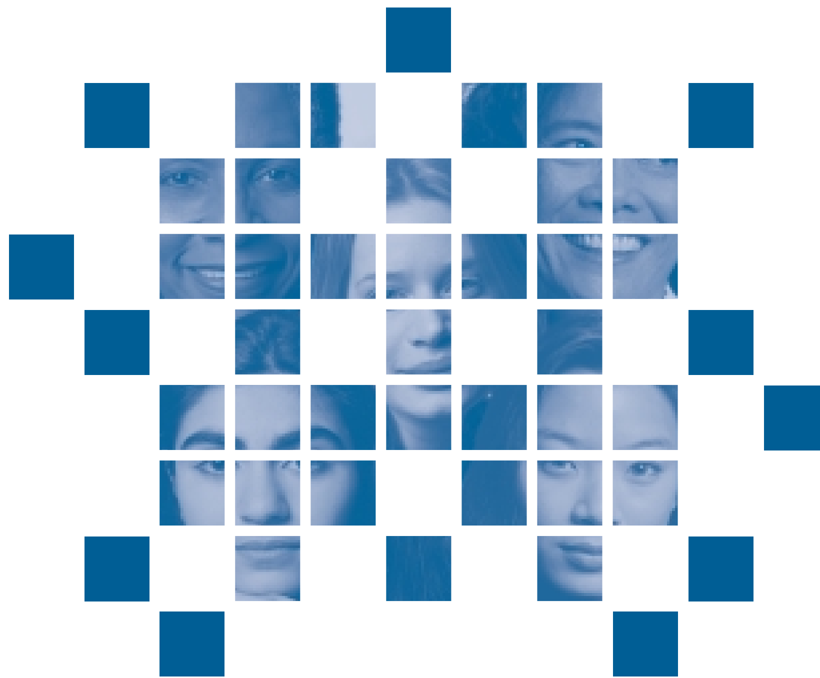

Chapter VI

# Key Health Disparities by Race, Ethnicity, Sexual Orientation and Disability

The health of women in the United States varies substantially by race, ethnicity, sexual orientation and disability, and general health statistics for all women fail to reflect significant disparities. Data regarding women's health are severely limited and often it is not possible to break out information by demographic characteristics. Where such data are available for the status indicators, the national and state report cards provide that information. However, the national and state report cards could not address many important disparities because of the data limitations. For example, there is great disparity in life expectancy among women of different races, but available data on this issue are limited. The data are only available by state disaggregated by white, black and other than white (and are provided on the national and state report cards) but consistent data by all races, ethnicities and ages are not available. In addition, white women are more likely to receive prenatal care in the first trimester than are black women or Hispanic women. However, data on prenatal care are only available by state disaggregated by total white, white non-Hispanic, total black, black non-Hispanic, and Hispanic women. Without data on other groups of women, such as Asian/Pacific Islander and American Indian/Alaskan Native, it is not known at what rate these women are getting prenatal care.

This chapter supplements the *Report Card* data with information from other, albeit sometimes inconsistent, sources. By highlighting some additional health information for women by race, ethnicity, age, sexual orientation and disability, the *Report Card* can provide a better look – although not a complete look – at the significant health disparities faced by American women today. Very little change has occurred in the area of disparities since last year's *Report Card*. In the areas where change has occurred, this *Report Card* notes it.

The nation is becoming increasingly diverse, with whites projected to make up barely 50 percent of the population by the middle of this century.[1] Two important changes were made to the 2000 census. First, the U.S. Census Bureau had previously aggregated information on race/ethnicity by four major race groups (American Indian or Alaskan Native, black or African American, White and Asian or Pacific Islander) and Hispanic origin. The "Asian and Pacific Islander" category is now divided into two groups, "Asian" and "Native Hawaiian and Other Pacific Islander". Therefore, there are now five minimum categories of race (American Indian or Alaskan Native, Black or African American, White, Asian, and Native Hawaiian and Other Pacific Islander) and Hispanic origin.[2] Secondly, people now have the option of identifying themselves as belonging to more than one race by marking multiple racial categories.[3] Although multiracial individuals constitute an increasing segment of the population, only two percent of respondents to the 2000 Census identified themselves as members of more than one race.[4]

How each group identified by the Census is defined is the source of much debate.[5] Each of these minority groups is actually composed of many different groups of people, who often do not share traditions, attitudes on gender roles, foods, communication styles, child-rearing practices, acceptance of American "culture," and attitudes towards "traditional" health care.[6] Generally, racial and ethnic minority populations tend to be younger than the general population, reflecting differences in death rates, fertility, immigration patterns and the age of immigrants.[7] How members of racial and ethnic groups are identified can bias statistics about critical health conditions. For example, the results from several studies show mortality data by race often underestimate the number of deaths and death rates for races other than white and black due to misclassification (i.e., a person who self-reported as Native American or Asian American on Census or survey forms was sometimes reported as white on a death certificate). In addition, underinclusion of minority groups in the Census and resultant population estimates introduce biases into death rates by race.[8]

Poverty, segregation and discrimination affect the well-being of all the groups of women discussed in this chapter. The link between socioeconomic status and race, and its impact on health is increasingly being studied, especially in the nation's effort to eliminate health disparities.[9] There are growing disparities in socioeconomic status within minority groups, with recent immigrants faring much worse in health outcomes than more established groups with greater financial resources.[10] White women have the highest economic status of all women, but even they are substantially poorer than white men.[11] Residential segregation by racial and ethnic group affects access to resources, including health care.[12] Linguistic isolation poses unique problems for Hispanic and Asian populations.[13] Such isolation and segregation contribute to the well-documented undercounting of minority groups on the Census, and affect the distribution of federal resources.[14]

Most of the data referred to in the text concerning key conditions and diseases, wellness and prevention, poverty and educational attainment are highlighted in the national report card on page 14 and on the charts that follow, and, unless otherwise cited, are from those sources. Data for causes of death in this chapter have not been updated due to changes in methodology.[15] Data for the leading causes of death for white women are provided on page 201 for ease of comparison with the race and ethnicity groups that are described in this chapter. Data on leading causes of death for all women can be found in chapter III. Since the last *Report Card*, data for many of the measures included on the state pages are now available by sex and race/ethnicity and age at the state level due to an interactive electronic data warehouse on the National Center for Health Statistics website: State Health Statistics by Sex and Race/Ethnicity. This database contains both mortality tables and health behavior and risk factor tables. Data by sex and race/ethnicity and age are now available at the state level for the following indicators: uninsured, Pap smears, mammograms, colorectal cancer screening, exercise, smoking, binge drinking, high blood pressure, and diabetes.

The data from the health behavior and risk factor tables are from the Behavioral Risk Factor Surveillance System (BRFSS) and do not provide a national number. Therefore, for some indicators, race/ethnicity and age data are available by state and are included on the state pages, but were not available at the national level.

A national initiative is now underway to address disparities in health care. Congress passed the Health Care Fairness Act in November 2000, which amends the Public Health Service Act to expand research and data collection on health disparities that affect minorities and underserved populations. The Act, however, does not explicitly refer to special issues concerning race and gender. Key components of the new law include establishing a new National Center on Minority Health and Health Disparities at the National Institutes of Health, directing a comprehensive study of the U.S. Department of Health and Human Services' data collection systems and practices regarding collection of data on race or ethnicity, and creating a research and demonstration grant program for training and educating health professionals on disparities in health care and the provision of culturally competent health care.[16]

The Institute of Medicine is conducting a study to determine sources of racial and ethnic disparities in health care, including bias, discrimination and stereotyping in the health system. The study will be released in January 2002, and will provide recommendations for interventions to eliminate disparities.[17] Throughout this section, unless otherwise noted, data about the percentage of women in the United States come from the demographic information for the nation on pages 14-15.

### Race/Ethnicity Data for Selected Indicators

| | White | Black | Asian/ Pacific Islander | American Indian/ Alaskan Native | Hispanic |
|---|---|---|---|---|---|
| ***Percent of Women Who Had a Pap Smear*** | 84.4 | 87.8 | 70.9 | 83.5 | 78.1 |
| ***Percent of Women Who Had a Mammogram*** | 67.1 | 66.7 | 69.5 | 65.6 | 62.2 |
| ***Percent of Women Who Had a Colorectal Screening Within the Past Two Years*** | 21.0 | 21.2 | 20.3 | 19.8 | 18.1 |
| ***Percent of Women Who Are Overweight*** | 22.7 | 39.7 | 9.6 | 35.5 | 26.5 |
| ***Percent of Women Who Do Eat Five Fruits and Vegetables a Day*** | 28.5 | 22.3 | 27.1 | 28.0 | 27.7 |
| ***Percent of Women Who Smoke*** | 21.7 | 20.2 | 10.3 | 30.7 | 14.3 |
| ***Percent of Women With Diabetes*** | 4.7 | 8.2 | 4.6 | 9.6 | 6.3 |

Source: Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 96-107.

# African American Women

African American women make up 13.1 percent of all women in the United States, and are the largest group of women of color. Black women are primarily "African American," the term commonly used to describe the descendants of Africans brought to the United States as slaves.[18] There is, however, increasing diversity among blacks, with foreign-born blacks accounting for six percent of all blacks in the United States.[19] Most other blacks in America are of Caribbean descent, coming from island nations including the Dominican Republic, Haiti, Jamaica, and Trinidad and Tobago.[20] Recent immigrants from African countries account for less than four percent of all U.S. immigrants between 1981 and 1998, but there is some indication that these numbers are increasing.[21] Sources used both the terms "African American" and "black" to describe all descendents of Africans living in the United States regardless of country of origin or immigrant status. Throughout the *Report Card*, the terms "African American" and "black" are used interchangeably to describe all black women.

