THE HENRY J. KAISER FAMILY FOUNDATION

PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP:

Examining Racial and Ethnic Disparities at the State Level

JUNE 2009

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EXECUTIVE SUMMARY

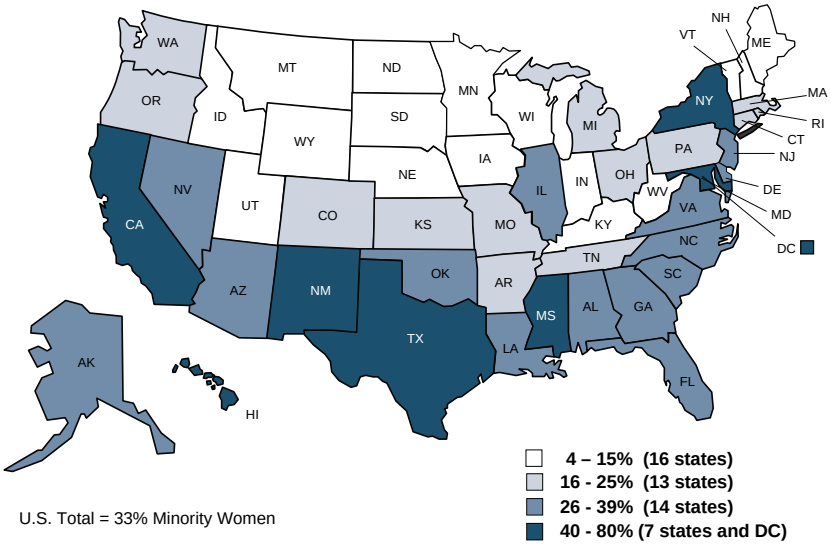
Nationally, one-third of women self-identify as a member of a racial or ethnic minority group and it is estimated that this share will increase to more than half by 2045.[1] The distribution of the population of women of color varies substantially by state (Figure A). As the country becomes more racially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

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

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

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

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



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

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

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

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

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

KEY FINDINGS

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

- **Disparities existed in every state on most measures.** Women of color fared worse than White women across a broad range of measures in almost every state, and in some states these disparities were quite stark. Some of the largest disparities were in the rates of new AIDS cases, late or no prenatal care, no insurance coverage, and lack of a high school diploma.
  - **In states where disparities appeared to be smaller, this difference was often due to the fact that both White women and women of color were doing poorly.** It is important to also recognize that in many states (e.g. West Virginia and Kentucky) all women, including White women, faced significant challenges and may need assistance.

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

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

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

  - **The enormous health and socioeconomic challenges that many American Indian and Alaska Native women faced was striking.** American Indian and Alaska Native women had higher rates of health and access challenges than women in other racial and ethnic groups on several indicators, often twice as high as White women. Even on indicators that had relatively low levels of disparity for all groups, such as number of days that women reported their health was "not good," the rate was markedly higher among American Indian and Alaska Native women. The high rate of smoking and obesity among American Indian and Alaska Native women was also notable. This pattern was generally evident throughout the country, and while there were some exceptions (for example, Alaska was one of the best states for American Indian and Alaska Native women across all dimensions), overall the rates of health problems for these women were alarmingly high. Furthermore, one-third of American Indian and Alaska Native women were uninsured or had not had a recent dental checkup or mammogram. They also had considerably higher rates of utilization problems, such as not having a recent checkup or Pap smear, or not getting early prenatal care.

  - **For Hispanic women, access and utilization were consistent problems, even though they fared better on some health status indicators.** A greater share of Latinas than other groups lacked insurance, did not have a personal doctor/health care provider, and delayed or went without care because of cost. Latina women were also disproportionately poor and had low educational status, factors that contribute to their overall health and access to care. Because many Hispanic women are immigrants, many do not qualify for publicly funded insurance programs like Medicaid even if in the U.S. legally, and some have language barriers that make access and health literacy a greater challenge.

  - **Black women experienced consistently higher rates of health problems. At the same time they also had the highest screening rates of all racial and ethnic groups.** There was a consistent pattern of high rates of health challenges among Black women, ranging from poor health status to chronic illnesses to obesity and cancer deaths. Paradoxically, fewer Black women went without recommended preventive screenings, reinforcing the fact that health outcomes are determined by a number of factors that go beyond access to care. The most striking disparity was the extremely high rate of new AIDS cases among Black women.

  - **Asian American, Native Hawaiian and Other Pacific Islander women had low rates of some preventive health screenings.** While Asian American, Native Hawaiian and Other Pacific Islander women as a whole were the racial and ethnic group with the lowest rates of many health and access problems, they had low rates of mammography and the lowest Pap test rates of all groups. However, their experiences often varied considerably by state.

  - **White women fared better than minority women on most indicators, but had higher rates of some health and access problems than women of color.** White women had higher rates of smoking, cancer mortality, serious psychological distress, and no routine checkups than women of color.

  - **Within a racial and ethnic group, the health experiences of women often varied considerably by state.** In some states, women of a particular group did quite well compared to their counterparts in other states. However, even in states where a minority group did well, they often had worse outcomes than White women.

DIMENSION HIGHLIGHTS

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

HEALTH STATUS DIMENSION

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

TABLE B. Highest and Lowest Health Status Indicator Disparity Scores

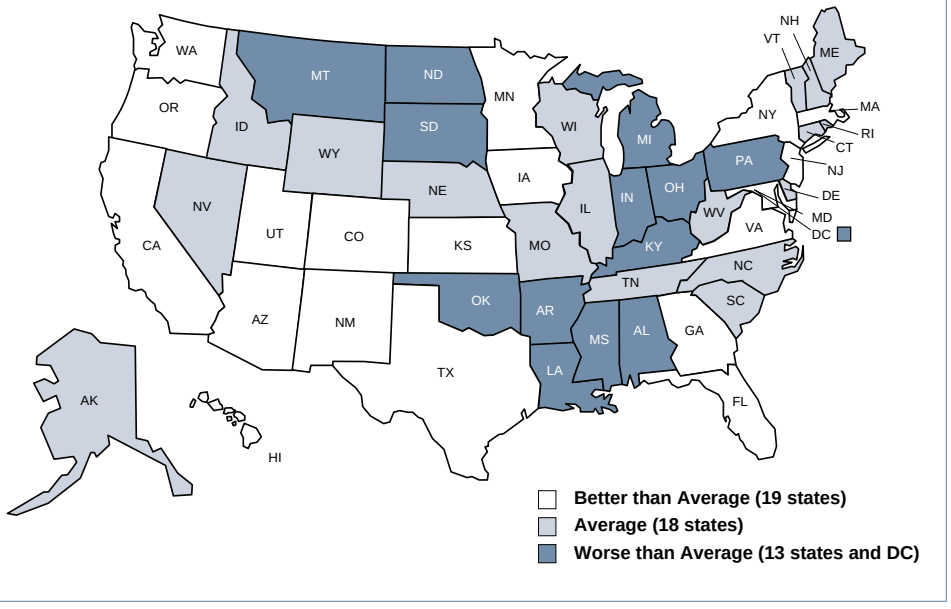
Indicator	U.S. Disparity Score	Highest Disparity State		Lowest Disparity State	
		State	Disparity Score	State	Disparity Score
Fair or Poor Health	2.07	DC	4.20	WV	0.86
Unhealthy Days	1.01	DC	1.38	WV	0.82
Limited Days	1.21	ND	2.49	TX & WV	0.92
Diabetes	1.87	DC	7.37	ME	0.83
Heart Disease	1.46	DC	5.40	WY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

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

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

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

FIGURE B. Health Status Dimension Scores, by State



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

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

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

ACCESS AND UTILIZATION DIMENSION

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

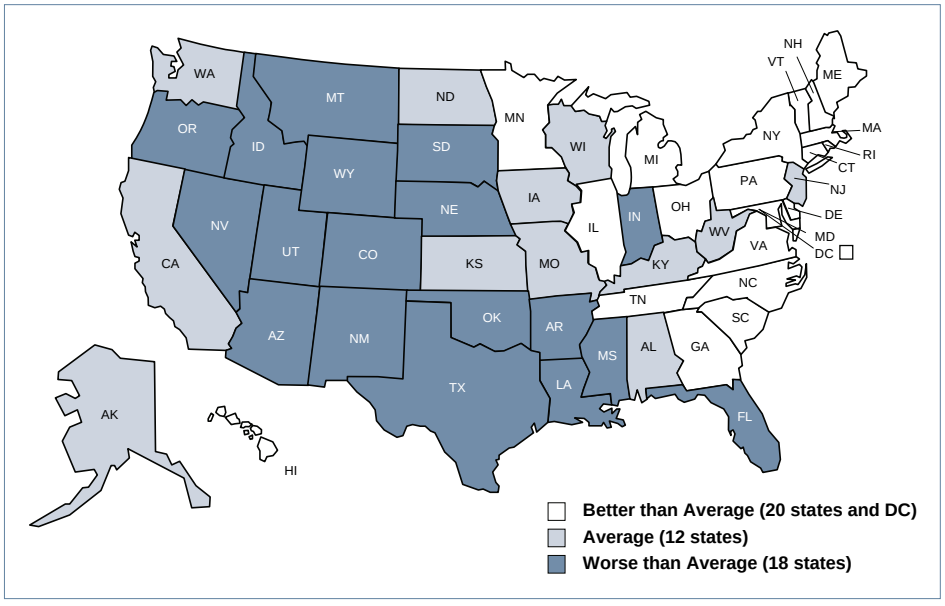
TABLE C. Highest and Lowest Access and Utilization Indicator Disparity Scores

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

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

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

FIGURE C. Access and Utilization Dimension Scores, by State



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

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

SOCIAL DETERMINANTS DIMENSION

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

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

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

TABLE D. Highest and Lowest Social Determinants Indicator Disparity Scores

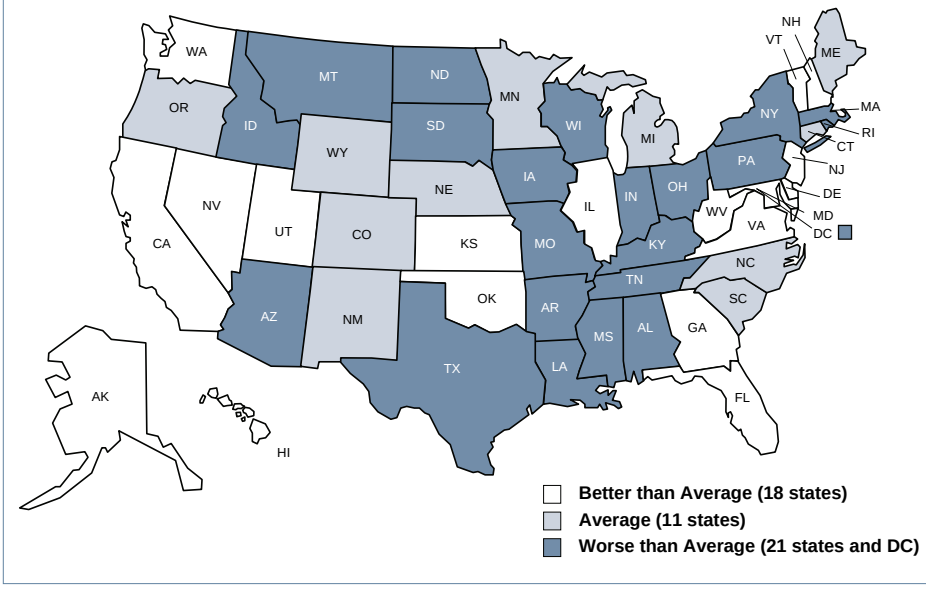
Indicator	U.S. Disparity Score	Highest Disparity States		Lowest Disparity States	
		State	Disparity Score	State	Disparity Score
Poverty	2.18	SD	4.09	WV	1.41
Median Household Income	1.82	MT	2.58	NH	1.14
Gender Wage Gap	1.21	DC	1.55	WV	0.93
No High School Diploma	3.11	DC	11.76	WV	0.63
Single Parent Household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

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

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

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

FIGURE D. Social Determinants Dimension Scores, by State



CONCLUSIONS

Putting Women's Health Care Disparities on the Map documents the persistence of disparities between women of different racial and ethnic groups in states across the country and on multiple dimensions. More than a decade after the Surgeon General's call to eliminate health disparities, the data in this study underscore the work that still remains.

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

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

This report demonstrates the importance of looking beyond national statistics to the state level to gain a better understanding of where challenges are greatest or different, and to determine how to shape policies that can ultimately eliminate racial and ethnic disparities. As states and the federal government consider options to reform the health care system in the coming years, efforts to eliminate disparities will also require an ongoing investment of resources from multiple sectors that go beyond coverage, and include strengthening the health care delivery system, improving health education efforts, and expanding educational and economic opportunities for women. Through these broad-scale investments, we can improve not only the health of women of color, but the health of all women in the nation.

DATA

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

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

DEFINITIONS

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

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

INTRODUCTION

The problem of racial and ethnic health and health care disparities has received growing attention in recent years, yet very significant gaps remain in our knowledge of what causes the differences—in some cases, inequities—in access to health care and health outcomes between minority and White Americans. Much of what is known about racial and ethnic disparities is drawn from national information sources. These data can mask many of the notable state-level differences in economics, policies, provider availability, and population demographics that shape health and health care. There also has been increasing recognition that women and men interact with the health care system in different ways and experience different health problems. Though we know that men and women have different health experiences, state-level disparity research has either focused on differences between racial and ethnic groups using data that combines men and women, or has looked only at gender differences without consideration of racial and ethnic disparities.

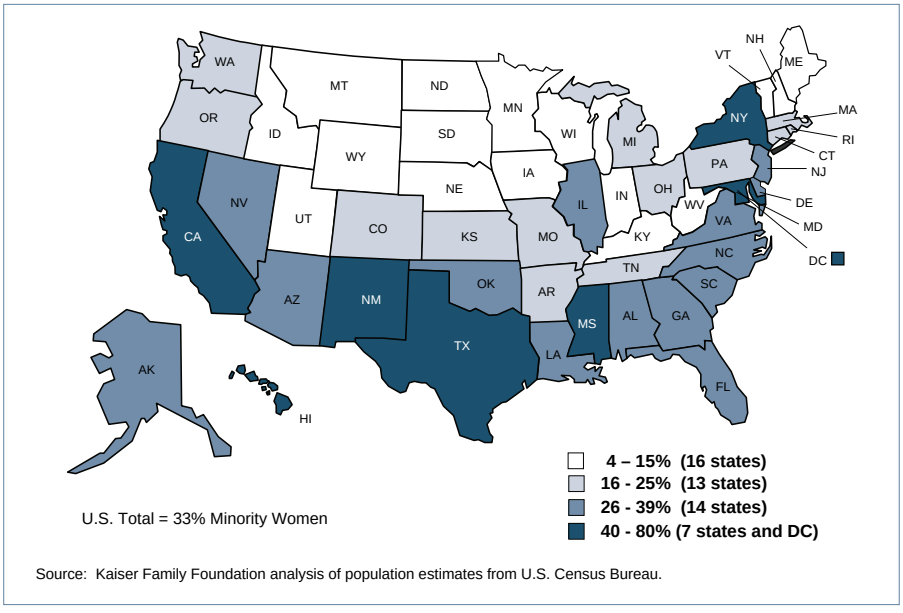
When we undertook this project we wanted to better understand not only how the health experiences of women of particular racial and ethnic population groups differed, but also how the broad range of women's experiences differed by state. We also wanted to document the health and health care access problems experienced by groups that are often off the radar screen of policymakers (Asian American, Native Hawaiian and Other Pacific Islanders, and American Indians and Alaska Natives) because information for these groups is often difficult and costly to obtain due, in part, to their relatively small proportion in the population. In this report, we looked at the magnitude of the differences between women of color and White women. We called these differences health disparities, but recognize that others may call them health inequities or health inequalities.

Our conception of health, like that of the World Health Organization,[3] consists of more than just the absence of disease. An individual's health is shaped by more than their biological make-up. It is affected by social and systemic factors which influence distribution of and access to health care services, and access to the resources necessary to survive and recover from an illness. *Putting Women's Health Care Disparities on the Map* provides new information about how women of color between the ages of 18 and 64 fare at the state level by measuring their health status, access to care, and level of social disparities in each state. It also examines the key health care policies and resources that shape access at the state level. It builds on the important contributions of many researchers and organizations in the areas of women's health and health care disparities at both the national and state level.[4]

Nationally, one-third of women between the ages of 18 and 64 self-identifies as a racial and ethnic minority. At the state level, variation is sizable. Around 5% of women in Maine, West Virginia, and Vermont are minorities, while in California, New Mexico, Hawaii, and the District of Columbia, minorities actually constitute a majority of the female population (Figure I.1 and Table I.1). These patterns reflect the general distribution of racial and ethnic minority Americans in the U.S.

Minority women often have different health and health care experiences than White women. Some communities of minority women have higher rates of chronic health problems, live shorter lives, and have higher levels of disability than White women.[5,6] While some minority groups have lower rates of some cancers, women of color who have those cancers are more likely to die as a result.[7] Fewer women of color graduate from high school, which translates into few economic opportunities, low-wage work, reduced access to employer-sponsored insurance, and greater coverage through publicly funded programs like Medicaid.

FIGURE I.1. Proportion of Women Who Self-Identify as a Racial and Ethnic Minority, by State, 2003–2005



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

They are also more likely to obtain services through government-supported providers such as Community Health Centers, public hospitals, and family planning clinics, and thus are disproportionately affected by public policies that shape these providers and the public programs that pay for them. Women are often the major health caregivers in the family—caring for their children and aging parents, and thus driving patterns of health care use for their families as well as themselves.

TABLE I.1. Percent Distribution of Adult Women Ages 18–64, by State and Race/Ethnicity, 2003–2005

States	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native	Two or More Races
All States	67.5	32.5	12.7	13.1	4.8	0.8	1.1
Alabama	68.6	31.4	27.3	1.8	1.0	0.5	0.8
Alaska	68.8	31.2	3.4	4.7	5.6	14.2	3.3
Arizona	62.9	37.1	3.1	25.9	2.8	4.3	1.0
Arkansas	77.3	22.7	16.0	3.7	1.2	0.7	1.0
California	45.2	54.8	6.4	32.4	13.7	0.6	1.7
Colorado	74.9	25.1	3.5	16.7	3.0	0.8	1.2
Connecticut	75.3	24.7	9.6	10.5	3.5	0.2	0.9
Delaware	70.0	30.0	20.9	5.0	2.9	0.3	0.8
District of Columbia	33.8	66.2	53.3	7.6	3.9	0.2	1.2
Florida	61.1	38.9	15.5	19.7	2.6	0.3	0.9
Georgia	60.1	39.9	30.6	5.3	2.9	0.3	0.8
Hawaii	25.0	75.0	2.0	7.1	50.5	0.4	15.0
Idaho	88.2	11.8	0.4	7.6	1.4	1.3	1.1
Illinois	66.6	33.4	15.3	12.7	4.6	0.2	0.7
Indiana	85.1	14.9	8.8	3.8	1.4	0.3	0.7
Iowa	92.2	7.8	2.1	3.0	1.7	0.3	0.6
Kansas	82.7	17.3	5.6	7.1	2.5	0.9	1.2
Kentucky	89.2	10.8	7.4	1.5	1.1	0.2	0.6
Louisiana	61.9	38.1	32.6	2.7	1.5	0.6	0.7
Maine	96.2	3.8	0.5	1.0	1.0	0.6	0.7
Maryland	58.0	42.0	30.3	5.1	5.3	0.3	1.0
Massachusetts	80.6	19.4	5.8	7.5	5.1	0.2	0.9
Michigan	78.1	21.9	14.5	3.3	2.4	0.6	1.0
Minnesota	87.8	12.2	3.8	3.0	3.4	1.1	0.9
Mississippi	59.2	40.8	37.6	1.4	0.9	0.4	0.5
Missouri	82.8	17.2	11.7	2.4	1.6	0.5	1.0
Montana	89.4	10.6	0.3	2.4	0.8	5.8	1.3
Nebraska	86.7	13.3	4.1	5.8	1.9	0.8	0.7
Nevada	62.2	37.8	7.1	20.5	7.4	1.1	1.8
New Hampshire	94.4	5.6	0.7	2.0	1.9	0.2	0.7
New Jersey	62.4	37.6	13.9	15.0	7.7	0.2	0.8
New Mexico	44.7	55.3	1.7	42.2	1.5	8.9	1.0
New York	59.8	40.2	15.8	15.9	7.2	0.3	1.0
North Carolina	69.0	31.0	22.3	4.8	2.0	1.2	0.7
North Dakota	91.2	8.8	0.6	1.6	0.8	5.0	0.7
Ohio	83.4	16.6	11.8	2.0	1.7	0.2	0.9
Oklahoma	73.8	26.2	7.6	5.6	2.0	7.7	3.4
Oregon	83.4	16.6	1.5	7.9	4.2	1.2	1.8
Pennsylvania	82.7	17.3	10.3	3.7	2.5	0.1	0.6
Rhode Island	81.1	18.9	4.6	9.9	3.0	0.4	1.0
South Carolina	65.4	34.6	29.8	2.5	1.3	0.4	0.6
South Dakota	88.4	11.6	0.6	1.7	0.9	7.5	0.9
Tennessee	78.2	21.8	17.1	2.3	1.4	0.3	0.7
Texas	50.9	49.1	12.0	32.3	3.6	0.4	0.8
Utah	85.0	15.0	0.6	9.4	2.9	1.2	0.9
Vermont	95.8	4.2	0.5	1.2	1.2	0.4	0.9
Virginia	68.2	31.8	19.8	5.4	5.1	0.3	1.1
Washington	78.4	21.6	3.0	7.3	7.7	1.5	2.1
West Virginia	94.5	5.5	3.0	0.9	0.7	0.2	0.6
Wisconsin	87.1	12.9	5.7	3.8	1.9	0.9	0.7
Wyoming	89.1	10.9	0.7	6.3	0.9	2.1	1.0

Note: *All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.
Data: SC-EST2007-agesex-res: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007.
Source: Population Division, U.S. Census Bureau. http://www.census.gov/popest/datasets.html.

Uniform state-level data on women's health status and access to care that allow for the comparison of various subgroups is difficult to come by. It is costly to collect, and the existing data sources are limited. For some racial and ethnic groups that represent a small fraction of a state's population, such as American Indian and Alaska Natives or Asian American, Native Hawaiian and Other Pacific Islanders, data are often altogether lacking due to survey sample sizes that are too small to analyze. To address these gaps, our analysis relies on national surveys that provide representative state-level data, and we have combined several years of survey data to allow us to learn more about the experiences of women of color in various states. When the sample is sufficiently large in a state, we have included statistics for African American, Latina, and White women. We have also attempted to present statistics for American Indian and Alaska Native, Asian American, Native Hawaiian and Other Pacific Islander women to the extent possible. It is important to recognize that even among these groups there is tremendous variation within populations. For example, Black women who have family ancestry in the Caribbean often have very different experiences from those with African ancestry. The same is true of Latinas who come from North as opposed to Central or South America, and for Asian American, Native Hawaiian and Other Pacific Islander women whose origins are from a broad swath of nations with very different cultures and experiences.

