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5

Health Care for African American and Hispanic Women

Report on Perceived Health Status, Access to Care, and Utilization Patterns

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Over the past decade, health care services in the United States have undergone remarkable changes. Driven largely by the need to control escalating health care costs, innovations in delivering and financing health care have been introduced into the American market. Initiated in the private sector, these innovative approaches (including various types of "managed" care and prospective or capitated funding approaches) are now moving into public sector care (Scanlon, Chernew, and Lave 1997). Although these newer health care strategies do reduce costs, great concern remains about the quality of the care they provide, particularly to vulnerable populations (Lillie-Blanton and Lillie 1996; Blumenthal, Mort, and Edwards 1995). Ethnic minorities, especially those with fewer resources, such as women and the poor, are among the many vulnerable populations that could be affected by these changes. Legislation in a number of states reflects this concern. Bills have been initiated to regulate, or set standards for, our competitive health care market.

One of the fundamental aims of health care reform has been to increase access to primary care for underserved and vulnerable populations (Blumenthal, Mort, and Edwards 1995), such as poor black and Hispanic women. However, it is not clear that access has improved. In a series of recently published studies by The Commonwealth Fund on women's health (Falik and Collins 1996), 14 percent of African Americans and 17 percent of Hispanics were not able to get medical treatment when they needed it (Lillie-Blanton, Bowie, and Ro 1996; Ramirez de Arellano 1996). This difficulty in accessing health services on a regular

basis is one of the factors that accounts for high rates of hospitalizations for conditions that could be treated and prevented through primary care visits (Valdez et al. 1993).

Overall in the United States, the number of black and Hispanic women who do not receive medical care when it is needed is increasing (Gaston et al. 1998). This is not inconsequential, given the higher rates of morbidity among these women relative to white women and the high costs of unnecessary hospitalizations both to the patients and to society.

RACIAL DISPARITIES IN WOMEN'S HEALTH

Disparities among the health status of African American, Hispanic, and white women in the United States, and the magnitude of these differences, are of significant concern (Krieger et al. 1993; Lillie-Blanton et al. 1993; Mays, Howard-Caldwell, and Jackson 1996; Zambrana 1987). In the last two decades there has been a greater interest in race and ethnicity as a powerful determinant of health status (Cooper 1986; Harwood 1981; Polednak 1989; Reynolds 1993; U.S. Department of Health and Human Services 1985).

Looking at most indices of health, African Americans and Latinos are worse off than their white counterparts. These differences are not easily explainable by genetic variation. Considering risk factors, such as obesity, hypertension, high cholesterol, and smoking, in findings drawn from the National Health and Nutrition Examination Surveys and National Health Interview Survey, African American women have a greater prevalence of obesity and hypertension than both white and Hispanic women. African American women are more likely than Hispanic women to have high cholesterol, but less likely than white women (Lillie-Blanton et al. 1993). Perhaps, as a consequence, African American women are twice as likely, and Hispanics one-and-a-half times as likely, to rate their own health as fair or poor, as compared to white women (Lillie-Blanton et al. 1993).

More recent investigations into the health of ethnic minorities have begun to examine the effect of not only race/ethnicity and gender but also of social class on health status (Lillie-Blanton et al. 1993; Zambrana 1987). When researchers compare both income and race as factors in the health behaviors of African American, Hispanic, and white women, they find that perceptions of health status are more similar by income than by race/ethnicity, although a larger percentage of the ethnic women, in contrast to white women, rated their health as poor. Perception of health status is inversely related to income; one in four women with incomes under $10,000 report fair/poor health, versus one in 25 with incomes $35,000 or more.

Research repeatedly shows that an individual's social status of origin, an individual's achievement, as well as gender, marital status, ethnic group, and the neighborhood resided in, are all correlates of physical and mental health and the likelihood of premature death (Fang, Madhavan, and Alderman 1996; Geronimus et al. 1996; Macintyre 1986; Miles 1991; Radley 1994; Waldron 1985; Waldron and Jacobs 1988, 1989). Here, women lag behind men on almost every social and economic indicator. In practically every country at every socioeconomic level, women control fewer productive assets than men. They also work longer hours but earn less money, despite the fact that they are responsible for meeting 40 to 100 percent of their family's basic needs (Jacobson 1993; Radley 1994; U.N. Department of International and Economic and Social Affairs 1991). The result is that women are likely to be found in jobs that are labor-intensive, provide little or no health benefits, and experience high levels of occupational risks.

ACCESS TO AND UTILIZATION OF CARE

For poor women and women of color in the United States, race, social class, and gender status are powerful factors that contribute to their poorer health status (Krieger et al. 1993; Lillie-Blanton, Martinez, Taylor, and Robinson 1993). These factors mediate the opportunities that can range from women's restrictive access to employment (which can provide the benefits of health insurance, sick leave, and on-site health clinics), to decision-making about their health—through health care providers' assumptions that women are incapable of making good decisions about their health (Mays 1999). Many of the factors that influence women's use of health care services (such as costs of services, location, or distance and transportation, their willingness and ability to seek services, the infrastructure of services, availability of appointments, waiting time to see health care personnel, and language compatibility) have also been noted as contributing factors in their health care (Timyan et al. 1993). As with demographic risk factors, these access barriers contribute to the poor health outcomes found in women of color in the United States.

Several studies also demonstrate that the poor have significantly less access to health care than others (Aday, Andersen, and Fleming 1980; Aday, Fleming, and Andersen 1984; Anderson 1972; Freeman et al.

