ISSUE BRIEF
AN UPDATE ON WOMEN'S HEALTH POLICY
THE HENRY J. KAISER FAMILY FOUNDATION

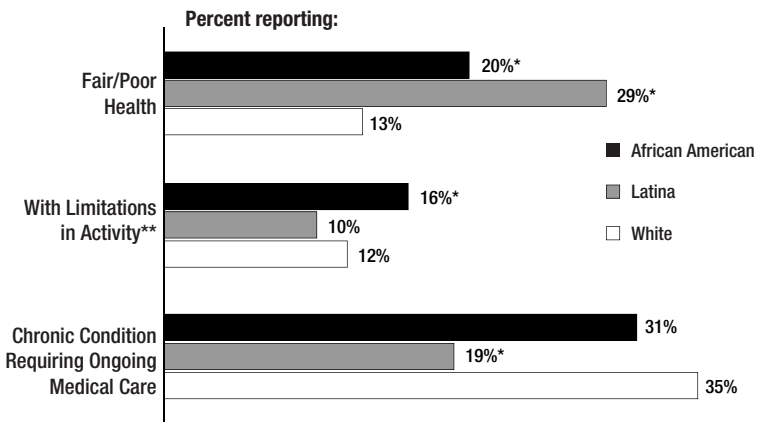
March 2004

Racial and Ethnic Disparities in Women's Health Coverage and Access To Care
Findings from the 2001 Kaiser Women's Health Survey

Attention to racial and ethnic differences in health status and access to care has increased markedly during the past decade. On many measures of health status and access to care, it has been documented that communities of color fare worse than whites.[1] The concerns facing women of color are further complicated by the differential access and use patterns evident between men and women.[2]

Using data from the *2001 Kaiser Women's Health Survey*, a nationally representative survey of nearly 4,000 women between the ages of 18 to 64, this issue brief explores racial and ethnic disparities in health care among women. These data provide new information on differences in health status, health insurance coverage, and selected measures of access to care across three racial/ethnic groups of women: African American, Latina, and white.[3] The findings raise several important areas for consideration in efforts to eliminate health disparities.

FIGURE 1
Differences in Health Status, by Race/Ethnicity



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
** Limitations in activity are due to a disability, handicap, or chronic disease that keeps respondents from participating fully in school, work, housework, or other activities.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Differences in health status

There are some notable differences in health status between white women and women of color, particularly African Americans (Figure 1).

- Women of color are more likely to report that they are in fair or poor health. One-fifth of African American women, 29% of Latinas, and 13% of white women assess their health status as fair or poor.
- African American women are more likely to have a physical condition that limits routine activities such as participating in school or work or conducting daily housework.
- Despite their reports of poorer health status, Latinas are actually less likely to report that they have a chronic condition in need of ongoing care.

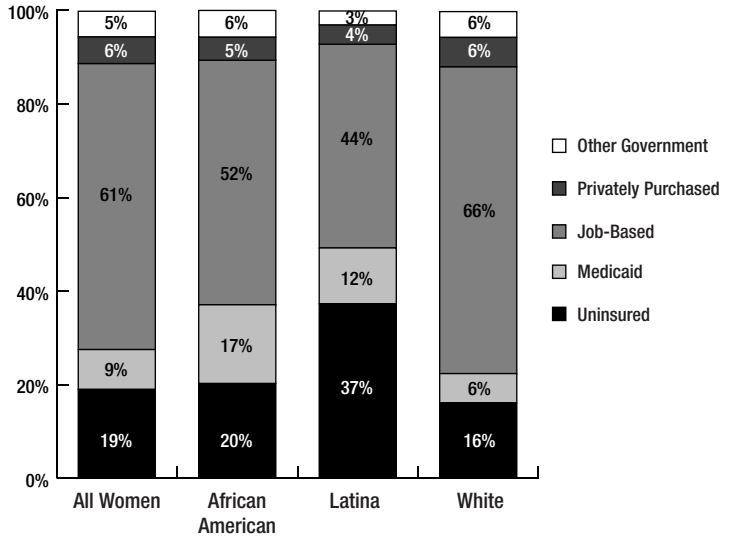
Incidence of chronic illnesses also varies for women by race and ethnicity.

