EXECUTIVE SUMMARY

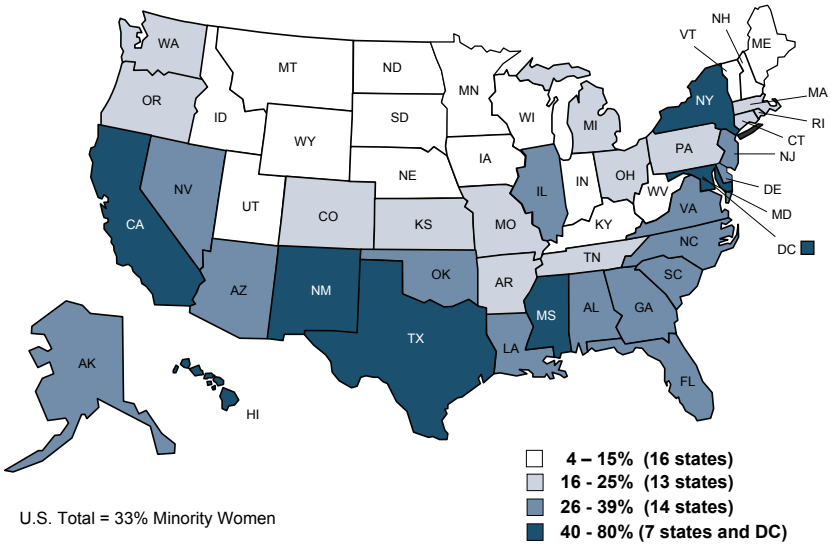
Nationally, one-third of women self-identify as a member of a racial or ethnic minority group and it is estimated that this share will increase to more than half by 2045.[1] The distribution of the population of women of color varies substantially by state (Figure A). As the country becomes more racially and ethnically diverse, understanding racial and ethnic disparities in health status and access to care has become a higher priority for many policymakers, researchers, and advocacy groups. There is also a growing recognition that problems differ geographically and effective solutions will need to address these challenges at federal, state, and local levels.

Much of what is currently known about racial and ethnic disparities is drawn from national information sources and combines both sexes. These data often mask many of the differences in state economics, policies, and demographics that shape health and health care. Furthermore, when available, most state-level data on health disparities do not examine men and women separately, despite the large body of evidence of sex and gender differences in both the prevalence of health conditions and the use of health services. Women have unique reproductive health care needs, have higher rates of chronic illnesses, and are greater users of the health care system. In addition, women take the lead on securing health care for their families and have lower incomes than men, both of which affect and shape their access to the health system.

Health is shaped by many factors, from the biological to the social and political. In order to improve women's health, it is critical to measure more than just the physical outcomes. This report, *Putting Women's Health Care Disparities on the Map*, provides new information about how women fare at the state level by assessing the status of women in all 50 states and the District of Columbia. Given the major role that insurance plays in so many areas of health and access to care, we limited the study to adult women before they reach the age for Medicare eligibility and focus on nonelderly women 18 to 64 years of age. For each state, the magnitude of the racial and ethnic differences between White women and women of color was analyzed for 25 indicators of health and well-being grouped in three dimensions—health status, access and utilization, and social determinants. The report also examines key health care payment and workforce issues that help to shape access at the state level. These indicators were selected based on criteria that included both the relevancy of the indicator as a measure of women's health and access to care, and the availability of the data by state. The national rates for these 25 indicators are evidence of the considerable racial and ethnic disparities that exist across the nation (Table A).

In this report, we refer to racial and ethnic differences as health disparities, but recognize that others may call them health inequities or health inequalities. We also recognize the variety of opinions regarding whether to refer to women as Black or African American, Hispanic or Latina, women of color or minorities. In this report we use these and other terms interchangeably. The differences in terminology, however, do not affect the central aim of this report: to understand not only how the health experiences of women of particular racial and ethnic groups differ across the nation, but also how the broad range of women's experiences differ by state.

FIGURE A. Proportion of Women Who Self-Identify as a Racial and Ethnic Minority, by State, 2003–2005



Source: Kaiser Family Foundation analysis of population estimates from U.S. Census Bureau.