1987; Freeman and Corey 1989). Poor but not impoverished women are least likely to visit a physician regardless of ethnic group (Lillie-Blanton et al. 1993). Hispanic women are less likely than both African American and white women to report contact with a physician or to have visited a physician in the last year. Even when income is controlled, both Hispanic and African American women make fewer visits to a physician (Lillie-Blanton et al. 1993).

CHANGING ENVIRONMENT FOR HEALTH COST COVERAGE

For many Latina and African American women, the inability to get medical care stems from a lack of health insurance coverage or a failure to meet eligibility standards for publicly financed health care. Federal and state legislators have investigated ways to extend coverage to these women to ensure that they will receive the necessary health care. This attention rises in part from a recognition that when routine medical care is treated through emergency room visits or hospitalizations for preventable health problems, health care costs rise (Short, Cornelius, and Goldstone 1990). However, with the failure of health care reform, individuals in the United States continue to rely on what have been traditional public and private insurance programs. Even though the unemployment rate is down, jobs with private insurance are hard to get, especially for women (Miles and Parker 1997; Baylis and Nelson 1997).

Miles and Parker (1997) note that health insurance coverage through private, Medicaid, or Medicare sources works differently for men and women in its capacity to act as a safety net for providing necessary health care services. Inequality in health insurance coverage exists because the conditions of men and women are different, particularly for ethnic minority women. Women are more likely to work at jobs in smaller firms, have less union participation, and be employed part-time. These are all situations that lead to fewer benefits. For example, people who work in jobs that do not offer health insurance can make too much money to qualify for Medicaid, although this varies widely from state to state. In one California study of 2 million nonelderly uninsured women, eight out of ten were workers or members of working families (Wyn, Brown, and Ng 1996).

At the same time that innovation and competition are increasing in the health care marketplace, and extending into public insurance programs, the ethnic composition of the American population is changing. The fastest growing population in the United States is the Hispanic population, which by the year 2000 is projected to be the largest racial/ethnic minority group in the United States (Zambrana and Ellis 1995). Hispanics and African Americans have higher-than-average fertility rates. Because ethnic minority women are more likely to be poor and unemployed, or to work in jobs that do not offer private health insurance, ethnic minority populations have traditionally been over-represented in public insurance programs where many of the changes are now occurring (Short, Cornelius, and Goldstone 1990).

To deliver care effectively to ethnic minority populations, in both public and private insurance programs, it is increasingly important to understand more about these populations in terms of their health beliefs, perceptions of barriers to access and utilization of care, and experiences with the health care system. This type of knowledge will facilitate the design of managed care programs to meet and address their needs.

The purpose of this analysis is to examine the differences in perceived health status, access to care, and health care utilization of African American, Hispanic, and white women. It is hoped that the results of this inquiry can serve as a foundation to consider the health policy needs of these women and to provide guidance for managed care providers.

METHODS OF ANALYSIS

Women represented slightly more than one-half of the respondents in The Commonwealth Fund Minority Health Survey (CMHS). For the purposes of this study, only women respondents were selected. Native Americans were excluded because their numbers were too small for meaningful analyses, and the 305 Asian women collected via nonprobability sampling procedures were also excluded because of our inability to assign weights and to determine the true population estimates necessary for multivariate analyses.

Given the nature of the sampling design, we report estimates calculated separately for white, African American, and Hispanic women. This sample was selected using a population-based cluster sampling frame that permitted the use of specialized survey analysis software (SUDAAN; see Shah et al. 1996) to generate both point estimates and their standard errors. Weights were assigned to the sample to adjust for selection probability and for under- or over-representation by ethnicity, gender, educational level, and insurance status. Weights were further adjusted to reflect the actual sample size for each analysis to permit significance testing based on the actual weighted sample size (Aday 1989). Based on this and

our interest in focusing on differences between ethnic/racial women's health, we also report when possible on comparisons between African Americans and Latinas.

Women in this sample differed significantly on several key demographic characteristics, including two major factors: age and household income. Specifically, the white women sampled tended to be older, were more likely to be retired, reported greater family incomes, and indicated that no children were present in the household. Because age and household income may confound associations between ethnic/racial background and health and health care utilization, we report both unadjusted and adjusted percentages controlling for these two factors. We conducted further analyses not reported here, controlling for children present in the home or use of prenatal services in the past year, but they did not result in any differences in findings.

To adjust for household income, we used 1993 poverty thresholds (U.S. Census Bureau 1998) as a guide. We first calculated approximate household income (reported income range divided by size of household). Then, because individuals indicated the range of their income and not the precise amount, we created four categories where the median income amount for each income range, divided by the number of individuals per household, was: (1) less than poverty as defined in 1993 (19% of the sample); (2) between 100 percent and 199 percent of poverty (22%); (3) between 200 percent and 299 percent of poverty (20%); and (4) 300 percent or more of poverty (38%).

Adjusted estimates standardize the age and household income distribution for each ethnic group to that of the total sample, thus controlling for age and household income differences across the three groups. We report both chi-square analyses of the unadjusted distributions and after adjustment for stratification by age and poverty status. Findings from the multiethnic sample can be used with some sense of certainty to estimate true population parameters for white, African American, and Hispanic women in the United States. For this reason we report 95 percent confidence intervals (CI) of the estimates to assist in extrapolating current findings.