- Over half (57%) of African American women ages 45 to 64 have been diagnosed with hypertension, twice the rate for white women (28%) of the same age. African American women (40%) are also significantly more likely to have arthritis than Latinas (33%) and white women (32%).
- African American (16%) and Latina (17%) women both experience higher prevalence of diabetes compared to white women (9%).
- However, African American women (4%) are less likely to have osteoporosis compared to Latinas (12%) and white women (10%).
- Overall, one-quarter of women have been diagnosed with depression or anxiety. There is little variation in reported rates between different racial and ethnic subgroups.

Differences in Health Insurance Coverage

Health insurance coverage rates and sources of coverage vary considerably among populations of women (Figure 2). Type of coverage is largely determined by employment status and income, with Latinas and African American women more likely to be low-income and have more restricted access to job-based coverage.[4,5]

FIGURE 2
Health Insurance Coverage by Race/Ethnicity



Note: Includes women ages 18 to 64.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

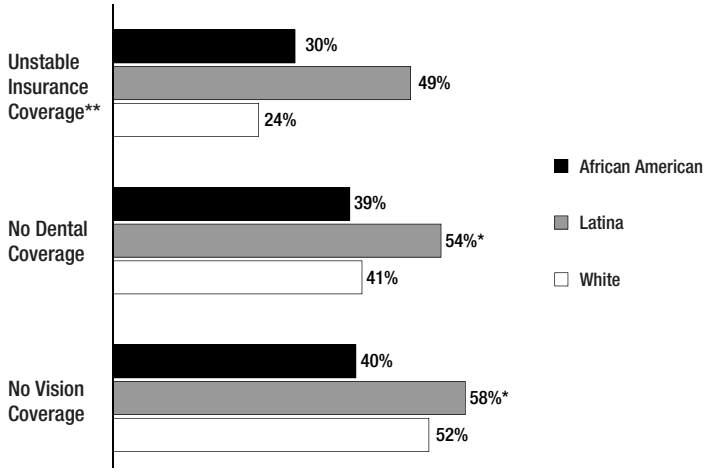
- More than one-third of Latinas are uninsured (37%), over twice the rate of white women (16%). African American women are also more likely to be uninsured (20%) than white women. The higher rates of uninsurance among women of color are related to lower rates of job-based coverage. [6]

- Four in ten Latinas (44%) and one-half of African American women (52%) have employer-based insurance, compared to two-thirds of white women (66%).

- Because women of color are more likely to be low-income, Medicaid, the joint state/federal program for the poor is an important source of coverage, covering 17% of African American women and 12% of Latinas.

Not surprisingly, given their higher uninsured rate, Latinas are more likely to experience gaps in their health insurance coverage (Figure 3).

FIGURE 3
Health Insurance Gaps by Race/Ethnicity



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
**Unstable coverage is defined as lack of continuous insurance coverage during past one year.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

- Half of Latinas (49%) experienced a spell without health insurance in a year period.

- Although African American women are less likely than Latinas to have unstable coverage throughout a year period, nearly one-third (30%) had gaps, as did one-quarter of white women (24%).

Vision and oral health care are important components of health care, yet coverage for these services is limited for women of all races.

- Over one-half of Latinas (54%), and four in ten African-American (39%) and white women (41%) do not have dental coverage.

- Over one-half of Latinas (58%) also lack coverage for vision care. Half of white women (52%) and four in ten African American women (40%) also do not have vision coverage.

Differences in Access to Health Care

In addition to health care need and insurance coverage, access to health care is determined by a wide range of factors, including contact with the health care system, ability to receive specialty and follow up treatment, availability of support services such as transportation and child care services, and relationships with providers. On many of these measures, Latina women in particular fare worse than their white counterparts.

Barriers to receiving health care

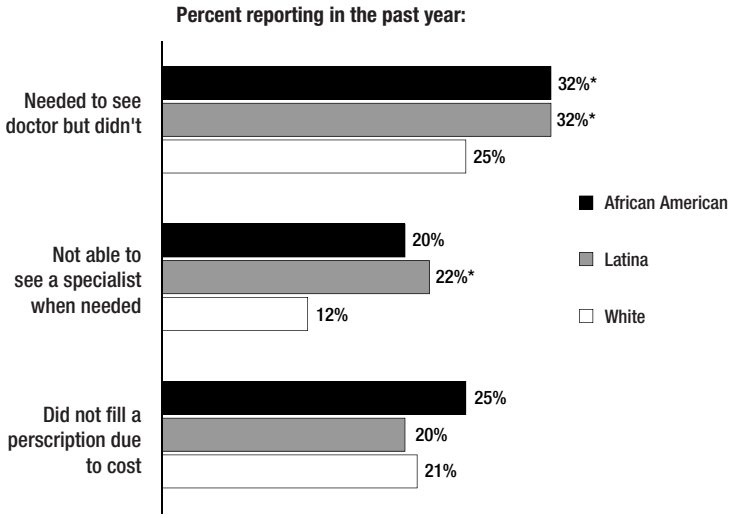
Overall, most women (87%) have visited a doctor in the past year; however, there are differences among subgroups of women.