Analysis of the data by state is also key in identifying how the broad range of women's experiences differ geographically. The report uses two metrics to describe the experiences of women of color relative to White women. It presents a *disparity score* for each indicator, a measure that captures the extent of the disparity between White women and women of color in the state and the U.S. overall, and a state *dimension score* for each of the three dimensions, a measure that rates each state as better than average, average, or worse than average based on how its dimension score compared to the national average.

TABLE A. National Averages and Rates of Indicators, by Race/Ethnicity

Health Status	All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
Fair or Poor Health	12.8%	9.5%	19.7%	16.9%	26.9%	7.9%	22.1%
Unhealthy Days (mean days/month)	7.3	7.2	7.3	7.6	7.4	5.5	10.5
Limited Days (mean days/month)	3.5	3.2	3.9	4.3	3.8	2.7	6.2
Diabetes	4.2%	3.3%	6.2%	7.5%	6.1%	3.2%	8.6%
Heart Disease	3.2%	2.7%	3.9%	4.8%	4.0%	1.2%	8.7%
Obesity	22.7%	20.1%	28.4%	37.8%	27.3%	8.4%	30.4%
Smoking	21.9%	24.7%	14.6%	18.7%	11.5%	8.4%	35.7%
Cancer Mortality/100,000 women	162.2	161.4	--	189.3	106.7	96.7	112.0
New AIDS Cases/100,000 women	9.4	2.3	26.4	50.1	12.4	1.8	7.0
Low-Birthweight Infants	8.1%	7.2%	9.9%	13.8%	6.8%	7.9%	7.4%
Serious Psychological Distress	15.7%	16.7%	13.8%	13.5%	14.1%	9.6%	26.1%
Access and Utilization							
No Health Coverage	17.7%	12.8%	27.9%	22.4%	37.3%	18.2%	33.7%
No Personal Doctor	17.5%	13.2%	25.7%	17.3%	36.9%	18.9%	21.1%
No Checkup in Past 2 Years	15.9%	16.7%	13.6%	8.1%	18.3%	14.4%	19.4%
No Dental Checkup in Past 2 Years	28.7%	25.4%	36.4%	35.9%	41.5%	25.1%	35.0%
No Doctor Visit Due to Cost	17.5%	14.7%	22.8%	21.9%	27.4%	12.1%	25.7%
No Mammogram in Past 2 Years	25.5%	24.9%	27.1%	24.1%	28.8%	29.2%	33.5%
No Pap Test in Past 3 Years	13.2%	12.2%	15.5%	11.0%	16.3%	24.1%	18.2%
Late Prenatal Care	16.2%	11.1%	22.7%	23.9%	22.9%	14.7%	30.1%
Social Determinants							
Poverty	16.4%	11.9%	25.8%	28.5%	27.4%	15.0%	32.8%
Median Household Income	$45,000	$54,536	$30,000	$26,681	$27,748	$52,669	$24,000
Gender Wage Gap	69.2%	73.3%	60.8%	61.1%	50.9%	77.4%	56.5%
No High School Diploma	12.4%	7.3%	22.8%	14.9%	35.8%	10.9%	18.1%
Single Parent Household	22.1%	17.4%	29.6%	45.0%	23.0%	9.2%	32.9%
Residential Segregation†	--	--	0.30	0.38	0.29	0.31	--

Note: *All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.
†Residential Segregation is reported as the proportion of the population that would need to move in order for full integration to exist.

KEY FINDINGS

Our analysis suggests that while women of color in the U.S. are resilient in a number of respects, they continue to face many health and socioeconomic challenges. The racial and ethnic and gender inequalities that are endemic throughout our society are also strongly reflected in key findings of this report:

- **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 far 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.

- **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 the 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.** 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.

DIMENSION HIGHLIGHTS

In addition to the key findings discussed above, *Putting Women's Health Care Disparities on the Map* also illustrates racial and ethnic and geographic patterns within each of the three dimensions: Health Status, Access and Utilization, and Social Determinants. Highlights, including which states had the highest and lowest disparity scores for each indicator, are presented below. Disparity scores approaching 1.00 indicate that White and minority women have similar outcomes in a state; both groups can be doing well, or both can be doing poorly.