Table 5.1 Perceived Health Status and Healthy Habits of White, African American, and Hispanic Women (unadjusted and adjusted for age and poverty status)

	White		African American		Hispanic	
Indicator	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval
Perceived health status rated as fair or poor						
Unadjusted[a]	18.1	14.7,21.5	27.2	22.7,31.7	26.4	21.0,31.8
Adjusted[b]	18.4	15.0,21.8	27.8	23.5,32.1	25.8	20.3,31.3
Dissatisfied with life these days						
Unadjusted	11.9	9.0,14.8	11.0	7.4,14.7	10.1	6.8,13.5
Adjusted	12.3	9.4,15.3	10.1	7.1,13.0	8.3	5.6,11.0
Reports health problem/ disability that impairs activities						
Unadjusted[b]	17.7	14.1,21.2	17.3	13.3,21.2	11.7	8.5,14.8
Adjusted[b]	18.5	15.0,22.1	16.5	13.5,19.5	12.9	9.0,16.8
Smokes cigarettes						
Unadjusted[a]	24.3	20.1,28.5	16.0	12.3,19.7	15.0	11.5,18.6
Adjusted[c]	25.3	21.2,29.5	15.2	11.8,18.5	12.6	9.6,15.7
Eats healthy diet ≥ four days a week						
Unadjusted[c]	66.9	62.5,71.4	50.6	46.0,55.2	55.6	50.7,60.2
Adjusted[a]	66.4	61.8,70.9	53.9	49.2,58.7	57.8	53.0,62.5
Exercises ≥ one time a week						
Unadjusted	58.2	53.5,62.9	53.8	48.5,59.1	52.1	47.0,57.3
Adjusted	58.8	54.1,63.5	54.8	49.7,59.9	51.5	46.1,56.9

Source: Data from The Commonwealth Fund Minority Health Survey, 1994.

[a] $p < 0.01$.

[b] $p < 0.05$.

[c] $p < 0.001$.

RESULTS OF ANALYSIS

Perceived Health Status and Healthy Behaviors

Approximately one-fifth of the women in this study perceive their health as fair or poor (Table 5.1). However, African American and Hispanic women are significantly more likely, when compared to white women, to rate their health this negatively. This effect is present even after controlling for differences in age and poverty status. In addition, approximately 12 percent of the women in the sample also indicate that they are currently dissatisfied with their lives; no differences were observed among the three ethnic/racial groups. Even though, overall, most women con-

sider themselves healthy, 17 percent of women report having a health problem or a disability that impairs their ability to participate fully in activities. Hispanic women are the least likely to report a health impairment. Contrasting Hispanic and African American women specifically, Hispanic women are significantly less likely to report a disability than African American women (unadjusted chi-square$_{(1)}$ = 4.50, $p < 0.05$; adjusted chi-square$_{(1)}$ = 4.64, $p < 0.05$).

Three important aspects of maintaining a healthy lifestyle are refraining from smoking cigarettes, engaging in routine exercise, and eating a healthy diet. Approximately 22 percent of women report that they are current cigarette smokers, with significantly greater numbers of white women reporting that they smoke, compared to African American or Hispanic women, even after controlling for the effects of age and poverty status. Slightly less than two-thirds of the women indicate that they eat a healthy diet four or more days a week; significantly more white women than ethnic minority women report doing so. These ethnic/racial differences hold even after controlling for differences in age and poverty status among the groups. We observe no differences across the ethnic groups in their prevalence of reporting exercising a minimum of one day a week; slightly more than half of all women say they do. Further, we observe no significant differences between African American and Hispanic women in any of the three health behaviors (see Chapter 12).

Health Insurance

Third-party coverage of costs is a major influence on an individual's ability to access medical care when needed. But a quarter of survey respondents (24.3%) report being without health insurance or health coverage at some time during the prior two years (Table 5.2). Risk for noncoverage appears to be far greater for ethnic minority women, even after adjusting for age and poverty status differences among the three ethnic/racial groups. Of particular significance, half of the Hispanic women report being without coverage at some time in the prior two years, in contrast to slightly more than a third of African American women (unadjusted chi-square$_{(1)}$ = 9.72, $p < 0.01$) and 20 percent of white women (unadjusted chi-square$_{(1)}$ = 26.71, $p < 0.001$). If the three groups had equivalent age and poverty status distributions, the pattern remains highly similar with 40 percent of Hispanic women reporting lack of coverage, significantly more than the 29 percent of African American women (adjusted chi-square$_{(1)}$ = 10.01, $p < 0.01$), and 22 percent of white women (adjusted chi-square$_{(1)}$ = 17.77, $p < 0.001$) who reported lacking coverage.

Current prevalence of health care coverage shows an identical disparity among women according to ethnic/racial background. Overall, 63

Table 5.2 Health Insurance Status of White, African American, and Hispanic Women (unadjusted percentages and adjusted for age and poverty status)

	White		African American		Hispanic	
Indicator	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval
No health care coverage at some time in past 2 years						
Unadjusted[a]	19.9	15.6,24.3	34.8	28.8,40.9	50.2	44.9,55.5
Adjusted[a]	21.9	17.9,25.9	29.1	24.7,33.6	39.9	35.3,44.5
Current health insurance coverage						
Unadjusted[a]						
None	10.0	6.4,13.6	23.2	28.6,28.9	38.7	32.7,44.6
Medicaid	3.9	1.8,6.0	8.0	4.8,11.2	7.0	4.5,9.6
Private/Medicare—not HMO	68.1	63.4,72.9	48.3	42.7,57.0	37.2	32.2,42.2
Private/Medicare—HMO	18.0	14.5,21.4	20.4	16.7,24.2	17.1	14.1,20.2
Adjusted[a]						
None	11.0	7.4,14.5	18.6	14.5,22.7	29.2	25.0,33.4
Medicaid	4.7	2.5,6.9	6.3	4.1,8.4	5.3	2.8,7.8
Private/Medicare—not HMO	66.4	61.9,71.0	53.8	49.7,57.8	45.3	40.4,50.2
Private/Medicare—HMO	17.9	14.5,21.4	21.4	18.0,24.8	20.3	16.6,23.9
Among those currently insured dissatisfied with health plan or health insurance						
Unadjusted	13.1	10.5,15.7	12.5	9.6,15.3	10.3	7.1,13.5
Adjusted	15.3	11.4,18.5	11.1	8.5,13.6	9.9	6.7,13.0

Source: Data from The Commonwealth Fund Minority Health Survey, 1994.