African American women face many barriers to quality health care services, including stereotyping and discrimination on the basis of race.[22] Although access to health care for African American women has improved in recent years, continued efforts are necessary to ensure that health services are of high quality and are culturally appropriate, as well as to address discrimination and stereotyping.

**Women's Access to Health Care Services.** African American women are less likely than white women to have health insurance coverage. When they are insured, they are more likely than other groups of women to have publicly funded health insurance through Medicaid and Medicare.[23] Even when African American women have health insurance, they often lack access to preventive care because of financial barriers, lack of information about disease symptoms and when to seek care, lack of neighborhood health care facilities and race discrimination encountered when seeking care.[24]

As with other data not provided by all four races and Hispanic origin, data on access to prenatal care disaggregated by race are very limited. However, these limited data show that a smaller percentage of African American women receive prenatal care in the first trimester (74.1 percent for black and black, non-Hispanic) than white women (85.1 percent for white and 88.4 percent for white, non-Hispanic) or Hispanic women (74.4 percent).

**Wellness and Prevention.** African American women are the most likely group to have had a Pap smear in the past three years, and compare favorably with other groups of women in securing mammograms and colorectal cancer screening. But they are also the most likely to be overweight (a major factor in African American women having the second highest rate of diabetes), and to not have eaten the recommended servings of fruits or vegetables. Although obesity rates are alarmingly high among

## Leading Causes of Death for White Women by Age

*Per 100,000 Women*

| Age | Cause | Rate |
|---|---|---|
| **All Ages** | Diseases of the Heart | 92.7 |
| | Lung Cancer | 27.4 |
| | Cerebrovascular Disease | 22.9 |
| | Breast Cancer | 19.7 |
| | Chronic Obstructive Pulmonary Diseases | 18.2 |
| | Accidents and Adverse Effects | 17.5 |
| | Diabetes | 10.7 |
| | Pneumonia and Influenza | 10.2 |
| | Colorectal Cancer | 9.9 |
| | Ovarian Cancer | 6.3 |
| **25 to 44** | Accidents and Adverse Effects | 15.6 |
| | Diseases of the Heart | 8.9 |
| | Breast Cancer | 8.1 |
| | Suicide | 6.4 |
| | HIV | 4.3 |
| | Homicide | 3.4 |
| | Cerebrovascular Disease | 3.0 |
| | Lung Cancer | 2.9 |
| | Cirrhosis, Chronic Liver Disease | 2.6 |
| | Cervical Cancer | 2.4 |
| **45 to 54** | Diseases of the Heart | 46.0 |
| | Breast Cancer | 37.5 |
| | Lung Cancer | 28.2 |
| | Accidents and Adverse Effects | 15.3 |
| | Cerebrovascular Disease | 12.4 |
| | Ovarian Cancer | 9.1 |
| | Colorectal Cancer | 9.0 |
| | Diabetes | 8.8 |
| | Chronic Obstructive Pulmonary Diseases | 8.1 |
| | Suicide | 7.7 |
| | Cirrhosis, Chronic Liver Disease | 7.7 |
| **55 to 64** | Diseases of the Heart | 168.9 |
| | Lung Cancer | 103.3 |
| | Breast Cancer | 66.5 |
| | Chronic Obstructive Pulmonary Diseases | 44.7 |
| | Cerebrovascular Disease | 33.2 |
| | Diabetes | 29.4 |
| | Colorectal Cancer | 28.1 |
| | Ovarian Cancer | 22.1 |
| | Accidents and Adverse Effects | 19.3 |
| | Cirrhosis, Chronic Liver Disease | 14.1 |
| **65 to 74** | Diseases of the Heart | 514.5 |
| | Lung Cancer | 209.2 |
| | Chronic Obstructive Pulmonary Diseases | 143.3 |
| | Cerebrovascular Disease | 111.4 |
| | Breast Cancer | 99.1 |
| | Diabetes | 70.9 |
| | Colorectal Cancer | 63.9 |
| | Pneumonia and Influenza | 41.6 |
| | Ovarian Cancer | 38.9 |
| | Accidents and Adverse Effects | 32.5 |
| **75 to 84** | Diseases of the Heart | 1648.0 |
| | Cerebrovascular Disease | 445.1 |
| | Chronic Obstructive Pulmonary Diseases | 294.8 |
| | Lung Cancer | 252.7 |
| | Pneumonia and Influenza | 188.5 |
| | Diabetes | 141.5 |
| | Breast Cancer | 138.7 |
| | Colorectal Cancer | 132.1 |
| | Mental Disorders | 100.0 |
| | Accidents and Adverse Effects | 81.3 |
| **85 and Over** | Diseases of the Heart | 6221.9 |
| | Cerebrovascular Disease | 1671.3 |
| | Pneumonia and Influenza | 953.5 |
| | Mental Disorders | 620.0 |
| | Chronic Obstructive Pulmonary Diseases | 423.8 |
| | Alzheimer's Disease | 314.5 |
| | Diabetes | 262.9 |
| | Colorectal Cancer | 258.8 |
| | Atherosclerosis | 250.3 |
| | Accidents and Adverse Effects | 244.6 |

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM]

## Leading Causes of Death for African American Women by Age

*Per 100,000 Women*

| Age | Cause | Rate |
|---|---|---|
| **All Ages** | Diseases of the Heart | 152.4 |
| | Cerebrovascular Disease | 38.9 |
| | Diabetes | 28.7 |
| | Lung Cancer | 26.9 |
| | Breast Cancer | 26.9 |
| | Accidents and Adverse Effects | 20.4 |
| | HIV | 19.1 |
| | Colorectal Cancer | 14.5 |
| | Pneumonia and Influenza | 13.1 |
| | Chronic Obstructive Pulmonary Diseases | 12.8 |
| **25 to 44** | HIV | 43.3 |
| | Diseases of the Heart | 29.4 |
| | Accidents and Adverse Effects | 20.3 |
| | Homicide | 15.8 |
| | Breast Cancer | 14.4 |
| | Cerebrovascular Disease | 10.4 |
| | Diabetes | 4.8 |
| | Pneumonia and Influenza | 4.3 |
| | Cirrhosis, Chronic Liver Disease | 4.3 |
| | Cervical Cancer | 4.2 |
| | Arthropathies and Related Disorders | 4.2 |
| **45 to 54** | Diseases of the Heart | 140.7 |
| | Breast Cancer | 59.3 |
| | Cerebrovascular Disease | 37.9 |
| | Lung Cancer | 33.8 |
| | HIV | 29.7 |
| | Diabetes | 28.0 |
| | Accidents and Adverse Effects | 22.6 |
| | Colorectal Cancer | 15.8 |
| | Cirrhosis, Chronic Liver Disease | 13.9 |
| | Chronic Obstructive Pulmonary Diseases | 12.8 |
| **55 to 64** | Diseases of the Heart | 380.9 |
| | Lung Cancer | 102.9 |
| | Diabetes | 93.1 |
| | Breast Cancer | 87.0 |
| | Cerebrovascular Disease | 84.5 |
| | Colorectal Cancer | 43.5 |
| | Chronic Obstructive Pulmonary Diseases | 35.2 |
| | Accidents and Adverse Effects | 25.0 |
| | Pneumonia and Influenza | 22.2 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 21.0 |
| **65 to 74** | Diseases of the Heart | 898.9 |
| | Cerebrovascular Disease | 214.2 |
| | Lung Cancer | 197.2 |
| | Diabetes | 193.8 |
| | Breast Cancer | 115.0 |
| | Colorectal Cancer | 94.5 |
| | Chronic Obstructive Pulmonary Diseases | 81.3 |
| | Pneumonia and Influenza | 58.5 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 51.5 |
| | Septicemia | 43.5 |
| **75 to 84** | Diseases of the Heart | 2097.9 |
| | Cerebrovascular Disease | 570.1 |
| | Diabetes | 326.5 |
| | Lung Cancer | 206.3 |
| | Pneumonia and Influenza | 192.9 |
| | Colorectal Cancer | 173.5 |
| | Breast Cancer | 152.9 |
| | Chronic Obstructive Pulmonary Diseases | 137.1 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 126.0 |
| | Septicemia | 109.3 |
| **85 and Over** | Diseases of the Heart | 5512.2 |
| | Cerebrovascular Disease | 1471.0 |
| | Pneumonia and Influenza | 695.9 |
| | Diabetes | 493.4 |
| | Colorectal Cancer | 288.6 |
| | Chronic Obstructive Pulmonary Diseases | 215.2 |
| | Breast Cancer | 204.3 |
| | Septicemia | 301.5 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 297.8 |
| | Mental Disorders | 381.5 |

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM]

black girls, studies have shown that they tend to have healthier body images, and higher self-esteem and confidence.[25] A smaller percent of African American women smoke than white or Native American women.[26]

**Key Health Conditions, Diseases and Causes of Death.** African American women have higher mortality rates than any other population group of women for nearly every major cause of death. The top three age-adjusted causes of death are heart disease, stroke and diabetes. These leading causes of death for African American women differ from the leading causes of death for white women. The disparity is especially dramatic for these three causes of death: heart disease (152.4 for African American women compared to 92.7 per 100,000 for white women); stroke (38.9 for African American women as compared to 22.9 per 100,000 for white women); for deaths related to HIV (19.1 for African American women as compared to 1.8 per 100,000 for white women);[27] and for deaths due to diabetes (28.7 for African American women as compared to 10.7 per 100,000 for white women). African American women have the highest death rate due to HIV of any racial/ethnic group of women. While the full explanation for these differences is not known, inadequate health care, delayed diagnosis, and high poverty rates contribute to the disparity.