HEALTH STATUS DIMENSION

The health status dimension examined in this report includes 11 indicators of health behaviors and outcomes, all of which are directly or indirectly related to the health care access and social indicators assessed in this report (Table B). Many of the indicators are leading causes of death and disability in women.

TABLE B. Highest and Lowest Health Status Indicator Disparity Scores

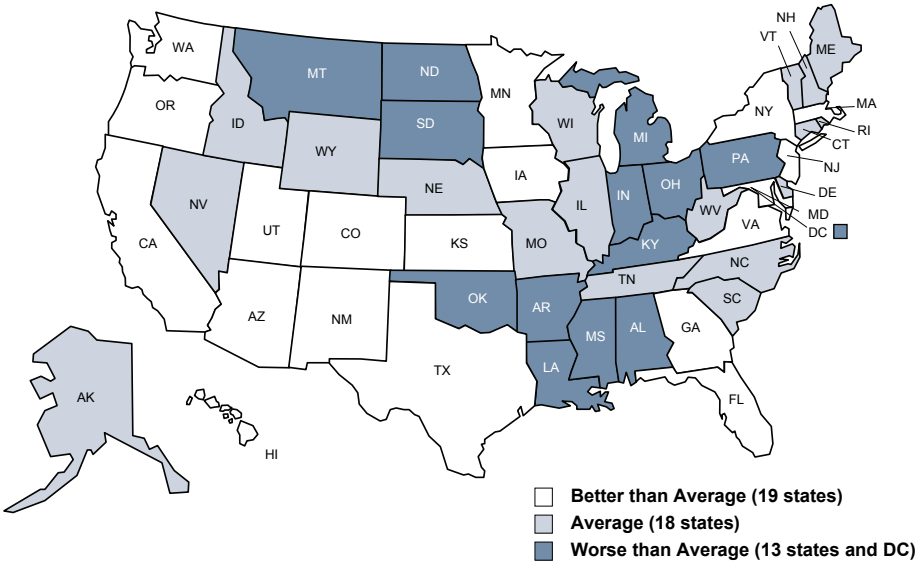
Indicator	U.S. Disparity Score	Highest Disparity State		Lowest Disparity State	
		State	Disparity Score	State	Disparity Score
Fair or Poor Health	2.07	DC	4.20	WV	0.86
Unhealthy Days	1.01	DC	1.38	WV	0.82
Limited Days	1.21	ND	2.49	TX & WV	0.92
Diabetes	1.87	DC	7.37	ME	0.83
Heart Disease	1.46	DC	5.40	WY	0.75
Obesity	1.41	DC	4.68	ME	0.97
Smoking	0.59	SD	1.98	FL	0.39
Cancer Mortality	0.86	ME	2.14	NV	0.60
New AIDS Cases	11.58	MN	36.98	MT	0.00
Low-Birthweight Infants	1.38	DC	2.18	WY	0.97
Serious Psychological Distress	0.83	ND	1.66	TN	0.50

States in the South Central, Mountain, and Midwest areas tended to have larger disparities compared to the national average. States are highlighted on the map based on their health status dimension scores of better than average, average, or worse than average (Figure B).

While the worse-than-average dimension scores in the South Central parts of the U.S. were driven largely by disparities between White and Black women, the worse-than-average scores of the Mountain states were due in part to the large differences between White and American Indian and Alaska Native women.

In much of the West, including Utah, Washington, Hawaii, Oregon, Colorado, Arizona, and California, disparities were lower than the national average, as reflected by their better-than-average dimension scores.

FIGURE B. Health Status Dimension Scores, by State



In order to get a fuller picture of how the health of women of color compares with the health of White women, it is also important to examine the individual indicators which constitute the health status dimension score (Table B). This provides information on specific conditions that would benefit from policy intervention at the state level to reduce disparities.

New AIDS cases and self-reported fair or poor health were the indicators with the highest disparity scores. For fair or poor health, women of color had rates that were more than twice that of White women, and for new AIDS cases, the average rate for women of color was 11 times that of White women.

The District of Columbia had the highest disparity score on 6 of the 11 indicators. This is likely related to the large inequalities associated with socioeconomic conditions of women in D.C. At the other end of the spectrum, West Virginia had the lowest disparity score on 3 of the 11 indicators—a finding related to the fact that women of color and White women had similarly poor rates for health indicators, rather than low rates of problems for both groups.