[a] $p < 0.001$.

percent of women report that they currently have some kind of health insurance coverage, including Medicare, that is not through a health maintenance organization (HMO). An additional 18 percent have HMO coverage, including a Medicare HMO. Approximately 4.7 percent are covered by Medicaid or public aid. Finally, 14 percent indicate that they do not currently have health care coverage. Significantly fewer Hispanic women report coverage, in contrast to both African American (unadjusted chi-square$_{(3)}$ = 10.28, $p < 0.01$) and white women (unadjusted chi-square$_{(3)}$ = 32.63, $p < 0.001$) (Table 5.2). Also, significantly fewer African American than white women report having health coverage (unadjusted chi-square$_{(3)}$ = 18.87, $p < 0.001$). This is true even after controlling for differences in age and poverty status among the women. While current noncoverage is relatively rare among white women (only 10 percent report that they are without any health care coverage), noncoverage is fairly common among Hispanic women (39%) and African American women (23%).

Among those respondents who have health care coverage, levels of dissatisfaction with their plan do not differ across the ethnic groups. Approximately 13 percent of women report being dissatisfied with their health coverage plan.

Accessing Health Care Services

Having a regular doctor or health care provider may facilitate both efficient and effective health care delivery. Over 80 percent of the women surveyed (82.7%) report that they do have a health care provider (Table 5.3). However, the percentage of women responding affirmatively varies by ethnic/racial background. A significantly greater number of white women report having a regular health care provider than either African American or Hispanic women. In turn, more African American women report having a provider than Hispanic women (unadjusted chi-square$_{(1)}$ = 5.93, $p < 0.05$). This pattern holds even after controlling for age and poverty status differences among the three groups.

One reason for this finding may be that points of access into the health care system vary among the three groups. Approximately 80 percent of white women report that their usual place of getting health care is in a doctor's office, a location more likely to involve a known provider. Some 14 percent of white women normally receive care at a clinic or outpatient department, and only 6 percent indicate that an emergency room is their usual place. In contrast, approximately two-thirds of African American and Hispanic women report that their usual place of care is a doctor's office. Significantly, more African American women (14.5%) than either white (6.2%, unadjusted chi-square$_{(3)}$ = 16.38, $p < 0.001$) or Hispanic (8.8%, unadjusted chi-square$_{(3)}$ = 8.21, $p < 0.05$) women report that an emergency room is their usual point of health care access. More than a quarter of Hispanic women report they normally receive care in a clinic or outpatient department.

Several barriers can impede access to health care. These include difficulties in getting convenient appointments, excessive waiting times at health care sites, not knowing where to go for care or having transportation difficulties getting there, language barriers, cost, and a service

Table 5.3 Points of Access to Health Care Services among White, African American, and Hispanic Women (unadjusted percentages and adjusted for age and poverty status)

	White		African American		Hispanic	
Point of Access	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval
Has a regular doctor or health care provider						
Unadjusted[a]	85.7	82.2,89.2	75.6	70.8,80.4	65.4	60.2,70.6
Adjusted[a]	85.4	81.9,88.9	77.3	73.3,81.4	69.6	65.0,74.3
Usual place of getting care						
Unadjusted[a]						
Doctor's office or group practice	79.7	75.7,86.7	66.3	61.2,71.4	64.0	58.7,69.3
Clinic, outpatient department, health center	14.1	10.4,17.7	19.3	14.2,24.3	27.2	22.7,31.7
Emergency room	6.2	3.8,8.6	14.5	10.8,18.1	8.8	5.6,12.0
Adjusted[b]						
Doctor's office or group practice	78.7	74.5,82.8	67.1	62.4,71.8	68.9	63.8,74.0
Clinic, outpatient department, health center	15.1	11.3,18.8	18.3	13.8,22.8	24.4	19.9,29.0
Emergency room	6.3	3.8,8.7	14.6	11.2,18.0	6.7	4.2,9.1

Source: Data from The Commonwealth Fund Minority Health Survey, 1994.

[a] $p < 0.001$.

[b] $p < 0.01$.

provider's outright refusal to provide services. Approximately 11 percent of all of the women in the study (11.3%) report that access difficulties had kept them from getting health care when needed in the past year. Significantly fewer numbers of African American, as opposed to white (unadjusted chi-square$_{(1)}$ = 4.92, $p < 0.05$) or Hispanic (unadjusted chi-square$_{(1)}$ = 7.29, $p < 0.01$) women report that access difficulties kept them from getting care—perhaps in part due to their greater use of emergency rooms (Table 5.4). In addition, 18 percent of women report that they put off getting care because of access difficulties. Outright refusal of care by service providers was not commonly reported; only 2.5 percent of women indicate that this had happened in the prior year, with prevalence not differing significantly among the three ethnic/racial groups.