HOW TO USE THIS REPORT

Using a wide range of data sources available from federal agencies and other research organizations, *Putting Women's Health Care Disparities on the Map* assesses the status of women in all 50 states and the District of Columbia. It focuses on the magnitude of the racial and ethnic disparity among women for 24 of the 25 indicators grouped in three dimensions: Health Status, Access and Utilization, and Social Determinants (it is not possible to calculate a disparity score for residential segregation). Indicators were selected based on criteria that included both the relevancy of the indicator as a measure of women's health and access to care and the availability of the data.

This report presents original data on the prevalence and rates for 25 indicators for women of multiple racial and ethnic populations—White, Black, Hispanic, Asian American, Native Hawaiian and Other Pacific Islander, and American Indian and Alaska Native.

The report presents state-level disparity scores for 24 of the 25 indicators, provides a dimension score for each state on each of the three dimensions, and classifies each state on each dimension:

- The **disparity score** for each indicator describes how minority women in a state fare relative to the average non-Hispanic White woman in the same state. A disparity score of 1.00 indicates no disparity between women of color and White women. A score greater than 1.00 indicates that minority women were experiencing health problems, health care barriers, or socioeconomic disadvantages at rates higher than White women. A score of less than 1.00 indicates that more White than minority women experienced a problem.
- The **dimension score** is a standardized summary measure that captures the average of the indicator disparity scores, after adjusting for the prevalence of the indicators for White women in the state relative to White women nationally. Based on testing results, states were categorized within their respective groups of better than average, average, or worse than average according to how their dimension score compared with the national average.

This report also presents state-level data on eight indicators reflecting state policies and payments for Medicaid and family planning, and health care workforce availability. These indicators provide a context to help understand some of the disparity scores in the other dimensions.

This report is organized into four chapters:

- **Health Status.** Includes indicators for fair or poor health status, unhealthy days, limited activity days, diabetes, cardiovascular disease, obesity, smoking, cancer mortality, new AIDS cases, low-birthweight infants, and serious psychological distress.
- **Access and Utilization.** Addresses access to and utilization of health care services and includes indicators for no health insurance coverage, no personal doctor/health care provider, no routine checkup, no dental checkup, no doctor visit due to cost, no mammogram, no Pap test, and late initiation of or no prenatal care.
- **Social Determinants.** Examines the disparities in six indicators that reflect the social determinants of health and health care use such as poverty level, median household income, gender wage gap, educational attainment, single-parent female-headed households, and the index of dissimilation, which is a measure of residential segregation.

- **Health Care Payments and Workforce.** Presents information on health care payments and workforce resources that shape the availability of care for women, including the physician diversity ratio, primary care health professional shortage areas, mental health professional shortage areas, the Medicaid-to-Medicare fee index, Medicaid income eligibility for working parents, Medicaid/SCHIP income eligibility for pregnant women, family planning funding, and abortion access policies.

Each chapter begins with a short description of the dimension as well as the indicators contained within it. We next show the dimension score, and a map shows how dimension scores range across the states. We then present a short description of each indicator as well as highlights of the findings. For each indicator there is a graph which shows how states perform in terms of both prevalence of the indicator and their disparity score relative to other states and the national average for all White women. Indicators in the Health Care Payments and Workforce dimension are applicable to all women in the state, and are therefore not documented by race/ethnicity. This chapter includes maps rather than graphs to show how states compare. Crosscutting findings from the report are presented in the conclusion.

We believe this analysis makes an important contribution to the existing body of research on women's health and on health disparities between racial and ethnic groups. This report documents some of the considerable disparities that appear across the nation, but it also shows that all states have significant room for improvement across a broad range of indicators. It shows that in some states women of color do much better than their counterparts who live elsewhere, and that in others White women are as challenged by health and access problems as minority women. We hope that policymakers will use this report to see how women in their state are doing and use this data to inform policy and program change to strengthen the health of women and to improve the systems that provide them with care.

METHODS

CONCEPTUAL ISSUES

In preparing this report, we were faced with three major issues: selecting an appropriate set of indicators and finding data which measure those indicators by state across different racial and ethnic populations, deciding how to measure disparities between groups, and agreeing on the language to describe these groups.

The first issue, selecting the indicators and the data, was critical to all other tasks. While there has been much work done to identify indicators that are measures of health and access to care, data that allow analysis by both gender and race/ethnicity at the state level are limited. We ultimately selected 25 indicators that are central to women's health and 8 indicators that reflect the policy environment which affects a woman's access to care. Several important indicators of interest (e.g., avoidable hospitalizations, hypertension, STDs) were not available by gender, race/ethnicity, and state. This is an area that merits further investment of resources if we are to truly understand the health and access of communities across the nation. Furthermore, it should be noted that the data we were able to use did not permit us to assess the severity of the problems women experienced, nor did it allow us to assess the quality of the care they received, which are major considerations. For example, it is one thing to document the percent of women with diabetes, but when trying to reduce disparities it would be also useful to know how many of these women have uncontrolled diabetes.

Our second major issue was deciding on the approach and standard we would use to measure disparities between population groups. One issue we initially faced was what comparison group to identify as the benchmark standard. Racial and ethnic disparities are commonly measured as a comparison between Whites and a population group or groups of color (e.g., African Americans). Yet, others have compared racial and ethnic groups defining the benchmark standard as the group with either the best or worst outcome. Both approaches have merit. We developed what we have termed a "disparity score" for each indicator, which measures the level of disparity between non-Hispanic White women and minority women in a state, and allows for consistent comparison across all indicators.

Our final set of considerations centered on terminology. The questions raised included, should we refer to women as Black or African American? Hispanic or Latina? Women of color or minority women? There is much debate as to which of these terms is appropriate, but no consensus has been reached. This ongoing debate highlights several larger points. The first is that each population group is diverse in their national origins, socioeconomic characteristics, and views about this issue. It also reemphasizes the point that race is a socially defined construct rather than a biological construct, with varying meanings to different people. Since the aforementioned terms are used interchangeably in society, we too use them interchangeably throughout the report.

CRITERIA FOR SELECTION OF INDICATORS

The decision to include an indicator was based on the following criteria: relevancy to the health of women; policy or programming relevance; adequate sample size to make estimates for minority populations, data reliability, and comparability across most or all states.

DATA SOURCES

The findings presented in this report are from several data sources that are collected by the federal government and research institutions. The primary sources of population-based data were the Behavioral Risk Factor Surveillance System (BRFSS) and the Current Population Survey (CPS), combining years 2004–2006, which represented the most recent data at the time the project began, and the base years for most of the sources of data. The BRFSS and CPS questionnaires ask respondents about their experiences in the prior year, so data from these sources reflect information for the years 2003–2005.

- **Behavioral Risk Factor Surveillance System.** The Behavioral Risk Factor Surveillance System (BRFSS) was used for most of the health status and access and utilization measures. Established by the Centers for Disease Control and Prevention (CDC), the BRFSS is a state-based survey that collects information on health risk behaviors, preventive health practices, and health care access. It is a cross-sectional, annual, random-digit-dial telephone survey of adults ages 18 and over.

Data from the 2004, 2005, and 2006 BRFSS databases were combined for this report to increase sample sizes and stabilize estimates. The one exception to the combined years was Hawaii. Data for Hawaii for 2004 were not included in the data released by the CDC; therefore the BRFSS estimates for Hawaii are for years 2005–2006 only.

The study population was females ages 18–64 in all 50 states and the District of Columbia (unless otherwise indicated). For each state, data were reported for individual racial and ethnic groups if there were at least 100 valid responses in the racial and ethnic cell based on the merged data. If that criterion was not met, the data for that racial and ethnic group were not reported, but were included in the "All Minority" racial and ethnic category and were used to calculate disparity scores.

- **Current Population Survey.** The Current Population Survey (CPS) was the data source for the health insurance indicator and most of the social determinant indicators in this report. The CPS, administered by the U.S. Census Bureau, is an annual probability sample of the civilian noninstitutionalized population 15 years of age and older. It is the primary source for labor force statistics in the U.S. and also contains extensive demographic data.

  The 2004, 2005, and 2006 CPS Annual Social and Economic Supplements were merged to increase sample size. Data were analyzed for females 18–64 in all 50 states and the District of Columbia. A minimum sample size criterion of 100 per cell was used to determine whether an estimate was reportable for a given population group. If a racial and ethnic group did not have a cell size of 100, that specific estimate was not reported and the data were included in the "All Minority" racial and ethnic group.

- **Area Resource File.** The Area Resource File (ARF) is a database containing more than 6,000 variables for each county in the U.S. The ARF was used to obtain Health Professional Shortage Area (HPSA) codes for each county, which were aggregated to the state level. The HPSA codes contained in the ARF are from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

  Based on the Primary Medical Care HPSA codes and the Mental Health HPSA codes, health professional shortage areas for primary care and mental health were calculated for each state and for the District of Columbia for the year 2004. The ARF does not contain HPSA codes for 2005 and 2006.

DIMENSIONS AND INDICATORS

The 25 indicators detailed in this report are grouped into three dimensions: health status, access and utilization, and social determinants. We also present eight indicators in a chapter on health care payments and workforce. Table M.1 lists all of the indicators used in this report, and their respective data sources.

ANALYSIS OVERVIEW

PREVALENCE ESTIMATES

- **BRFSS Indicators.** For indicators derived from BRFSS, we retained records for all women aged 18–64 in the 50 states and the District of Columbia, for 2004–2006. We concatenated the three years' data into a single dataset retaining only selected variables. Variables with trivial questionnaire changes were synchronized across years.

  Respondents to the BRFSS survey were asked whether they are Hispanic, and then what is their race. Respondents who did not provide a single race were asked which racial group best represents their race. Analyses for this report used the single race identified in the first question or the best representative race identified in the follow-up question as the racial and ethnic group of the respondent. Responses to these questions were used to classify women into the following racial and ethnic groups: Latina, and Latina-exclusive race groups of White, Black, American Indian and Alaska Native, and the combined group of Asian American, Native Hawaiian and Other Pacific Islander.

  With the exception of the unhealthy days and limited activity days indicators, each indicator from BRFSS was defined as a dichotomous variable with 1 representing the respondent being at risk and 0 representing her not being at risk. Definitions of the dichotomous indicators are included in Table M.1.

TABLE M.1. Description of Indicators, by Dimension

INDICATOR NAME	DESCRIPTION	DATA SOURCE
SECTION 1. HEALTH STATUS		
Fair or Poor Health	Percent of women who reported their health was fair or poor, based on the possible response categories of excellent, very good, good, fair, or poor.	BRFSS
Unhealthy Days	Mean number of days in the past 30 days when respondents felt their physical or mental health was "not good." It is based on two separate questions that measure the number of days when physical health or mental health were not good.	BRFSS
Limited Activity Days	Mean number of the past 30 days when physical or mental health kept respondents from doing their usual activities. The question was asked only of those respondents who reported at least one day when their physical or mental health was not good.	BRFSS
Diabetes	Percent of women who were ever been told by a doctor that they have diabetes, excluding those with only gestational diabetes.	BRFSS
Cardiovascular Disease	Percent of women who were ever told that they had any of the following cardiovascular diseases: heart attack, angina or coronary heart disease, or stroke.	BRFSS
Obesity	The percent of women whose body mass index (BMI) is greater than or equal to 30.	BRFSS
Current Smoking	Percent of women who currently smoke. This measure is based on respondents who reported they have smoked at least 100 cigarettes in their lifetime and currently smoke either every day or some days.	BRFSS
Cancer Mortality Rate	The number of women who died from any cancer per 100,000 women in each population, between 2000-2004.	National Vital Statistics System from NCI
New AIDS Cases	The number of new AIDS cases per 100,000 women ages 13 and older, in 2004.	HIV/AIDS Surveillance Supplemental Report 2006; 12 (No. 2)
Low-Birthweight Infants	Percent of live births weighing less than 2,500 grams, in 2003-2005.	National Vital Statistics System, from Health US, 2007
Serious Psychological Distress	Percent of women who had a score of 13 or higher on the K6 scale.	SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004, 2005, 2006, and 2007.
SECTION 2. ACCESS AND UTILIZATION		
Health Coverage	Percent of women without health coverage.	CPS
Lack of Personal Doctor/Health Care Provider	Percent of women who do not have a regular place they go to get care.	BRFSS
Routine Checkup	Percent of women who have not had a routine physical exam in the past two years.	BRFSS
Dental Checkup	Percent of women who have not had a routine dental exam in the past two years.	BRFSS
No Doctor Visit Due to Cost	Percent of women who did not see a doctor in the past year for financial reasons.	BRFSS
Mammogram	Percent of women ages 40–64 who did not have a mammogram in the past two years.	BRFSS
Pap Test	Percent of women who did not have a routine pap smear in the past two years.	BRFSS
Prenatal Care	Percent of women who initiated prenatal care late, or did not receive any prenatal care.	National Vital Statistics System, from Health US, 2007
SECTION 3. SOCIAL DETERMINANTS		
Women in Poverty	Percent of women ages 18–64 with incomes below 100 percent of the federal poverty level.	CPS
Median Household Income	Median income of households with at least one woman between the ages of 18–64.	CPS
Gender Wage Gap	Ratio of earnings for full-time year round women to the earnings of full-time year round non-Hispanic White men.	CPS
Women with No High School Degree	Percent of women ages 18–64 who have not graduated from high school.	CPS
Female-Headed Households w/Children	Percent of women ages 18–64 living in a household with children that is headed by a woman.	CPS
Index of Dissimilation	How evenly distributed the population is relative to non-Hispanic Whites. Data were measured at the county level and aggregated to the state level.	Census Population Estimates
SECTION 4. HEALTH CARE PAYMENTS AND WORKFORCE		
Physician Diversity Ratio	The factor by which the physician workforce would need to be changed so that the ratio of minority physicians to the minority population would match the ratio of White physicians to the White population living in a state.	Trivedi AN, et al. Health Affairs, 2005.
Primary Care Shortage Area	The percent of women (all ages) living in a full or partial primary care health professional shortage area.	Area Resource File, 2004
Mental Health Shortage Area	The percent of women (all ages) living in a full or partial mental health professional shortage area.	Area Resource File, 2004
Medicaid/Medicare Fee Index	A measure of the differences between Medicaid and Medicare fees in 2003. The weighted sum of the ratios of each state's Medicaid fee for a given service to the Medicare fee, using 2000 expenditure weights.	Zuckerman S, et al. Health Affairs, 2004.
Medicaid Income Eligibility for Working Parents	State income eligibility threshold for working parents applying for Medicaid coverage.	Center on Budget and Policy Priorities
Medicaid/SCHIP Income Eligibility for Pregnant	State income eligibility threshold for pregnant women applying for Medicaid coverage.	National Governors' Association.
Total Family Planning Funding Per Woman in Need	Per capita funding states invest in family planning services for low-income women who are considered in need of contraceptive services.	Guttmacher Institute
Abortion Composite Measure	Composite measure of three state policies affecting access to abortion services: waiting period, no use of state funds for abortions, percent of women living in counties without an abortion provider.	Guttmacher Institute

Note: BRFSS - Behavioral Risk Factor Surveillance System; CPS - Current Population Survey.

For indicators in the Health Status dimension, data were adjusted for differences in the age distribution of respondents among races using a post-stratification approach. Weights of observations were adjusted so that each sample of respondents represented the standardized age distribution shown in Table M.2. Indicators in the Access and Utilization and Social Determinants dimensions were not age-adjusted.

TABLE M.2. Standardized Population of Women in the U.S., by Age

Age Group	Standardized Population
18-29	22,852,201
30-39	21,576,587
40-49	21,515,659
50-64	21,607,152

Note: These groups were the basis for age-adjustment of indicators in the health status dimension.

In estimating the prevalence of each indicator, respondents who refused to answer the specific question that was the basis of the indicator, and those who stated that they did not know the answer, were omitted. If fewer than 100 responses remained within a racial or ethnic category, data for that group were not reported. Prevalence estimates were obtained using SAS PROC SURVEYMEANS. Overall prevalence was estimated applying the procedure to all women in the dataset. The prevalence among all minority women was estimated by applying the procedure to the dataset after excluding non-Hispanic White women. Finally, the prevalence for each racial or ethnic group was estimated.

The prevalence was estimated for each year, then averaged across the three years weighted by effective sample size.[8] The coefficient of variation (CV) was expressed as the ratio of the standard error (SE) to the mean, and 95% confidence intervals were computed about prevalence estimates as the mean ± 1.96 × SE.

- **CPS and Area Resource File Indicators**. Prevalence rates for indicators from the ARF and CPS were calculated in a similar manner using SPSS. Data from the Area Resource File were aggregated to the state level, using weighted averages for each county. County weights were determined by the proportion of the state population residing in the county.

INDICATOR DISPARITY SCORES

The disparity score for each indicator was obtained using the weighted average of the ratio of the mean prevalence for each racial and ethnic group divided by the mean prevalence for non-Hispanic White women in that state. Weights for averaging were based on the proportion of the state's minority population. The exceptions to this calculation were median household income and gender wage gap, for which disparity scores were calculated using the inverse ratio. This was done to preserve the relationship between disparity scores greater than 1.00 and worse outcomes for women of color. All variables were coded so that higher prevalence rates were associated with poor outcomes, and lower prevalence rates were positive.

For indicators such as median household income and gender wage gap where higher numbers are considered to be positive, the disparity score was calculated as the ratio of median household income for non-Hispanic White women to that of women from all other racial and ethnic populations. With this method, a disparity score below 1.00 reflected a state where minority women had higher incomes than White women, as is the case for all other indicators. In the case of the gender wage gap, larger numbers represent more equitable wages. Here again, the disparity score was calculated as the ratio of White women to the weighted average for minority women.

In all instances, disparity scores equivalent to 1.00 corresponded to there being no disparity between women of color and non-Hispanic White women (i.e. the prevalence rates for both groups were the same). Disparity scores above 1.00 reflected worse outcomes for women of color compared to White women (i.e. the prevalence rate was higher for women of color than for White women), and disparity scores below 1.00 corresponded to women of color having better outcomes than White women (i.e., the prevalence rate for women of color was lower than that of White women). Table M.3 illustrates the relationship between disparity scores and prevalence rates for White women and women of color.

TABLE M.3. Disparity Scores and Prevalence Rates for White and All Minority Women

State	Disparity Score	Prevalence White Women	Prevalence All Minority Women
State A	0.75	20.0%	15.0%
State B	1.00	20.0%	20.0%
State C	1.50	20.0%	30.0%
State D	2.00	20.0%	40.0%

DIMENSION SCORES

Dimension scores were calculated for Health Status, Access and Utilization and Social Determinants using a three-step process. First, we adjusted all indicator disparity scores using the ratio of the prevalence of the indicator among White women in each state relative to its prevalence of the indicator among White women nationally. This process created disparity scores which compared the experiences of minority women in a given state to those of the average White woman nationwide (See Table M.4). In effect, the adjustment increased or decreased disparities depending on the relationship of minority women in a state to the average White woman nationwide. State A in Table M.4, for example, already had a disparity score less than 1.00 because women of color had a lower prevalence than White women. Since the prevalence for women of color in State A was lower than the national average for White women, the disparity score decreased. In contrast, State C saw its disparity score increase because minority women in State C had a higher prevalence than the national average for White women.

TABLE M.4. Comparison of Unadjusted and Adjusted Disparity Scores

State	Disparity Score	Adjusted Disparity Score	Prevalence White Women	Prevalence All Minority Women
All States	1.30	--	20.0%	26.0%
State A	0.75	0.375	10.0%	7.50%
State B	1.00	1.00	20.0%	20.0%
State C	1.50	2.25	30.0%	45.0%
State D	2.00	1.50	15.0%	30.0%

Following the adjustment, we standardized disparity scores to the average disparity score of the 50 states and the District of Columbia. We did this by subtracting from the disparity score for each state and dividing by the standard deviation of all disparity scores. Finally, we calculated dimension scores as the average of each standardized disparity score. Thus, each indicator disparity score was weighted equally in calculating the dimension score. The resulting dimension score reflected how far a given state was from the average disparity score. The average disparity score is equivalent to 0. States with negative dimension scores (States A and C in Table M.5) did better than the national average, while states with positive numbers (States B and D) did worse than the national average. It is important to note that the average dimension score is not the equivalent of having parity between White women and women of color.

TABLE M.5. Calculation of Standardized Dimension Score

State	Indicator 1 Disparity Score	Indicator 2 Disparity Score	Indicator 3 Disparity Score	Dimension Score	P-Value
State A	-0.96	0.63	-0.80	-0.38	0.002
State B	1.01	-0.15	0.63	0.50	0.0001
State C	-0.14	-0.38	0.27	-0.08	0.067
State D	1.21	0.12	0.59	0.64	<0.0001

Using the bootstrap estimate procedure, we obtained variance estimates of the disparity score for all indicators from the BRFSS and CPS. Variance estimates were unavailable for indicators from secondary sources. These included new AIDS cases, low-birthweight, cancer mortality, and late prenatal care. Data from registries, such as low-birthweight infants and new AIDS cases, do not vary because they are reported cases, not estimates of these indicators.

DIMENSION SCORE GROUPINGS

We classified states as "better than average," "average," or "worse than average" based on their relationship to the mean dimension score, which was represented by 0. We calculated the appropriate designation by testing each dimension score to determine whether it was different from 0. States with dimension scores no different from 0, such as State C in Table M.5, were labeled "average." States with dimension scores less than 0 that were statistically different from 0 ($p \leq 0.05$), were classified as "better than average" (e.g. State A) and states with positive dimension scores and p-values less than or equal to 0.05 were labeled "worse than average" (e.g. States B and D). In some cases, states with lower dimension scores (i.e. less disparity) were grouped differently from states with higher dimension scores because the statistical test provided evidence that the difference from the average was real or significant. Similarly, states with higher dimension scores (i.e. greater disparity) were grouped differently from states with lower dimension scores because of their p-values. For example, a state might have been classified as "better than average" with a dimension score of -0.15 while another state was classified as "average" with a dimension score of -0.30.

HEALTH STATUS

Women's health status is one of the strongest determinants of how women use the health care system. The poorer their health, the more women need and benefit from high-quality, appropriate care. Overall, the majority of women in the U.S. report that they are healthy and live life free of disability. However, many women deal with a wide range of chronic illnesses such as diabetes, cardiovascular disease, or cancer throughout their lives. Some of these conditions can be prevented or cured through preventive screenings and early detection. Others can be managed effectively with ongoing medical attention and lifestyle changes without compromising women's ability to work or raise families, or their general quality of life. Some conditions, however, can inflict severe disability. Physical or mental limitations are also a facet of health and well-being and can affect a woman's ability to participate in daily activities, such as work, recreation, or household management. Additionally, women play a leading role as the primary caregivers for both children and older, frail, or disabled family members, which means that women's health and well-being have important implications for those who rely on them.