- Nearly a quarter (24%) of Latina women have not had a physician visit, compared to 14% of African American and 11% of white women.

- One-third of Latinas (32%) and African American women (32%) report delaying or forgoing needed care in the past year, as did one-quarter of white women (Figure 4).

FIGURE 4

Problems Accessing Care, by Race and Ethnicity



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

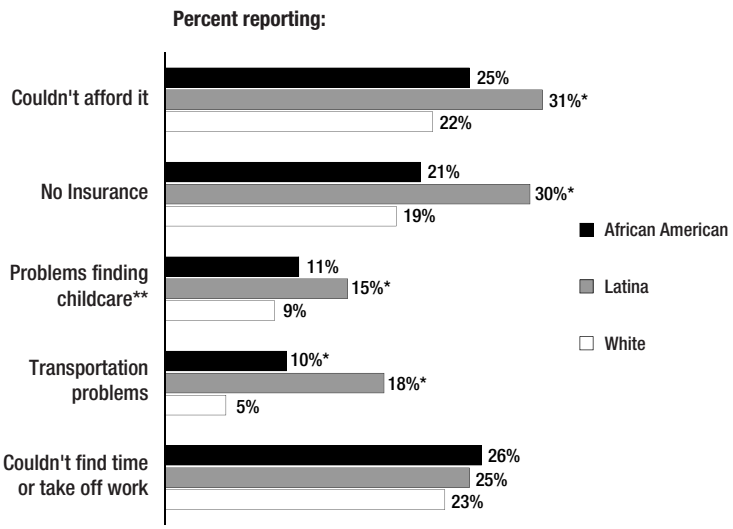
- Women of color have markedly more difficulty seeing a specialist when needed. In particular, Latinas (22%) were significantly more likely to report difficulties accessing specialist care.

- Women are more likely to use prescription drugs on an ongoing basis than men,[7] and a sizable minority of women of all racial and ethnic groups report trouble affording needed prescriptions. Between one in five and one in four women reported that they didn't fill a prescription because of cost.

Women report several reasons for delaying care, including cost, lack of insurance, and competing family and work responsibilities (Figure 5).

FIGURE 5

Reasons for Delays of Care in Past Year, by Race/Ethnicity



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
**Among women with children.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

- Costs and lack of insurance are the most frequently reported reasons for delaying care, and are a problem for nearly one-third of Latinas.

- Nearly one in five Latinas (18%) and one in 10 African American women delayed care because of transportation problems, compared with 5% of white women.

- Latinas (15%) are also more likely to report that problems in obtaining childcare resulted in delayed or unmet care.

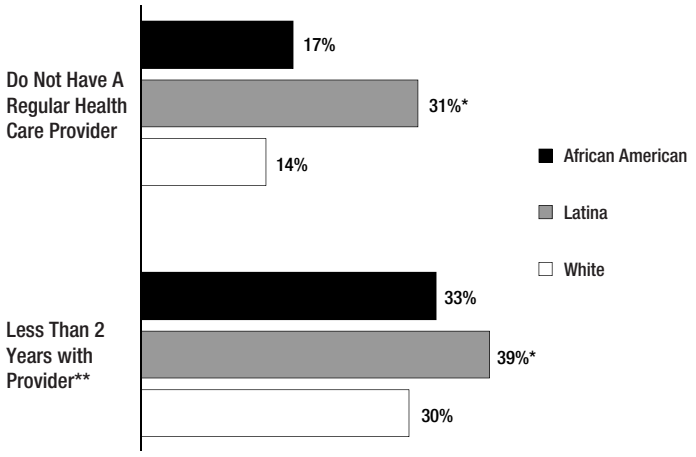
- About one-quarter of women in all the racial/ethnic groups examined delayed needed medical care because of difficulties finding time or taking time off work.

Relationships with Providers

Continuity of care, including having a regular health care provider, promotes access to needed preventive services and generally facilitates entrée into the health care system.[8] Latinas have less stable connections with health care providers, and both Latinas and African American women are more likely than white women to receive routine care in clinics and health centers (Figures 6, 7).