Causes of death for African American women also vary by age. HIV is the leading cause of death for African American women between the ages of 25 and 44, in contrast to accidents for white women. Notably, homicide is the fourth leading cause of death for African American women in this age group. The leading cause of death for African American women in all age groups 45 and over is the same as for white women, heart disease. For both African American and white women age 45 to 54, the second leading cause of death is breast cancer. For African American women age 55 to 64, the second leading cause of death is lung cancer, while for white women it is the second leading cause of death for women age 55 to 74. Stroke is the second leading cause of death for African American women age 65 and over, and for white women age 75 and over.

The limited data available for several conditions addressed in the *Report Card*, although not provided by all four races and Hispanic origin, suggest a number of important findings. First, African American women fare worse than women in other racial and ethnic groups for several conditions, including arthritis (second highest rate), unintended pregnancy (highest rate), and maternal mortality (the highest rate, which is almost four times higher than white women). However, African American women have the lowest prevalence of osteoporosis (ten percent compared to 21 percent for white women and 16 percent for Mexican American women, the only group of Hispanic women for whom data were available). In addition, a smaller percentage of African American women have experienced violence in their lifetimes (55.1 percent) than Native American women (64.8 percent) and women of mixed race (61.2 percent).[28]

**Living in a Healthy Community.** The limited data available for life expectancy, although not provided by all four races and Hispanic origin, suggest several important findings. The data that are available suggest that African American women have shorter life expectancies than white women (73.7 years as compared to 79.5 years). African American women have the highest infant mortality rate of any racial or ethnic group, more than double that of white women (13.9 and 6.0 per 1000, respectively).

African American women have significantly higher rates of poverty than white American women.[29] On average, nearly 24.3 percent of black women in the United States live in poverty. Nationally, 78.6 percent of African American women over age 21 have 12 or more years of education, compared to 88.3 percent of white women.[30] Nationally, 14.4 percent of African American women have 16 or more years of education, compared to 23.9 percent of white women.[31] Race discrimination contributes to stress-related health problems, such as hypertension and diabetes, as well as overeating that leads to obesity.[32]

## Hispanic Women

Hispanic women are the second largest minority group of women (11.5 percent of all women in the United States) and are expected to surpass African American women in total numbers by 2005.[33] The Hispanic population in the United States is highly diverse, and aggregated measures of health status for "Hispanics" can mask important differences. Most Hispanics in the United States are of (in descending order of population size) Mexican, Central and South American, Puerto Rican and Cuban descent. Thirty-six percent are born outside of the United States.[34] In addition, cultural differences can exist between Hispanic women born in the United States and Hispanic women born abroad. Hispanic women can be of any race.

**Women's Access to Health Care Services.** Low socioeconomic status creates many barriers to health insurance and health services for Hispanic women. Approximately 30 percent of Hispanics live in poverty, and their rate of unemployment exceeds that of the non-Hispanic population.[35] Hispanics make up more than 25 percent of the 44 million individuals without health insurance in the United States.[36] While 80 percent of whites and blacks reported seeing a physician in the last year, only 68 percent of Hispanics reported seeing a physician.[37] This lack of access to necessary services has led to poorer medical outcomes. For example, the data available suggest uninsured Hispanic women with breast cancer are more than twice as likely to be diagnosed at a late stage than white women.[38] More traditional Hispanic immigrants and those with limited English proficiency use outpatient health services less frequently than other immigrants. Those who are not citizens may be less willing to use public clinics and other health facilities for fear of deportation, or in fact may be ineligible to do so.[39]

### Leading Causes of Death for Hispanic Women by Age

*Per 100,000 Women*

| Age | Cause | Rate |
|---|---|---|
| **All Ages** | Diseases of the Heart | 65.5 |
| | Diabetes | 18.0 |
| | Cerebrovascular Disease | 17.3 |
| | Accidents and Adverse Effects | 13.6 |
| | Breast Cancer | 12.7 |
| | Lung Cancer | 8.3 |
| | Pneumonia and Influenza | 7.7 |
| | Chronic Obstructive Pulmonary Diseases | 7.0 |
| | Cirrhosis, Chronic Liver Disease | 6.0 |
| | HIV | 5.9 |
| | Colorectal Cancer | 5.9 |
| **25 to 44** | HIV | 12.4 |
| | Accidents and Adverse Effects | 12.3 |
| | Breast Cancer | 5.7 |
| | Homicide | 5.1 |
| | Diseases of the Heart | 5.0 |
| | Cerebrovascular Disease | 2.8 |
| | Suicide | 2.5 |
| | Cervical Cancer | 2.5 |
| | Cirrhosis, Chronic Liver Disease | 2.4 |
| | Diabetes | 1.7 |
| | Arthropathies and Related Disorders | 1.7 |
| **45 to 54** | Diseases of the Heart | 31.6 |
| | Breast Cancer | 27.3 |
| | Cerebrovascular Disease | 14.3 |
| | Diabetes | 13.2 |
| | Accidents and Adverse Effects | 13.2 |
| | HIV | 10.8 |
| | Cirrhosis, Chronic Liver Disease | 9.7 |
| | Cervical Cancer | 7.0 |
| | Lung Cancer | 6.8 |
| | Colorectal Cancer | 6.4 |
| **55 to 64** | Diseases of the Heart | 130.9 |
| | Diabetes | 52.5 |
| | Breast Cancer | 43.1 |
| | Cerebrovascular Disease | 34.5 |
| | Lung Cancer | 26.3 |
| | Cirrhosis, Chronic Liver Disease | 19.8 |
| | Accidents and Adverse Effects | 18.1 |
| | Colorectal Cancer | 17.2 |
| | Chronic Obstructive Pulmonary Diseases | 12.5 |
| | Ovarian Cancer | 12.2 |
| **65 to 74** | Diseases of the Heart | 392.7 |
| | Diabetes | 139.5 |
| | Cerebrovascular Disease | 94.8 |
| | Lung Cancer | 63.1 |
| | Breast Cancer | 54.8 |
| | Chronic Obstructive Pulmonary Diseases | 40.0 |
| | Colorectal Cancer | 36.7 |
| | Cirrhosis, Chronic Liver Disease | 35.6 |
| | Pneumonia and Influenza | 35.5 |
| | Accidents and Adverse Effects | 23.9 |
| **75 to 84** | Diseases of the Heart | 1133.7 |
| | Cerebrovascular Disease | 285.7 |
| | Diabetes | 224.6 |
| | Pneumonia and Influenza | 137.2 |
| | Chronic Obstructive Pulmonary Diseases | 123.4 |
| | Lung Cancer | 100.9 |
| | Breast Cancer | 77.5 |
| | Colorectal Cancer | 74.0 |
| | Accidents and Adverse Effects | 49.5 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 43.5 |
| **85 and Over** | Diseases of the Heart | 3794.7 |
| | Cerebrovascular Disease | 826.5 |
| | Pneumonia and Influenza | 589.7 |
| | Diabetes | 360.1 |
| | Chronic Obstructive Pulmonary Diseases | 336.2 |
| | Mental Disorders | 231.3 |
| | Alzheimer's Disease | 131.8 |
| | Atherosclerosis | 125.1 |
| | Colorectal Cancer | 122.4 |
| | Lung Cancer | 117.0 |

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM]

The limited data available concerning prenatal care, although not provided by all four races and Hispanic origin, suggest that a smaller percentage of Hispanic women get prenatal care in the first trimester (74.4 percent) than white, non-Hispanic women (88.4 percent).

**Wellness and Prevention.** Cultural traditions regarding privacy and gender roles discourage some Hispanic women from receiving screening services. Hispanic women, for example, are the least likely group of women to receive mammograms and colorectal cancer screening and the second least likely group to have been screened for cervical cancer in the last three years. They are more likely than white women to be overweight. They are as likely as other groups of women to eat the recommended servings of fruits and vegetables and they are less likely to smoke than white women. It is important to note that there is great disparity in the rates of exercise, weight and obesity within the different groups of Hispanic women, particularly between immigrant Hispanic women and U.S.-born Hispanic women.[40] Hispanic women experience the highest lifetime prevalence of depression (24 percent) than of any other women and are 37 percent more likely to suffer from severe depression than white women.[41]

**Key Health Conditions, Diseases and Causes of Death.** The leading causes of death for Hispanic women are heart disease, diabetes and stroke. The age-adjusted rankings of causes of death are similar to those of white women except that deaths due to lung cancer and chronic obstructive pulmonary disease (COPD) (including asthma, bronchitis, emphysema and other airway obstruction disorders) are much less common for Hispanic women. Hispanic women have the second highest death rate due to HIV – more than three times greater than the rate in white women (5.9 as compared to 1.8 per 100,000 for white women).[42] Hispanic women also have a higher death rate from diabetes than do white women (18 as compared to 10.7 per 100,000, respectively). Hispanic women overall are the only group for which the breast cancer death rate is higher than the lung cancer death rate.

The leading cause of death for Hispanic women age 25 to 44 is HIV. Just as it is for most other groups of women, heart disease is the leading cause of death for Hispanic women in all age groups 45 and over. Breast cancer is the second leading cause of death for Hispanic women between the ages of 45 and 54. A recent study found that Hispanic women are more likely than white women to have a higher percentage of large breast cancer tumors, which is indicative of advanced stage disease.[43] Diabetes is the second leading cause of death for Hispanic women between the ages of 55 and 74. The second leading cause of death for Hispanic women in all age groups 74 and over is stroke.