Health status measures used in this report cover a variety of health conditions, associated behaviors, and outcomes. Indicators in this section reflect many of the leading causes of death and disability in women. In 2005, heart disease and cancer accounted for 48% of all deaths among U.S. women.[9] There are sizable differences in the rates at which various subgroups of women experience certain diseases and conditions. For example, diabetes and obesity affect a greater percentage of African American, Hispanic, and American Indian and Alaska Native women than White and Asian American, Native Hawaiian and Other Pacific Islander women. Causes of death and disability also vary across racial and ethnic groups. For example, among all nonelderly adult women, AIDS is ranked tenth as the cause of death, but for African American women it is fifth.[10]

Historically, most clinical research was focused on men, particularly White men. But as more efforts have been invested in women's health, research has found that women have health-related experiences that are different from men's on several levels, including screening, detection, and treatment. This chapter compares state-level rates for women of different racial and ethnic groups on a spectrum of health status indicators. An indicator disparity score, assessing the level of disparity between White women and women of color for each state on each indicator, is also presented, as is a dimension score for each state on the overall health status dimension.

The data for these indicators are drawn from a number of sources including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), the National Vital Statistics System, and the CDC's HIV/AIDS Surveillance Supplemental Report. The indicators included in this dimension are:

1. Fair or Poor Health Status
2. Unhealthy Days
3. Limited Activity Days
4. Diabetes
5. Cardiovascular Disease
6. Obesity
7. Smoking
8. Cancer Mortality
9. New AIDS Cases
10. Low-Birthweight Infants
11. Serious Psychological Distress

HEALTH STATUS DIMENSION SCORES

The dimension score is a standardized summary measure that captures the average of the indicator disparity scores along with an adjustment for the relative prevalence of the indicators for women in the state. States were grouped according to whether their dimension score was better than, equal to, or worse than the national average.

- Nineteen states received better-than-average ratings in the health status dimension, meaning they fared better than the national average on the combined health status indicators. These states included Iowa, Hawaii, Washington, Utah, Oregon, Arizona, California, New Mexico, and Colorado (Figure 1.0). Many of the states were in the Southwest. The remainder of the top-performing states were scattered throughout other regions.
  - Iowa's above-average rating was driven by fairly low disparity scores overall, and especially for obesity, cancer mortality, and serious psychological distress.
  - Washington and Hawaii also had lower disparity scores on a number of health measures and had lower prevalence on a number of indicators as well.
  - Utah's better-than-average grouping was driven by the fact that it had among the lowest disparity scores for unhealthy days, cardiovascular disease, and obesity. This reflects White women in the state having among the lowest prevalence rates in the nation for the indicators examined, and women of color having fairly comparable rates.
- Eighteen states' dimension scores measured near the average for the nation as a whole.
- Thirteen states and the District of Columbia had health status dimension scores that were worse than average for the nation. Several of these states are in the South Central region (Kentucky, Mississippi, Arkansas, Louisiana, Oklahoma, and Alabama) and an additional five are in the Midwest (North Dakota, Ohio, Indiana, South Dakota, and Michigan).
  - Kentucky was at the bottom of the nation in its health status dimension score. Although, its disparity scores were small on many individual health indicators, its worse-than-average dimension score was largely driven by the fact that White women and women of color in the state were both doing poorly (i.e., had high prevalence of the indicators analyzed). West Virginia had a similar profile but received an average rating because White women in the state fared poorly, but not as poorly as White women in Kentucky.
  - North and South Dakota also scored worse than average primarily due to large disparities between White women (who did well compared to the national average on a number of measures) and American Indian and Alaska Native women, who scored at the bottom on many health indicators.
  - The District of Columbia, which scored worse than average, consistently had among the highest disparity scores on all indicators. White women in D.C. were among the healthiest in the nation, which often resulted in D.C. being an outlier (in the upper left quadrant) on most indicator graphs. Black women in the District, who represented the largest group of women in D.C., had health outcomes that were considerably worse than those of White women in the District, yet they were comparable to those of Black women nationally.
- The national disparity score for new AIDS cases was the highest of all health status indicators (11.58), and was more than five times higher than any other health status indicator.

FIGURE 1.0. Health Status Dimension Scores, by State

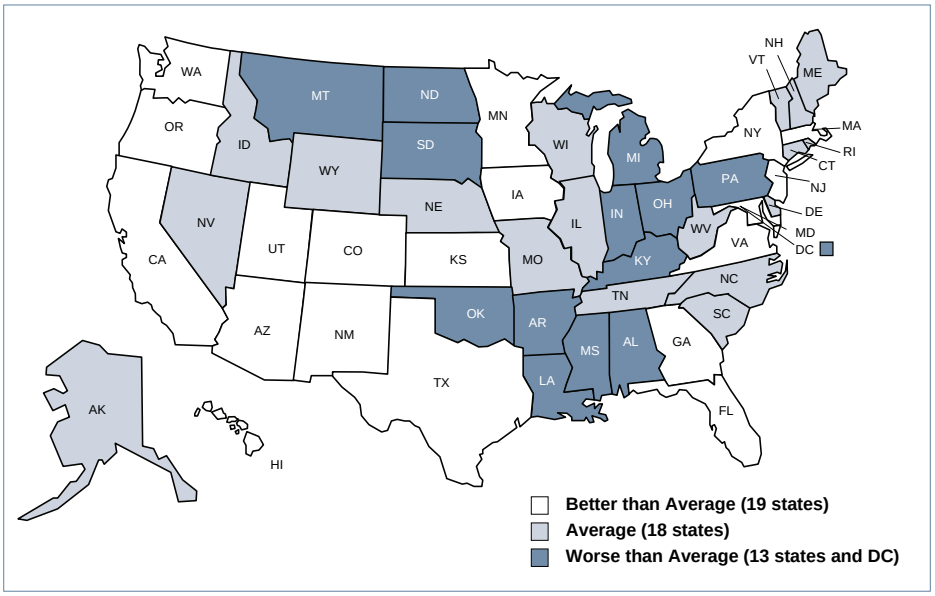


TABLE 1.0. Health Status Dimension Scores, by State

	State	Dimension Score
Better than Average	Iowa	-0.85
	Hawaii	-0.75
	Washington	-0.72
	Utah	-0.70
	Oregon	-0.65
	Arizona	-0.54
	Minnesota	-0.53
	California	-0.50
	Massachusetts	-0.47
	Maryland	-0.47
	Virginia	-0.46
	New Mexico	-0.43
	Colorado	-0.41
	New Jersey	-0.38
	Kansas	-0.30
	New York	-0.26
	Georgia	-0.23
	Florida	-0.22
	Texas	-0.19
Average	Vermont	-0.40
	New Hampshire	-0.38
	Alaska	-0.32
	Nebraska	-0.28
	Idaho	-0.18
	Connecticut	-0.17
	Wyoming	-0.14
	Nevada	-0.13
	Maine	0.00
	Wisconsin	0.02
	Illinois	0.03
	North Carolina	0.11
	South Carolina	0.16
	Delaware	0.16
	Rhode Island	0.18
	Tennessee	0.20
	West Virginia	0.27
	Missouri	0.33
Worse than Average	District of Columbia	0.32
	Michigan	0.33
	South Dakota	0.46
	Alabama	0.53
	Montana	0.53
	Oklahoma	0.57
	Louisiana	0.63
	Indiana	0.68
	Pennsylvania	0.68
	Ohio	0.73
	Arkansas	0.81
	Mississippi	0.91
	North Dakota	0.95
	Kentucky	1.50

State	Dimension Score
Alabama	0.53
Alaska	-0.32
Arizona	-0.54
Arkansas	0.81
California	-0.50
Colorado	-0.41
Connecticut	-0.17
Delaware	0.16
District of Columbia	0.32
Florida	-0.22
Georgia	-0.23
Hawaii	-0.75
Idaho	-0.18
Illinois	0.03
Indiana	0.68
Iowa	-0.85
Kansas	-0.30
Kentucky	1.50
Louisiana	0.63
Maine	0.00
Maryland	-0.47
Massachusetts	-0.47
Michigan	0.33
Minnesota	-0.53
Mississippi	0.91
Missouri	0.33
Montana	0.53
Nebraska	-0.28
Nevada	-0.13
New Hampshire	-0.38
New Jersey	-0.38
New Mexico	-0.43
New York	-0.26
North Carolina	0.11
North Dakota	0.95
Ohio	0.73
Oklahoma	0.57
Oregon	-0.65
Pennsylvania	0.68
Rhode Island	0.18
South Carolina	0.16
South Dakota	0.46
Tennessee	0.20
Texas	-0.19
Utah	-0.70
Vermont	-0.40
Virginia	-0.46
Washington	-0.72
West Virginia	0.27
Wisconsin	0.02
Wyoming	-0.14

— — — Best state in column

——— Worst state in column

FAIR OR POOR HEALTH STATUS

Individuals who report their health as fair or poor tend to have higher need for, and use of, health care services than those in better health. They also tend to have higher mortality.[11] Generally speaking, women of color are more likely to report fair or poor health than their White counterparts.[12] Data presented for self-reported health status are age-adjusted and drawn from the Behavioral Risk Factor Surveillance System (BRFSS).

Highlights

- Nationally, more than one in eight (12.8%) women rated their health as fair or poor (Table 1.1). Hispanic (26.9%) and American Indian and Alaska Native women (22.1%) had the highest rates of fair or poor health status, followed by Black women (16.9%), White women (9.5%), and Asian American, Native Hawaiian and Other Pacific Islander women (7.9%).
- There was considerable variation among racial and ethnic groups across the states. For example only 7.4% of Latinas in Missouri reported fair or poor health compared to 34.3% in Illinois.
- The U.S. disparity score for fair or poor health was 2.07, which can be interpreted as meaning that rates of fair or poor health status for women of color were more than double that of White women. State disparity scores ranged from a low of 0.86 in West Virginia (the only state with a disparity score less than 1.00 where a higher share of White women reported fair or poor health than minority women) to a high of 4.20 in District of Columbia.
- Only Maine had a disparity score that approached 1.00, meaning that a similar share of White women and women of color reported fair or poor health.
- As shown in Figure 1.1, the vast majority of states clustered in the upper quadrants, with disparity scores above 1.00 and with state prevalence rates for White women dispersed around the national average for White women. In the states in the upper left quadrant, White women had lower rates of fair or poor health than the national average for White women, while in the states in the upper right quadrant, they had higher rates.
- In the District of Columbia, found at the upper left side of the upper left quadrant (Figure 1.1), only 3.0% of White women reported fair or poor health, the lowest rate for White women in the nation and a rate considerably lower than their Latina counterparts (13.7%).
- Similarly, in California, also in the upper left quadrant, only a small share of White women reported fair or poor health (6.2%), and the gap between them and minority women led to the second highest disparity score.
- In contrast, in the upper right quadrant along the bottom right, in states like Arkansas, Mississippi, Kentucky, and Tennessee, White women had rates of fair or poor health that were far higher than the national average for White women, but still better than the minority women in those states. For example, in Arkansas, 13.6% of White women reported fair or poor health, compared to the national average for White women of 9.5%. The rates, however, were considerably higher for Black women (23.4%) and Latinas (25.3%) in the state.
- Only West Virginia fell into a lower quadrant, with a disparity score under 1.00. This was because such a large share of White women (16.8%) reported fair or poor health, the highest rate of any state for White women, and a rate slightly higher than for all minority women (14.5%) in the state.

FIGURE 1.1. State-Level Disparity Scores and Prevalence of Fair or Poor Health Status for White Women Ages 18–64

TABLE 1.1. Fair or Poor Health Status, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**2.07**	**12.8%**	**9.5%**	**19.7%**	**16.9%**	**26.9%**	**7.9%**	**22.1%**
Alabama	**1.71**	14.3%	12.0%	20.5%	21.2%			
Alaska	**1.58**	11.7%	9.6%	15.2%		9.3%		20.9%
Arizona	**2.40**	12.7%	8.6%	20.5%	19.8%	22.0%		22.7%
Arkansas	**1.82**	15.6%	13.6%	24.8%	23.4%	25.3%		
California	**3.48**	15.9%	6.2%	21.7%	16.5%	29.9%	6.5%	
Colorado	**2.88**	10.0%	7.0%	20.3%	10.5%	24.5%	6.2%	
Connecticut	**2.80**	8.5%	6.5%	18.3%	14.1%	26.6%	5.5%	
Delaware	**1.32**	9.7%	9.1%	12.0%	11.8%	14.3%		
District of Columbia	**4.20**	9.5%	3.0%	12.7%	13.3%	13.7%	2.8%	
Florida	**1.86**	13.5%	10.1%	18.8%	14.8%	22.9%	11.9%	
Georgia	**1.36**	11.9%	10.5%	14.3%	14.7%	14.2%		
Hawaii	**1.82**	11.6%	7.9%	14.5%		16.2%	12.6%	
Idaho	**1.87**	11.2%	10.3%	19.3%		20.8%		19.3%
Illinois	**2.70**	13.1%	8.4%	22.8%	18.3%	34.3%	10.9%	
Indiana	**2.08**	13.3%	11.4%	23.7%	20.5%	32.2%		
Iowa	**2.90**	7.7%	6.9%	20.0%	15.7%	25.9%		
Kansas	**1.64**	10.4%	9.4%	15.3%	16.4%	18.3%	10.5%	23.0%
Kentucky	**1.46**	16.5%	15.7%	23.0%	21.2%	28.1%		
Louisiana	**1.78**	14.3%	11.2%	19.9%	20.1%	17.7%		
Maine	**1.03**	10.5%	10.4%	10.8%				
Maryland	**1.59**	9.4%	7.4%	11.9%	13.0%	7.6%	8.6%	
Massachusetts	**2.10**	9.6%	7.8%	16.4%	15.7%	27.4%	4.5%	
Michigan	**1.50**	11.4%	10.3%	15.5%	18.2%	11.3%	4.1%	
Minnesota	**1.55**	8.0%	7.7%	11.9%	10.0%			
Mississippi	**1.42**	17.3%	14.9%	21.2%	21.4%	24.2%		
Missouri	**1.39**	11.7%	11.0%	15.4%	14.8%	7.4%		
Montana	**1.93**	9.0%	8.2%	15.8%		14.2%		17.7%
Nebraska	**2.88**	8.8%	7.3%	20.9%	16.5%	26.5%		
Nevada	**2.15**	17.1%	11.5%	24.7%	24.0%	31.2%	10.2%	
New Hampshire	**1.52**	7.9%	7.7%	11.7%		9.8%		
New Jersey	**2.63**	12.6%	7.8%	20.5%	14.7%	32.3%	8.0%	
New Mexico	**1.95**	14.8%	10.0%	19.5%		20.4%		17.0%
New York	**2.45**	13.5%	8.1%	19.9%	15.9%	29.7%	8.1%	
North Carolina	**1.69**	13.6%	11.1%	18.8%	17.5%	30.1%	8.3%	20.2%
North Dakota	**2.34**	7.1%	6.6%	15.4%				18.1%
Ohio	**2.03**	10.3%	8.9%	18.1%	19.5%	12.7%		
Oklahoma	**1.64**	14.7%	12.5%	20.4%	22.3%	28.1%	7.7%	19.4%
Oregon	**1.61**	12.2%	11.0%	17.7%		23.5%	8.4%	24.4%
Pennsylvania	**2.07**	11.1%	9.5%	19.6%	19.5%	24.5%	7.6%	
Rhode Island	**2.83**	9.3%	7.3%	20.5%	12.3%	28.7%		
South Carolina	**1.53**	12.6%	10.7%	16.3%	16.5%	13.1%		
South Dakota	**2.20**	8.2%	7.4%	16.2%		13.4%		18.4%
Tennessee	**1.36**	14.2%	13.3%	18.0%	18.8%			
Texas	**2.11**	17.0%	11.3%	23.9%	19.4%	26.9%	13.0%	
Utah	**1.97**	10.7%	9.3%	18.3%		24.3%	6.0%	
Vermont	**1.94**	7.8%	7.5%	14.5%		10.9%		
Virginia	**1.65**	8.8%	7.6%	12.5%	12.2%	16.8%		
Washington	**1.66**	10.6%	9.1%	15.2%	15.5%	23.7%	8.8%	24.6%
West Virginia	**0.86**	16.7%	16.8%	14.5%	15.2%			
Wisconsin	**2.27**	8.8%	8.0%	18.1%	20.9%	15.2%		
Wyoming	**1.69**	10.1%	9.3%	15.8%		16.8%		23.8%

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

——— Worst state in column

UNHEALTHY DAYS

In recent years, there has been increasing recognition of other self-reported measures of health status that capture dimensions of quality of life and well-being.[13] Unhealthy days quantifies the number of days during the past month that women stated their physical or mental health was "not good." Overall, women report a higher number of days of poor physical and mental health than men.[14] This indicator is based on the sum of two questions in the BRFSS—one that asks respondents about the number of days in the preceding 30 days that their *physical health*, including physical illness and injury, were not good, and the other that asks about the number of days in the past 30 days that their *mental health*, including stress, depression, and problems with emotions, was not good. This measure, along with fair or poor health status, and days with limited activities, constitutes a measure of health related quality of life.

Highlights

- On average in the U.S., women reported their physical or mental health was "not good" during 7.3 of the past 30 days (Table 1.2). This rate was highest for American Indian and Alaska Native women, who reported an average of 10.5 days in the past 30 days when their physical or mental health was not good compared to approximately 7 days for White, Black, and Hispanic women, and 5.5 days for Asian American, Native Hawaiian, and Other Pacific Islander women.
- There was variation within racial and ethnic groups living in different states. For example, White women in the District of Columbia averaged 4.7 unhealthy days, nearly half the rate of White women in Mississippi, West Virginia, and Kentucky, which all averaged close to 9 unhealthy days in the past 30 days. American Indian and Alaska Native women in Oregon had the highest number, averaging 12.9 unhealthy days in the past month.
- Nationally, the disparity score for unhealthy days was 1.01, or no disparity. This is the only indictor in this report for which there is practically no difference on a national level between White and minority women.
- At the state level, there were also modest differences between the average number of unhealthy days reported by White women and women in most other racial and ethnic groups, which is reflected in the low disparity scores, which ranged from 0.82 in West Virginia to 1.38 in the District of Columbia.
- In Figure 1.2, about one-third of the states fell into the upper left quadrant. White women in those states had a lower average number of unhealthy days than their minority counterparts, and also lower than the national average for White women.
- About one-quarter of the states fell into the upper right quadrant. In these states, the disparity score was greater than 1.00 (women of color had a higher number of unhealthy days than White women), even though White women in these states had a greater-than-average number of unhealthy days than the national average for White women.
- In the states in the lower quadrants, women of color had fewer average unhealthy days than White women.
- In Kansas (in the lower left quadrant), White women had fewer unhealthy days than the national average, but American Indian and Alaska Native women had more than the average number of days. This number was offset by Black and Latina women who comprise the majority of women of color in Kansas.
- Of the nine states in the lower right quadrant, White women in Mississippi and West Virginia in particular had far greater numbers of unhealthy days than the national average and also more, on average, than minority women in the state, leading to their disparity scores of less than 1.00.

FIGURE 1.2. State-Level Disparity Scores and Mean Number of Days that Physical or Mental Health Was "Not Good" in Past 30 Days for White Women Ages 18–64

TABLE 1.2. Days Physical or Mental Health Was "Not Good" in Past 30 Days, by State and Race/Ethnicity

State	Disparity Score	Mean Number of Days: All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.01**	**7.3**	**7.2**	**7.3**	**7.6**	**7.4**	**5.5**	**10.5**
Alabama	**1.05**	8.1	8.1	8.5	8.5			
Alaska	**1.14**	7.4	7.0	8.0		6.8		9.1
Arizona	**0.92**	7.4	7.5	6.9	6.9	6.3		8.5
Arkansas	**1.20**	8.2	7.9	9.5	9.6	7.3		
California	**1.02**	7.3	7.1	7.3	8.0	7.8	5.4	
Colorado	**1.15**	6.6	6.3	7.3	7.2	7.4	4.9	
Connecticut	**1.05**	6.9	6.8	7.1	7.8	6.9	5.5	
Delaware	**0.94**	7.2	7.3	6.9	6.8	7.2		
District of Columbia	**1.38**	5.9	4.7	6.5	6.6	6.8	3.8	
Florida	**0.92**	7.5	7.7	7.1	7.4	6.8	6.1	
Georgia	**1.02**	7.2	7.2	7.3	7.2	6.9		
Hawaii	**1.17**	6.2	5.8	6.7		7.4	6.3	
Idaho	**1.09**	7.7	7.6	8.3		7.9		10.3
Illinois	**1.04**	7.0	6.9	7.2	7.4	7.2	5.2	
Indiana	**1.17**	7.7	7.5	8.7	8.7	7.8		
Iowa	**1.07**	6.0	6.0	6.4	6.9	6.0		
Kansas	**0.98**	6.3	6.3	6.2	7.2	5.5	3.7	10.0
Kentucky	**1.16**	8.7	8.5	9.9	9.5	9.5		
Louisiana	**1.03**	6.8	6.8	7.0	7.1	6.7		
Maine	**0.90**	7.7	7.8	7.0				
Maryland	**0.90**	6.8	7.0	6.3	6.5	6.4	4.6	
Massachusetts	**1.11**	7.0	6.8	7.6	7.5	8.8	6.3	
Michigan	**1.06**	7.5	7.3	7.8	8.1	7.6	4.1	
Minnesota	**1.06**	6.5	6.5	6.9	6.2			
Mississippi	**0.96**	8.9	9.0	8.7	8.6	9.2		
Missouri	**1.06**	7.1	7.1	7.5	6.8	7.1		
Montana	**1.23**	6.5	6.3	7.8		7.5		7.9
Nebraska	**1.26**	6.2	6.1	7.6	8.7	7.4		
Nevada	**1.02**	8.4	8.1	8.3	8.3	8.9	6.1	
New Hampshire	**1.17**	7.1	7.0	8.2		8.4		
New Jersey	**0.96**	7.2	7.2	6.9	7.2	7.3	5.4	
New Mexico	**1.04**	7.3	7.2	7.4		7.5		7.3
New York	**1.05**	7.5	7.1	7.5	7.3	8.6	5.4	
North Carolina	**1.00**	7.0	7.0	7.0	7.3	5.8	5.1	9.8
North Dakota	**1.28**	5.7	5.6	7.2				7.6
Ohio	**1.10**	7.8	7.7	8.5	8.9	5.9		
Oklahoma	**1.14**	8.1	8.0	9.1	8.2	7.5	4.0	9.4
Oregon	**0.96**	8.0	8.0	7.7		6.6	7.0	12.9
Pennsylvania	**1.10**	7.8	7.7	8.4	8.7	9.1	3.9	
Rhode Island	**1.16**	7.0	6.9	8.0	7.3	8.2		
South Carolina	**1.02**	7.3	7.3	7.4	7.2	8.7		
South Dakota	**1.35**	5.8	5.6	7.6		7.3		8.3
Tennessee	**1.00**	7.2	7.2	7.2	7.2			
Texas	**1.02**	7.2	7.1	7.2	8.5	6.9	5.1	
Utah	**0.95**	7.7	7.7	7.3		7.1	5.6	
Vermont	**1.23**	7.0	6.9	8.5		9.0		
Virginia	**1.01**	7.2	7.2	7.3	7.0	6.8		
Washington	**0.98**	7.6	7.5	7.4	8.9	7.9	5.5	12.0
West Virginia	**0.82**	8.8	8.9	7.3	7.1			
Wisconsin	**1.28**	6.7	6.5	8.3	9.4	6.8		
Wyoming	**1.19**	7.3	7.2	8.6		8.5		7.4

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

——— Worst state in column

LIMITED ACTIVITY DAYS

The ability of a woman to conduct routine daily activities is an aspect of her functional health status. This indicator, a complement to the unhealthy days indicator, seeks to measure the impact of unhealthy days on women's lives. This includes effects on the ability to work, take care of one's self and family, or participate in recreational activities. Overall, women report a greater number of days with limits in activity than men.[15] This age-adjusted indicator from the BRFSS asks respondents who said they had at least one unhealthy day in the prior month to report the number of days in the past month that their physical or mental health prevented them from engaging in their usual activities.