Table 5.4 Indicators of Health Access Difficulties among White, African American, and Hispanic Women (unadjusted percentages and adjusted for age and poverty status)

	White		African American		Hispanic	
Indicator	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval
Did not get care in past year due to access difficulties[a]						
Unadjusted[b]	11.8	8.3,15.2	6.7	4.0,9.4	14.0	10.4,17.5
Adjusted[c]	12.8	9.5,16.2	5.8	3.5,8.1	12.3	8.9,15.7
Put off getting care in past year due to access difficulties[a]						
Unadjusted[b]	18.1	14.1,24.9	16.3	12.2,20.4	22.0	17.7,26.3
Adjusted[c]	19.2	15.4,22.9	14.2	10.7,17.8	19.8	15.8,23.8
Refused care in past 12 months						
Unadjusted[b]	2.2	0.2,4.3	4.0	1.6,6.3	2.8	1.1,4.5
Adjusted[c]	2.5	0.4,4.7	3.6	1.5,5.7	1.8	0.7,3.0

Source: Data from The Commonwealth Fund Minority Health Survey, 1994.

[a]Access difficulties included unavailability of appointment, inconvenient appointment hours, wait at site, paperwork or bureaucracy, language barriers, not knowing who to see or where to go, cost, lack of insurance coverage, and transportation difficulties.

[b]$p < 0.05$.

[c]$p < 0.01$.

Utilization of Health Care Services

The great majority of women in the study (91.7%) report that they saw a health care provider at least once during the course of the prior year. However, Hispanic women, in contrast to both white (unadjusted chi-square$_{(1)}$ = 14.63, $p < 0.001$) and African American women (unadjusted chi-square$_{(1)}$ = 13.59, $p < 0.001$) are significantly less likely to report having seen someone (Table 5.5). Approximately three-quarters of women report that they received some form of preventive care, such as blood pressure checks, Pap smears, or cholesterol level readings. However, once again Hispanic women report significantly less frequently having received preventive care than either white (unadjusted chi-square$_{(1)}$ = 16.57, $p < 0.001$) or African American women (unadjusted chi-square$_{(1)}$ = 14.03, $p < 0.001$). Hispanic women are also less likely to report that they had been hospitalized in the previous year than either African American (unadjusted chi-square$_{(1)}$ = 5.32, $p < 0.05$) or white women (unadjusted chi-square$_{(1)}$ = 7.68, $p < 0.01$). These differences remain even after controlling for age and poverty status.

Because African American women are more likely than white or Hispanic women to have an emergency room as their usual point of access to health care, a greater percentage of African American women than Hispanic women also report having used an emergency room in the prior year (unadjusted chi-square$_{(1)}$ = 5.24, $p < 0.05$). When age and poverty status differences among the three groups are statistically controlled, African American women are still more likely than Hispanic women to report using an emergency room (adjusted chi-square$_{(1)}$ = 6.55, $p < 0.05$).

We also studied other indicators of the breadth of health care utilization (Table 5.5). Although the percentages of women reporting the receipt of prenatal care did not differ across the three ethnic/racial groups, greater percentages of white women report obtaining a second medical opinion, seeing a mental health care provider, and receiving treatment from a chiropractor.

Levels of Satisfaction and Experiences with Discrimination

Women in the study were asked several questions related to satisfaction and comfort with health care services. Overall, 76 percent of women report being very satisfied with their regular provider. For this and other responses to satisfaction questions concerning women's regular provider,

Table 5.5 Indicators of Health Care Utilization in Past Year among White, African American, and Hispanic Women (unadjusted percentages and adjusted for age and poverty status)

	White		African American		Hispanic	
Indicator	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval
Saw a health care provider						
Unadjusted[a]	92.6	90.3,95.0	92.2	89.4,94.9	81.6	77.0,86.3
Adjusted[a]	92.8	90.5,95.1	93.2	90.7,95.7	83.8	79.6,88.1
Received preventive care						
Unadjusted[a]	74.8	70.7,79.0	73.3	68.5,78.0	59.1	54.5,63.7
Adjusted[a]	74.4	70.2,78.5	75.0	71.1,79.0	59.8	54.7,64.9
Used an emergency room						
Unadjusted	20.1	16.0,24.1	25.6	21.6,29.6	18.7	15.0,22.4
Adjusted[b]	21.0	17.1,24.8	24.5	20.5,28.4	18.6	14.9,22.3
Was hospitalized						
Unadjusted[b]	17.7	13.9,21.5	15.5	12.0,19.0	10.6	7.7,13.5
Adjusted	17.9	14.1,21.7	16.1	12.5,19.7	10.2	7.3,13.1
Received prenatal care						
Unadjusted	6.4	3.7,9.1	8.6	5.9,11.4	8.0	5.4,10.7
Adjusted	7.1	4.2,10.1	6.9	4.8,9.1	5.7	4.0,7.4
Received a second medical opinion						
Unadjusted[b]	20.0	16.2,23.8	14.4	11.6,17.1	13.3	9.2,17.4
Adjusted[b]	20.3	16.5,24.1	13.7	11.0,16.4	12.6	9.1,16.1
Saw mental health care provider						
Unadjusted	8.1	5.6,10.6	4.6	2.5,6.6	5.3	3.1,7.5
Adjusted[b]	8.6	5.9,11.2	4.1	2.3,5.9	4.6	2.9,6.2
Treated by a chiropractor						
Unadjusted[a]	14.4	11.1,17.6	3.8	2.2,5.4	8.0	5.2,10.9
Adjusted[a]	14.3	11.2,17.4	4.2	2.5,5.8	8.9	5.6,12.2

Source: Data from The Commonwealth Fund Minority Health Survey, 1994.

[a] $p < 0.001$.