ACCESS AND UTILIZATION DIMENSION

The access and utilization dimension of the report focused on eight indicators that measure a woman's ability to obtain timely care and use of preventive services (Table C). These indicators are widely used markers of potential barriers to care.[2]

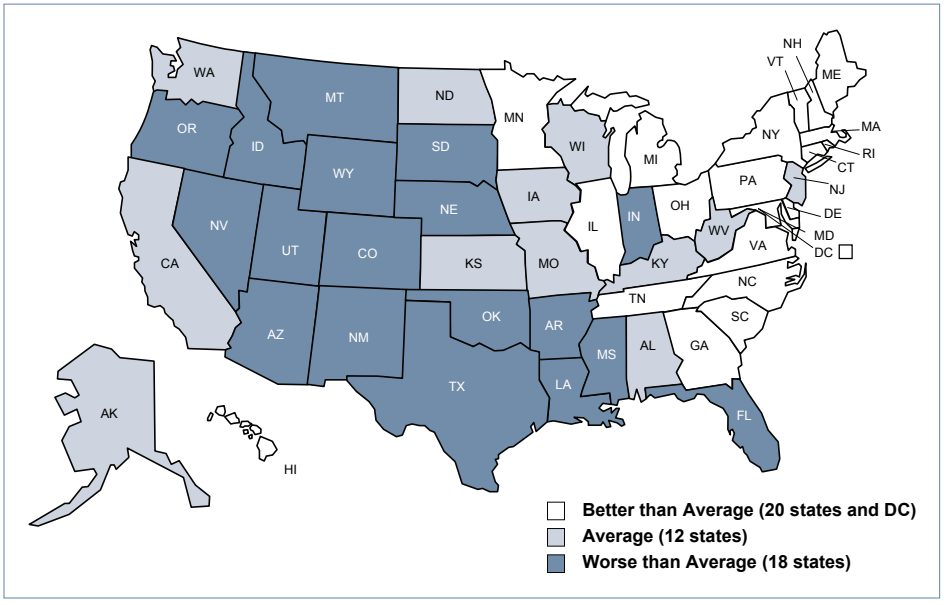
TABLE C. Highest and Lowest Access and Utilization Indicator Disparity Scores

Indicator	U.S. Disparity Score	Highest Disparity States		Lowest Disparity States	
		State	Disparity Score	State	Disparity Score
No Health Coverage	2.18	ND	4.59	HI	0.92
No Personal Doctor	1.94	IA	2.86	HI	0.65
No Checkup in Past 2 Years	0.82	TX	1.29	DC	0.39
No Dental Checkup in Past 2 Years	1.43	MA	1.80	WV	0.93
No Doctor Visit Due to Cost	1.55	WI	2.43	HI	0.81
No Mammogram in Past 2 Years	1.09	IA	1.59	TN	0.78
No Pap Smear in Past 3 Years	1.27	MA	2.08	ME	0.66
Late Prenatal Care	2.04	DC	3.04	HI	1.39

The majority of states on the East Coast and in the Midwest had better than average (i.e., had smaller disparity) dimension scores for access and utilization (Figure C). In contrast, the Gulf Coast southern states, the Mountain states, and a number of western states scored worse than average (i.e., had greater disparity).

The indicators that constitute the access and utilization dimension score are useful in understanding specific health care challenges facing states (Table C). For two of the indicators—not having a checkup and not having a mammogram—there was little or no disparity nationally, which was reflected in disparity scores below or close to 1.00. The higher rates for women of color getting a routine checkup were largely driven by the fact that Black women got a routine checkup at almost twice the rate of Whites. The largest disparities nationally were for no health coverage, no regular provider,

FIGURE C. Access and Utilization Dimension Scores, by State



and late initiation of prenatal care, where women of color had rates that were about double those of White women, and consequently, had disparity scores that neared 2.00 or higher.

Disparity scores varied considerably by state, reflecting, in part, patterns of access and utilization by specific racial and ethnic groups. In North Dakota, for example, the state with the largest disparity score for no health insurance, American Indian and Alaska Native women, the predominant population of color, had uninsured rates that were more than five times the rate of White women. In the District of Columbia, which had the highest disparity score for late prenatal care, African American and Hispanic women are the major population groups of color and had rates of late prenatal care three times that of White women. Hawaii had the lowest disparity scores on four of the eight indicators. This finding was largely driven by Asian American, Native Hawaiian and Other Pacific Islander women, who had patterns of health care access that were either better than or did not differ greatly from Whites in the state.

