation in the experiences of women of color in terms of their health and the factors that affect their health and their ability to access quality care. Minority women in some states are doing much better than their counterparts in other states; however, even in states where minority women fare better, they usually have higher rates of health conditions, experience more problems gaining access to care, and face social and economic challenges at higher rates than White women. Third, in states where disparities appear to be lower, this difference is sometimes due to the fact that White and minority women are doing equally poorly, not that minority women are doing better. Thus, it is important to recognize that in some states women of all races and ethnicities, including White women, face significant challenges.

STATE-LEVEL HIGHLIGHTS

Disparities existed in every state on most measures. Women of color fared worse than White women across a broad range of measures in almost every state, and in some states these disparities were quite stark. Some of the largest disparities were in the rates of new AIDS cases, late or no prenatal care, no insurance coverage, and lack of a high school diploma.

- **In states where disparities appeared to be smaller, this difference was often due to the fact that both White women and women of color were doing poorly.** It is important to also recognize that in many states (e.g. West Virginia and Kentucky) all women, including White women, faced significant challenges and may need assistance.

Few states had consistently high or low disparities across all three dimensions. Virginia, Maryland, Georgia, and Hawaii all scored better than average on all three dimensions. At the other end of the spectrum, Montana, South Dakota, Indiana, and several states in the South Central region of the country (Arkansas, Louisiana, and Mississippi) were below average on all dimensions.

States with small disparities in access to care were not necessarily the same states with small disparities in health status or social determinants. While access to care and social factors are critical components of health status, our report indicates that they are not the only critical components. For example, in the District of Columbia, disparities in access to care were better than average, but the District had the highest disparity scores for many indicators of health and social determinants.

Regional variation across and within dimensions was evident. Many states in the Pacific Region were classified with better-than-average levels of disparities for both the health status and social determinants dimensions. Their scores on the access and utilization dimension, however, showed average or worse-than-average levels of disparities. Three states in the South Central region of the country scored worse than average across all three dimensions, and nearly all scored worse than average on two dimensions. Finally, the Mountain states, which have large populations of American Indian and Alaska Natives compared to other regions of the country, all had worse-than-average disparities on access and utilization.

POPULATION HIGHLIGHTS

Each racial and ethnic group faced its own particular set of health and health care challenges.

- **The enormous health and socioeconomic challenges that many American Indian and Alaska Native women faced was striking.** American Indian and Alaska Native women had higher rates of health and access challenges than women in other racial and ethnic groups on several indicators, often twice as high as White women. Even on indicators that had relatively low levels of disparity for all groups, such as number of days that women reported their health was “not good,” the rate was markedly higher among American Indian and Alaska Native women. The high rate of smoking and obesity among American Indian and Alaska Native women was also notable. This pattern was generally evident throughout the country, and while there were some exceptions (for example, Alaska was one of the best states for American Indian and Alaska Native women across all dimensions), overall the rates of health problems for these women were alarmingly high. Furthermore, one-third of American Indian and Alaska Native women were uninsured or had not had a recent dental checkup or mammogram. They also had considerably higher rates of utilization problems, such as not having a recent checkup or Pap smear, or not getting early prenatal care.
- **For Hispanic women, access and utilization were consistent problems, even though they fared better on some health status indicators.** A greater share of Latinas than other groups lacked insurance, did not have a personal doctor/health care provider, and delayed or went without care because of cost. Latina women were also disproportionately poor and had low educational status, factors that contribute to their overall health and access to care. Because many Hispanic women are immigrants, many do not qualify for publicly funded insurance programs like Medicaid even if in the U.S. legally, and some have language barriers that make access and health literacy a greater challenge.
- **Black women experienced consistently higher rates of health problems.** At the same time they also had the highest screening rates of all racial and ethnic groups. There was a consistent pattern of high rates of health challenges among Black women, ranging from poor health status to chronic illnesses to obesity and cancer deaths. Paradoxically, fewer Black women went without recommended preventive screenings, reinforcing the fact that health outcomes are determined by a number of factors that go beyond access to care. The most striking disparity was the extremely high rate of new AIDS cases among Black women.
- **Asian American, Native Hawaiian and Other Pacific Islander women had low rates of some preventive health screenings.** While Asian American, Native Hawaiian and Other Pacific Islander women as a whole were the racial and ethnic group with lowest rates of many health and access problems, they had low rates of mammography and the lowest Pap test rates of all groups. However, their experiences often varied considerably by state.
- **White women fared better than minority women on most indicators, but had higher rates of some health and access problems than women of color.** White women had higher rates of smoking, cancer mortality, serious psychological distress, and no routine checkups than women of color.

Within a racial and ethnic group, the health experiences of women often varied considerably by state. Though this report did not statistically test whether a specific racial and ethnic group differed across states, there were notable patterns within racial and ethnic groups. In some states, women of a particular group did quite well compared to their counterparts in other states. However, even in states where a minority group did well, they often had worse outcomes than White women.