[b] $p < 0.05$.

there are no statistical ethnic/racial differences among the three groups of women sampled. Regular providers were viewed by 70 percent of women as doing an excellent job of treating them with respect. Sixty-four percent of women report that their provider does an excellent job of making sure they understand instructions. Additionally, 62 percent report that their regular provider does an excellent job of listening to their concerns, and 58 percent feel that their provider does an excellent job at providing good health care. Women are less sanguine about their provider's availability; only 51 percent feel that their provider does an excellent job of being accessible by telephone or in person.

Despite the lack of ethnic/racial differences in women's satisfaction with their regular provider, women in the study do differ in their overall satisfaction with the quality of their health care services (Table 5.6). White women are more likely to report being very satisfied with the quality of their health care services in contrast to African American (unadjusted chi-square$_{(1)} = 11.56$, $p < 0.001$) and also to Hispanic women (unadjusted chi-square$_{(1)} = 9.94$, $p < 0.001$), who do not differ significantly from each other. Although this overall difference does not quite achieve overall statistical significance ($p = 0.06$) when the possible confounding effects of age and poverty status are controlled for, a higher percentage of white women report being very satisfied with the quality of their health care services when contrasted with African American women (adjusted chi-square$_{(1)} = 5.61$, $p < 0.05$).

Women were also asked about levels of satisfaction with four other aspects of their medical care. We observed no ethnic/racial differences in terms of women's satisfaction with the convenience of hours and location of their health care setting (with the overall percent reporting that they are very satisfied being 66%), and in terms of sensitivity of the office staff to cost concerns (with the overall percent reporting that they were very satisfied being 47%). However, white women most frequently report being very satisfied with the skills of the medical staff and the helpfulness of the office staff. This satisfaction level is in contrast, particularly, to Hispanic women, who appear to be the most dissatisfied ethnic/racial group concerning aspects of their health care services. Contrasting specifically Hispanic and African American women, we observed no differences in satisfaction in the perceived skill of the medical staff or in the quality of health care, but Hispanic women are also more likely than African American women to report being less satisfied with the helpfulness of office staff (unadjusted chi-square$_{(1)} = 9.58$, $p < 0.01$: adjusted chi-square$_{(1)} = 6.83$, $p < 0.01$).

Table 5.6 Satisfaction with Health Care Services and Experiences with Discrimination among White, African American, and Hispanic Women

	White		African American		Hispanic	
Indicator	%	95% Confidence Interval	%	95% Confidence Interval	%	95% Confidence Interval
Overall, very satisfied with:						
Skill of medical staff						
Unadjusted[a]	73.0	68.7,77.2	63.1	58.2,68.0	56.0	49.7,62.2
Adjusted[b]	72.6	68.4,76.8	65.5	60.8,70.2	57.7	52.2,63.2
Helpfulness of office staff						
Unadjusted[a]	68.5	64.1,72.9	61.7	57.1,62.2	50.3	45.5,55.1
Adjusted[b]	67.6	63.3,71.9	64.6	60.6,68.7	52.5	47.6,57.3
Quality of health care services						
Unadjusted[a]	61.5	57.0,66.1	48.8	43.6,56.9	49.3	44.1,54.5
Adjusted	60.4	55.7,65.0	50.5	45.7,55.3	53.1	47.9,58.3
Has ever changed doctors because dissatisfied						
Unadjusted[b]	44.2	39.6,48.9	33.6	29.5,37.8	32.7	28.2,37.2
Adjusted[a]	45.2	40.6,49.8	33.2	29.3,37.2	32.5	28.3,36.6
Believes there was a time she would have received better care if of a different race						
Unadjusted[a]	2.8	1.0,4.6	16.0	12.7,19.4	13.0	8.9,17.2
Adjusted[a]	3.2	1.2,5.2	14.9	11.8,17.9	10.2	6.9,13.5
Was treated badly or felt uncomfortable when getting health care in past year						
Unadjusted	8.8	6.1,11.5	6.6	4.5,8.8	8.5	6.1,11.0
Adjusted	9.4	6.5,12.2	5.5	3.6,7.4	8.3	5.5,11.1

Source: Data from The Commonwealth Fund Minority Health Survey, 1994.

[a] $p < 0.001$.

[b] $p < 0.01$.

White women, more frequently than either African American (unadjusted chi-square$_{(1)} = 7.76$, $p < 0.01$) or Hispanic women (unadjusted chi-square$_{(1)} = 10.14$, $p < 0.001$), report that they had changed doctors at some time in the past because they were dissatisfied with their care (Table 5.6). But a sizable minority of African American women, followed by Hispanic/Latina women, believe that at some time in the past they would have received better care if they had been of a different race. This effect is quite robust and holds even after the effects of age and poverty status differences are statistically controlled. But when women are asked specifically about experiences of being treated badly in the prior year, we find no statistically significant differences by ethnic minority.

DIFFERENCES REMAIN BETWEEN WHITES AND MINORITY GROUPS

We find, like other researchers (Lillie-Blanton et al. 1993; Zambrana and Ellis 1995), that African American and Hispanic/Latina women are worse off than white women in their level of health care coverage, in their utilization of health care services, and in the perceived quality of their health care. This is true even after controlling for the effects of poverty. Further, our results suggest that patterns of access to health care for African American and Hispanic women are less likely to result in optimum health care than other patterns of access. Both African American and Hispanic women are less likely than white women to have a regular health care provider. Also, African American women are more likely than white or Hispanic/Latina women to use emergency rooms as their usual place of care, which is an environment unlikely to provide preventive health services well (although in the current study we observe no differences between African American and white women in their receipt of preventive care the prior year) or continuity of care.