FIGURE 6

Women's Connection to the Health Care System by Race/Ethnicity



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
**Based on women who have reported having a regular health care provider.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

- Nearly one-third (31%) of Latinas lack a regular health care provider, approximately twice the rate for white (14%) and African American women (17%).

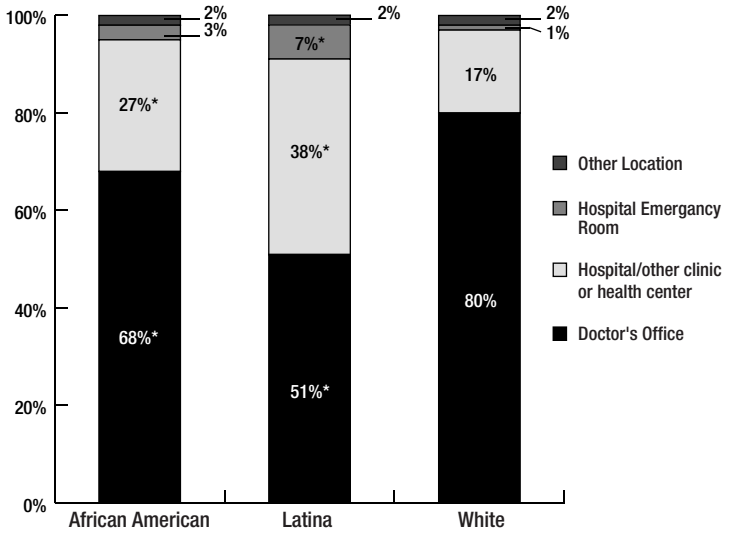
- Latinas are also less likely than African American or white women to have long-term relationships with their health care providers. Four in ten Latinas (39%) have been with their provider for less than two years compared to about one-third of African American (33%) and white women (30%).

- African American women and Latinas are more likely to obtain routine care at clinics or health centers (27% and 38%, respectively), and less likely than white women to receive care in a doctor's office. This is due in part to minority women's lower insurance coverage rates and heavier reliance on Medicaid, which has had historically low participation by private physicians.

- Despite common misperceptions, very few women of any race/ethnicity rely on emergency rooms for routine care.

FIGURE 7

Where Women Receive Medical Care, by Race/Ethnicity



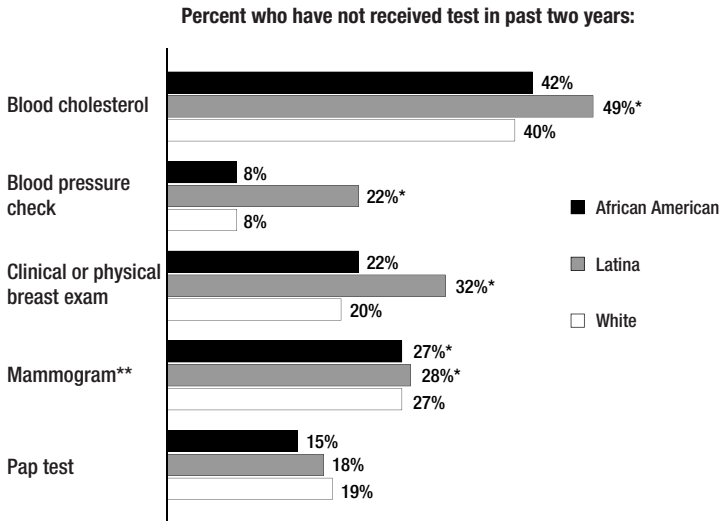
Note: Includes women ages 18 to 64 who have had a check-up in last two years.
* Significantly different from reference group, white women, at p< .05.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Use of preventive services

Early detection is critical for effective treatment and management of several illnesses that affect women. Women of all races fall short of maximizing use of available screening tests and racial and ethnic differences are apparent in this area as well (Figure 8).

- In particular, Latinas are least likely to have received several important screening tests, including blood cholesterol and blood pressure checks. Given the higher rates of hypertension for African American women and diabetes among both African American and Latina women, routine serum cholesterol and blood pressure checks are of particular importance to these populations of women.