INDICATOR AND POLICY HIGHLIGHTS

The AIDS epidemic is strongly concentrated among women of color, particularly Black women. The disparity score for new AIDS cases was striking and the starkest among all indicators studied in this report. With a national disparity score of 11.58, the disparity was nearly four times higher than any other indicator. While all women are affected by AIDS, this burden has fallen heaviest on Black women. The epidemic has also had a disproportionate effect on Latinas and American Indian and Alaska Native women. Policies that support HIV/AIDS prevention and treatment programs for women are greatly needed to reduce this disparity.

Smoking and obesity are major challenges that put the health of women at risk. Nationally, over one-fifth of all women were smokers and one-fifth were obese. These are both known risk factors for a wide range of chronic illnesses. Obesity was highest among Black women, and smoking was highest among American Indian and Alaska Native women, with high smoking rates among White women as well. Smoking rates have declined over time, but rates are still high across the nation. Though states face different degrees of challenges on these public health indicators, attention to and support of programs to address smoking, diet, and exercise across the board could have ripple effects in reducing the disparities in chronic diseases, such as diabetes and cardiovascular disease.

Women of color, most notably large shares of Latinas and American Indian and Alaska Native women, were most likely to be uninsured. States have many tools at their disposal to improve access to care for women in need. These tools include expanding Medicaid eligibility, adjusting provider reimbursement levels, and increasing state funding for family planning. Though Medicaid eligibility thresholds have been expanded for pregnant women, relatively few states have comparable access expansions to Medicaid for working parents or poor adults without children, leaving many low-income women uninsured.

Problems with access to care, particularly primary care, are evident throughout the nation. Many women live in areas with a shortage of health care providers. Having a usual source of care has been shown to promote access to health care services and increases the likelihood that individuals receive recommended screening and preventive services. Furthermore, building a diverse and adequate supply of providers is important for providers' understanding of, and responsiveness to, the particular issues that many communities of color face.

There were stark racial and ethnic disparities on many social determinants. A higher share of women of color than White women were poor, lacked a high school diploma, and bore family responsibilities on their own. On economic indicators, Black, Latina, and American Indian and Alaska Native women had median incomes half that of White women and poverty rates that were twice as high. Income and education are factors that are integral to a woman's health and well-being, and investments in these areas are likely to have positive implications for women of color.

Many states have adopted policies that make women's access to the full range of reproductive and health services challenging. Access to reproductive services, including family planning, abortion, and maternity care, is important for women in their child-bearing years. Many low-income women rely on publicly funded reproductive health and family planning services, of which Medicaid is a major payer. However, in many states, provider participation in Medicaid is limited, due, in part, to low reimbursement rates. State policies in financing and coverage can play a major role in improving women's access to reproductive care.



Putting Women's Health Care Disparities on the Map documents the persistence of disparities between women of different racial and ethnic groups in states across the country and on multiple dimensions: health status, access and utilization, and social determinants. This report demonstrates the importance of looking beyond national statistics to better understand, at the state level where challenges are greatest, and to help shape policies that can ultimately eliminate these gaps. It also highlights some of the policy areas for which states have authority that could make a difference women's health and access to health care. State-level policies often reflect the particular demographics, traditions, and larger political climate of the state.

Financing, delivery system, and reproductive health policies all have an underlying role in the indicators that are examined in this study. For example, coverage is a critical factor in health care access. For millions of low-income women, Medicaid provides a vital link to the health system and obtaining care. As the country's economic conditions continue to decline, particularly with rising unemployment, the demand for Medicaid programs increases. At the same time, state revenues are decreasing and policymakers may consider changes to the program to offset shortfalls, but need to carefully consider the impact of their decisions on the very low-income populations that the program serves.

There is a growing consensus that the country will face critical shortages in primary care, and for some parts of the country shortages already exist. For many women, their primary care provider is their first point of contact with the health care system. A shortage in primary care providers can impede a woman's ability to detect, minimize and manage health problems, and to obtain timely care when needed. State policies can have a direct impact on the availability of providers, the willingness of providers to see certain patients, and the availability of comprehensive services. This is particularly true of reproductive health services such as family planning and abortion, and of providers' willingness to treat Medicaid and Medicare recipients.

More than a decade after the Surgeon General's call to eliminate health disparities, the data in this report underscore that overcoming these significant and long-standing disparities in women's health remains a formidable challenge. As states and the federal government consider options to reform the health care system in the coming years, efforts to eliminate disparities will also require an ongoing investment of resources from multiple sectors that go beyond coverage and include strengthening the health care delivery system, improving health education efforts, and expanding educational and economic opportunities for women. Through these broad-scale investments we can improve not only the health of women of color, but the health of all women in the nation.