Highlights

- In the U.S., women with at least one unhealthy day in the past month experienced an average of 3.5 days with limited activity in the past 30 days (Table 1.3). American Indian and Alaska Native and Black women were more likely to experience days with limited activity, averaging 6.2 and 4.3 days, respectively, whereas White women averaged 3.2 days. Asian American, Native Hawaiian and Other Pacific Islander women had the lowest average number of limited activity days (2.7).
- The range of limited activity days varied within racial and ethnic groups. For example, among Hispanic women, limited activity days ranged from 2.1 days in the District of Columbia and Iowa to 5.7 days in Pennsylvania.
- The national disparity score for limited activity days was 1.21. The disparity scores for states ranged from a low of 0.92 in Texas and West Virginia to a high of 2.49 in North Dakota.
- In Figure 1.3, most states were in the upper quadrants with disparity scores above 1.00, meaning that women of color in these states reported a greater number of days with limits in activity relative to White women. Several states had rates close to the national average for White women.
- Disparity scores in North Dakota and South Dakota were among the highest because their American Indian and Alaska Native populations experienced a high number of days with limited activity (5.5 and 5.0, respectively), which was at least twice the number of their White counterparts (1.9 and 2.5, respectively).
- The District of Columbia's disparity score was higher than 2.00 due to the high average number of days with limited activity experienced by African American (4.4) compared to White women (1.8).
- Three states (Tennessee, Texas, and West Virginia) were in the lower right quadrant and had disparity scores less than 1.00 (meaning women of color had fewer unhealthy days compared to White women). This is largely attributable to comparable rates of limited activity days between White and minority women, and to these rates being higher than the national average.

FIGURE 1.3. State-Level Disparity Scores and Mean Number of Limited Activity Days in Past 30 Days for White Women Ages 18–64

TABLE 1.3. Days Activities Were Limited in Past 30 Days, by State and Race/Ethnicity

State	Disparity Score	Mean Number of Days: All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.21**	**3.5**	**3.2**	**3.9**	**4.3**	**3.8**	**2.7**	**6.2**
Alabama	**1.15**	4.0	3.9	4.5	4.5			
Alaska	**1.34**	3.5	3.2	4.3				4.5
Arizona	**1.18**	3.5	3.3	3.9		4.0		4.7
Arkansas	**1.41**	3.6	3.4	4.8	4.7	4.6		
California	**1.19**	3.7	3.3	3.9	5.5	4.0	2.7	
Colorado	**1.17**	3.0	2.9	3.4	4.1	3.2		
Connecticut	**1.26**	3.0	2.9	3.6	4.0	3.4		
Delaware	**1.34**	3.3	3.1	4.1	4.1	3.5		
District of Columbia	**2.19**	3.3	1.8	4.0	4.4	2.1		
Florida	**1.19**	3.6	3.4	4.0	4.4	3.6		
Georgia	**1.28**	3.3	3.0	3.9	3.8	3.8		
Hawaii	**1.28**	3.0	2.9	3.7		3.5	2.8	
Idaho	**1.29**	3.4	3.3	4.3		3.7		
Illinois	**1.49**	3.2	2.8	4.2	4.0	3.9		
Indiana	**1.28**	3.3	3.1	4.0	3.7	3.2		
Iowa	**1.29**	2.5	2.5	3.2		2.1		
Kansas	**1.55**	3.0	2.9	4.4	4.9	3.0		
Kentucky	**1.36**	4.7	4.5	6.1	5.2			
Louisiana	**1.17**	4.0	3.8	4.4	4.5	5.1		
Maine	**1.38**	3.6	3.5	4.9				
Maryland	**1.29**	3.3	2.9	3.8	4.0	3.1	3.1	
Massachusetts	**1.59**	3.1	2.8	4.4	4.3	5.4	3.0	
Michigan	**1.53**	3.5	3.1	4.8	5.3	3.8		
Minnesota	**1.58**	2.7	2.6	4.1				
Mississippi	**1.17**	4.3	4.0	4.7	4.6			
Missouri	**1.41**	3.7	3.5	4.9	4.2			
Montana	**1.42**	3.0	2.8	4.1				4.5
Nebraska	**1.36**	2.8	2.7	3.7	4.6	3.0		
Nevada	**1.27**	3.8	3.5	4.5		3.9		
New Hampshire	**1.25**	3.2	3.1	3.9				
New Jersey	**1.46**	3.4	2.9	4.2	4.4	4.9	2.5	
New Mexico	**1.29**	3.6	3.1	4.0		4.1		3.8
New York	**1.20**	3.3	2.9	3.5	3.6	3.6	2.7	
North Carolina	**1.25**	3.6	3.4	4.2	4.2	3.6		5.2
North Dakota	**2.49**	2.1	1.9	4.7				5.5
Ohio	**1.58**	3.3	3.1	4.8	5.4	2.3		
Oklahoma	**1.09**	4.0	3.9	4.2	4.6	4.2		4.7
Oregon	**1.23**	3.5	3.4	4.2		3.6	3.7	6.5
Pennsylvania	**1.56**	3.6	3.3	5.2	4.9	5.7		
Rhode Island	**1.51**	3.3	3.1	4.6	4.6	4.5		
South Carolina	**1.08**	3.4	3.3	3.6	3.5	3.7		
South Dakota	**1.80**	2.6	2.5	4.4				5.0
Tennessee	**0.98**	4.1	4.2	4.1	3.5			
Texas	**0.92**	3.8	3.9	3.6	4.6	3.3		
Utah	**1.27**	2.9	2.8	3.5		3.4		
Vermont	**1.50**	2.9	2.8	4.2		3.9		
Virginia	**1.15**	3.1	3.0	3.5	3.5	3.4		
Washington	**1.15**	3.3	3.2	3.7	4.3	4.3	2.6	6.2
West Virginia	**0.92**	4.3	4.3	4.0				
Wisconsin	**1.66**	2.7	2.6	4.3	5.7			
Wyoming	**1.64**	3.1	2.9	4.8		4.2		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

———— Worst state in column

DIABETES

Diabetes is a growing public health challenge across the nation. Among women ages 18 to 64, diabetes is the sixth-leading cause of death.[16] Women of color are particularly at risk for this disease, which has severe health implications, raising the risk for heart disease, kidney disease, high blood pressure, complications during pregnancy, and a host of associated health problems if not well controlled. Some consequences of diabetes are also more acute for women than men. Research has found that among people with diabetes who have had a heart attack, women have lower survival rates and poorer quality of life than men.[17] Diabetic women are also at greater risk for blindness than men.[18] This indicator, also from the BRFSS, measures the share of women who have ever been diagnosed with diabetes by a physician.

Highlights

- Nationally, 4.2% of women had ever been diagnosed with diabetes (Table 1.4). The rates for American Indian and Alaska Native (8.6%), African American (7.5%), and Hispanic women (6.1%) were two to three times higher than those of White (3.3%) and Asian American, Native Hawaiian and Other Pacific Islander (3.2%) women.
- This is a condition for which there is tremendous state-to-state variation within communities of color. For example, American Indian and Alaska Native women in South Dakota were the hardest hit by diabetes (13.5%), a rate over three times higher than their counterparts in Alaska (3.5%). Similarly, 12.1% of Black women in Iowa had received a diabetes diagnosis compared to 5.0% of those living in Rhode Island.
- Nationally, the disparity score for diabetes was 1.87, meaning that diabetes rates were 87% higher for women of color than White women. State disparity scores varied greatly, ranging from 0.83 in Maine (the only state with a disparity score less than 1.00) to 7.37 in the District of Columbia. Almost half of the states had disparity scores greater than 2.00.
- States in the Northern Central and Southwestern regions tended to have higher disparity scores, whereas states in the Southeastern region tended to have lower disparity scores. States in the Southeastern region also tended to have higher-than-average prevalence rates for White women.
- Figure 1.4 shows that all states except Maine and West Virginia are located in the upper quadrants, with disparity scores higher than 1.00, meaning that diabetes rates are higher for women of color than for White women. White women in the states in the upper left quadrant had diabetes rates below the national average for White women and those in the upper right quadrant had rates above.
- The states with the highest disparity scores in the upper left quadrant (District of Columbia, Minnesota, Montana, North Dakota, South Dakota) also had the lowest rates of diabetes for White women at roughly 2.5% or lower. Furthermore, more than 1 in 8 American Indian and Alaska Native women (13%) in the Dakotas had diabetes, driving the high disparity score for those states.
- Six percent of White women in West Virginia had diabetes, representing the highest rate for White women in the U.S. West Virginia had a disparity score of 1.00 because the diabetes rate for the small Black population in the state, which constitutes the largest minority group, was also approximately 6% (which is lower than the national average for Black women).

FIGURE 1.4. State-Level Disparity Scores and Prevalence of Diabetes for White Women Ages 18–64

TABLE 1.4. Diabetes, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.87**	**4.2%**	**3.3%**	**6.2%**	**7.5%**	**6.1%**	**3.2%**	**8.6%**
Alabama	**1.90**	5.4%	4.3%	8.1%	7.8%			
Alaska	**1.55**	3.0%	2.7%	4.1%		5.0%		3.5%
Arizona	**2.25**	4.0%	2.9%	6.4%		6.0%		7.8%
Arkansas	**1.74**	4.3%	3.8%	6.6%	6.1%	7.3%		
California	**2.40**	4.5%	2.5%	5.9%	6.4%	6.8%	3.0%	
Colorado	**2.18**	2.6%	2.1%	4.5%	5.3%	5.2%	1.0%	
Connecticut	**2.68**	3.5%	2.8%	7.4%	7.3%	9.1%	2.7%	
Delaware	**2.58**	4.4%	3.3%	8.4%	9.2%	9.7%		
District of Columbia	**7.37**	4.6%	0.8%	6.2%	7.1%	1.9%	3.3%	
Florida	**1.79**	4.4%	3.4%	6.1%	7.0%	5.5%	6.3%	
Georgia	**1.89**	4.6%	3.5%	6.5%	7.2%	5.1%		
Hawaii	**2.93**	4.2%	1.7%	5.0%		6.8%	5.2%	
Idaho	**2.02**	3.8%	3.5%	7.0%		6.8%		10.9%
Illinois	**2.64**	4.2%	2.8%	7.3%	7.5%	8.9%	4.0%	
Indiana	**1.83**	4.4%	4.1%	7.4%	8.9%	4.9%		
Iowa	**1.53**	3.0%	2.9%	4.4%	12.1%	3.6%		
Kansas	**1.45**	3.9%	3.6%	5.2%	6.4%	5.4%	2.6%	12.9%
Kentucky	**1.76**	4.9%	4.6%	8.1%	8.2%	7.4%		
Louisiana	**1.90**	5.3%	4.0%	7.6%	7.8%	8.1%		
Maine	**0.83**	3.1%	3.2%	2.6%				
Maryland	**1.87**	4.1%	3.0%	5.7%	6.8%	3.9%	1.3%	
Massachusetts	**2.17**	2.9%	2.4%	5.2%	6.1%	7.3%	1.9%	
Michigan	**1.51**	4.2%	3.8%	5.7%	6.2%	6.9%	0.7%	
Minnesota	**2.96**	2.4%	2.1%	6.2%	5.4%			
Mississippi	**1.65**	6.3%	5.1%	8.4%	8.7%	4.3%		
Missouri	**1.80**	4.2%	3.9%	6.9%	7.9%	6.1%		
Montana	**3.47**	3.0%	2.4%	8.4%		7.7%		11.2%
Nebraska	**2.17**	3.5%	3.1%	6.8%	6.4%	6.8%		
Nevada	**1.74**	4.3%	3.3%	5.7%	8.9%	5.9%	1.8%	
New Hampshire	**2.27**	3.2%	3.0%	6.8%		9.7%		
New Jersey	**2.53**	3.4%	2.2%	5.6%	7.1%	5.5%	3.4%	
New Mexico	**2.09**	4.0%	2.6%	5.5%		5.0%		9.3%
New York	**2.32**	3.7%	2.4%	5.7%	7.7%	4.5%	4.2%	
North Carolina	**1.73**	5.0%	4.2%	7.2%	8.0%	6.0%	2.2%	7.9%
North Dakota	**5.03**	2.6%	2.1%	10.4%				13.2%
Ohio	**2.26**	3.6%	3.0%	6.9%	8.1%	2.2%		
Oklahoma	**2.37**	5.4%	4.3%	10.2%	8.4%	7.3%	7.2%	12.0%
Oregon	**1.26**	3.3%	3.1%	4.0%		4.9%	2.3%	6.0%
Pennsylvania	**2.16**	4.1%	3.5%	7.5%	8.2%	6.8%	4.8%	
Rhode Island	**2.45**	3.1%	2.5%	6.1%	5.0%	8.0%		
South Carolina	**1.97**	5.3%	4.0%	7.9%	8.3%	6.1%		
South Dakota	**3.50**	3.4%	2.7%	9.5%		8.2%		13.5%
Tennessee	**1.62**	5.8%	5.1%	8.3%	9.3%			
Texas	**1.75**	5.3%	4.0%	7.0%	9.1%	6.8%	0.8%	
Utah	**2.36**	2.9%	2.4%	5.8%		5.8%	2.8%	
Vermont	**1.86**	2.5%	2.5%	4.6%		2.9%		
Virginia	**1.73**	3.3%	2.8%	4.8%	6.6%	0.7%		
Washington	**1.51**	3.8%	3.4%	5.2%	9.2%	6.7%	3.5%	6.0%
West Virginia	**1.00**	6.0%	6.0%	6.0%	5.8%			
Wisconsin	**1.85**	3.0%	2.8%	5.2%	6.9%	2.9%		
Wyoming	**1.44**	3.2%	3.0%	4.3%		4.9%		8.8%

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

———— Worst state in column

CARDIOVASCULAR DISEASE

Cardiovascular disease is the second-leading cause of death among women, and it is also a major cause of disability.[19] Heart disease kills more women than men annually, and over the past several years research has found important differences in how women and men experience cardiovascular disease in terms of risk factors, diagnosis, and treatment. On average, heart disease strikes women later in life than men.[20] Cardiovascular disease can also be harder to detect in women, as some of the symptoms associated with heart disease may present differently in men and women. As more research has emerged about the gender differences in heart disease, there have been increasing efforts to educate providers and the public on the manifestations of heart disease in women. Many women of color are at higher risk for cardiovascular disease because major risk factors, including hypertension and obesity, affect some racial and ethnic groups at very high rates. Access to health care is also critical for prevention and management of cardiovascular disease.

This age-adjusted indicator combines responses to three questions in the BRFSS. Respondents were asked whether they had ever been told that they had a heart attack, stroke, or angina. Data presented reflect the percentage of women who responded "yes" to any of the three questions.

Highlights

- The rate of cardiovascular disease nationwide for women was 3.2%, with American Indian and Alaska Native women having the highest rate at 8.7%, followed by Black (4.8%), Hispanic (4.0%) and White (2.7%) women. Asian American, Native Hawaiian and Other Pacific Islander women had the lowest rate at 1.2% (Table 1.5).
- Among American Indian and Alaska Native women, those in North Carolina were hardest hit by cardiovascular disease, with 8.8% reporting at least one cardiovascular condition, compared to the lowest rate of 3.0% in New Mexico. The prevalence rates of cardiovascular disease for Black women in Michigan (7.3%) and Ohio (6.6%) were among the highest in the nation, considerably higher than the 1.3% for Black women in Colorado.
- The national disparity score for cardiovascular disease was 1.46, with state-level disparity scores ranging from a low of 0.75 in Wyoming to a high of 5.40 in District of Columbia. Five states had disparity scores less than 1.00, and twelve states had disparity scores higher than 2.00.
- As shown in Figure 1.5, most states were aggregated in the upper left quadrant, where disparity scores were higher than 1.00 and the prevalence of cardiovascular disease for White women was lower than the national average for White women.
- White women in the District of Columbia had a very low rate of cardiovascular disease (<1%) compared to 4.1% of Black women (who account for over half of the female population), increasing the disparity score to more than 5.00.
- North Dakota's high disparity score of 3.48 was attributable to the high rate of cardiovascular disease among American Indian and Alaska Native women (5.3%), compared to 1.3% of White women.
- While the disparity score for West Virginia was 1.15, White women in the state had the highest rate of cardiovascular disease among White women in the nation, and a rate higher than the rate reported by minority women in the state.

FIGURE 1.5. State-Level Disparity Scores and Prevalence of Cardiovascular Disease for White Women Ages 18–64

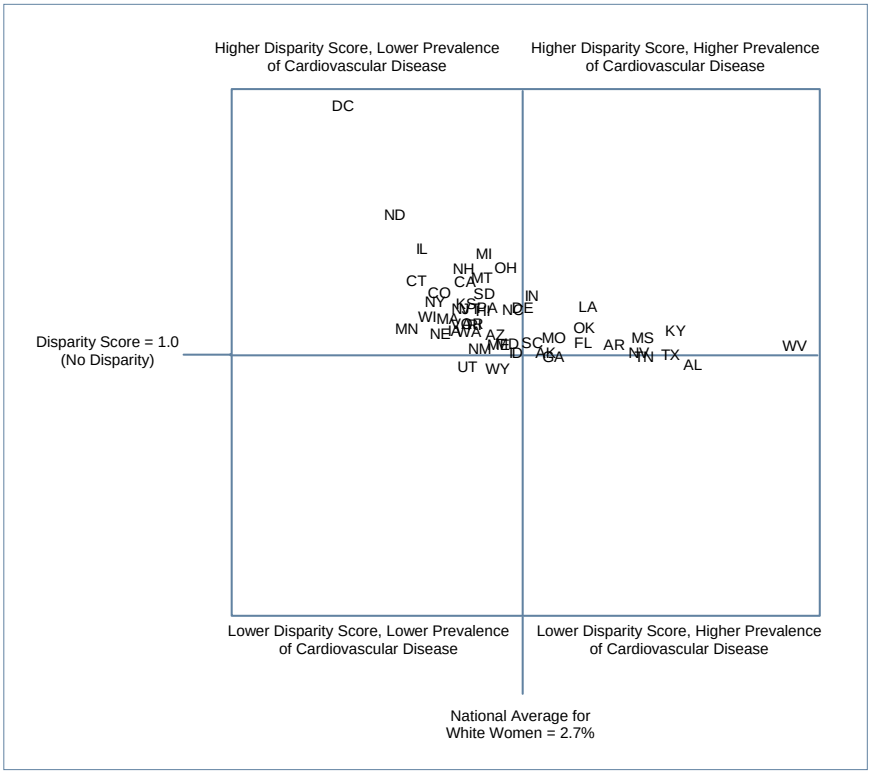


TABLE 1.5. Cardiovascular Disease, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.46**	**3.2%**	**2.7%**	**3.9%**	**4.8%**	**4.0%**	**1.2%**	**8.7%**
Alabama	**0.82**	4.4%	4.6%	3.8%	3.6%			
Alaska	**1.04**	3.1%	3.0%	3.1%				3.6%
Arizona	**1.36**	2.7%	2.4%	3.3%		2.9%		3.6%
Arkansas	**1.17**	3.9%	3.8%	4.4%	4.1%	2.8%		
California	**2.29**	3.8%	2.1%	4.8%	6.0%	6.3%	0.4%	
Colorado	**2.10**	2.2%	1.8%	3.8%	1.3%	4.3%		
Connecticut	**2.29**	1.9%	1.5%	3.5%	3.2%	3.7%	3.5%	
Delaware	**1.83**	3.2%	2.7%	5.0%	5.7%	3.9%		
District of Columbia	**5.40**	2.9%	0.7%	3.8%	4.1%	2.0%		
Florida	**1.21**	3.6%	3.4%	4.1%	5.5%	3.1%		
Georgia	**0.96**	3.1%	3.1%	2.9%	3.2%	1.1%		
Hawaii	**1.78**	2.9%	2.3%	4.0%		2.7%	3.0%	
Idaho	**1.03**	2.7%	2.7%	2.7%		3.0%		
Illinois	**2.87**	2.7%	1.6%	4.6%	4.4%	4.2%	1.9%	
Indiana	**2.05**	3.3%	2.8%	5.8%	5.9%	4.3%		
Iowa	**1.42**	2.0%	2.0%	2.8%		2.0%		
Kansas	**1.91**	2.3%	2.1%	4.0%	7.1%	1.7%		
Kentucky	**1.43**	4.6%	4.4%	6.3%	3.8%			
Louisiana	**1.85**	4.5%	3.5%	6.4%	6.6%	6.1%		
Maine	**1.17**	2.5%	2.5%	2.9%				
Maryland	**1.19**	2.8%	2.6%	3.0%	3.3%	2.7%	1.4%	
Massachusetts	**1.64**	2.2%	1.9%	3.1%	4.3%	3.8%	0.9%	
Michigan	**2.79**	3.0%	2.3%	6.4%	7.3%	5.1%		
Minnesota	**1.45**	1.5%	1.4%	2.1%				
Mississippi	**1.29**	4.5%	4.1%	5.3%	5.2%			
Missouri	**1.32**	3.2%	3.1%	4.1%	3.4%			
Montana	**2.34**	2.5%	2.3%	5.3%		6.9%		3.2%
Nebraska	**1.37**	1.8%	1.8%	2.5%	2.0%	1.6%		
Nevada	**1.05**	4.1%	4.0%	4.2%		4.2%		
New Hampshire	**2.52**	2.2%	2.1%	5.2%				
New Jersey	**1.82**	2.6%	2.0%	3.7%	4.8%	4.5%	0.1%	
New Mexico	**1.11**	2.3%	2.2%	2.5%		2.3%		3.0%
New York	**1.93**	2.4%	1.7%	3.4%	4.0%	4.1%	1.0%	
North Carolina	**1.80**	3.3%	2.6%	4.7%	4.6%	6.1%	0.0%	8.8%
North Dakota	**3.48**	1.5%	1.3%	4.5%				5.3%
Ohio	**2.54**	3.1%	2.5%	6.5%	6.6%	4.8%		
Oklahoma	**1.47**	3.9%	3.4%	5.1%	7.0%	4.9%	0.5%	5.9%
Oregon	**1.54**	2.3%	2.2%	3.3%		2.0%	3.7%	5.5%
Pennsylvania	**1.83**	2.7%	2.3%	4.3%	4.3%	5.0%	2.2%	
Rhode Island	**1.53**	2.4%	2.2%	3.3%	4.1%	3.6%		
South Carolina	**1.21**	3.1%	2.8%	3.4%	3.2%	4.9%		
South Dakota	**2.09**	2.6%	2.3%	4.8%				7.2%
Tennessee	**0.98**	4.1%	4.1%	4.0%	3.6%			
Texas	**1.01**	4.3%	4.4%	4.4%	5.2%	4.1%		
Utah	**0.79**	2.1%	2.1%	1.7%		1.9%		
Vermont	**1.82**	2.2%	2.1%	3.9%				
Virginia	**1.54**	2.3%	2.0%	3.1%	2.9%	3.8%		
Washington	**1.42**	2.3%	2.1%	3.0%	5.4%	3.0%	1.7%	7.2%
West Virginia	**1.15**	5.8%	5.8%	6.7%	3.9%			
Wisconsin	**1.67**	1.7%	1.7%	2.8%	4.0%			
Wyoming	**0.75**	2.4%	2.4%	1.8%		2.3%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006. The cardiovascular disease module was only used by 8 states in 2004: DE, LA, OH, OK, PA, SC, VA, WV.