FIGURE 8
Use of Preventive Services, by Race/Ethnicity



Note: Includes women ages 18 to 64 except for mammogram.
* Significantly different from reference group, white women, at p< .05.
**Includes women ages 40-64.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

- One area where racial and ethnic differences have narrowed is screening for breast and cervical cancers, although there has been improvement in rates, a sizable minority of women still are not getting these needed screening services.
  - Approximately one in four women ages 40 to 64 across racial and ethnic groups have not had a mammogram within the past two years.
  - However, one-third of Latinas (32%) have not had a clinical breast examination, compared with one-fifth of white women (20%).

While disparities in screening rates have declined, African American and Latina women continue to experience higher mortality from breast cancer, despite their lower incidence level than white women. Compared to white women, African American women also have higher incidence and mortality rates of cervical cancer, which is generally considered treatable when detected in early stages.[9,10]

Concerns about Quality

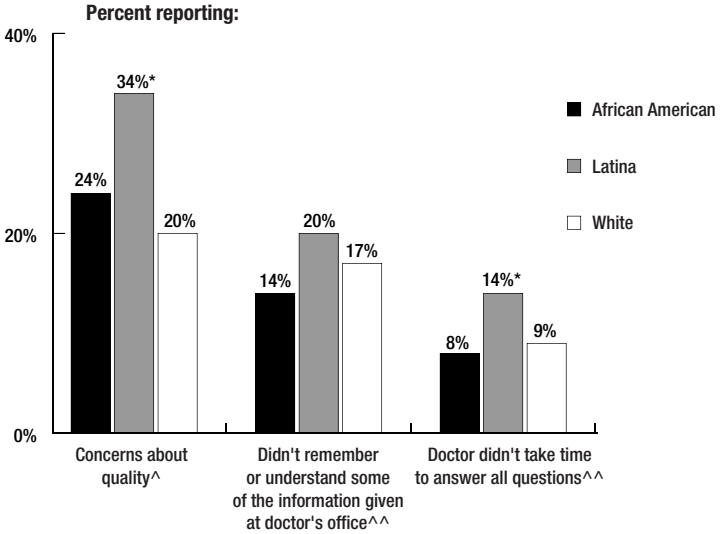
Quality of care continues to be a concern for many women, but Latinas in particular reported high rates of dissatisfaction with their care (Figure 9).

- One-third (34%) of Latinas express concerns about quality, compared with one-fourth (24%) of African American and one-fifth (20%) of white women.

One problem that may contribute to a patient's perception of quality is communication with her physician.

- Latina women are more likely to feel that their doctors do not take time to answer all of their questions and are more likely to leave the doctor's office without understanding all of the information they received. This disparity may be due in part to language and cultural differences between patients and health care providers.

FIGURE 9
Problems Communicating with Physicians, by Race/Ethnicity



Note: Includes women ages 18 to 64.
* Significantly different from reference group, white women, at p< .05.
^In past year. ^^In past two years.
Source: Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Conclusions and Implications

A sizable minority of women face considerable challenges in accessing even basic health care services. While access is shaped by a number of factors, the data from this survey provide compelling evidence that race and ethnicity play a role in women's access and use of the health care system. In particular, Latinas and African American women are more likely to experience certain barriers to care than white women.

Disparities are evident across several areas, such as health status, health insurance coverage rates, access to physicians, coping with health care costs, transportation and childcare availability, use of preventive services, and perceptions of quality. Latinas, in particular, consistently are more likely to report that they encounter numerous barriers, such as limited access to child care and transportation services, poorer continuity of care, and inability to receive specialty care. For many Latina women, language barriers may also complicate communication with their health care providers affecting their health care quality and satisfaction with care.[11] African American women report higher rates of several chronic illnesses and also face problems receiving timely care, contributing to the increasing burden of preventable illness for this group of women.

Although many factors influence receipt of care, having insurance coverage is associated with significantly better access to care. Lack of health insurance may amplify the burden of out-of-pocket costs, which would disproportionately affect women of color, who are more likely to be economically disadvantaged than white women.

Employer-based coverage is less accessible to Latinas and African American women. This has much to do with their own and their spouse's work status, the type of industries where they labor, their wages as well as their ability to pay for premiums when offered by their employers.

Medicaid remains a vital source of coverage for women of color. However, Medicaid eligibility is very restrictive and is typically only extended to women who are mothers, pregnant, or disabled. The recent economic downturn has resulted in budget shortfalls in nearly every state. This in turn has led to limits in Medicaid eligibility and benefits, which has had a disproportionate impact on women of color.