Hispanic Women Have Less Coverage and Care

The Hispanic/Latina women in our study often have the least health care coverage, resources, and utilization of services of all the ethnic groups. Of pressing concern is our finding that approximately half of the Hispanic/Latina women report that they have not had any health care coverage at some point during the past two years. Also, in contrast to the African American and white women respondents, the Hispanics are most likely to report that they currently have no health insurance coverage.

Unfortunately, the pattern of Hispanics/Latinos accounting for a large proportion of the uninsured population is one that is increasing rather then decreasing (Weissman and Epstein 1994). It is therefore not surprising that in this study the Hispanic/Latina women are the most likely group not to get care, to put if off because of difficulties in accessing health services, or not to have received preventive services or to have seen a health care provider within the last year. These findings increase our concern for the health of Hispanic women, in light of the fact that heart disease, diabetes, and breast and lung cancer are the leading causes of death in this population (Zambrana and Ellis 1995). These are all diseases whose outcomes benefit from early screening, preventive services, and monitoring.

The Hispanic women in our study are also the least likely to believe that their health problems impair their activities. What our findings cannot tell us, however, is whether the health problems of the Hispanic/Latina women respondents are mild, and present no handicap to the business of meeting their daily activities, or whether these women's definitions and/or cultural norms of illness and health (as an impediment in meeting their obligations) account for their responses. Other studies indicate that Hispanics seek health care only when they view their illness as serious (Andersen et al. 1981 and 1986). Merely documenting that Hispanic/Latina women do not perceive that their health problems hamper them from meeting daily obligations does not give us an adequate insight into the true nature of their health problems. It is not clear, for example, whether it is culturally unacceptable (in the press of family obligations) to fail to meet those obligations except in the face of serious illness, or whether the intolerance of ill health differs from other cultural groups.

The Hispanic women in our study, when they do access health care, are the least satisfied with the health care services they receive. While both African American and Latinas perceive less satisfaction than others with the quality of health care and skills of their medical professionals, only approximately half of the Latinas feel that the office staff is helpful. As managed care providers seek to provide quality health care, and to design measures of patient satisfaction that will review their service delivery performance, this study indicates that there may be differences in cultural expectations of how service delivery should be structured.

In contrast to minority women, white women appear to make greater and perhaps better use of health care resources, including getting second medical opinions, mental health care services, and chiropractic care, and in changing doctors when they are dissatisfied with their care. They also perceive, in contrast to African American women or Hispanic/Latina women, both their health and the quality of their health services as being better. The white women in our study were more likely to eat a healthy diet, but they were also more likely to be smokers. White women, however, did not significantly differ from African American or Hispanic/Latina women in their amount of exercise, or their perception of being treated badly or feeling uncomfortable when getting health care.

The Social Nature of Health Disparities

Results of the CMHS indicate that a small but nonetheless important percentage of women have not seen a health care provider in the last year, do not receive preventive health care services, do smoke, and do not eat a healthy diet or exercise at least once a week. The social nature of health disparities requires a broader focus on more issues than the physical aspects of disease. The medical care delivery sector alone is not an adequate source for the improvement of women's health (U.S. Department of Health and Human Services 1994), particularly the health disparities experienced by African American and Hispanic/Latina women. Although changes in the delivery of health care services by managed care and capitated health plans will increase accessibility, preventive services, and the quality of those services (U.S. Department of Health and Human Services 1994), it is not clear whether African American and Hispanic women would benefit if these were the sole changes to the delivery of their health care.

On the other hand, relying on the public health system to monitor the health status of women, to assure quality accessibility and accountability in medical care and planning for women, is not without its own problems. Public health activities accounted for less than 1 percent of the aggregate amount spent in budget year 1992 on health care in the United States (U.S. Department of Health and Human Services 1994). Rather, a better collaborative relationship between the medical care delivery service and public health systems will be necessary if the country is to meet the Healthy People 2000 goals outlined for the health of women (U.S. Department of Health and Human Services 1991).

In this status report on perceptions of access to health care, health status, and utilization patterns of African American and Latina women, based on a national probability sample, we have found some striking differences between these two groups. Despite the fact that both African

American and Latina women report poorer health relative to that reported by whites, Hispanics are far more likely to lack health insurance. One of every three Latina women interviewed lacked health insurance in the past year, compared to one of every five African American women. These alarming results are similar to facts revealed in the 1990 Census, in which 40 percent of Latinos were uninsured, compared to one-fourth of African Americans and only one-seventh of whites (Valdez et al. 1993).

BETTER HEALTH POLICIES FOR ALL WOMEN

More attention is now being focused on strategies and policies aimed at reducing the burden of illness and rectifying the disparities in the health of poor and ethnic minority women. It is important for these efforts to focus on two distinctly different but interrelated areas. First, as women have long been neglected as the subjects of biomedical research, much of the data that guides clinical practice for the treatment and prevention of disease is based on studies of men (Mastroianni, Faden, and Federman 1994). For epidemiologic and biomedical research to contribute to a clearer understanding of disease etiology and transmission, and to offer better choices in pharmacologic, surgical, and other medical interventions, it will be important to prioritize more female-specific (Leslie 1992) and race-specific research (Mays 1999). However, we must also concentrate equally on efforts to gain a clearer understanding about how culture, ethnicity, social status, socioeconomic resources, and individual priorities *interact* with women's health to positively affect their health behaviors and health status (Kreiger 1987, 1989, 1990a,b; Bassett and Krieger 1986; Krieger et al. 1993; Lillie-Blanton et al. 1993; Zambrana 1987).