— — — Best state in column

———— Worst state in column

OBESITY

Obesity rates have been on the rise over the past three decades. More deaths in the United States are associated with obesity and inactivity than with alcohol and motor vehicles combined.[21] Individuals who are obese have higher rates of several chronic diseases, including diabetes, cardiovascular disease, and hypertension, than those who are not obese.[22] For women, obesity has also been associated with arthritis, infertility, and post-menopausal breast cancer.[23] The far-reaching impact of obesity has affected the health system as well. One study estimated that the rise in obesity prevalence accounted for 12 percent of the growth in health spending during the 1990s.[24] Women are more likely to be obese than men, and with the exception of Asian American, Native Hawaiian and Other Pacific Islander women, women of color have higher rates than White women.

These age-adjusted data are based on body mass index (BMI) calculations computed from weight and height data collected in the BRFSS. Women with BMIs greater than or equal to 30 are classified as obese.

Highlights

- Nationally, more than one in five women (22.7%) were obese, with Black (37.8%), American Indian and Alaska Native (30.4%), and Hispanic (27.3%) women having the highest rates (Table 1.6). Asian American, Native Hawaiian and Other Pacific Islander women had the lowest obesity rate at 8.4%, followed by White women at 20.1%.
- As with other health indicators, there was sizable variation in obesity rates within racial and ethnic groups of women. For example, obesity rates for American Indian and Alaska Native women ranged from a low of 30.9% in Kansas to 50.2% in North Dakota (the highest rate for any subgroup). Similarly, the rates for Hispanic women ranged from 9.9% in the District of Columbia to 33.8% in Wisconsin.
- The national disparity score for obesity was 1.41 and the scores of states ranged from a low of 0.97 in Maine to a high of 4.68 in the District of Columbia. The District of Columbia's obesity rate for Black women was near the national average for Black women, but was five times higher than the obesity rate for White women (6.8%), which was the lowest in the nation for White women.
- In Figure 1.6, most states' disparity scores were clustered in the center of the upper quadrants, meaning that most states had disparity scores above 1.00 and their rate for White women was similar to the national average for White women.
- West Virginia had the highest rate of obesity for White women at 27.8%, and one of the lowest disparity scores in the nation (1.04).
- North Dakota was also notable in that it had a disparity score greater than 2.00 due to the fact that half of its American Indian and Alaska Native population was obese, compared to 19.1% of the state's White women. South Carolina also had a high disparity score attributable to the fact that 42.8% of its Black women were obese (accounting for nearly one-third of the population) compared to 21.4% of White women in the state.
- The District of Columbia was the most notable state, isolated in the upper left corner of Figure 1.6. The disparity score in the District was largely driven by the extremely low rate of obesity among White women (6.8%), which is less than half the rate of White women in Colorado, the next lowest state.
- Southern states tended to have higher disparity scores for obesity than other regions, driven in large part by the high obesity rates among Black women, even though a greater share of White women were obese than the national average for White women in many of those states. Western states tended to have lower disparity scores.

FIGURE 1.6. State-Level Disparity Scores and Prevalence of Obesity for White Women Ages 18–64

TABLE 1.6. Obesity, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.41**	**22.7%**	**20.1%**	**28.4%**	**37.8%**	**27.3%**	**8.4%**	**30.4%**
Alabama	**1.70**	28.4%	23.6%	40.3%	43.0%			
Alaska	**1.25**	25.3%	23.4%	29.3%		30.3%		32.6%
Arizona	**1.68**	19.3%	15.8%	26.6%		27.0%		34.3%
Arkansas	**1.55**	27.0%	24.9%	38.6%	42.6%	29.1%		
California	**1.44**	21.5%	16.8%	24.2%	34.2%	29.4%	6.7%	
Colorado	**1.59**	16.3%	14.5%	23.1%	25.9%	25.7%	6.1%	
Connecticut	**1.69**	17.6%	16.0%	27.1%	37.3%	24.3%	9.1%	
Delaware	**1.60**	22.0%	19.3%	30.8%	36.1%	16.4%		
District of Columbia	**4.68**	24.1%	6.8%	31.8%	36.7%	9.9%	9.6%	
Florida	**1.65**	20.5%	16.9%	27.8%	36.6%	23.9%	8.2%	
Georgia	**1.59**	24.3%	19.9%	31.7%	36.1%	21.1%		
Hawaii	**1.31**	18.5%	15.0%	19.6%		25.1%	19.8%	
Idaho	**1.28**	21.3%	20.6%	26.5%		26.1%		45.1%
Illinois	**1.45**	23.5%	20.5%	29.8%	38.6%	30.4%	4.0%	
Indiana	**1.49**	25.3%	24.1%	35.8%	42.0%	27.2%		
Iowa	**1.07**	21.7%	21.6%	23.0%	42.4%	20.9%		
Kansas	**1.29**	23.6%	22.5%	29.2%	42.6%	28.7%		30.9%
Kentucky	**1.37**	27.9%	27.1%	37.2%	46.0%	22.4%		
Louisiana	**1.87**	25.8%	19.8%	36.9%	38.8%	26.6%		
Maine	**0.97**	21.2%	21.2%	20.6%				
Maryland	**1.74**	22.3%	17.2%	30.0%	36.5%	17.3%	7.5%	
Massachusetts	**1.38**	16.6%	15.4%	21.2%	33.6%	25.4%	5.6%	
Michigan	**1.43**	24.0%	22.1%	31.5%	37.9%	26.0%	5.2%	
Minnesota	**1.12**	21.0%	20.7%	23.2%	30.5%			
Mississippi	**1.68**	32.0%	25.3%	42.5%	44.4%	25.1%		
Missouri	**1.45**	24.7%	23.4%	33.9%	38.2%	22.0%		
Montana	**1.70**	17.7%	16.5%	28.1%		32.9%		34.5%
Nebraska	**1.40**	22.2%	21.4%	29.8%	34.4%	29.5%		
Nevada	**1.24**	21.2%	19.4%	24.0%	31.1%	26.9%	10.6%	
New Hampshire	**1.20**	18.7%	18.5%	22.1%		32.4%		
New Jersey	**1.51**	18.6%	15.9%	23.9%	34.4%	23.4%	7.5%	
New Mexico	**1.57**	22.2%	17.5%	27.5%		26.6%		33.3%
New York	**1.37**	20.4%	17.6%	24.1%	34.1%	23.5%	6.4%	
North Carolina	**1.66**	25.1%	21.3%	35.3%	41.5%	23.1%	6.2%	34.1%
North Dakota	**2.15**	20.6%	19.1%	41.0%				50.2%
Ohio	**1.54**	24.0%	22.2%	34.3%	38.2%	23.0%		
Oklahoma	**1.25**	26.1%	24.1%	30.3%	34.9%	32.4%	16.0%	34.2%
Oregon	**1.02**	21.9%	21.5%	22.0%		27.7%	8.8%	31.2%
Pennsylvania	**1.63**	21.1%	19.2%	31.4%	38.4%	25.4%	6.6%	
Rhode Island	**1.55**	17.9%	16.7%	25.8%	27.1%	28.0%		
South Carolina	**1.83**	27.2%	21.4%	39.1%	42.8%	16.9%		
South Dakota	**1.54**	21.7%	20.5%	31.5%		24.2%		43.9%
Tennessee	**1.48**	26.8%	24.5%	36.3%	40.9%			
Texas	**1.45**	25.0%	20.9%	30.3%	38.5%	29.6%	8.5%	
Utah	**1.11**	18.7%	18.5%	20.4%		21.8%		
Vermont	**1.25**	17.9%	17.7%	22.2%		18.7%		
Virginia	**1.40**	22.9%	20.9%	29.2%	35.9%	24.9%		
Washington	**1.04**	21.6%	21.1%	21.8%	34.2%	28.2%	11.4%	34.6%
West Virginia	**1.04**	27.8%	27.8%	28.9%	37.3%			
Wisconsin	**1.65**	21.0%	20.1%	33.1%	39.3%	33.8%		
Wyoming	**1.28**	20.6%	20.1%	25.7%		24.6%		

Note: Among women ages 18–64. Obesity is defined by body mass index.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

———— Worst state in column

SMOKING

The relationship between smoking and illness, particularly lung cancer, the leading cause of cancer mortality among women, is well documented. Smoking is more common among men than women, but takes an enormous toll on both sexes. High quantity and duration of smoking have been shown to have adverse effects on several health conditions, including cancer, heart disease, stroke, and respiratory illness. For women, there are strong negative effects on fertility and pregnancy. Based on the evidence linking smoking to negative health outcomes, many public health experts view smoking as a leading cause of preventable illness in the developed world.[25]

This indicator reports the age-adjusted rate of women who are current smokers. It is based on two questions in the BRFSS, which ask the respondent if she has smoked at least 100 cigarettes in her lifetime, and if so, whether she currently smokes every day, some days, or not at all.

Highlights

- Nationally, one in five adult women was a current smoker in 2003–2005 (Table 1.7). Unlike many of the previous health indicators, White women had a higher rate of smoking (24.7%) than Black (18.7%) and Hispanic (11.5%) women. American Indian and Alaska Native women had the highest rate at 35.7%, and Asian American, Native Hawaiian and Other Pacific Islander women had the lowest rate at 8.4%.
- Smoking rates among White women in the District of Columbia (11.0%) and Utah (10.2%) were the lowest in the country; the rate for White women was highest in West Virginia (33.1%). In Utah, smoking rates among minority women were also among the lowest in the country, but rates among minority women in the District of Columbia were above the national average.
- The national disparity score for smoking was 0.59. Disparity scores ranged from 0.39 in Florida to 1.98 in South Dakota. Most states had disparity scores less than 1.00 since a smaller share of women of color smoked than White women.
- Unlike other health indicators, most states clustered in the lower quadrants (Figure 1.7) with disparity scores less than 1.00 (White women had higher smoking rates than women of color). Eleven states had disparity scores greater than 1.00 (women of color had higher smoking rates), most of them concentrated in the Northern Central region.
- North Dakota and South Dakota had particularly high disparity scores because of the high rates of smoking among their American Indian and Alaska Native women, with rates of 46.8% and 48.9%, respectively.
- In the states found in the lower right quadrant, smoking rates reported by White women were higher than the national average and higher than the rates for minority women. For example, in Florida almost one-third of White women smoked compared to 12.8% of Hispanic women, contributing to its very low disparity score of 0.39.
- In the lower left quadrant, the disparity scores were less than 1.00, and White women had lower smoking rates than the national average. For example, the smoking rate for White women in California was one of the lowest in the nation at 18.3%, but was still considerably higher than the combined rate for minority women in the state (8.9%).

FIGURE 1.7. State-Level Disparity Scores and Prevalence of Current Smoking for White Women Ages 18–64

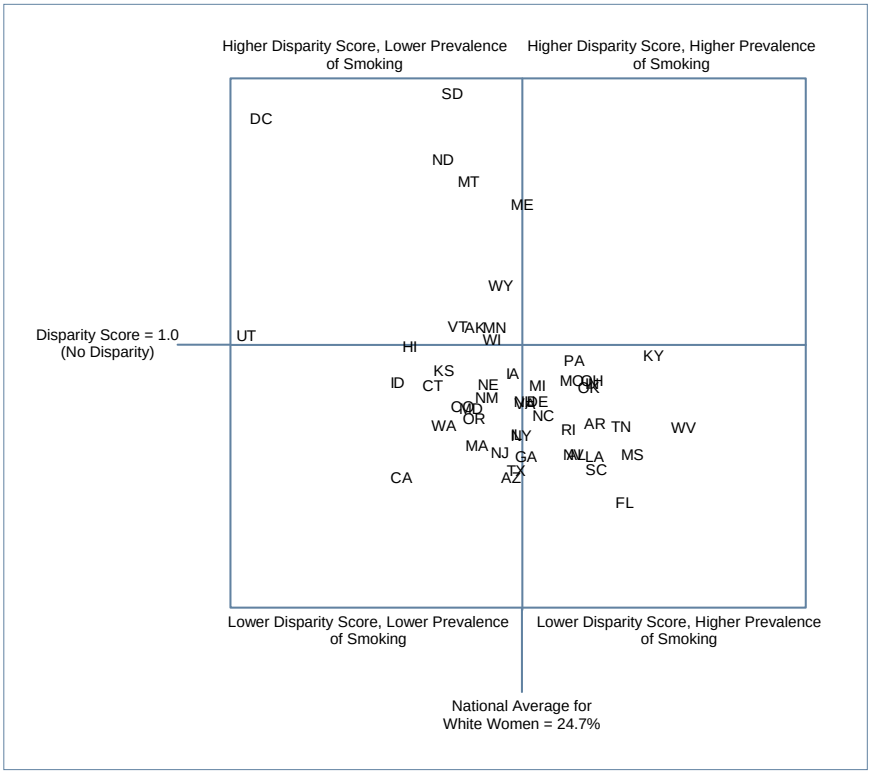


TABLE 1.7. Current Smoking, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**0.59**	**21.9%**	**24.7%**	**14.6%**	**18.7%**	**11.5%**	**8.4%**	**35.7%**
Alabama	**0.58**	24.2%	27.5%	16.0%	14.5%			
Alaska	**1.07**	24.5%	22.2%	23.8%		14.5%		42.1%
Arizona	**0.49**	19.9%	24.0%	11.8%	23.0%	8.8%		20.3%
Arkansas	**0.70**	27.0%	28.4%	19.8%	17.5%	16.1%		
California	**0.49**	13.3%	18.3%	8.9%	15.1%	7.3%	8.7%	
Colorado	**0.77**	20.5%	21.5%	16.5%	20.1%	16.5%	8.2%	
Connecticut	**0.85**	19.5%	19.9%	16.9%	20.1%	17.6%	3.2%	
Delaware	**0.79**	24.2%	25.5%	20.0%	20.3%	20.8%		
District of Columbia	**1.88**	17.7%	11.0%	20.7%	22.3%	14.4%	11.5%	
Florida	**0.39**	23.4%	30.0%	11.8%	11.5%	12.8%	5.0%	
Georgia	**0.57**	21.1%	24.8%	14.2%	13.3%	12.7%		
Hawaii	**1.00**	18.6%	18.7%	18.7%		23.4%	18.1%	
Idaho	**0.86**	17.9%	18.1%	15.6%		13.3%		33.6%
Illinois	**0.66**	22.0%	24.4%	16.0%	19.7%	13.6%	5.8%	
Indiana	**0.86**	27.7%	28.3%	24.2%	27.2%	15.7%		
Iowa	**0.89**	23.9%	24.1%	21.5%	25.5%	18.0%		
Kansas	**0.91**	20.3%	20.6%	18.7%	21.8%	13.6%	9.0%	34.9%
Kentucky	**0.96**	31.4%	31.5%	30.3%	25.9%	35.3%		
Louisiana	**0.57**	24.1%	28.4%	16.2%	15.5%	18.1%		
Maine	**1.55**	25.3%	24.7%	38.1%				
Maryland	**0.76**	20.1%	22.0%	16.7%	18.4%	17.9%	5.5%	
Massachusetts	**0.62**	21.1%	22.3%	13.7%	18.9%	15.1%	6.5%	
Michigan	**0.85**	24.9%	25.4%	21.6%	22.6%	23.1%	6.8%	
Minnesota	**1.07**	23.4%	23.2%	24.9%	27.8%			
Mississippi	**0.58**	25.5%	30.4%	17.6%	16.9%	23.8%		
Missouri	**0.87**	26.8%	27.3%	23.6%	22.4%	22.7%		
Montana	**1.64**	23.2%	21.8%	35.7%		34.9%		44.6%
Nebraska	**0.85**	22.5%	22.9%	19.5%	21.9%	13.6%		
Nevada	**0.58**	23.4%	27.3%	15.8%	18.9%	14.1%	14.0%	
New Hampshire	**0.78**	24.5%	24.7%	19.4%		17.7%		
New Jersey	**0.59**	20.4%	23.5%	13.8%	18.7%	13.3%	5.2%	
New Mexico	**0.80**	20.7%	22.8%	18.2%		19.1%		12.3%
New York	**0.65**	21.7%	24.6%	16.0%	21.4%	16.3%	4.8%	
North Carolina	**0.73**	23.7%	25.7%	18.8%	19.8%	9.8%	11.9%	35.2%
North Dakota	**1.72**	21.3%	20.5%	35.3%				46.8%
Ohio	**0.87**	27.7%	28.3%	24.5%	26.2%	11.1%		
Oklahoma	**0.84**	27.6%	28.1%	23.6%	27.2%	11.8%	11.4%	36.6%
Oregon	**0.72**	21.2%	22.1%	15.8%		7.5%	16.0%	31.8%
Pennsylvania	**0.94**	27.4%	27.4%	25.9%	26.8%	29.4%	9.1%	
Rhode Island	**0.67**	25.4%	27.1%	18.2%	28.5%	11.0%		
South Carolina	**0.52**	24.0%	28.5%	14.9%	13.7%	22.8%		
South Dakota	**1.98**	22.9%	21.0%	41.6%		35.2%		48.9%
Tennessee	**0.69**	28.0%	29.8%	20.5%	19.8%			
Texas	**0.52**	19.2%	24.4%	12.6%	20.0%	10.4%	3.0%	
Utah	**1.04**	10.2%	10.2%	10.6%		8.8%	5.8%	
Vermont	**1.08**	21.3%	21.3%	22.9%		25.1%		
Virginia	**0.78**	23.3%	24.8%	19.3%	18.5%	24.5%		
Washington	**0.69**	19.7%	20.6%	14.2%	22.2%	11.0%	8.0%	37.3%
West Virginia	**0.68**	32.5%	33.1%	22.6%	18.8%			
Wisconsin	**1.02**	23.2%	23.0%	23.6%	27.4%	20.0%		
Wyoming	**1.23**	24.2%	23.5%	29.0%		30.9%		33.5%

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

——— Worst state in column

CANCER MORTALITY

While there has been great progress in prevention, detection, and treatment of cancer, over 270,000 women in the U.S. are expected to die from cancer each year.[26] Cancer remains the leading cause of death among women ages 18–64. This is particularly troubling as research has found that survival time for many cancers are extended with early detection, often through access to preventive and screening services. Although deaths from cancer have declined over the past 30 years, the decline has been sharper for men than for women.[27] While breast cancer is the most common form of cancer affecting women, lung cancer is the deadliest. More women die from lung cancer than any other cancer, and 90 percent of all deaths from lung cancer are attributable to smoking.[28]

Though White women have higher rates of cancer incidence overall, certain cancers have disturbingly high incidence and mortality rates among sub-populations of women. For example, cervical cancer, which is relatively rare in the U.S., is more likely to affect and kill Black and Latina women.[29] This is striking, given that cervical cancer can be detected early through regular Pap test screening. This indicator is based on age-adjusted cancer death rates per 100,000 women, and public death records that were analyzed by the National Cancer Institute's surveillance system for the years 2000–2004.

Highlights

- The national cancer mortality rate for women of all ages was 162.2 deaths from cancer per 100,000 women (Table 1.8). Black women had the highest mortality rate (189.3 per 100,000), followed by White (161.4), American Indian and Alaska Native (112.0), Hispanic (106.7), and Asian American, Native Hawaiian and Other Pacific Islander (96.7) women.
- The national disparity score was 0.86, and state disparity scores ranged from a low of 0.60 in Nevada to a high of 2.14 in Maine, which had the highest cancer mortality rate for American Indian and Alaska Native women (375.7 per 100,000) in the nation.
- In Figure 1.8, the states were more dispersed on cancer mortality than on other measures. The cancer mortality rate for White women was higher than for minority women in most states, so most states had disparity scores of less than 1.00. For the 16 states and District of Columbia located in the upper quadrants, with disparity scores higher than 1.00, the cancer mortality rates for Black women were particularly high, with many exceeding 200 deaths per 100,000 women.
- In the upper left quadrant, North Dakota, South Dakota, and Montana had among the highest disparity scores, largely due to the high rate of cancer mortality experienced by American Indian and Alaska Native women in these states (243.8, 203.3, and 230.6 per 100,000 women, respectively).
- In the upper right quadrant, Maine was notable for its very high disparity score, driven by the fact that cancer mortality rates for American Indian and Alaska Native women were the highest of any racial and ethnic population in the nation.
- In Utah, situated in the lower left quadrant, White women had the lowest cancer mortality in the nation, and still the disparity score was below 1.00, driven by the low cancer mortality rates for Hispanic and Asian American, Native Hawaiian and Other Pacific Islander women.
- In Nevada, in the bottom right quadrant and with the lowest disparity score, the cancer mortality rate for White women was among the highest in the nation, higher than the rates for Hispanic, Asian American, Native Hawaiian and Other Pacific Islander, and American Indian and Alaska Native women, and comparable to the rate for Black women.