There are no disaggregated data for Hispanic women for many of the conditions addressed in the *Report Card*. The limited data available, although these data are not provided by all four races and Hispanic origin, suggest that Hispanic women have a higher rate of unintended pregnancies (48.6 percent) than white women (42.9 percent), and a lower rate than African American women (50 percent). In addition, 16 percent of Mexican American women (the only group of Hispanic women for which data are available) have osteoporosis, and 54.9 percent of Hispanic women have reported being victims of violence.

**Living in a Healthy Community.** Hispanic women have similar infant mortality rates as white women (5.9 vs. 6.0 per 1000 live births), which is lower than that for African American women (13.9 per 1000). Hispanic women experience some of the highest rates of poverty. Hispanic women experience a wider wage gap than other women.[44] One reason for Hispanic women's lower earnings is their concentration in jobs with lower than average wages, such as administrative support and service jobs.[45] Hispanic women have the lowest rate of high school graduation, with only 57.8 percent of Hispanic women over age 21 having 12 or more years of education.[46] Hispanic women also have the lowest rate of higher educational attainment, with only 10.2 percent of Hispanic women over age 21 having 16 or more years of education.[47] Hispanic women often face discrimination based on language, skin color and national origin.[48] Large proportions of Hispanic women also work in the semiconductor and agriculture industries, both of which have substantial occupational hazards. Agricultural workers, for example, are exposed to pesticides and are often required to use faulty equipment.[49]

## Asian American/Pacific Islander Women

Asian American and Pacific Islander women make up 3.9 percent of women in the United States. They have ties to more than 20 countries and speak more than 100 different languages. The largest groups of Asian Americans (in descending order) are of Chinese, Filipino, Japanese, Asian Indian, Korean and Southeast Asian ancestry.[50] Pacific Islander Americans come from more than 22 islands (Polynesian, Micronesian or Melanesian) and speak as many as 1,000 different languages. The largest group of Pacific Islanders are Native Hawaiians, who constitute 66 percent of all Pacific Islanders, followed by Samoans, at 15 percent.[51] Cultural differences also exist between women of Asian and Pacific Island descent born in the United States and those born abroad. While efforts are underway to collect and analyze data separately for women of Asian descent and women of Pacific Island descent (as well as groups within these two categories), most data available conform to the U.S. Census Bureau's designation of "Asian and Pacific Islander" as one group. Where available in this section, data specific to Asian Americans, and to women of Pacific Island heritage, are provided.

**Women's Access to Health Care Services.** Many Asian American and Pacific Islander women must confront language barriers,

cultural differences and race and sex-based stereotypes that limit their ability to meet their health needs. While Asian American and Pacific Islander women tend to have health insurance (81 percent have public and/or private insurance), some groups, particularly those from Southeast Asia, have high poverty rates and are significantly less likely to have insurance.[52] Simply having insurance, however, may not meet Asian American and Pacific Islander women's health care needs since some traditional Asian models of medicine, such as acupuncture and herbal medicines, are often not covered by health insurance plans. Communication barriers further limit Asian women's ability to obtain appropriate health care services. Even women who speak English well may have difficulty translating medical terms without help.[53]

**Wellness and Prevention.** Asian American women do not have adequate access to reproductive health care providers.[54] Asian American/Pacific Islander women are least likely to have had a Pap smear within the last three years (70.9 percent).[55] However, among women age 50 and over, they are the most likely to have had a mammogram (69.5 percent) and fare similarly to other groups for colorectal cancer screening in having low rates.[56] Although Asian American/Pacific Islander women in general have the lowest rates of overweight (9.6 percent), Native Hawaiian and American Samoan women (63 percent and 66 percent, respectively) have the highest occurrence of obesity of any other major racial or ethnic group or specific population within those major groups.[57] Asian American/Pacific Islander women are also the least likely population to smoke, but there is great variation among groups. Studies in California have revealed that 19 percent of Japanese American women smoke as compared to fewer than one percent of Vietnamese women.[58]

**Key Health Conditions, Diseases and Causes of Death.** Asian American women constitute a heterogeneous group and there are few data on Chinese American, Japanese American, or Southeast Asian populations specifically. Asian American/Pacific Islander women die primarily of heart disease and stroke. Age-adjusted death rates are dramatically lower for Asian American/Pacific Islander women compared with white American women for HIV (0.4 compared to 1.8 per 100,000),[59] chronic obstructive pulmonary disease (COPD) (5.5 compared to 18.2 per 100,000), heart disease (51.0 compared to 92.7 per 100,000) and lung cancer (11.4 compared to 27.4 per 100,000). As is true for other women, for Asian American/Pacific Islander women there are great differences in the key causes of death by age. The leading cause of death for younger Asian American/Pacific Islander women (age 25 to 44) is accidents. Asian American/Pacific Islander women age 45 to 54 are unique among the population groups because breast cancer is the leading cause of death instead of heart disease. For Asian American/Pacific Islander women in all age groups 55 and over, the leading causes of death are heart disease followed by stroke.

There are no data disaggregated for Asian American/Pacific Islander women for many of the conditions addressed in the *Report Card*. The limited data available, although these data are

### Leading Causes of Death for Asian American/Pacific Islander Women by Age

*Per 100,000 Women*

| Age | Cause | Rate |
|---|---|---|
| **All Ages** | Diseases of the Heart | 51.0 |
| | Cerebrovascular Disease | 21.0 |
| | Accidents and Adverse Effects | 11.5 |
| | Lung Cancer | 11.4 |
| | Breast Cancer | 9.6 |
| | Diabetes | 8.2 |
| | Pneumonia and Influenza | 7.2 |
| | Colorectal Cancer | 6.4 |
| | Chronic Obstructive Pulmonary Diseases | 5.5 |
| | Suicide | 3.5 |
| **25 to 44** | Accidents and Adverse Effects | 8.3 |
| | Breast Cancer | 4.9 |
| | Diseases of the Heart | 4.2 |
| | Suicide | 4.0 |
| | Homicide | 2.7 |
| | Cerebrovascular Disease | 2.2 |
| | Lung Cancer | 1.6 |
| | Colorectal Cancer | 1.5 |
| | Cervical Cancer | 1.3 |
| | Arthropathies and Related Disorders | 1.2 |
| **45 to 54** | Breast Cancer | 25.2 |
| | Diseases of the Heart | 19.4 |
| | Cerebrovascular Disease | 15.8 |
| | Accidents and Adverse Effects | 11.7 |
| | Lung Cancer | 10.9 |
| | Colorectal Cancer | 7.5 |
| | Ovarian Cancer | 6.8 |
| | Cervical Cancer | 5.6 |
| | Suicide | 4.7 |
| | Diabetes | 4.2 |
| **55 to 64** | Diseases of the Heart | 87.0 |
| | Cerebrovascular Disease | 39.4 |
| | Lung Cancer | 33.7 |
| | Breast Cancer | 31.8 |
| | Diabetes | 20.1 |
| | Accidents and Adverse Effects | 16.0 |
| | Colorectal Cancer | 15.6 |
| | Ovarian Cancer | 11.5 |
| | Chronic Obstructive Pulmonary Diseases | 10.0 |
| | Cervical Cancer | 9.2 |
| **65 to 74** | Diseases of the Heart | 286.6 |
| | Cerebrovascular Disease | 109.5 |
| | Lung Cancer | 80.6 |
| | Diabetes | 58.0 |
| | Colorectal Cancer | 39.0 |
| | Breast Cancer | 37.5 |
| | Chronic Obstructive Pulmonary Diseases | 31.8 |
| | Accidents and Adverse Effects | 31.4 |
| | Pneumonia and Influenza | 27.3 |
| | Ovarian Cancer | 15.9 |
| **75 to 84** | Diseases of the Heart | 993.4 |
| | Cerebrovascular Disease | 405.0 |
| | Pneumonia and Influenza | 151.6 |
| | Lung Cancer | 150.4 |
| | Diabetes | 143.4 |
| | Chronic Obstructive Pulmonary Diseases | 104.8 |
| | Colorectal Cancer | 82.9 |
| | Accidents and Adverse Effects | 68.7 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 51.3 |
| | Breast Cancer | 45.0 |
| **85 and Over** | Diseases of the Heart | 3452.2 |
| | Cerebrovascular Disease | 1150.0 |
| | Pneumonia and Influenza | 742.1 |
| | Chronic Obstructive Pulmonary Diseases | 232.2 |
| | Mental Disorders | 227.8 |
| | Diabetes | 219.2 |
| | Lung Cancer | 188.8 |
| | Colorectal Cancer | 157.3 |
| | Accidents and Adverse Effects | 125.8 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 119.3 |

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM]