SOCIAL DETERMINANTS DIMENSION

There is growing evidence that social factors (e.g., income, education, occupation, neighborhoods, and housing) are associated with health behaviors, access to health care, and health outcomes. Six indicators of these factors are examined in this report (Table D). Examining the individual indicators which make up the social determinants dimension score provides important information about areas in which policy intervention may be warranted to reduce racial and ethnic health disparities.

Few regional patterns were found in the social determinants dimension (Figure D). Many of the Gulf states (Texas Louisiana, Mississippi), states in the Rust Belt (Indiana, Wisconsin, Ohio), and northern Mountain states with large American Indian and Alaska Native populations (South Dakota, Montana) had worse-than-average dimension scores. In contrast, New Hampshire, Hawaii, Vermont, Washington, and Delaware had better-than-average scores and among the lowest disparities in this dimension.

In almost every state and every social determinant measure, women of color fared worse than White women (Table D). Unlike in the health status and access dimensions, there were no indicators in this dimension for which minority women had lower national prevalence rates than White women, and thus all U.S. disparity scores were above 1.00. The highest disparity scores were found for no high school diploma, poverty, and median household income, and the relatively lower disparity scores were for the gender wage gap and single-parent, female-headed households.

TABLE D. Highest and Lowest Social Determinants Indicator Disparity Scores

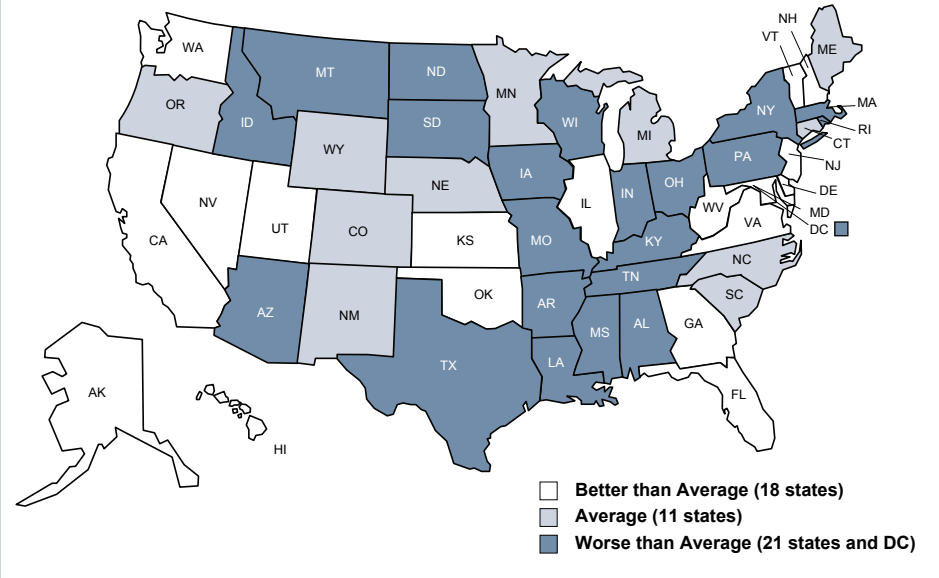
Indicator	U.S. Disparity Score	Highest Disparity States		Lowest Disparity States	
		State	Disparity Score	State	Disparity Score
Poverty	2.18	SD	4.09	WV	1.41
Median Household Income	1.82	MT	2.58	NH	1.14
Gender Wage Gap	1.21	DC	1.55	WV	0.93
No High School Diploma	3.11	DC	11.76	WV	0.63
Single Parent Household	1.70	DC	4.79	NH	0.82
Residential Segregation*	0.30	DC	0.75	AZ	0.08

Note: *Residential Segregation is reported as the proportion of the population that would need to move in order for full integration to exist. This is not a disparity score.