FIGURE 1.8. State-Level Disparity Scores and Cancer Mortality Rate for White Women All Ages

TABLE 1.8. Cancer Mortality, by State and Race/Ethnicity

State	Disparity Score	Cancer Death Rate Per 100,000 Women: All Women	White	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**0.86**	**162.2**	**161.4**	**189.3**	**106.7**	**96.7**	**112.0**
Alabama	**1.04**	164.8	161.3	179.3	53.4	73.1	73.6
Alaska	**0.94**	161.8	159.5	142.4	151.6	87.4	205.3
Arizona	**0.85**	145.9	146.7	175.3	121.8	100.0	116.5
Arkansas	**0.95**	167.9	165.3	191.7	43.6	102.1	52.7
California	**0.74**	152.4	157.3	193.0	108.4	102.5	71.9
Colorado	**0.88**	146.6	147.5	160.6	128.5	104.4	94.3
Connecticut	**0.75**	159.0	159.4	168.4	87.5	77.8	79.0
Delaware	**0.96**	172.2	169.5	194.3	99.3	78.1	
District of Columbia	**1.30**	181.9	137.3	204.6	34.0	99.5	
Florida	**0.85**	152.8	151.7	171.1	103.2	68.5	58.3
Georgia	**0.97**	163.0	159.2	178.2	72.1	77.1	243.8
Hawaii	**0.84**	120.6	144.3	79.0	200.4	113.9	
Idaho	**0.74**	149.0	149.0		97.0	131.1	168.8
Illinois	**0.91**	170.1	165.8	217.1	90.1	82.1	45.3
Indiana	**0.96**	173.8	172.1	209.6	85.9	76.9	77.9
Iowa	**0.77**	156.9	156.7	207.1	84.4	104.2	
Kansas	**0.89**	104.2	156.6	199.5	97.4	88.8	194.0
Kentucky	**1.09**	182.1	180.2	221.5	166.0	114.0	
Louisiana	**1.14**	179.5	170.0	207.2	80.5	108.1	68.0
Maine	**2.14**	175.6	175.7				375.7
Maryland	**0.96**	170.0	166.0	191.1	55.3	91.9	83.4
Massachusetts	**0.65**	169.5	171.6	164.0	90.2	89.3	68.9
Michigan	**1.05**	166.3	162.5	198.6	105.6	90.0	209.8
Minnesota	**0.86**	156.1	156.0	181.0	88.2	117.9	196.8
Mississippi	**1.14**	168.3	159.2	190.0	41.3	104.4	184.3
Missouri	**1.10**	170.2	167.6	207.9	120.1	109.3	83.1
Montana	**1.20**	161.7	159.9		109.5	184.1	230.6
Nebraska	**0.93**	153.8	152.6	193.1	108.2	124.3	211.1
Nevada	**0.60**	176.2	180.5	184.0	83.8	105.0	95.7
New Hampshire	**0.63**	165.9	166.5		87.0	119.4	
New Jersey	**0.72**	171.9	173.1	191.0	91.8	74.7	73.4
New Mexico	**0.85**	140.8	144.4	128.8	130.9	88.5	98.9
New York	**0.73**	159.0	163.0	157.7	101.2	79.2	54.6
North Carolina	**0.94**	162.0	158.4	180.4	46.3	85.7	132.0
North Dakota	**1.68**	146.9	144.8				243.8
Ohio	**1.04**	173.2	170.8	204.9	94.9	79.0	51.2
Oklahoma	**0.85**	166.8	168.1	194.9	96.5	109.8	130.9
Oregon	**0.64**	169.2	170.6	171.5	86.0	118.3	163.5
Pennsylvania	**1.02**	169.2	166.6	208.6	111.3	82.8	48.3
Rhode Island	**0.65**	167.6	169.0	157.7	83.8	99.0	149.1
South Carolina	**1.06**	161.5	155.3	179.9	42.4	115.0	77.3
South Dakota	**1.35**	153.0	150.9				203.3
Tennessee	**1.08**	172.0	167.3	209.3	66.3	98.2	78.9
Texas	**0.88**	156.6	153.9	200.5	118.2	87.9	29.7
Utah	**0.82**	120.8	121.0	152.6	91.1	88.9	142.1
Vermont		160.1	160.6				
Virginia	**1.00**	165.5	161.2	195.9	103.3	100.4	67.0
Washington	**0.72**	165.1	167.9	180.5	102.1	108.9	170.8
West Virginia	**1.14**	181.2	181.3	205.8			
Wisconsin	**0.86**	157.5	156.3	197.4	59.1	100.4	172.4
Wyoming	**1.02**	159.0	158.6		152.5		218.5

Note: Among women of all ages.
Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.
Source: Data from 2000–2004 and provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat.

— — — Best state in column
——— Worst state in column

NEW AIDS CASES

Women have been affected by HIV/AIDS since the beginning of the epidemic, but the impact on women has grown over time. Women now comprise over one-quarter of new AIDS cases in the U.S., and women of color have been especially hard hit. Black women represent the majority of new HIV and AIDS cases among women, and the majority of women living with the disease. Research suggests that women with HIV face limited access to care, and experience disparities in access relative to men.[30] Women are also more biologically susceptible to HIV infection during sex, and experience different clinical symptoms and complications. Regionally, the concentration of new AIDS cases among women is highest in the Northeast and the South.

This indicator measures the number of new AIDS cases in 2004 per 100,000 women in each racial and ethnic group. It includes both adolescents and adults, and is drawn from the CDC's HIV/AIDS Surveillance Supplemental Report.

Highlights

- Nationally, there were 9.4 new AIDS cases in 2004 per 100,000 women (Table 1.9). A considerably higher share of minority women had an AIDS diagnosis than White women (26.4 vs. 2.3). Black women had the highest case rate (50.1), followed by Hispanic women (12.4) and American Indian and Alaska Native women (7.0). Asian American, Native Hawaiian and Other Pacific Islander women had the fewest (1.8) new AIDS diagnoses in 2004.
- There was also tremendous state-to-state variation within racial and ethnic groups. For example, the rates for African American women in the District of Columbia (176.2), New Hampshire (138.4), New York (115.3), and Florida (114.2) showed that Black women were still being strongly affected by the epidemic in 2004, while there were no reported cases among Black women in Idaho, Montana, and Wyoming. Similarly, the impact of the epidemic on Hispanic women was most evident in Connecticut (70.8), New York (53.1), District of Columbia (48.3), Maine (41.3), and Pennsylvania (40.7).
- The national disparity score for AIDS (11.58) was more than 5 times higher than national disparity scores for other health indicators in this report. Disparity scores ranged from high of 36.98 in Minnesota to a low of 0.0 in Montana, where no women of color had a new AIDS diagnosis in 2004.
- In Figure 1.9, most states clustered in the upper left quadrant, which reflects the low case rates for White women and the higher rates for African American and Latina women across the nation.
- Though White women in the states that lie in the upper right quadrant had higher rates of new AIDS cases than the national average for White women, the disparity scores in many of these states were still extremely high. Seven states in this quadrant had disparity scores that were higher than 10.00 despite the fact that White women in their states had a new AIDS case rate that was higher than the national average for White women.

FIGURE 1.9. State-Level Disparity Scores and AIDS Case Rate for White Women Ages 13 and Older

TABLE 1.9. New AIDS Cases, by State and Race/Ethnicity

State	Disparity Score	AIDS Case Rate Per 100,000 Women						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**11.58**	**9.4**	**2.3**	**26.4**	**50.1**	**12.4**	**1.8**	**7.0**
Alabama	**10.52**	7.8	2.1	21.6	23.4	6.6	6.0	0.0
Alaska	**8.04**	5.2	1.7	13.8	35.2	8.8	14.1	10.4
Arizona	**5.95**	3.8	1.4	8.5	39.3	5.1	0.0	11.2
Arkansas	**5.05**	3.6	2.0	9.9	12.9	0.0	0.0	0.0
California	**2.79**	4.1	2.2	6.0	23.4	4.6	0.9	6.2
Colorado	**7.10**	2.5	1.0	7.5	21.7	4.7	0.0	30.4
Connecticut	**9.14**	16.5	6.0	54.8	56.6	70.8	2.3	0.0
Delaware	**11.79**	18.1	4.6	54.7	67.6	19.4	22.4	0.0
District of Columbia	**31.12**	108.4	5.0	154.4	176.2	48.3	0.0	153.6
Florida	**9.70**	23.0	5.8	55.8	114.2	16.4	2.5	19.6
Georgia	**12.06**	12.0	2.3	28.3	34.0	7.6	3.1	0.0
Hawaii	**0.37**	3.1	5.7	2.1	11.4	0.0	2.1	0.0
Idaho	**15.35**	1.4	0.6	9.2	0.0	10.4	0.0	14.8
Illinois	**13.53**	7.4	1.5	20.7	36.0	7.0	1.9	11.6
Indiana	**13.75**	2.9	1.1	14.7	20.1	5.9	3.2	0.0
Iowa	**9.71**	1.4	0.9	9.2	25.6	3.1	0.0	0.0
Kansas	**16.65**	2.4	0.7	12.1	19.8	9.8	4.2	0.0
Kentucky	**16.03**	2.6	1.1	17.2	19.9	8.6	6.2	27.1
Louisiana	**12.05**	16.5	3.3	39.2	43.5	14.3	0.0	0.0
Maine	**16.01**	2.3	1.6	26.0	71.9	41.3	0.0	0.0
Maryland	**14.18**	22.7	3.7	52.8	68.4	10.3	0.9	0.0
Massachusetts	**13.07**	6.1	2.0	26.4	43.2	30.1	0.0	18.8
Michigan	**25.08**	3.2	0.6	14.1	18.8	3.2	1.1	0.0
Minnesota	**36.98**	2.7	0.6	21.5	54.4	9.0	1.5	4.7
Mississippi	**8.04**	11.9	3.2	25.8	26.5	18.9	10.7	19.9
Missouri	**14.10**	2.5	0.8	11.6	15.6	0.0	0.0	0.0
Montana	**0.00**	0.3	0.3	0.0	0.0	0.0	0.0	0.0
Nebraska	**12.52**	2.5	1.1	13.7	29.0	5.6	8.9	0.0
Nevada	**2.74**	6.5	4.1	11.3	37.9	4.0	4.8	9.8
New Hampshire	**18.55**	2.0	1.1	21.2	138.4	0.0	0.0	0.0
New Jersey	**12.22**	16.9	3.5	43.2	85.2	22.1	1.6	37.3
New Mexico	**1.77**	3.5	2.5	4.4	7.6	4.4	0.0	4.4
New York	**13.48**	29.3	5.2	70.4	115.3	53.1	4.0	16.1
North Carolina	**11.41**	9.3	2.3	26.6	32.9	8.3	1.6	7.2
North Dakota	**4.34**	1.5	1.2	5.3	70.0	0.0	0.0	0.0
Ohio	**12.25**	2.5	0.9	11.6	12.7	14.6	0.0	0.0
Oklahoma	**3.60**	2.5	1.6	5.8	14.2	1.4	0.0	1.8
Oregon	**6.47**	1.8	1.0	6.5	28.0	5.8	0.0	5.8
Pennsylvania	**15.95**	9.1	2.8	44.2	54.5	40.7	0.9	42.5
Rhode Island	**21.59**	8.8	2.0	44.1	98.9	29.4	8.4	0.0
South Carolina	**14.62**	12.8	2.3	34.1	37.3	12.9	0.0	0.0
South Dakota	**4.53**	0.9	0.7	3.2	62.8	0.0	0.0	0.0
Tennessee	**13.22**	7.3	2.1	28.2	32.4	12.3	3.3	0.0
Texas	**5.87**	8.8	2.7	15.9	48.6	5.1	3.1	3.0
Utah	**8.80**	1.5	0.7	6.5	34.4	6.2	0.0	9.4
Vermont	**11.01**	1.5	1.2	12.8	81.7	0.0	0.0	0.0
Virginia	**19.24**	7.7	1.2	23.3	31.1	8.7	5.6	11.5
Washington	**7.12**	2.8	1.3	9.3	35.1	5.9	1.1	13.7
West Virginia	**20.86**	3.1	1.6	33.5	42.7	34.0	0.0	0.0
Wisconsin	**22.10**	1.5	0.4	9.7	17.7	4.0	0.0	0.0
Wyoming	**NA**	1.5	0.0	15.4	0.0	24.4	0.0	0.0

Note: Among women ages 13 and older.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Data: Centers for Disease Control and Prevention. AIDS cases, by geographic area of residence and metropolitan statistical area of residence, 2004. HIV/AIDS Surveillance Supplemental Report 2006;12(No. 2). http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. SC-EST2007-agesex-res: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007.

Source: Population Division, U.S. Census Bureau. http://www.census.gov/popest/datasets.html.

— — — Best state in column (Due to the large number of states with a rate of 0.0, we did not indicate the best state for Black, Hispanic, Asian and NHPI, and AI/AN women)

——— Worst state in column

LOW-BIRTHWEIGHT INFANTS

Low birthweight is one of the leading determinants of infant mortality. Despite significant improvements in knowledge and medical technology, disparities in both infant mortality and low-birthweight births persist. Low-birthweight infants weigh less than 2,500 grams at birth, the equivalent of 5.5 lbs. The reduction of low-birthweight births was a goal of *Healthy People 2010*.[31] Maternal behaviors have significant impact on the likelihood of a low-birthweight birth. Women who smoke, drink, or have poor nutrition during pregnancy are at increased risk, as are women who are physically or emotionally abused.[32] The rate of low-birthweight births is also affected by the mother's education. Women who have not graduated from high school are more likely to deliver a low-birthweight baby than women with more than a high school education.[33] In recent years there has been an increase in low-birthweight and very low-birthweight births due in large part to the increased use of assisted reproductive technology.[34]

Highlights

- Approximately 8% of all live births in the U.S. were low-birthweight infants (Table 1.10). African American women had the highest rate of low-birthweight births (13.8%), nearly twice the rate of White women (7.2%). Hispanic women had the smallest share of low-birthweight infant deliveries (6.8%), followed by White (7.2%), American Indian and Alaska Native (7.4%), and Asian American, Native Hawaiian and Other Pacific Islander (7.9%) women.
- The low-birthweight rate for African American women was 15% or higher in Alabama, Colorado, Louisiana, Mississippi, Montana, New Mexico, and South Carolina. Those states with the lowest rates for Black women—Idaho (7.0%), and South Dakota (7.3%)—had rates comparable to the national average for White women (7.2%).
- The national disparity score for low birthweight was 1.38. A handful of states had disparity scores around 1.00. States in the South, including Louisiana, South Carolina, Mississippi, and the District of Columbia had among the highest disparity scores. Some states in the Southwest (e.g., New Mexico, Arizona, California, Nevada) that had a large proportion of Hispanic women, the group least likely to deliver a low-birthweight infant, had among the lowest disparity scores.
- All states, with the exception of Wyoming, were situated in the two upper quadrants of Figure 1.10, indicating that women of color had higher rates of low-birthweight births than White women.
- In the upper right quadrant, states in the South Central region (Alabama, Mississippi, Tennessee, Arkansas, and Louisiana) and South Atlantic region (Delaware, Florida, North and South Carolina, and Georgia) tended to have higher disparity scores and also high rates of low-birthweight infants among White women.

FIGURE 1.10. State-Level Disparity Scores and Prevalence of Low-Birthweight Babies for All Live Births among White Women

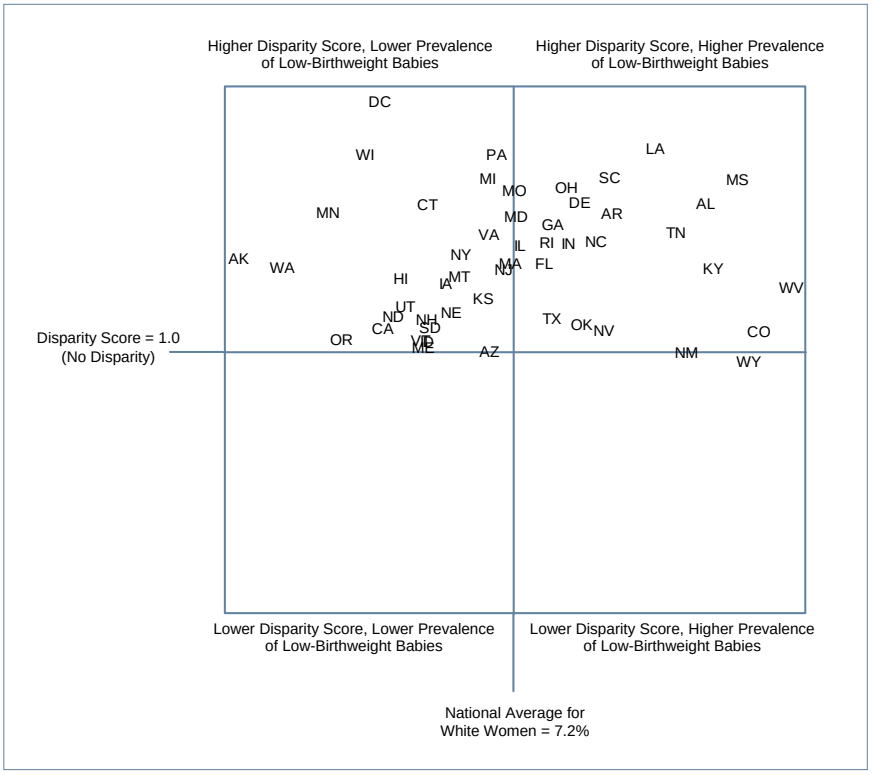


TABLE 1.10. Percent of Live Births that are Low-Birthweight, by State and Race/Ethnicity

State	Disparity Score	Percent of Live Births That Are Low Birthweight: All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.38**	**8.1%**	**7.2%**	**9.9%**	**13.8%**	**6.8%**	**7.9%**	**7.4%**
Alabama	**1.71**	10.4%	8.5%	14.4%	15.0%	6.9%	8.0%	10.5%
Alaska	**1.45**	6.0%	5.3%	7.7%	11.7%	5.3%	6.6%	5.9%
Arizona	**1.01**	7.1%	7.0%	7.1%	12.4%	6.7%	7.9%	7.1%
Arkansas	**1.66**	9.0%	7.8%	13.0%	14.9%	6.5%	6.7%	8.9%
California	**1.12**	6.7%	6.3%	7.0%	12.5%	6.1%	7.4%	6.5%
Colorado	**1.11**	9.0%	8.8%	9.7%	15.2%	8.5%	10.3%	9.5%
Connecticut	**1.70**	7.7%	6.6%	11.2%	12.9%	8.5%	7.8%	7.5%
Delaware	**1.71**	9.3%	7.6%	13.0%	14.3%	7.0%	9.3%	
District of Columbia	**2.18**	11.1%	6.3%	13.7%	14.0%	7.5%	9.0%	
Florida	**1.42**	8.6%	7.4%	10.5%	13.3%	7.0%	8.7%	7.4%
Georgia	**1.61**	9.3%	7.4%	12.0%	13.8%	6.0%	8.4%	9.0%
Hawaii	**1.35**	8.2%	6.4%	8.7%	11.4%	8.3%	8.8%	
Idaho	**1.06**	6.7%	6.6%	7.0%	7.0%†	6.7%	6.7%	8.3%
Illinois	**1.51**	8.4%	7.2%	10.9%	14.7%	6.6%	8.3%	9.5%
Indiana	**1.52**	8.1%	7.5%	11.4%	13.5%	6.3%	7.9%	10.0%†
Iowa	**1.33**	6.9%	6.7%	8.9%	12.2%	6.1%	7.7%	9.2%
Kansas	**1.26**	7.3%	7.0%	8.8%	13.4%	6.1%	7.3%	7.1%
Kentucky	**1.40**	8.9%	8.5%	11.9%	13.5%	6.9%	7.6%	8.5%†
Louisiana	**1.97**	11.0%	8.1%	16.0%	15.3%	7.6%	8.5%	10.1%
Maine	**1.04**	6.6%	6.6%	6.8%	8.5%	4.7%†	8.7%	
Maryland	**1.64**	9.2%	7.2%	11.8%	13.1%	7.2%	7.9%	10.9%
Massachusetts	**1.43**	7.8%	7.2%	10.2%	11.8%	8.4%	7.6%	7.6%†
Michigan	**1.82**	8.3%	7.0%	12.8%	14.4%	6.5%	8.3%	7.0%
Minnesota	**1.67**	6.4%	5.9%	9.9%	10.7%	5.7%	7.4%	6.9%
Mississippi	**1.82**	11.6%	8.7%	15.8%	15.6%	6.4%	8.1%	6.2%
Missouri	**1.76**	8.1%	7.2%	12.7%	13.9%	6.3%	7.6%	7.6%
Montana	**1.36**	7.0%	6.8%	9.3%	15.6%†	8.6%	8.7%†	7.8%
Nebraska	**1.19**	7.0%	6.8%	8.1%	12.2%	6.2%	7.6%	6.8%
Nevada	**1.11**	8.1%	7.8%	8.6%	14.0%	6.7%	10.4%	7.6%
New Hampshire	**1.16**	6.7%	6.6%	7.7%	10.9%	6.6%	7.8%	
New Jersey	**1.40**	8.2%	7.1%	9.9%	13.5%	7.3%	8.1%	9.8%
New Mexico	**1.01**	8.4%	8.3%	8.4%	15.0%	8.5%	8.6%	7.3%
New York	**1.47**	8.1%	6.8%	10.0%	12.8%	7.6%	7.9%	7.3%
North Carolina	**1.53**	9.1%	7.7%	11.8%	14.3%	6.3%	7.8%	11.0%
North Dakota	**1.18**	6.5%	6.4%	7.5%	9.4%†	5.8%†	8.4%†	6.8%
Ohio	**1.78**	8.5%	7.5%	13.4%	13.8%	7.1%	8.3%	10.2%
Oklahoma	**1.14**	7.9%	7.6%	8.7%	13.6%	6.5%	6.8%	6.7%
Oregon	**1.07**	6.1%	6.0%	6.4%	11.2%	5.4%	7.0%	7.3%
Pennsylvania	**1.94**	8.2%	7.1%	13.7%	13.7%	9.0%	8.0%	11.0%
Rhode Island	**1.52**	8.1%	7.4%	11.2%	11.2%	8.6%	10.1%	13.7%
South Carolina	**1.83**	10.2%	7.8%	14.3%	15.2%	6.7%	8.1%	10.8%
South Dakota	**1.13**	6.7%	6.6%	7.5%	7.3%†	5.9%	9.5%†	7.0%
Tennessee	**1.57**	9.4%	8.3%	13.0%	14.5%	6.0%	7.8%	6.6%†
Texas	**1.17**	8.1%	7.4%	8.7%	13.9%	7.2%	8.3%	7.3%
Utah	**1.22**	6.7%	6.5%	7.9%	12.1%	7.3%	8.2%	7.5%
Vermont	**1.06**	6.6%	6.6%	7.0%			8.1%†	
Virginia	**1.56**	8.2%	7.0%	10.9%	12.8%	6.3%	7.7%	9.2%†
Washington	**1.41**	6.1%	5.6%	7.9%	10.6%	5.9%	6.9%	7.3%
West Virginia	**1.31**	9.2%	9.0%	11.9%	13.2%		9.5%†	
Wisconsin	**1.94**	6.9%	6.2%	12.0%	13.6%	6.3%	7.5%	6.0%
Wyoming	**0.97**	8.7%	8.7%	8.4%		8.4%		8.4%

Note: Percent of live births weighing less than 2,500 grams, in 2003-2005. † Based on fewer than 50 births. Percents not shown are based on fewer than 20 births. Excludes live births with unknown birthweight.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: *Health, United States, 2007* . Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Birth File.

— — — Best state in column

——— Worst state in column

SERIOUS PSYCHOLOGICAL DISTRESS

Mental health is a critical component of women's overall health and well-being. Research has found that women and men experience mental illness in different ways. In particular, rates of depression and related disorders are at least twice as high among women as men.[35] Several factors also place women at elevated risk for mental disorders, including their lower incomes, stress due to multiple family responsibilities, and gender-based violence. Research has also found substantial differences between racial and ethnic communities in the management of mental illness, with people in minority communities less likely to receive services and less represented in mental health research.[36] Furthermore, stigma is still pervasive and affects the identification, prevention, and treatment of mental illness.[37]

Serious psychological distress is associated with a host of limitations in daily function and activity.[38] This indicator reports the age-adjusted rate of women who meet the criteria for serious psychological distress. It is based on six questions about the frequency of symptoms associated with psychological distress.