## Leading Causes of Death for American Indian/Alaskan Native Women by Age

*Per 100,000 Women*

| Age | Cause | Rate |
|---|---|---|
| **All Ages** | Diseases of the Heart | 75.3 |
| | Accidents and Adverse Effects | 33.8 |
| | Diabetes | 28.9 |
| | Cerebrovascular Disease | 20.1 |
| | Cirrhosis, Chronic Liver Disease | 18.0 |
| | Lung Cancer | 15.9 |
| | Chronic Obstructive Pulmonary Diseases | 11.8 |
| | Breast Cancer | 10.9 |
| | Pneumonia and Influenza | 10.7 |
| | Mental Disorders | 7.8 |
| **25 to 44** | Accidents and Adverse Effects | 38.7 |
| | Cirrhosis, Chronic Liver Disease | 17.9 |
| | Diseases of the Heart | 11.2 |
| | Mental Disorders | 8.9 |
| | Suicide | 7.5 |
| | Homicide | 6.9 |
| | Diabetes | 4.7 |
| | Cerebrovascular Disease | 4.4 |
| | Breast Cancer | 4.1 |
| | HIV | 3.6 |
| **45 to 54** | Diseases of the Heart | 63.1 |
| | Cirrhosis, Chronic Liver Disease | 44.4 |
| | Accidents and Adverse Effects | 39.6 |
| | Diabetes | 25.8 |
| | Breast Cancer | 23.8 |
| | Cerebrovascular Disease | 18.4 |
| | Mental Disorders | 13.6 |
| | Lung Cancer | 13.6 |
| | Colorectal Cancer | 10.5 |
| | Pneumonia and Influenza | 9.3 |
| **55 to 64** | Diseases of the Heart | 192.1 |
| | Diabetes | 96.8 |
| | Lung Cancer | 59.0 |
| | Cirrhosis, Chronic Liver Disease | 51.0 |
| | Cerebrovascular Disease | 41.1 |
| | Breast Cancer | 38.7 |
| | Chronic Obstructive Pulmonary Diseases | 36.3 |
| | Accidents and Adverse Effects | 33.5 |
| | Colorectal Cancer | 20.3 |
| | Pneumonia and Influenza | 19.0 |
| **65 to 74** | Diseases of the Heart | 496.5 |
| | Diabetes | 222.7 |
| | Lung Cancer | 121.3 |
| | Cerebrovascular Disease | 116.3 |
| | Chronic Obstructive Pulmonary Diseases | 81.6 |
| | Pneumonia and Influenza | 54.6 |
| | Breast Cancer | 53.2 |
| | Cirrhosis, Chronic Liver Disease | 52.5 |
| | Nephritis, Nephrotic Syndrome and Nephrosis | 46.8 |
| | Accidents and Adverse Effects | 46.1 |
| **75 to 84** | Diseases of the Heart | 1064.7 |
| | Cerebrovascular Disease | 331.8 |
| | Diabetes | 298.3 |
| | Lung Cancer | 172.3 |
| | Chronic Obstructive Pulmonary Diseases | 165.9 |
| | Pneumonia and Influenza | 141.4 |
| | Accidents and Adverse Effects | 86.2 |
| | Colorectal Cancer | 75.9 |
| | Nephritis, Nephrotic Syndrome | 66.9 |
| | Mental Disorders | 55.3 |
| | Breast Cancer | 55.3 |
| **85 and Over** | Diseases of the Heart | 2099.9 |
| | Cerebrovascular Disease | 649.8 |
| | Pneumonia and Influenza | 531.6 |
| | Diabetes | 280.6 |
| | Mental Disorders | 251.1 |
| | Chronic Obstructive Pulmonary Diseases | 206.8 |
| | Accidents and Adverse Effects | 147.7 |
| | Colorectal Cancer | 127.0 |
| | Septicemia | 109.3 |
| | Atherosclerosis | 82.7 |
| | Alzheimer's Disease | 82.7 |

Source: National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM]

not provided by all four races and Hispanic origin, suggest that Asian American women have the lowest rate of arthritis (13.2 percent) and the lowest rate of experiencing violence in their lifetimes (51.9 percent) than any other racial or ethnic group. The differences between Asia and the United States make the acculturation process difficult and isolating for many Asian women, which may contribute to the prevalence of mental health problems among this population. Asian American women have the second highest suicide rate among all women, and have the highest suicide rate among women over age 65.[60]

**Living in a Healthy Community.** Asian American/Pacific Islander women experience high rates of poverty.[61] Many women are employed in small businesses or factories with unsafe and unhealthy working conditions and no employment benefits such as health insurance. Although there is a great degree of difference in the level of educational attainment between the different groups of Asian American/Pacific Islander women, overall Asian American/Pacific Islander women have lower high school graduation rates than white women. Nationally, an average of 84.1 percent of Asian American/Pacific Islander women over age 21 have 12 or more years of education, and 40 percent graduate from a four-year college.[62]

# American Indian/Alaskan Native Women

Native American women (used throughout the *Report Card* to mean "American Indian and Alaskan Native" women) constitute 0.9 percent of all women in the United States. There are more than 550 recognized tribes, and 300 spoken languages. Although this population is very diverse, their shared experiences have had a direct impact on their socioeconomic and health status. These experiences include the rapid and forced change from a cooperative and clan-based society to a capitalistic and nuclear family based system, and the outlawing of language and spiritual practices.[63]

**Women's Access to Health Care Services.** The Indian Health Service (IHS) is charged with providing health care services to approximately 1.5 million members (60 percent) of federally recognized Indian tribes and their descendants. Nonetheless, Native American women face logistical and cultural barriers to obtaining health care services. Because many women live in rural communities, have limited access to transportation and appointments at a small number of facilities, they face great difficulties in obtaining needed care. Many older Native American women are uncomfortable being examined by male health care professionals due to the tradition that only women provide care for other women.[64] Communication barriers also limit access. Many of the commonly spoken languages do not include words for cancer, and it is a common belief that talking about a disease

will bring it on, making women less likely to seek preventive services.[65]

**Wellness and Prevention.** Over 83 percent of Native American women have had recent cervical cancer screenings but only 65.6 percent of these women have had a mammogram. Native American women fare comparably to other groups for colorectal cancer screenings by also having low rates. They have the second highest rate of being overweight (more than 35 percent) which places them at high risk for diabetes (Native American women have the highest diagnosed rate at 9.7 per 100,000).[66] Native American women by far have the highest rate of smoking. Native American women have the highest rate of alcohol use and have the highest mortality rate from illicit drug use (7.0 per 100,000) of any other population of women, but do not receive adequate treatment for their addiction. Native American women with substance abuse issues often serve jail time and lose their parental rights.[67] The limited data available, although these data are not provided by all four races and Hispanic origin, suggest that existing addiction treatment programs are culturally inaccessible and ineffective for many Native American women because they fail to incorporate healing elements from Native American cultures.[68]

**Key Health Conditions, Diseases and Causes of Death.** Although the primary cause of death for Native American women is cardiovascular disease, Native American women are unique among the population groups in that accidents rank as the second most common cause of death. Overall Native American women also have the highest age-adjusted death rates for diabetes (28.9 per 100,000) as well as cirrhosis and chronic liver disease (18 per 100,000) compared to other groups. Native American women's health also differs greatly from other populations when examined by age. The leading cause of death for young Native American women (age 25 to 44) is accidents. Although accidents are also the leading cause of death for young white women, the accident rate for young Native American women is more than twice that for white women (38.7 per 100,000 for Native American women as compared to 15.6 per 100,000 for white women). The second leading cause of death among young Native American women (age 25 to 44) is cirrhosis (chronic liver disease). The cirrhosis rate for these women is more than four times greater than that of African American women this age. Cirrhosis is not one of the top five leading causes of death among women age 25 to 44 for any other population group. The limited data available, although these data are not provided by all four races and Hispanic origin, suggest that young Native American women have the highest mortality rate from suicide of all women age 15 to 24.[69]

Like other women, the leading cause of death among Native American women in age groups 45 and over is heart disease. However, Native American women age 45 to 54 are unique as their second leading cause of death is chronic liver disease and the third is accidents. The second leading cause of death for Native American women age 55 to 74 is diabetes. For Native American women over 75, the second leading cause of death is stroke.

There are no data disaggregated for Native American women for many of the conditions addressed in the *Report Card*. The limited data available, although these data are not provided by all four races and Hispanic origin, suggest that Native American women have the highest rate of arthritis (34.5 percent) and the highest rate of experience of violence in their lifetimes (64.8 percent) as compared to any other racial or ethnic group.

**Living in a Healthy Community.** Native American women experience higher rates of poverty than white women: 22.5 percent of all Native American women live in poverty.[70] Native American women have the third lowest rate of high school graduation (79.7 percent), and the second lowest rate of rate of college graduation (15.5 percent).[71] Forced relocation of Native Americans has resulted in race discrimination and hostility from non-Native neighbors, which in turn has led to high unemployment and poverty rates. Native American women's health is also affected by environmental degradation. Many live in poor quality housing (often with poisonous lead-based paint) and are exposed to local toxins. Fifty percent of Native Americans live in areas with uncontrolled toxic waste sites, and a large number of their homes lack access to a safe water supply or sewage disposal treatment, placing them at greater risk of illness and disease. On some reservations, 20 percent of homes do not have indoor plumbing.[72]

## Immigrant Women

Immigrant women represent ten percent of the total population of women in the United States. Among the immigrant population, 51 percent are from Latin America, 25.5 percent are from Asian countries, 15.3 percent were born in Europe, and the remaining 8.1 percent are from other parts of the world.[73] Although there has been much growth in the U.S. immigrant population, current research dealing specifically with immigrant women's health is limited. Immigrants generally do better than the comparable U.S. born population in health status and health outcomes such as self-assessed health; number of restricted activity days; bed disability days; work-loss days; physician visits; and hospitalization rates as well as reduced risk of overall mortality.[74] Furthermore, immigrant women from various ethnic backgrounds are generally shown to have more favorable birth outcomes than their U.S. born counterparts.[75] Although vast cultural differences exist between and within the many immigrant populations, many foreign-born women share similar barriers to accessing adequate health care that may not be experienced by United States born women of color.

**Women's Access to Health Care Services.** Immigrant women's ability to secure access to health care services is largely complicated by the lack of health insurance. Non-native born people make up approximately 20 percent of the low-income uninsured with an uninsured rate of nearly 59 percent, yet they are less likely to receive Medicaid than native-born low-income individuals.[76] The lack of health insurance compounded with language and cultural differences often prevent many foreign-born women from meeting their health care needs.