The decisions that women make about when to seek help, or whether to seek traditional or informal sources of care for their health problems, are decisions made within the context of other priorities, availability of resources, and role demands in women's lives (Leslie 1992; Mays, Beckman, Ornacheck, and Harper 1994; Mays, Howard-Caldwell, and Jackson 1996). Previous studies demonstrate the significance of families, social networks, and peer groups in influencing the engagement in or resistance to such health behaviors as smoking, diet, and exercise (Mays 1999).

Anticipatory responses of possible discrimination and mistreatment based on race and/or gender also influence an individual's search for help for health concerns (see Chapter 11). African American and Hispanic women in this study feel that if their race had been different they would have received better health services. What our results help to illustrate is that the health status of women is not just a matter of individual behaviors. Women's health behaviors and health status may be influenced or constrained by other factors. While researchers are beginning to document that the health problems of women are an interaction of family, resource availability, cultural and social status norms of illness and health, and biological factors, policymakers should review how interventions to enhance women's health should take contextual factors into account (Leslie 1992; Cochran and Mays 1994; Zambrana 1987). As managed care companies extend into populations of ethnic minority women, they need to realize that they cannot be effective without being sensitive to the issues of poverty, culture, and intragroup diversity that characterize these populations.

Women's Cultural Patterns about Health Practices

Studies of women's health must begin to move beyond mere documentation of the problems to investigating better answers to the questions of why and how poor and ethnic women experience the worst health of all women. To do this, we need to include contextual questions that assess social inequalities—such as how racism, discrimination, and oppression influence women's health (Cochran and Mays 1994; Mays, Coleman, and Jackson 1996). These contextual questions will require greater attention to the demand side of women's health utilization by increasing our knowledge of women's cultural patterns concerning their health practices (Timyan, Brechin, Measham, and Ogunleye 1993). It will be necessary to take into account women's relationships with their families, their systems of social support, their use of alternative sources of care for health problems, their priorities, and their definitions of ill health. This can only be accomplished by listening and talking with women before designing and implementing research endeavors, health programs, or health policies that affect women or their families (Brems and Griffith 1993; Baylis and Nelson 1997).

What we have failed to accomplish here is to explore the unique health needs and health habits of the intra-ethnic groups of the women in this study. While data were collected that identifies Caribbean-born African Americans and subgroups of the Hispanic/Latina populations, sample size and data collection methods do not allow for comparisons.

Yet, to make quantitative advancements in understanding the health of ethnic women, we need to examine ethnic subgroup differences—because the incidence and prevalence of disease as well as health behaviors, cultural norms, access and utilization can be expected to differ by subpopulations.

For example, our study has found that Hispanics are the least likely to have health insurance. But any design of health policy on this issue would be best guided by data broken down by geographic region, ethnic subpopulations, and age. Women's health insurance coverage differs substantially among Hispanic subpopulations; Puerto Ricans are most likely to be insured and Mexican-origin women the least likely (Torre et al. 1996). Several factors contribute to these differences. Puerto Ricans are more likely to be U.S. citizens and to reside in the Northeast, where states have favorable benefits and eligibility requirements for Medicaid (Valdez et al. 1993). Mexican-origin women, on the other hand, face stringent immigration laws, and they tend to reside in the Southwest, where Medicaid eligibility is among the most restrictive, with fewer benefits (Valdez et al. 1993).

The labor force participation of Hispanics differs from that of whites and African Americans just enough to make a difference in the type of health care coverage that is based in employer-sponsored benefits. Latinos are most likely to be employed in agriculture, sales, and personal service industries, and to work for employers with small businesses; these are conditions that traditionally offer few to no health benefits (Valdez et al. 1993). Thus, although our study presents results for Hispanics as a group, the reader is cautioned that identifying a particular Hispanic subpopulation, and noting where that group geographically resides, are important considerations when formulating health policies that will be adequate and effective for that subgroup.

Policies Must Be Multifaceted to Address Ethnic Differences

From a policy standpoint, the data in this study question the wisdom of developing policies and managed care strategies that attempt to address the broad group of "racial/ethnic minorities." While many managed care settings will contain a mixed-ethnic population of both African Americans and Hispanics, planners must accept that not all policies will serve each group equally well. *Significant* differences exist between these two ethnic groups as well as within them in terms of labor force participation, family formation, immigration status, and state eligibility requirements for publicly financed coverage. Proposals for reforming either the design or financing of health care should be based on an examination of whether outcomes will be equitable, given the many differences among and within the ethnic groups' participation in the larger societal structure. Designers of managed care programs for these populations should learn about the differences, particularly between African American and Hispanic women, in their perceived health status.

For health care reform to be effective for all ethnic groups, the unique structural and cultural experiences of each group (for whom we are responsible for delivering medical services) must be a part of the discussion for solutions. Sensitivity to how poverty and culture influence perceived health status and interact with affordability, acceptability, and accessibility of services, is critical if managed care groups are to maintain optimal and cost-efficient health care services to ethnic minority women.

To ensure adequate and effective health care services for ethnic minority women, reform must address cultural competence among providers and systems as well as financing mechanisms and medical care delivery system structures. Systems that recognize the cultural realities of women's lives will be more effective in their treatment and prevention of the morbidity and mortality that is disproportionately high for these populations.

By including standards of cultural competence in the delivery of health care for women of all ethnicities, health care treatment and prevention efforts based on reality will emerge. Providers will understand that treating hypertension, obesity, or diabetes occurs within the context of how that woman's cultural, social class, work and community life, age, household composition, immigration status, and a host of other factors affect the way she takes care of herself.

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