Highlights

- Nationally, 15.7% of adult women were in serious psychological distress in 2004–2007 (Table 1.11). Unlike many of the other health status indicators, White women (16.7%) had a higher rate of serious psychological distress than Black (13.5%) and Hispanic (14.1%) women. American Indian and Alaska Native women had the highest rate, with more than one-quarter (26.1%) in serious psychological distress. Asian American, Native Hawaiian and Other Pacific Islander women had the lowest rate at 9.6%.
- The rate of serious psychological distress among White women in South Dakota (10.4%) was the lowest among White women in the country, less than half the rate for White women in West Virginia (23.3%), the highest in the nation for White women.
- The national disparity score for serious psychological distress was 0.83, and state disparity scores ranged from 0.50 in Tennessee to 1.66 in North Dakota. Most states had disparity scores less than 1.00 since White women had higher rates of serious psychological distress than women of color overall.
- Most states clustered in the lower quadrants, reflecting higher rates of serious psychological distress among White women (Figure 1.11). Nonetheless, eleven states had disparity scores greater than 1.00; several of these had large American Indian and Alaska Native populations, which had the highest rate nationally of serious psychological distress.
- North Dakota had the highest disparity score because of the high rates of psychological distress among their minority women (28.5%), most of whom were American Indian and Alaska Native.
- In the states in the lower right quadrant, rates of serious psychological distress among White women were higher than the national average for White women and higher than the rates for minority women. For example, one-fifth of White women (20.5%) in Tennessee were in serious psychological distress compared to 10.4% of Black women, contributing to its very low disparity score of 0.50.
- Utah and Kansas were both on the edge of the lower right quadrant. Both states had disparity scores of 0.99. In both states, though, the rates for both groups of women were higher than the national averages, with over a fifth of women in these states in serious psychological distress.
- In lower left quadrant, the disparity scores were less than 1.00, and White women had lower rates of serious psychological distress than the national average. In some states (Maryland, Florida, New Jersey, North Carolina, Illinois, and Delaware), women in all racial and ethnic groups had rates that were lower than the national averages, but the rates were higher among White women than women of color in the state.

FIGURE 1.11. State-Level Disparity Scores and Prevalence of Serious Psychological Distress in the Past Year for White Women Ages 18–64

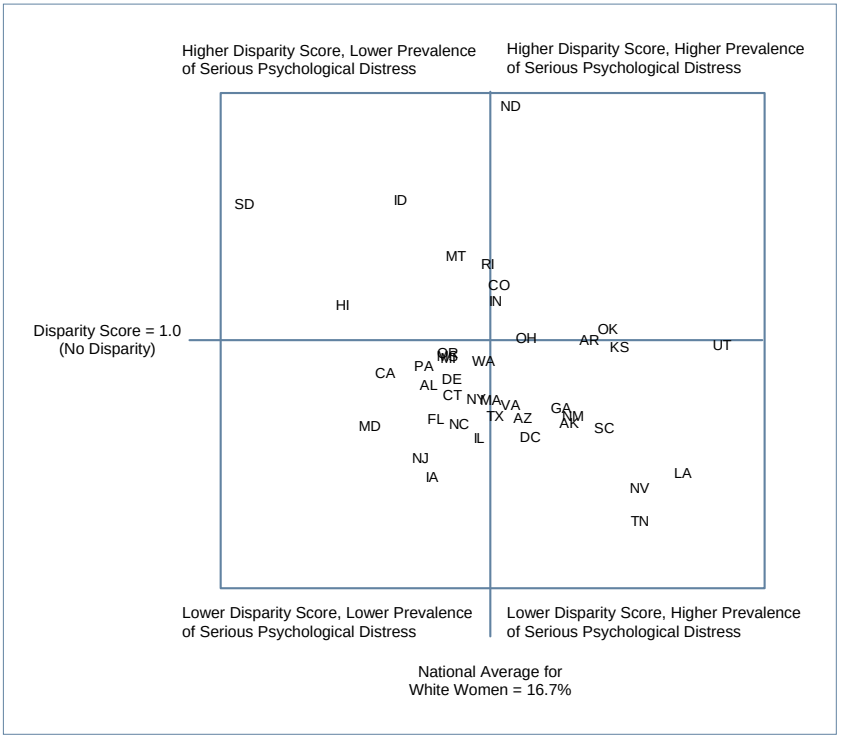


TABLE 1.11. Serious Psychological Distress in Past Year, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**0.83**	**15.7%**	**16.7%**	**13.8%**	**13.5%**	**14.1%**	**9.6%**	**26.1%**
Alabama	**0.88**	14.5%	15.1%	13.3%	14.3%			
Alaska	**0.78**	17.4%	18.7%	14.5%				11.2%
Arizona	**0.79**	16.1%	17.5%	13.8%		13.2%		
Arkansas	**1.01**	19.2%	19.2%	19.3%	18.5%			
California	**0.91**	13.3%	14.0%	12.8%	8.3%	14.5%	8.9%	
Colorado	**1.16**	17.6%	16.9%	19.6%		13.6%		
Connecticut	**0.85**	15.1%	15.7%	13.4%				
Delaware	**0.90**	15.2%	15.7%	14.1%	12.4%			
District of Columbia	**0.73**	14.7%	17.7%	13.0%	13.1%	6.1%		
Florida	**0.78**	14.0%	15.3%	12.0%	12.6%	11.4%		
Georgia	**0.82**	17.2%	18.5%	15.1%	13.3%			
Hawaii	**1.10**	13.9%	12.9%	14.2%		23.9%	12.2%	
Idaho	**1.40**	15.0%	14.4%	20.1%				
Illinois	**0.73**	14.9%	16.4%	12.0%	13.0%	11.8%	9.0%	
Indiana	**1.11**	17.1%	16.8%	18.7%	20.9%			
Iowa	**0.63**	14.6%	15.2%	9.5%				
Kansas	**0.99**	20.0%	20.0%	19.7%				
Kentucky		21.6%	22.6%					
Louisiana	**0.63**	18.6%	21.6%	13.7%	14.3%			
Maine		17.6%	17.2%					
Maryland	**0.76**	12.3%	13.6%	10.4%	11.1%	5.0%		
Massachusetts	**0.84**	16.1%	16.7%	14.0%		12.7%		
Michigan	**0.96**	15.4%	15.6%	14.9%	13.6%	18.8%		
Minnesota		13.4%	13.3%					
Mississippi	**0.96**	15.3%	15.6%	15.0%	13.5%			
Missouri		22.4%	21.7%					
Montana	**1.24**	16.2%	15.8%	19.6%				
Nebraska		15.4%	14.8%					
Nevada	**0.60**	17.2%	20.5%	12.2%		11.7%		
New Hampshire		14.4%	14.5%					
New Jersey	**0.68**	13.2%	14.9%	10.1%	8.1%	14.0%		
New Mexico	**0.79**	16.7%	18.8%	14.9%		16.3%		13.3%
New York	**0.84**	15.2%	16.3%	13.7%	14.2%	14.0%	9.5%	
North Carolina	**0.77**	14.7%	15.9%	12.3%	11.3%			
North Dakota	**1.66**	18.1%	17.2%	28.5%				
Ohio	**1.01**	17.6%	17.6%	17.8%	17.3%	22.0%		
Oklahoma	**1.04**	19.9%	19.7%	20.4%				
Oregon	**0.97**	15.5%	15.6%	15.1%				
Pennsylvania	**0.93**	14.8%	15.0%	14.0%	14.4%	16.0%		
Rhode Island	**1.22**	17.4%	16.6%	20.2%				
South Carolina	**0.76**	18.0%	19.6%	14.9%	16.1%			
South Dakota	**1.38**	10.8%	10.4%	14.4%				
Tennessee	**0.50**	18.3%	20.5%	10.3%	10.4%			
Texas	**0.79**	15.1%	16.8%	13.3%	11.9%	13.8%		
Utah	**0.99**	22.5%	22.6%	22.4%				
Vermont		18.0%	17.4%					
Virginia	**0.83**	16.2%	17.2%	14.2%	12.2%			
Washington	**0.95**	16.3%	16.5%	15.6%				
West Virginia		23.7%	23.3%					
Wisconsin		16.7%	16.1%					
Wyoming		19.0%	18.7%					

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Serious Psychological Distress (SPD) is defined as having a score of 13 or higher on the K6 scale. These estimates are based on the 2004, 2005, 2006, and 2007 full adult samples, where the 2004 sample includes both short-form and adjusted long-form responses. Therefore these estimates are not comparable with SPD estimates published in prior NSDUH reports. See Section B.4.4 in Appendix B of the Results from the 2007 National Survey on Drug Use and Health: National Findings.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2004, 2005, 2006, and 2007

– – – Best state in column

——— Worst state in column

ACCESS AND UTILIZATION

A large body of literature has documented the fact that women use health care services at greater rates than men. Women's reproductive health care needs and higher rates of chronic illness are primary drivers of these differences. In addition to gender differences, there are many striking disparities in the rates of use and access experienced by women of different races and ethnicities. Women of color, African American, Latina, and American Indian and Alaska Native women, in particular, face greater barriers and challenges in access to care, which often translate into lower use of recommended health services. As there is considerable state variation on measures of access and utilization, aggregate statistics that describe women nationally or even statewide often mask gaping disparities between women of different racial and ethnic groups.

While many measures of access and use of services could be examined, this chapter focuses on measures that have been widely accepted as indicators that can impede access, such as being uninsured, lacking a regular doctor, and experiencing a delay in care because of cost. This chapter also examines the patterns of underuse of some preventive services for which there are standard clinical guidelines: Pap tests, mammograms, prenatal care, and dental care.

Financial issues can be considerable factors in women's access, particularly as health care costs rise. Interactions with the health care system, such as an ongoing relationship with a physician, also influence how women obtain and use services. The importance of screening services, like mammograms and Pap smears, have been well documented. Services like routine dental care, which maintains healthy teeth and gums, and medical check ups, are also recognized as important. For pregnant women, late initiation of or receiving no prenatal care can affect birth outcomes, including infant birthweight and mortality, as well as maternal outcomes.

The state-level data presented in this chapter are drawn from several sources including the Current Population Survey conducted by the U.S. Census Bureau every March, the Behavioral Risk Factor and Surveillance Survey conducted annually by the U.S. Centers for Disease Control and Prevention (CDC), and the National Vital Statistics System, also collected from states by the CDC.

The sections that follow present indicators that describe access and preventive care utilization and show the disparities in these indicators between White women and women of color. The indicators included in this dimension are:

1. No Health Insurance Coverage
2. No Personal Doctor/Health Care Provider
3. No Routine Checkup in the Past Two Years
4. No Dental Checkup in Past Two Years
5. No Doctor Visit in the Past Year due to Cost
6. No Mammogram in Past Two Years
7. No Pap Test in Past Three Years
8. Late Initiation of or No Prenatal Care

ACCESS AND UTILIZATION DIMENSION SCORES

The dimension score is a standardized summary measure that captures the average of the indicator disparity scores along with an adjustment for the relative prevalence of the indicators for women in the state. States were grouped according to whether their dimension score was better than, equal to, or worse than the national average.

- Twenty states and the District of Columbia fared better than the national average for the access and utilization dimension, including Delaware, Rhode Island, Maine, District of Columbia, and Hawaii. Several of these states are located in either the New England or South Atlantic region of the country.
  - Delaware's better-than-average grouping was driven by the fact that it had among the lowest disparity scores for rates of no personal doctor/health care provider, no doctor visit due to cost, no routine checkups, no mammograms, and prenatal care, and that White and minority women had similarly low prevalence rates on these indicators relative to the national average.
  - Hawaii, another better-than-average state, had the lowest disparity score in the nation on rates of uninsurance, no personal doctor/health care provider, no doctor visit due to cost, and late initiation of or no prenatal care, and was among the top states on rates of no dental care. On several indicators, White women in Hawaii had lower prevalence rates than the national average for White women, and women of color had even lower rates than White women.
- Twelve states had dimension scores on par with the average for the nation, including Missouri, Alabama, Alaska, Wisconsin, and New Jersey.
  - Iowa's dimension score fell in the average group, but was nearly worse-than-average because of the state's high level of disparity on no personal doctor and mammography rates.
- Eighteen states' dimension scores were worse-than-average, including Texas, Utah, Oklahoma, Idaho, and Arizona. Most of the states in this category are located in the Mountain and West South Central regions of the U.S.
  - Texas was at the bottom of the nation on its access and utilization dimension score, as the state had the highest disparity score in the nation on the no routine checkup indicator, and also had low scores on health insurance coverage, personal doctor, and mammography rates. Texas was also consistently located as one of the upper-most states in the upper right quadrant of the indicator graphs, meaning that White women in the state had higher prevalence rates than the national average for White women on many indicators (e.g., no health care coverage and no dental checkup), but these rates were typically lower than those for women of color, particularly Black and Hispanic women, who had among the highest prevalence rates on access indicators in the nation.
  - In Oklahoma, another worse-than-average state, White women and women of color had similarly poor access on most indicators, but White women had much higher prevalence rates than the national average for White women, which is reflected in the state's position in the upper right quadrant on most indicator graphs, and the state's low dimension score.

FIGURE 2.0. Access and Utilization Dimension Scores, by State

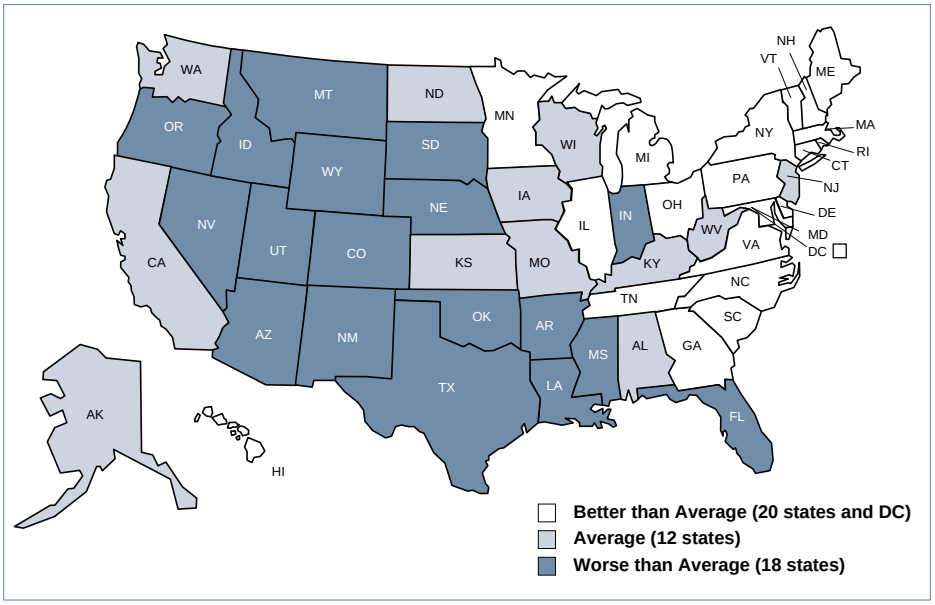


TABLE 2.0. Access and Utilization Dimension Scores, by State

	State	Dimension Score
Better than Average	Delaware	-1.30
	Rhode Island	-1.19
	Maine	-1.17
	District of Columbia	-1.04
	Hawaii	-1.01
	Maryland	-0.92
	Tennessee	-0.86
	Massachusetts	-0.86
	New Hampshire	-0.78
	Ohio	-0.74
	Michigan	-0.70
	Connecticut	-0.68
	New York	-0.59
	Virginia	-0.58
	Vermont	-0.47
	Minnesota	-0.46
	Illinois	-0.35
	Pennsylvania	-0.30
	Georgia	-0.27
	South Carolina	-0.20
	North Carolina	-0.17
Average	Missouri	-0.28
	Alabama	-0.17
	Alaska	-0.13
	Wisconsin	-0.12
	New Jersey	-0.09
	California	-0.07
	Kentucky	0.00
	Washington	0.02
	West Virginia	0.05
	Kansas	0.05
	North Dakota	0.20
	Iowa	0.27
Worse than Average	Louisiana	0.24
	Mississippi	0.29
	Nebraska	0.35
	Florida	0.35
	South Dakota	0.52
	Indiana	0.59
	Colorado	0.64
	New Mexico	0.74
	Wyoming	0.78
	Arkansas	0.78
	Nevada	0.88
	Montana	0.95
	Oregon	1.01
	Arizona	1.16
	Idaho	1.19
	Oklahoma	1.28
	Utah	1.55
	Texas	1.58

State	Dimension Score
Alabama	-0.17
Alaska	-0.13
Arizona	1.16
Arkansas	0.78
California	-0.07
Colorado	0.64
Connecticut	-0.68
Delaware	-1.30
District of Columbia	-1.04
Florida	0.35
Georgia	-0.27
Hawaii	-1.01
Idaho	1.19
Illinois	-0.35
Indiana	0.59
Iowa	0.27
Kansas	0.05
Kentucky	0.00
Louisiana	0.24
Maine	-1.17
Maryland	-0.92
Massachusetts	-0.86
Michigan	-0.70
Minnesota	-0.46
Mississippi	0.29
Missouri	-0.28
Montana	0.95
Nebraska	0.35
Nevada	0.88
New Hampshire	-0.78
New Jersey	-0.09
New Mexico	0.74
New York	-0.59
North Carolina	-0.17
North Dakota	0.20
Ohio	-0.74
Oklahoma	1.28
Oregon	1.01
Pennsylvania	-0.30
Rhode Island	-1.19
South Carolina	-0.20
South Dakota	0.52
Tennessee	-0.86
Texas	1.58
Utah	1.55
Vermont	-0.47
Virginia	-0.58
Washington	0.02
West Virginia	0.05
Wisconsin	-0.12
Wyoming	0.78

— — — Best state in column
——— Worst state in column

NO HEALTH INSURANCE COVERAGE

Health insurance, be it private or public, has been demonstrated to greatly facilitate the use of health care services. In the U.S., the majority of women get their insurance through the employer-based system, through either their own or their spouse's employer. There is a significant body of research that has demonstrated the important role that insurance plays in making health care affordable and accessible. Women who are insured are much more likely to get recommended levels of preventive care, get higher quality care, and have better health outcomes. There are also numerous studies that demonstrate access challenges faced by the uninsured. This indicator reports the percentage of women ages 18–64 without any health insurance. Data are from the 2004–2006 Current Population Survey.

Highlights

- Nationally, about 1 in 6 (17.7%) women ages 18–64 lacked health insurance coverage (Table 2.1). On average, 12.8% of White women were uninsured compared to 37.3% of Hispanics, 33.7% of American Indians and Alaska Natives, 22.4% of Blacks, and 18.2% of Asian American, Native Hawaiian and Other Pacific Islanders.
- There was considerable variation within racial and ethnic groups by state. For example, only 9.8% of Asian American, Native Hawaiian and Other Pacific Islander women in Hawaii were uninsured compared to 18.9% in California.
- The U.S. disparity score for uninsurance was 2.18. State disparity scores ranged from a low of 0.92 in Hawaii (the only state with a disparity score less than 1.00) to a high of 4.59 in North Dakota, meaning that women of color in North Dakota had an uninsured rate that was four times as high as White women. The high disparity score in North Dakota was due to the high rate of uninsurance among American Indian and Alaska Native (41%) women compared to White women (7.5%).
- In Figure 2.1, in all states except Hawaii, uninsurance rates were higher for women of color than for White women. These states were in the upper quadrants, with disparity scores above 1.00.
- Several states in the upper left quadrant (Connecticut, Minnesota, Nebraska, New Jersey, and North Dakota) had among the lowest rates of uninsurance in the nation for White women and higher-than-average disparity scores, a result of the stark difference in rates for White women and minority women in the state. The District of Columbia also had a low rate of uninsurance for White women, but its disparity score was below the national average, meaning that the gap in coverage between White women and women of color was relatively small for this indicator.
- Four states (Arkansas, Oklahoma, Louisiana, and West Virginia) in the upper right quadrant stood out from the group because they had the highest rates of uninsurance for White women and yet disparity scores below the national average of 2.18. In these states, both White women and women of color had high rates of uninsurance.

FIGURE 2.1. State-Level Disparity Scores and Percent of White Women Ages 18–64 Who are Uninsured

TABLE 2.1. No Health Insurance Coverage, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**2.18**	**17.7%**	**12.8%**	**27.9%**	**22.4%**	**37.3%**	**18.2%**	**33.7%**
Alabama	**1.45**	18.1%	15.8%	22.9%	21.0%			
Alaska	**1.60**	19.8%	16.9%	27.1%		23.5%	18.6%	35.8%
Arizona	**2.84**	22.3%	12.9%	36.5%	26.3%	40.3%		37.5%
Arkansas	**1.48**	23.3%	21.0%	31.0%	30.4%	38.1%		
California	**2.40**	20.9%	11.9%	28.5%	17.5%	35.4%	18.9%	
Colorado	**2.72**	18.0%	12.6%	34.4%	19.2%	39.1%	27.6%	
Connecticut	**2.36**	12.1%	9.1%	21.4%	20.0%	25.9%	14.7%	
Delaware	**2.09**	12.6%	9.4%	19.7%	15.2%	37.5%	21.5%	
District of Columbia	**1.98**	11.5%	7.1%	14.0%	12.0%	29.0%		
Florida	**1.91**	23.6%	17.5%	33.4%	30.8%	37.7%	21.0%	
Georgia	**1.93**	19.7%	14.3%	27.6%	22.6%	55.7%	22.0%	
Hawaii	**0.92**	10.1%	10.8%	9.9%		11.8%	9.8%	
Idaho	**2.34**	17.8%	15.2%	35.6%		42.5%		
Illinois	**2.33**	15.7%	11.0%	25.5%	24.7%	34.1%	10.6%	
Indiana	**1.92**	15.6%	13.8%	26.5%	21.8%	44.8%		
Iowa	**2.24**	11.5%	10.3%	23.1%		30.8%		
Kansas	**2.13**	13.9%	11.7%	24.9%	21.6%	31.7%		
Kentucky	**1.66**	17.0%	15.9%	26.3%	23.3%			
Louisiana	**1.84**	25.9%	19.7%	36.3%	36.9%			
Maine	**1.65**	10.6%	10.3%	17.0%				
Maryland	**1.97**	15.1%	10.6%	21.0%	19.2%	38.0%	15.7%	
Massachusetts	**1.82**	11.2%	9.6%	17.5%	12.9%	25.8%	14.2%	
Michigan	**1.63**	13.2%	11.5%	18.8%	18.7%	21.2%	13.6%	
Minnesota	**2.94**	8.7%	7.0%	20.6%	11.7%	46.0%	10.9%	
Mississippi	**1.84**	20.9%	15.5%	28.5%	27.0%			
Missouri	**1.99**	15.8%	13.5%	26.9%	28.7%	33.3%		
Montana	**2.61**	20.1%	17.7%	46.1%				56.1%
Nebraska	**2.90**	12.8%	9.8%	28.4%	29.7%	30.8%		
Nevada	**1.74**	20.4%	15.9%	27.6%	19.0%	37.6%	12.4%	
New Hampshire	**1.23**	12.4%	12.2%	15.0%				
New Jersey	**3.08**	16.2%	9.0%	27.9%	22.7%	38.3%	18.5%	
New Mexico	**1.84**	25.6%	17.4%	32.1%		28.5%		49.7%
New York	**1.94**	15.1%	10.9%	21.2%	17.0%	24.5%	23.3%	
North Carolina	**1.99**	18.4%	13.9%	27.7%	21.7%	50.3%	26.9%	36.8%
North Dakota	**4.59**	10.4%	7.5%	34.6%				41.0%
Ohio	**1.89**	12.2%	10.6%	20.0%	20.1%	28.4%		
Oklahoma	**1.64**	24.0%	20.5%	33.6%	21.3%	51.1%		49.7%
Oregon	**2.11**	20.1%	17.0%	35.8%		50.4%	21.4%	
Pennsylvania	**1.97**	11.6%	9.9%	19.5%	18.9%	23.7%	16.1%	
Rhode Island	**1.91**	11.7%	10.0%	19.0%	11.5%	22.9%	21.7%	
South Carolina	**1.23**	19.1%	17.6%	21.8%	20.2%	45.3%		
South Dakota	**2.57**	13.3%	11.4%	29.4%				34.4%
Tennessee	**2.03**	14.7%	11.8%	24.1%	18.0%	58.4%		
Texas	**2.43**	27.8%	16.0%	39.0%	26.8%	45.4%	24.4%	
Utah	**2.63**	18.4%	14.6%	38.2%		41.0%	28.5%	
Vermont	**1.37**	12.3%	12.1%	16.5%				
Virginia	**2.24**	14.7%	10.6%	23.8%	20.7%	42.5%	16.8%	
Washington	**1.64**	13.9%	12.2%	19.9%		29.6%	14.4%	
West Virginia	**1.12**	20.1%	20.0%	22.4%				
Wisconsin	**2.34**	10.8%	9.2%	21.5%		29.3%		
Wyoming	**1.52**	17.8%	16.9%	25.7%		28.4%		

Note: Among women ages 18–64.
*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.
Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: Current Population Survey, 2004–2006.