The passage of the Personal Responsibility Work Opportunity and Reconciliation Act of 1996 (PRWORA) (also referred to as "welfare reform")has further restricted immigrant women's access to health care services. PRWORA allows states to deny Medicaid to qualified immigrants (those who entered the United States before 1996) and bars those who enter the country after August 1996 from receiving Medicaid.[77] In addition to diminishing the already low numbers of non-native women who receive health care, the law has been proven to decrease immigrants' legitimate use of Medicaid and health care. A recent study cited "heightened fears" of losing residency and the inability to understand the changes as reasons for not participating in Medicaid. Other immigrants highlighted the complex Medicaid applications and the inability to afford health care services as reasons for not seeking care.[78]

**Wellness and Prevention.** While immigrants encounter a host of health care difficulties, recent studies show that many voluntary immigrant women are healthier than women born in the United States. Some researchers attribute this to a self-selection process in which only the most resilient women choose to emigrate, as well as the practice of healthy behaviors such as abstention from smoking and alcohol consumption.[79] In the area of oral health, recent research has suggested a link between gum disease and an increased risk of pre-term births. Oral health may be neglected in the country of origin of some immigrants. More research is needed to determine if immigrants are disproportionately affected by gum disease both upon arrival to the United States or over the course of their U.S. residency.[80]

**Key Health Conditions, Diseases and Causes of Death.** A recent study concluded that immigrant women had a 13 percent lower overall mortality rate than native-born women.[81] In addition, immigrant women also have a lower risk of death from cardiovascular diseases and lung cancer than native-born women.[82]

**Living in a Healthy Community.** Immigrant women often have difficulty gaining access to resources, and as a result are more likely to live in poverty than American-born women. Immigrants, as a whole, are less likely to graduate from high school than non-immigrants; however, graduation rates vary among ethnicities.[83] Nationally, 16.8 percent of foreign-born residents live below the poverty line compared with 11.2 percent of United States born citizens, and immigrants are twice as likely to live in poverty.[84] In addition, non-native residents earn substantially less than native citizens because they often hold lower-level service industry jobs rather than managerial positions or professional specialty occupations.[85] Immigrant women are also more likely to be unemployed (5.5 percent) than native women (4.2 percent).[86]

## Lesbians

Studies estimate that between one and 3.6 percent of the female population are lesbians (figures unknown for bisexual population). The lack of attention to health issues facing lesbians presents a significant barrier to their health and well-being – adversely affecting access to health care, health research and data collection.[87] Furthermore, much of the current research often fails to address the health concerns experienced by lesbians of different age groups, ethnicities and cultures.[88] A number of the health problems faced by lesbian women also face bisexual and transgendered women as well. A recent report by the Institute of Medicine identified the serious limitations in current knowledge about lesbian health, and an urgent need for more research.[89]

**Women's Access to Health Care Services.** There is some indication that lesbians are less likely to have insurance coverage than other women. Many lesbian women experience employment discrimination, and as a result work in jobs that do not include health insurance benefits. Also, while many heterosexual women obtain health insurance through their spouses' plans, lesbian women are often not covered by their partners' insurance.[90]

Presumptions that patients are heterosexual, stereotyping of lesbians and misconceptions about lesbians' health needs can all create significant barriers to comprehensive, quality health care.[91] Lesbians face a lack of health care providers who adequately provide services to them – either due to outright discrimination or to damaging misconceptions – making it difficult for them to get comprehensive care and actually inhibiting their willingness to seek care.[92] In fact, studies indicate that lesbians generally seek health care less often than other women do.[93] Managed care worsens the problem of finding and keeping health care providers competent to treat lesbians by limiting the choice of providers and preventing new enrollees from selecting providers.[94] Third-party insurance systems also raise privacy concerns where explicit medical information must be provided for expenses to be approved, and they hinder candid communication between provider and patient.[95] Due to a lack of legal recognition of partners, many lesbians are denied financial support and other benefits during illness, including family leave, workers' compensation, and rights concerning medical care and treatment decisions, organ donation and hospital visitation rights.

**Wellness and Prevention.** Many factors limit lesbians' receipt of adequate preventive health care, including the general barriers to health care discussed above.[96] The fact that lesbians do not usually use contraception means that they also may lose the benefit of other important preventive services, such as breast and cervical cancer screenings, cholesterol tests and blood pressure monitoring that often take place during visits to family planning programs.[97] Surveys on important risk factors, including smoking and overweight, often fail to inquire about sexual orientation, but those that do reveal a higher prevalence of both among lesbians.[98] One study reports that almost one third of lesbians and 50 percent of bisexual women reported current tobacco use. Furthermore lesbians and bisexual women are more likely to report alcohol consumption than heterosexual women.[99]

**Key Health Conditions, Diseases and Causes of Death.** Given the little information about the incidences of specific health conditions among lesbians, even basic data on the causes of mortality have not been collected.[100] However, existing information does suggest areas needing further research. For example, domestic violence among lesbians is a neglected topic. Even those trained to help victims of domestic violence often are not well versed in the dynamics of violence between same-sex partners, and lesbian perpetrators find little support in treatment groups made up primarily of men.[101] Research is needed on mental health issues, including those related to chronic stress resulting from discrimination and public acknowledgment of sexual orientation.[102] Studies indicate a lower prevalence of STDs among lesbians, possibly due to physiological factors and relative social isolation.[103] HIV among lesbians, especially the risks of transmission between women, is another area where research is needed.[104]

**Living in a Healthy Community.** The failure of the federal and state governments to recognize the status of lesbian partners has had a substantial impact on lesbians' financial well-being, and their ability to afford health care.[105] Hate crimes against lesbians present another serious health threat. While surveys vary, one study reported that more than three-fourths of lesbians surveyed had been verbally harassed, and one in ten had been physically assaulted because of her sexual orientation.[106] In addition, the *Report Card* reviews state enactment of laws to prevent employment discrimination based on sexual orientation. Twenty-eight states and the federal government have not enacted such laws.

## Women With Disabilities

Under the Americans with Disabilities Act (ADA), an individual with a disability is defined as "a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment."[107] It is estimated that approximately half of the 54 million people in the United States who currently experience some level of disability are women and girls,[108] and approximately 5.5 million of these women receive Social Security benefits.

**Women's Access to Health Care Services.** Women with disabilities face unique barriers to health care, including physical inaccessibility of medical offices and equipment, limited availability of health information because it is in print format only, and a lack of transportation and related services.[109] In addition, many women with disabilities experience inadequate treatment or outright refusals to be treated by health care providers. Although health care providers must take steps to eliminate these barriers through compliance with accessibility requirements under the ADA, compliance is not yet uniform.[110]

States can help women with disabilities access health care by implementing the "Ticket to Work" option. This program allows states to extend Medicaid coverage to working people with disabilities whose income levels would otherwise disqualify them.[111]

The nationwide shift to managed care, particularly in the context of Medicaid, is creating new problems for disabled women, as people with disabilities represent 12 percent of the managed care population.[112] Heath maintenance organizations have traditionally placed strict limits on therapeutic, supportive and home care services, thus restricting opportunities for people with disabilities to obtain independent living support.[113] Restricted access to specialists, and the inability to name a specialist as a primary care provider, has strong implications for women with disabilities since disabled women use specialists more often than nondisabled women and only specialists may have the necessary training to treat certain disabilities.[114]

**Wellness and Prevention.** Women with disabilities face barriers to preventive health care and health-promoting activities. For example, in the area of mammography screening, standards do not take into account the fact that women with disabilities face special barriers to obtaining these services (e.g., lack of adaptive equipment, providers' lack of familiarity or sensitivity to special needs of women with disabilities).[115]

**Key Health Conditions, Diseases and Causes of Death.** There is little research on special health issues faced by women with disabilities, but special risks and barriers in mental health issues, reproductive health, and violence have been identified. The failure to focus on health issues specific to women with disabilities often means that policies promoting women's health generally are

applied to disabled women, regardless of whether they will actually benefit this population. Disabled women and girls face particular issues regarding mental health. They are at a very high risk for depression, facing struggles with employment discrimination and a lack of accessible and affordable health care, housing and transportation.[116] A recent study found that eating disorders are more prevalent among female adolescents with disabilities than non-disabled adolescents.[117] Women with disabilities also face destructive stereotypes about their sexuality that adversely affect their reproductive health. Disabled women have been subjected to forced sterilizations, coerced abortions, unauthorized hysterectomies, and x-ray screening without protection of their reproductive organs. Women with disabilities have a significantly higher rate of hysterectomy as a method of birth control than nondisabled women, and disabled women are also more likely to not use birth control at all.[118]

**Living in a Healthy Community.** Despite enactment of the Americans with Disabilities Act (ADA) in 1990, people with disabilities continue to face discrimination. Further, women and girls with disabilities are more likely than nondisabled women and girls to experience emotional, physical and sexual abuse by partners, family members and caregivers.[119] Disabled women are less likely to be believed, however, when they report incidents of abuse or assault, and many of these crimes go unreported.[120] Care-giver abuse is a particular issue faced by women with disabilities. It can include denial of medications or oversedation, disconnecting a wheelchair's power supply and other forms of abuse. Girls with disabilities are also almost twice as likely to be sexually abused as nondisabled children, and women and girls with developmental disabilities are far more likely to be sexually assaulted (and revictimized by the same person).[121] Disabled girls also experience higher rates of sexual harassment in school than disabled boys or nondisabled children.[122]

# Chapter VI Notes

[1] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (1999), Introduction.