There is increasing evidence that the underlying racial and ethnic inequities in health care extend beyond the logistic and economic factors. In a large-scale analysis of racial and ethnic disparities, the Institute of Medicine concluded that "…evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to the differences in care." While this does not account for the multiple disparities that women of color experience, it is an area that providers and other health care professionals can address to close some of the access and coverage gaps.

National initiatives to eliminate racial and ethnic disparities in health care have been proposed and continue to evolve as more evidence about health inequities emerge.[12] The success of these initiatives will require broad-based efforts that tackle difficult societal, economic, and cultural issues.

References

[1] Institute of Medicine, *Unequal Treatment*, National Academies Press, 2002.

[2] Salganicoff, et al., *Kaiser Women's Health Survey*, Kaiser Family Foundation, May 2002.

[3] The sample sizes were too small to report information for Asian American/Pacific Islander and American Indian/Alaska Native women.

[4] U.S. Census Bureau, "Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race," *CPS Annual Demographic Survey*, 2002.

[5] Salganicoff, et al. *Kaiser Women's Health Survey*, Kaiser Family Foundation, May 2002.

[6] Brown, et al. "Disparities in Health Insurance and Access to Care For Residents Across U.S. Cities," The Commonwealth Fund and UCLA Center for Health Policy Research, August 2000.

[7] Salganicoff, et al. Kaiser Women's Health Survey, Kaiser Family Foundation, May 2002.

[8] Starfield B. Primary Care: *Balancing Health Needs, Services and Technology*. New York: Oxford University Press. 1998.

[9] National Center for Health Statistics, *Health, United States*, 2003, Hyattsville, MD: 2003.

[10] National Cancer Institute, "Cervical Cancer: Prevention, Genetics, and Causes," available at www.cancer.gov.

[11] Doty, M. "Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English," The Commonwealth Fund, February 2003.

[12] "The Closing the Health Care Gap Act of 2003: Legislative Summary," Federal legislation proposed by Senator Bill Frist, available at http://www.kaisernetwork.org/health_cast/uploaded_files/FristBillSummary.pdf.

This issue brief was prepared by Roberta Wyn, Ph. D. and Victoria Ojeda, Ph.D. of the UCLA Center for Health Policy Research, with Usha Ranji, M.S. and Alina Salganicoff, Ph.D. of the Henry J. Kaiser Family Foundation.

This paper is based on data from the *2001 Kaiser Women's Health Survey*, a national telephone survey of 3,966 women ages 18 to 64 in the United Sates. A disproportionate stratified random sample was used to over-sample African American women, Latinas, those in low-income households (defined as having incomes below 200% of the federal poverty level), and those who were medically uninsured or Medicaid beneficiaries, so that sample sizes would be adequate to allow for subanalysis of these populations. The sample was then weighted using the Census Bureau Demographic Profile (from the March 2000 Current Population Survey) to adjust for variations in the sample relating to region of residence, sex, age, race, and education to provide nationally representative statistics. Interviews were conducted in either English or Spanish, depending on participants' preference. A shorter companion survey of 700 English-speaking men was conducted for the purposes of gender comparison.

Foundation staff designed the survey in collaboration with Princeton Survey Research Associates (PSRA) and analyzed it with researchers from UCLA. Fieldwork was conducted by PSRA between March 28 and July 29, 2001. The margin of sampling error is +/-2 percentage points for the total women sample, +/-4 percentage points for the men, and is larger for subgroups. Note that in addition to sampling error, there are other possible sources of measurement error, though every effort was undertaken to minimize these other sources. A copy of the survey instrument is available upon request.

For additional findings from the *2001 Kaiser Women's Health Survey*, please refer to the full report, available on the Kaiser Family Foundation website, www.kff.org.

Additional copies of this publication (#7018) are available on the Kaiser Family Foundation website at www.kff.org.

Additional Kaiser Family Foundation publications based on the *Kaiser Women's Health Survey, 2001*:

"Women's Health in the United States: Health Coverage and Access to Care," May 2002, pub. #6027.

"Women, Work, and Family Health: A Balancing Act," April 2003, pub. #3336.

"Health Coverage and Access Challenges for Low-Income Women," March 2004, pub. #7037.

All reports are available on the Kaiser Family Foundation's website at www.kff.org/womenshealth.

The Henry J. Kaiser Family Foundation: 2400 Sand Hill Road, Menlo Park, CA 94025 (650) 854-9400 Facsimile: (650) 854-4800
Washington Office: 1330 G Street, NW, Washington, D.C. 20005 (202) 347-5270 Facsimile: (202) 347-5274 **www.kff.org**