The economic and educational disparities between White women and most women of color were particularly stark. Poverty rates for Black, Hispanic, and American Indian and Alaska Native women were 2.5 to 3.0 times higher than those for White women, median income among these groups was roughly half that of White women, and the percentage without a high school diploma was also much higher. The major exception was for Asian American, Native Hawaiian and Other Pacific Islander women, who were both economically and educationally on a par with, and sometimes better off than, White women.

The District of Columbia had the highest disparity score on three of the five indicators, as well as neighborhood segregation. The proportion of women of color in the District of Columbia who lacked a high school diploma was more than 11 times that of White women. In contrast, either New Hampshire or West Virginia had the lowest disparity score for all five indicators for which disparity scores were calculated. West Virginia's low disparity scores were largely driven by the high rates of disadvantage faced by both minority and White women. In New Hampshire, however, minority and White women had rates that met, or exceeded, the national average on most indicators. Notably, both states had relatively small populations of minority women. Arizona was the state with the least segregated population.

FIGURE D. Social Determinants Dimension Scores, by State



CONCLUSIONS

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. More than a decade after the Surgeon General's call to eliminate health disparities, the data in this study underscore the work that still remains.

While the data provide evidence of disparities in women's health in every state across the nation, the indicators in this report are affected by a broad range of factors, including state-level policies. This report brings to light the intersection of major health policy concerns, women's health, and racial and ethnic disparities. National and state policy discussions on issues such as covering the uninsured, health care costs, and shoring up the primary care workforce all have implications for women's health and access, though they are often not viewed with that lens. Policies on health care workforce, financing, and reproductive health have both direct and indirect impacts on women's health and access to care. These policies establish the context for the operation of the private health care marketplace, the role of public payers and providers, and, ultimately, women's experiences in the health care system. Compared to men, women have lower incomes to meet rising health care costs, are more reliant on public programs such as Medicaid, have higher rates of chronic conditions, and are more likely to be raising children alone. Women of color also have lower incomes, are more likely to be on Medicaid, and higher rates of illness than White women, and therefore have much at stake in policy decisions. Moreover, state policies regarding coverage for reproductive health services, such as family planning and abortions, have direct impacts on meeting women's unique reproductive health needs.

These are a just a few of the areas that have important consequences for women's health and access. State policymakers make key decisions that shape health care financing, access, and infrastructure, and are often able to enact policies with more efficiency and expediency than the federal government. This report highlights disparities in some of the key areas where states have authority. As the country's economic conditions continue to decline, state budgets may also get tighter, and policymakers will need to carefully consider how their decisions may affect communities of color.

This report demonstrates the importance of looking beyond national statistics to the state level to gain a better understanding of where challenges are greatest or different, and to determine how to shape policies that can ultimately eliminate racial and ethnic disparities. 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.

DATA

The data in this report are drawn from several sources. The primary data sources for the indicators were the Behavioral Risk Factor Surveillance System (BRFSS) and the Current Population Survey (CPS), combining years 2004–2006 for both data sources, which represented the most recent data at the time the project began, and the base years for most of the sources of data.

This report also presents state-level data on eight state policies regarding Medicaid, reproductive health, and health care workforce availability. These indicators, providing a context to help understand some of the disparity scores in the other dimensions, were drawn from a number of sources including the Area Resource File and the National Governors' Association.

DEFINITIONS

The **disparity score** for each indicator describes how minority women in a state fare relative to the average non-Hispanic White woman in the same state. A disparity score of 1.00 indicates no disparity between women of color and White women; scores of greater than 1.00 indicate that minority women were experiencing health problems, health care barriers, or socioeconomic disadvantages at rates higher than White women. A score of less than 1.00 which indicates that more White than minority women experienced a problem.

The **dimension score** for the state is a summary measure that captures the average of the indicator disparity scores in each of the areas of health, access, and social determinants, after adjusting for the prevalence of the indicators for White women in the state relative to White women nationally. States were categorized as better than average, average, or worse than average by comparing their dimension score to the national average.

[1] Census Bureau. National Population Projections. Projections of the Population by Sex, Race, and Hispanic Origin for the United States: 2010 to 2050, http://www.census.gov/population/www/projections/summarytables.html (accessed 24 November 2008).

[2] U.S. DHHS, Agency for Healthcare Research and Quality, *National Healthcare Disparities Report 2007*, February 2008.