[2] Sharon M. Lee, *Using the New Racial Categories in the 2000 Census* (Baltimore, MD: Annie E. Casey Foundation, 2001), 7.

[3] Sharon M. Lee, *Using the New Racial Categories in the 2000 Census* (Baltimore, MD: Annie E. Casey Foundation, 2001), 8.

[4] Mary M. Kent and others, "First Glimpses from the 2000 Census," *Population Bulletin* 56 (June 2001) [Online]; Available: WWW URL: http://www.ameristat.org, accessed 13 October 2001.

[5] Sharon M. Lee, *Using the New Racial Categories in the 2000 Census* (Baltimore, MD: Annie E. Casey Foundation, 2001), 2-3.

[6] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (1999), Pt. I.

[7] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, 1998), 5.

[8] National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, 1999) [CD-ROM].

[9] U.S. Department of Health and Human Services, *Healthy People 2010*, 2nd ed. (Washington, D.C.: U.S. Department of Health and Human Services, 2000), [Online]; Available: WWW URL: http://www.health.gov/healthypeople, accessed 30 September 2001 (hereafter "Healthy People 2010"); Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (1999), Pt. III. See also Arlene S. Bierman and others, "Health Disparities Among Older Women Enrolled in Medicare Managed Care," *Health Care Financing Review* 22 (Summer 2001), 187-198.

[10] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, 1998), 40-41.

[11] In 2000, white men working full time earned a median yearly salary of $38,869; white women, $28,080; black men, $30,409; and black women, $25,117. U.S. Census Bureau, "Historical Income Tables – People," Tables P-38A, P-38B (5 October 2001) [Online]; Available: WWW URL: http://www.census.gov/hhes/income/histinc/incperdet.html, accessed 10 October 2001.

[12] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 60.

[13] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 60-61, 67.

[14] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 60; Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. III.

[15] More recent mortality data are not reported in the *Report Card* because more recent data are age-adjusted using the new 2000 standard age population. This *Report Card* uses mortality rates age-adjusted to the 1940 standard age population. Data in this chapter are from the National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-1997* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, Sepember 1999 [CD-ROM]).

[16] 42 U.S.C. § 287c-31 *et seq*. Underscoring this need for better data collection, the Commonwealth Fund recently undertook a study of federal statutes, regulations, policies and procedures of federal agencies (primarily within the Department of Health and Human Services) that collect health data by race, ethnicity and primary language to determine the standards and reporting methods used by the agencies. Researchers found that while existing policies reflect the need for and importance of racial and ethnic data, laws, policies and practices for collection are often unclear and inconsistent. The Commonwealth's report recommends that HHS revise its standards and policies to address these inconsistencies and ensure the standards are followed by the agencies that implement them. Ruth T. Perot and Mara Youdelman, *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices* (New York: Commonwealth Fund, Inc., 2001).

[17] "Lawmakers, Agencies Take Steps to Curb Disparities in Health," *Health Care Policy Report* 9 (26 February 2001); [Online] Available: WWW URL: http://pubs.bna.com, accessed 1 March 2001.

[18] "Factors Affecting the Health of Women of Color: Black Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/black.htm, accessed 8 October 2001.

[19] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 4.

[20] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. II. The Caribbean nations are also a leading source of Hispanic immigrants, who may be of any race, but come from a Spanish-speaking nation. *Ibid.*, Part II, Hispanics.

[21] Kevin M. Pollard and William P. O'Hare, "American's Racial and Ethnic Minorities," *Population Bulletin* 54 (September 1999), Pt. III.

[22] Vernellia R. Randall, "Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African Americans," in *Health Matrix* 3 (1993), 127; and N. Murrell, "Racism and Health Care Access: A Dialogue with Childbearing Women," *Health Care for Women International* 17, No. 2 (London: Taylor & Francis Group, 1996), 149-159, both articles as described in Vernellia R. Randall, *The Current Status of Minorities' Access to Health Care: Annotated Bibliography* (Spring 1997) [Online]; Available: WWW URL: http://academic.udayton.edu/health/03access/97unknow.htm, accessed 9 October 2001.

[23] "Access to Health Insurance: Women of Color," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/figure28.htm, accessed 8 October 2001.

[24] "Factors Affecting the Health of Women of Color: Black Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/black.htm, accessed 8 October 2001.

[25] Sheila Parker and others, "Body Image and Weight Concerns among African Americans and White Adolescent Females: Differences that Make a Difference," *Human Organization* 54 (Summer 1995), 103-114. Though there is indication that such disorders are less prevalent, black girls are still vulnerable to eating disorders such as binge eating. "Minority Women's Health Concerns: Psychiatric Disorders," in *The Health of Minority Women* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, May 2000) [Online]; Available: WWW URL: http://www.4woman.org/owh/pub/minority/concerns.htm, accessed 8 October 2001.

[26] Centers for Disease Control and Prevention, "Cigarette Smoking Among Adults—United States, 1998, " *Morbidity and Mortality Weekly Report* 49 (6 October 2000), Table 1, 882.

[27] Throughout this chapter, the information on deaths due to HIV comes from a data set in which individuals who die from HIV include those who die from AIDS as well as those who die with HIV and/or a condition associated with HIV (as consistent with the ICD-9 definition of HIV infection). National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM].

[28] Patricia Tjaden, Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey (Atlanta: Centers for Disease Control and Prevention, 1998), 2, 5-6.

[29] For poverty, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic).

[30] For high school education, the data reported here considers persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic).

[31] U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics). To compensate for small sample size, Decision Demographics combined the applicable data from the two supplements to arrive at more reliable estimates.

[32] "Factors Affecting the Health of Women of Color: Black Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/black.htm, accessed 8 October 2001.

[33] Council of Economic Advisors for the President's Initiative on Race, *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (Washington, D.C.: Government Printing Office, September 1998), 6.

[34] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 14 October 2001; "Gaps in Preventive Care between African Americans and Whites Close, While Hispanics Still Lag Far Behind," Center for Studying Health System Change (21 January 2001) [Online]; Available: WWW URL: http://www.hschange.org/CONTENT/288/?words=hispanics+preventive+health+services, accessed 8 October 2001.

[35] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 8 October 2001.

[36] American College of Physicians – American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk* (Philadelphia: American College of Physicians – American Society of Internal Medicine, 2000), White Paper, 6.

[37] "Gaps in Preventive Care between African Americans and Whites Close, While Hispanics Still Lag Far Behind," Center for Studying Health System Change (21 January 2001) [Online]; Available: WWW URL: http://www.hschange.org/CONTENT/288/?words=hispanics+preventive+health+services, accessed 8 October 2001.

[38] American College of Physicians – American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk* (Philadelphia: American College of Physicians – American Society of Internal Medicine, 2000), White Paper, 14.

[39] "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 8 October 2001; U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, 2001), 37-38.

[40] "Minority Women's Health Status," in *The Health of Minority Women* (Washington, D.C.: Office on Women's Health, U.S. Department of Health and Human Services, May 2000) [Online]; Available: WWW URL: http://4woman.org/owh/pub/minority/status.htm, accessed 8 October 2001.

[41] "Minority Women's Health Concerns," in *The Health of Minority Women* (Washington, D.C.: Office on Women's Health, U.S. Department o Health and Human Services, May 2000) [Online]: Available: WWW URL: http://4woman.org/owh/pub/minority/concerns.htm, accessed 8 October 2001.

[42] National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM].

[43] Ashley Hedeen and Emily White, "Breast Cancer Size and Stage in Hispanic American Women, by Birthplace 1992-1995," *American Journal of Public Health* 91 (2001), 122-125.

[44] The ratio of Hispanic women's earnings to those of all men in 2000 was only 55 percent, while the overall ratio of women's earnings to those of men was 73 percent. U.S. Census Bureau, "Historical Income Tables – People," Tables P-38, P-38D (5 October 2001) [Online]; Available: WWW URL: http://www.census.gov/hhes/income/histinc/incperdet.html, accessed 12 October 2001.

[45] Women's Bureau, U.S. Department of Labor, "Facts on Working Women: Women of Hispanic Origin in the Labor Force," (Washington, D.C.: Women's Bureau, U.S. Department of Labor, April 2000) [Online]; Available: WWW URL: http://www.dol.gov/dol/wb/public/wb_pubs/hispwom2.htm, accessed 8 October 2001.

[46] For high school completion, the data reported here consider persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as black and Hispanic ethnicity would be considered Hispanic). U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics conducted for the *Report Card*).

47 U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics conducted for the *Report Card*). To compensate for small sample size, Decision Demographics combined the applicable data from the two supplements to arrive at more reliable estimates.

48 "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 8 October 2001.

49 "Factors Affecting the Health of Women of Color: Hispanics," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/hispanic.htm, accessed 8 October 2001.

50 "Factors Affecting the Health of Women of Color: Asian Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/asian.htm, accessed 8 October 2001.

51 "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 8 October 2001.

52 "Factors Affecting the Health of Women of Color: Asian Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/asian.htm, accessed 8 October 2001.

53 For example, the Cantonese translation for "cancer" is the word "nham," which loosely translates into English as "growth" but is not mentioned as a disease in texts on Chinese medicine. "Factors Affecting the Health of Women of Color: Asian Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online], Available: WWW URL: http://www.4women.gov/owh/pub/woc/asian.htm, accessed 8 October 2001.

54 According to a 1997 study published by the National Asian Women's Health Organization, almost 50 percent of the participants had not seen a health care provider within the past year for reproductive health services, and 25 percent had never seen such a provider. National Asian Women's Health Organization, *Report of Activities 1997-1999* (Washington, D.C.: National Asian Women's Health Organization, 1997), 9-10.

55 Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 97.

56 Robert A. Hahn and others, "The Prevalence of Risk Factors Among Women in the United States by Race and Age, 1992-1994: Opportunities for Primary and Secondary Prevention," *Journal of American Medical Women's Association* 53 (Spring 1998), 98.

57 Marisa Urgo, "New Obesity Guidelines: Minority Women at Risk," in *Closing the Gap* (Washington, D.C.: Office of Minority Health, U.S. Department of Health and Human Services, June/July 1998), 6; "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 8 October 2001.

58 "Minority Women's Health Status," in *The Health of Minority Women* (Washington, D.C.: Office on Women's Health, U.S. Department of Health and Human Services, May 2000) [Online]; Available: WWW URL: http://4woman.org/owh/pub/minority/status.htm, accessed 8 October 2001.

59 National Center for Health Statistics, Centers for Disease Control and Prevention, *Women's Health Data by State and U.S. Territory: Mortality 1994-97* (Hyattsville: National Center for Health Statistics, Centers for Disease Control and Prevention, September 1999) [CD-ROM].

60 U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, 2001), 115; "Minority Women's Health Concerns," in *The Health of Minority Women* (Washington, D.C.: Office on Women's Health, U.S. Department o Health and Human Services, May 2000) [Online]: Available: WWW URL: http://4woman.org/owh/pub/minority/concerns.htm, accessed 8 October 2001.

61 For poverty, the data reported here consider persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Asian and Hispanic ethnicity would be considered Hispanic).

62 For high school completion, the data reported here consider persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Asian and Hispanic ethnicity would be considered Hispanic). U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics conducted for the *Report Card*).

63 "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 8 October 2001.

64 Conversation with Rita Harding, Nurse Program Officer, Indian Health Service (24 May 2000).

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67 "Minority Women's Health Status," in *The Health of Minority Women*, Office on Women's Health (May 2000) [Online] Available: WWW URL: http://www.4women.gov/owh/pub/minority/status.htm, accessed 8 October 2001; "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 8 October 2001.

68 "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 8 October 2001.

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70 For poverty, the data reported here consider persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Asian and Hispanic ethnicity would be considered Hispanic).

71 For high school education, the data reported here consider persons of any race who also reported Hispanic ethnicity as Hispanic only (e.g., someone who identifies herself as Asian and Hispanic ethnicity would be considered Hispanic). U.S. Bureau of Labor Statistics and U.S. Census Bureau, *Current Population Survey, March 1999 and March 2000 Supplements* (Washington, D.C.: U.S. Census Bureau, 1999, 2000) (databases) (unpublished data analyses by Decision Demographics conducted for the *Report Card*). To compensate for small sample size, Decision Demographics combined the applicable data from the two supplements to arrive at more reliable estimates.

72 "Factors Affecting the Health of Women of Color: Native Americans," in *Women of Color Health Data Book* (Washington, D.C.: Office of Research on Women's Health, National Institutes of Health, 1998) [Online]; Available: WWW URL: http://www.4women.gov/owh/pub/woc/native.htm, accessed 8 October 2001.

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76 Kaiser Commission on Medicaid and the Uninsured, *Immigrants' Health Care Coverage and Access*, March 2001 [Online]; Available: WWW URL: http://www.kff.org/content/2001/2241/2231.pdf, accessed 9 October 2001.

77 Kaiser Commission on Medicaid and the Uninsured, *Immigrants' Health Care Coverage and Access*, March 2001 [Online]; Available: WWW URL: http://www.kff.org/content/2001/2241/2231.pdf, accessed 9 October 2001.

78 Kathleen A. Maloy and others, *Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants' Ability and Willingness to Access Medicaid and Health Care Services* (Washington, D.C.: Center for Health Services Research and Policy, 2000), 32-35.

79 "Immigrant Women's Health," *The Journal of the American Medical Association* 283 (2000), 2451 ((reviewing Elizabeth J. Kramer and others, *Immigrant Women's Health: Problems and Solutions* (San Francisco: Jossey-Bass Publishers, 1999)).

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82 Gopal K. Sing and Mohammad Siahpush, "All-Cause and Cause-Specific Mortality of Immigrants and Native Born in the United States," *American Journal of Public Health* 91 (March 2001), 396.

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87 Allison L. Diamant and others, "Health Behaviors, Health Status, and Access to and Use of Health Care," *Archives of Family Medicine* 9 (2000), 1050. One advocacy group noted that the draft report of the goals and objectives of Healthy People 2010, the nation's health "blue print," was virtually silent on issues of lesbian health, and urged the project to incorporate the findings and recommendations made by the Institute of Medicine, discussed herein. Human Rights Campaign, Press Release, "Federal Blueprint Healthy People 2010 Overlooks Gay and Lesbian Americans, HRC Asserts," 27 January 1999 [Online]; Available URL: http://www.hrc.org/newsreleases/1999/990127.asp, accessed 9 October 2001; Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, *Healthy People 2010 Objectives, Draft for Public Comment* (Washington, D.C.: U.S. Department of Health and Human Services, 1998).

88 Allison L. Diamant and others, "Health Behaviors, Health Status, and Access to and Use of Health Care," *Archives of Family Medicine* 9 (2000).

89 Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future – Executive Summary* (Washington, D.C.: National Academy Press, 1999).

90 With the exception of Vermont, states do not require insurance companies to offer health insurance coverage for the partners of homosexual employees on par with married spouses. Vt. Stat. Ann. tit. 15, ch. 23 (2000); "Vermont: New Civil Unions Law Mandates Plans Cover Same-Gender Couples," *BNA's Health Care Policy Report* 8 (2000), 737. Employment discrimination also relegates some lesbians to self-employment, freelance work or lower paying jobs which do not offer insurance. Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 106.

91 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 107. (The presumption that a patient is heterosexual, as evidenced by forms that inquire about marital status, and standard questions on birth control use, serve to alienate lesbian women from the health care system, and discourage preventive care); Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future – Executive Summary* (Washington, D.C.: National Academy Press, 1999). Stereotypes and misconceptions, such as the idea that lesbians do not need Pap smears and other gynecological care, still prevail among both community members and providers. In an effort to address these issues, the Association of Reproductive Health Professionals dedicated a recent issue of its quarterly magazine, *Health and Sexuality*, to lesbian health issues. It developed the issue in conjunction with the Mautner Project for Lesbians with Cancer to improve health provider awareness and sensitivity to address current disparities for lesbians. The issue includes suggestions for intake and health history forms and addresses risk factors among lesbians for sexually transmitted infections and breast and gynecologic cancers. Association of Reproductive Health Professionals, "Lesbian Health," *Health & Sexuality* 6 (Washington, D.C.: Association of Reproductive Health Professionals, 2001) [Online]; Available: WWW URL: http://www.ahrp.org, accessed 19 October 2001.

92 Winnie Stachelberg, "Advancing A Lesbian Health Agenda," *Human Rights Campaign Quarterly* Spring 1996; Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 107; The Gay, Lesbian, Bisexual and Transgender Health Access Project, *Health Concerns of the Gay, Lesbian, Bisexual and Transgender Community*, Preface to the 2nd Edition (Boston: The Medical Foundation, 1997).

93 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 106; The Gay, Lesbian, Bisexual and Transgender Health Access Project, *Health Concerns of the Gay, Lesbian, Bisexual and Transgender Community*, Preface to the 2nd Edition (Boston: The Medical Foundation, 1997).

94 Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future – Executive Summary* (Washington, D.C.: National Academy Press, 1999). "Cultural competency" – a common notion when dealing with other patients across racial, ethnic and linguistic lines – is crucial to increase access and appropriate services. The Gay and Lesbian Medical Association's Physician Referral Program links lesbians with providers who express a commitment to addressing their unique health needs. Gay and Lesbian Medical Association, "Physician Referral Program," undated [Online]; Available: WWW URL: http://www.glma.org/programs/prp/index.html, accessed 9 October 2001.

95 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 106. Vermont's statute also conveys these benefits to same-gender partners. Vt. Stat. Ann. tit. 15, ch. 23; "Vermont: New Civil Unions Law Mandates Plans Cover Same-Gender Couples," *BNA's Health Care Policy Report* 8 (2000), 737; see also The Mautner Project for Lesbians with Cancer, "Removing the Barriers to Accessing Care for Lesbians," (undated) [Online]; Available: WWW URL: http://www.mautnerproject.org/barriers.html, accessed 9 October 2001.

96 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 106-107.

97 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 108.

98 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 118-119, 121.

99 Allison L. Diamant and others, "Health Behaviors, Health Status, and Access to and Use of Health Care," *Archives of Family Medicine* 9 (2000), 1045.

100 A review of national databases on causes of death failed to reveal any national sampling that included sexual orientation as a demographic.

101 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 125.

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104 Laura Dean and others, "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association* 4 (2000), 115.

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108 *Healthy People 2010*, 15; Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 3 (stating that one of every five women in the United States is disabled).

109 Barbara Waxman Fiduccia and Leslie R. Wolfe, *Women and Girls with Disabilities* (Washington, D.C.: Center for Women and Policy Studies and Women and Philanthropy, 1999), 8; Ronald L. Mace, *Removing Barriers to Health Care: A Guide for Health Professionals* (Raleigh: Center for Universal Design, undated) [Online]; Available: WWW URL: http://www.fpg.unc.edu/~ncodh/rbar/, accessed 9 October 2001.

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