— — — Best state in column

——— Worst state in column

NO PERSONAL DOCTOR/HEALTH CARE PROVIDER

Having a regular doctor or health care provider improves access to health care services and increases the likelihood that individuals receive recommended screening and preventive services, as well as ongoing care to manage chronic health problems.[39] Women who lack a regular doctor also may experience greater difficulties navigating a complex health care system. The likelihood that an individual will have a regular doctor is driven by many factors, including having insurance and the availability of care in the communities where patients reside.

Highlights

- Nationally, about 1 in 6 (17.5%) women ages 18–64 did not have a personal doctor/health care provider (Table 2.2). On average, 36.9% of Latina and 21.1% of American Indian and Alaska Native women lacked a personal health care provider as did 17.3% of African American and 18.9% of Asian American, Native Hawaiian and Other Pacific Islander women, all notably higher than the 13.2% of White women.
- The share of women who did not have a personal health care provider ranged from a low of 7.4% of women in Maine to a high of 30.5% in Nevada. There was also variation within racial and ethnic groups across states. For example, 8.7% of Hispanic women in Vermont lacked a personal health care provider compared with 57.2% of Hispanic women in North Carolina.
- Women of color lacked a personal doctor at nearly twice the rate of White women, reflected by the U.S. disparity score of 1.94.
- State disparity scores ranged from a low of 0.65 in Hawaii to a high of 2.86 in Iowa, where a large proportion of Hispanic women were without a personal doctor.
- In Figure 2.2, all but three states were in the upper quadrants, with disparity scores above 1.00. The three states (Hawaii, the District of Columbia, and Tennessee) that were in the lower quadrants (reflecting disparity scores less than 1.00) differed in their population makeup and patterns. In Tennessee, a similar share of White women and women of color lacked a personal doctor.

In the District of Columbia, lower shares of Black and Hispanic, but not Asian American, Native Hawaiian and Other Pacific Islander women, went without a personal doctor than White women. In Hawaii, smaller shares of women of color (largely Asian American, Native Hawaiian and Other Pacific Islander and Hispanic women) went without a personal doctor than White women.

- Of the states in the upper left quadrant, Connecticut, Nebraska, and Iowa were in the uppermost part of the quadrant. These states had among the highest disparity scores in the U.S. and yet the share of White women without a personal health care provider was lower than the national average for White women.

FIGURE 2.2. State-Level Disparity Scores and Percent of White Women Ages 18–64 Who Do Not Have a Health Care Provider

TABLE 2.2. No Personal Doctor/Health Care Provider, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.94**	**17.5%**	**13.2%**	**25.7%**	**17.3%**	**36.9%**	**18.9%**	**21.1%**
Alabama	**1.20**	16.4%	15.4%	18.5%	19.0%			
Alaska	**1.19**	22.6%	21.4%	25.4%		24.7%		25.8%
Arizona	**2.32**	24.8%	16.6%	38.6%	15.9%	44.1%		35.9%
Arkansas	**1.38**	15.8%	14.4%	19.9%	15.6%	39.6%		
California	**2.02**	25.7%	15.7%	31.6%	19.3%	38.6%	23.1%	
Colorado	**1.87**	17.2%	14.2%	26.4%	15.8%	30.9%	14.8%	
Connecticut	**2.71**	10.9%	8.1%	22.1%	13.8%	32.4%	17.3%	
Delaware	**1.29**	8.8%	8.2%	10.6%	9.2%	12.9%		
District of Columbia	**0.75**	16.6%	19.4%	14.6%	13.7%	15.7%	22.6%	
Florida	**1.64**	23.0%	18.2%	29.8%	21.2%	38.4%	19.1%	
Georgia	**1.40**	16.7%	14.5%	20.4%	19.1%	25.3%		
Hawaii	**0.65**	12.8%	18.1%	11.8%		11.5%	9.9%	
Idaho	**1.54**	23.1%	21.7%	33.6%		37.8%		24.6%
Illinois	**1.81**	14.7%	11.4%	20.6%	16.1%	29.5%	14.4%	
Indiana	**2.10**	12.8%	11.0%	23.0%	18.7%	37.1%		
Iowa	**2.86**	11.2%	9.8%	28.0%	14.6%	43.1%		
Kansas	**2.05**	13.0%	10.7%	21.9%	14.9%	34.1%	14.5%	12.1%
Kentucky	**1.41**	15.0%	14.3%	20.2%	18.3%	25.1%		
Louisiana	**1.66**	19.4%	15.5%	25.8%	26.4%	20.7%		
Maine	**2.22**	7.4%	7.0%	15.5%				
Maryland	**1.36**	11.7%	10.3%	14.0%	12.2%	17.2%	20.6%	
Massachusetts	**2.23**	9.6%	7.7%	17.1%	12.3%	23.8%	15.9%	
Michigan	**1.60**	11.3%	10.0%	16.0%	16.1%	16.7%	14.6%	
Minnesota	**1.38**	18.2%	17.6%	24.3%	24.8%			
Mississippi	**1.25**	18.2%	16.4%	20.6%	20.7%	19.6%		
Missouri	**1.43**	13.9%	12.7%	18.1%	15.8%	21.1%		
Montana	**1.47**	22.3%	21.2%	31.1%		25.3%		34.8%
Nebraska	**2.83**	12.3%	9.8%	27.7%	12.6%	37.1%		
Nevada	**1.57**	30.5%	23.7%	37.1%	27.0%	52.6%	10.0%	
New Hampshire	**1.90**	8.6%	8.3%	15.7%		10.7%		
New Jersey	**2.14**	15.0%	10.0%	21.4%	10.2%	36.2%	12.1%	
New Mexico	**1.67**	22.6%	16.9%	28.3%		26.8%		37.7%
New York	**2.21**	13.5%	8.8%	19.4%	13.0%	27.6%	16.3%	
North Carolina	**1.68**	18.6%	14.3%	24.1%	17.5%	57.2%	20.5%	17.2%
North Dakota	**1.55**	16.2%	15.5%	24.1%				27.0%
Ohio	**1.50**	12.6%	11.7%	17.6%	18.5%	17.1%		
Oklahoma	**2.02**	20.3%	16.3%	33.0%	26.1%	50.2%	25.6%	22.3%
Oregon	**1.98**	20.9%	17.7%	35.0%		48.0%	25.4%	29.6%
Pennsylvania	**1.60**	8.4%	7.5%	12.0%	10.2%	12.0%	20.2%	
Rhode Island	**2.31**	12.1%	9.5%	22.0%	9.5%	29.5%		
South Carolina	**1.29**	14.2%	12.8%	16.5%	15.6%	23.4%		
South Dakota	**2.15**	14.0%	12.6%	27.2%		16.0%		31.2%
Tennessee	**0.99**	14.2%	14.2%	14.0%	10.3%			
Texas	**2.31**	26.2%	16.0%	36.9%	25.3%	43.3%	17.4%	
Utah	**1.72**	19.6%	17.6%	30.3%		35.8%	23.1%	
Vermont	**1.56**	9.7%	9.5%	14.8%		8.7%		
Virginia	**1.35**	13.9%	12.8%	17.3%	12.0%	36.5%		
Washington	**1.47**	18.3%	16.4%	24.2%	25.7%	33.8%	17.6%	20.7%
West Virginia	**1.65**	19.8%	19.2%	31.8%	36.2%			
Wisconsin	**1.48**	11.8%	11.3%	16.8%	13.8%	21.8%		
Wyoming	**1.34**	20.9%	20.0%	26.9%		25.6%		29.1%

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

———— Worst state in column

NO ROUTINE CHECKUP IN PAST TWO YEARS

Women's contact with the health care system can be measured by a number of indicators, including whether they have had a recent checkup. While the U.S. Preventive Services Task Force does not have a specific recommendation regarding the frequency of routine checkups, they do make recommendations on a number of services that might be included in a checkup, such as blood pressure tests and cholesterol screenings. Furthermore, for women with chronic illnesses, regular contact with a provider is important for obtaining both preventive and treatment services. The Behavioral Risk Factor Surveillance Survey asked women how long it had been since they visited a doctor for a routine checkup (defined as a general physical exam, not an exam for a specific injury, illness, or condition).

Highlights

- Nationally, 15.9% of women ages 18–64 reported that they did not have a routine checkup in the prior two years (Table 2.3). 8.1% of Black women had not had a checkup in the past two years, compared to 16.7% of White, 14.4% of Asian American, Native Hawaiian and Other Pacific Islander, 18.3% of Latina, and 19.4% of American Indian and Alaska Native women.
- There was variation within racial and ethnic groups by state. For example, only 0.3% of Black women in Rhode Island did not have a routine checkup in the past two years compared with 20.1% of Black women in Oklahoma.
- The U.S. disparity score for this measure was 0.82, indicating that White women had lower rates of routine checkups than women of color overall. State disparity scores ranged from a low of 0.39 in the District of Columbia to a high of 1.29 in Texas.
- In Figure 2.3, most states clustered in the lower quadrants, with disparity scores below 1.00, meaning that White women had a higher rate of not having a routine checkup in the past two years than women of color.
- In the lower left quadrant, several states that had among the lowest disparity scores (District of Columbia, Delaware, and Tennessee) were ones in which Black women had fairly low rates of not having a routine checkup, but White women had relatively high rates.
- In the lower right quadrant, two states (Oklahoma and Arkansas) stood out because they had among the highest rates of White women who had not had a checkup and relatively low disparities between racial and ethnic groups.

FIGURE 2.3. State-Level Disparity Scores and Percent of White Women Ages 18–64 with No Routine Checkup in Past Two Years

TABLE 2.3. No Routine Checkup in Past Two Years, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**0.82**	**15.9%**	**16.7%**	**13.6%**	**8.1%**	**18.3%**	**14.4%**	**19.4%**
Alabama	**0.66**	13.6%	15.0%	9.9%	8.0%			
Alaska	**0.87**	20.6%	21.3%	18.6%				18.7%
Arizona	**0.99**	16.4%	16.3%	16.0%		18.1%		15.3%
Arkansas	**0.54**	24.1%	26.1%	14.2%	10.5%	26.1%		
California	**0.91**	18.6%	19.0%	17.2%	14.8%	20.0%	12.2%	
Colorado	**1.08**	19.7%	19.1%	20.7%	8.4%	23.8%		
Connecticut	**0.70**	13.0%	13.8%	9.6%	6.4%	11.8%	12.0%	
Delaware	**0.47**	8.7%	10.2%	4.8%	3.8%	6.5%		
District of Columbia	**0.39**	8.1%	13.4%	5.2%	4.0%	10.1%		
Florida	**0.75**	14.2%	15.6%	11.6%	7.9%	13.8%		
Georgia	**0.58**	13.4%	16.1%	9.4%	6.9%	17.9%		
Hawaii	**0.87**	17.1%	18.8%	16.4%		13.5%	17.1%	
Idaho	**1.03**	25.6%	25.5%	26.4%		27.6%		
Illinois	**0.70**	14.0%	15.3%	10.8%	8.3%	13.8%	9.8%	
Indiana	**0.66**	21.8%	22.7%	15.0%	10.7%	21.2%		
Iowa	**1.26**	11.3%	11.1%	14.1%		15.6%		
Kansas	**0.80**	13.6%	13.8%	11.1%	6.9%	16.3%		
Kentucky	**0.62**	16.6%	17.3%	10.7%	9.6%			
Louisiana	**0.55**	11.8%	14.2%	7.7%	7.3%	12.7%		
Maine	**1.03**	10.9%	10.9%	11.2%				
Maryland	**0.49**	11.8%	15.1%	7.3%	6.4%	8.4%	11.4%	
Massachusetts	**1.04**	9.3%	9.4%	9.8%	5.8%	8.0%	15.5%	
Michigan	**0.69**	13.1%	14.0%	9.6%	5.7%	16.4%		
Minnesota	**0.88**	9.2%	9.3%	8.2%				
Mississippi	**0.46**	17.1%	21.8%	10.1%	9.7%			
Missouri	**0.65**	20.8%	21.8%	14.2%	6.4%			
Montana	**0.96**	20.2%	20.4%	19.6%		22.9%		16.5%
Nebraska	**1.05**	16.7%	16.6%	17.5%	6.5%	20.5%		
Nevada	**0.90**	23.4%	23.8%	21.4%		25.3%		
New Hampshire	**0.98**	9.8%	9.8%	9.6%				
New Jersey	**0.68**	13.4%	15.0%	10.2%	6.5%	13.4%	9.8%	
New Mexico	**0.90**	20.6%	21.6%	19.4%		21.0%		15.6%
New York	**0.56**	13.1%	15.8%	8.9%	6.2%	11.0%	9.3%	
North Carolina	**0.74**	11.1%	11.7%	8.6%	6.9%	15.5%	7.0%	11.4%
North Dakota	**1.00**	16.2%	16.2%	16.1%				16.9%
Ohio	**0.45**	19.1%	20.7%	9.3%	7.2%	12.1%		
Oklahoma	**0.80**	25.8%	26.8%	21.5%	20.1%	28.3%		19.3%
Oregon	**0.90**	20.1%	20.1%	18.1%		19.3%	15.0%	30.0%
Pennsylvania	**0.50**	18.7%	20.1%	10.1%	8.3%	12.2%	13.0%	
Rhode Island	**0.67**	7.4%	7.7%	5.1%	0.3%	6.1%		
South Carolina	**0.50**	17.3%	20.6%	10.4%	9.1%	15.8%		
South Dakota	**1.17**	13.0%	12.8%	15.0%				15.9%
Tennessee	**0.53**	9.6%	10.7%	5.6%	3.4%			
Texas	**1.29**	19.1%	16.6%	21.4%	12.5%	23.5%		
Utah	**0.94**	25.0%	25.1%	23.6%		26.6%		
Vermont	**0.78**	16.5%	16.7%	13.0%				
Virginia	**0.52**	13.2%	15.0%	7.8%	5.7%	8.0%		
Washington	**0.95**	15.8%	15.9%	15.1%	7.3%	16.8%	14.7%	16.1%
West Virginia	**1.01**	15.3%	15.4%	15.5%				
Wisconsin	**0.62**	12.7%	13.2%	8.2%	3.8%			
Wyoming	**0.95**	24.5%	24.6%	23.3%		24.5%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2005–2006 (The question was added in 2005).

— — — Best state in column

———— Worst state in column

NO DENTAL CHECKUP IN PAST TWO YEARS

Dental health is an important yet often overlooked aspect of overall health and well-being. In 2000, the Surgeon General's first-ever report on oral health documented links between oral diseases and other physical illnesses, such as ear and sinus infections, weakened immune systems, diabetes, and several other serious health conditions. Lack of dental care has the potential to affect speech, nutrition, growth and function, social development, and quality of life.

While most seek dental care regularly, some groups, including those who are poor, disabled, or are of racial and ethnic minorities, often face challenges accessing dental care.[40] These groups may suffer a disproportionate share of oral disease, and may need particular help accessing dental care.

Highlights

- Nationally, at least 1 in 4 (28.7%) women ages 18–64 did not have a dental checkup in the past two years (Table 2.4). Four in ten (41.5%) Hispanic women had no dental checkup, compared to 25.4% of White, 35.9% of Black, 35.0% of American Indian and Alaska Native women, and 25.1% Asian American, Native Hawaiian and Other Pacific Islander women.
- There was variation within racial and ethnic groups on this indicator across states. For example, 22.5% of Black women in Nebraska had not had a dental checkup in the past two years compared with 45.1% of Black women in Arkansas.
- The U.S. disparity score for this measure was 1.43, meaning that women of color had a 40% higher rate of no dental checkup in the past two years. State disparity scores ranged from a low of 0.93 in West Virginia to a high of 1.80 in Massachusetts, where the percentage of women of color without a dental checkup was about 80% higher than the percentage of White women.
- With the exception of two states, all states were in the upper quadrants in Figure 2.4. Both Alaska and West Virginia had disparities at or slightly below 1.00, meaning that women of color had dental checkups at rates comparable to that those of White women. However, White women in both of those states fared worse than White women nationally.
- In Figure 2.4, about half of the states clustered in the upper left quadrant, meaning that White women in those states did better than White women nationally, but women of color had lower rates of dental checkups than White women.
- The other half of states clustered in the upper right quadrant, where White women in those states had higher rates of no dental checkup than the national average for White women, but women of color were still at a disadvantage relative to White women.

FIGURE 2.4. State-Level Disparity Scores and Percent of White Women Ages 18–64 with No Dental Checkup in Past Two Years

TABLE 2.4. No Dental Checkup in Past Two Years, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.43**	**28.7%**	**25.4%**	**36.4%**	**35.9%**	**41.5%**	**25.1%**	**35.0%**
Alabama	**1.34**	28.5%	25.8%	34.6%	34.1%			
Alaska	**0.99**	29.1%	29.0%	28.8%				29.9%
Arizona	**1.49**	32.4%	27.7%	41.3%		39.6%		38.8%
Arkansas	**1.44**	36.6%	33.7%	48.6%	45.1%	58.6%		
California	**1.40**	29.2%	22.9%	32.2%	32.2%	37.6%	19.4%	
Colorado	**1.68**	27.7%	23.8%	40.0%	26.5%	44.1%		
Connecticut	**1.78**	17.9%	15.5%	27.6%	26.6%	30.2%	24.5%	
Delaware	**1.57**	21.8%	19.1%	30.0%	29.2%	33.5%		
District of Columbia	**1.79**	27.5%	18.0%	32.3%	32.7%	31.5%		
Florida	**1.40**	31.4%	27.2%	38.0%	37.7%	38.7%		
Georgia	**1.36**	28.8%	25.3%	34.4%	35.1%	35.3%		
Hawaii	**1.14**	25.8%	23.1%	26.3%		34.2%	26.2%	
Idaho	**1.22**	31.0%	30.3%	36.9%		39.9%		26.1%
Illinois	**1.58**	27.1%	22.4%	35.4%	33.4%	43.7%	23.6%	
Indiana	**1.49**	29.6%	27.7%	41.1%	40.3%	42.6%		
Iowa	**1.68**	20.6%	19.7%	33.1%		41.4%		
Kansas	**1.65**	25.0%	22.9%	37.6%	36.9%	35.4%		
Kentucky	**1.19**	30.9%	30.4%	36.2%	39.6%	23.6%		
Louisiana	**1.31**	32.1%	29.0%	38.0%	38.8%	30.0%		
Maine	**1.06**	26.7%	26.6%	28.3%				
Maryland	**1.53**	23.0%	18.8%	28.8%	29.5%	30.7%	22.9%	
Massachusetts	**1.80**	19.0%	16.7%	30.1%	30.3%	31.5%	28.8%	
Michigan	**1.44**	21.4%	19.6%	28.4%	28.9%	19.2%		
Minnesota	**1.45**	17.7%	16.9%	24.5%	29.1%			
Mississippi	**1.23**	37.9%	34.7%	42.7%	43.4%	31.3%		
Missouri	**1.18**	32.1%	31.2%	36.9%	36.0%			
Montana	**1.24**	32.1%	31.4%	39.1%		46.2%		33.1%
Nebraska	**1.47**	22.8%	21.6%	31.8%	22.5%	33.4%		
Nevada	**1.34**	33.3%	29.0%	38.8%	34.8%	44.2%	27.8%	
New Hampshire	**1.23**	20.8%	20.6%	25.4%				
New Jersey	**1.69**	23.4%	18.4%	31.1%	30.3%	34.0%	27.3%	
New Mexico	**1.30**	32.6%	28.0%	36.5%		37.7%		31.6%
New York	**1.24**	26.7%	24.1%	30.0%	29.9%	31.6%	27.7%	
North Carolina	**1.42**	29.4%	25.6%	36.5%	34.4%	50.2%	29.9%	34.1%
North Dakota	**1.38**	24.1%	23.7%	32.6%				39.7%
Ohio	**1.33**	24.1%	23.1%	30.8%	30.5%	45.2%		
Oklahoma	**1.08**	38.2%	36.8%	39.8%	42.9%	44.2%		43.7%
Oregon	**1.25**	30.2%	28.9%	36.2%		40.3%		
Pennsylvania	**1.35**	26.7%	25.4%	34.2%	34.5%	33.3%		
Rhode Island	**1.76**	18.0%	16.1%	28.3%	27.2%	29.5%		
South Carolina	**1.45**	30.5%	26.4%	38.3%	37.6%	43.5%		
South Dakota	**1.44**	24.4%	23.5%	34.0%				30.1%
Tennessee	**1.05**	29.5%	29.2%	30.7%	28.8%			
Texas	**1.47**	40.1%	32.8%	48.3%	43.5%	50.8%		
Utah	**1.45**	27.7%	25.8%	37.3%		43.0%		
Vermont	**1.57**	23.3%	22.7%	35.5%				
Virginia	**1.46**	24.1%	21.5%	31.4%	33.9%	32.8%		
Washington	**1.23**	26.8%	25.3%	31.2%	33.0%	38.2%	24.5%	40.0%
West Virginia	**0.93**	32.7%	32.9%	30.4%				
Wisconsin	**1.59**	20.0%	19.0%	30.2%	32.2%			
Wyoming	**1.32**	30.9%	29.9%	39.3%		38.5%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006 (Only 5 states used the oral health module in 2005: ID, ME, MS, NV, VA).

— — — Best state in column

———— Worst state in column

NO DOCTOR VISIT IN PAST YEAR DUE TO COST

Affordability of health care is increasingly a problem for all Americans.[41] Even among women with insurance, costs associated with co-payments and coinsurance cause many to forgo needed care. Medicaid, the federal-state program to assist low-income families, the elderly, and people with disabilities, has no premiums and only nominal cost-sharing if any, but even those costs can be a barrier to women with very few resources.

Highlights

- Nationally, 17.5% of women ages 18—64 reported they did not visit a doctor in the prior year due to cost (Table 2.5). On average, 27.4% of Latina, 25.7% of American Indian and Alaska Native women, and 21.9% of Black women reported this problem. By comparison, 12.1% Asian American, Native Hawaiian and Other Pacific Islander and 14.7% of White women reported cost as a barrier to care.
- There was variation within racial or ethnic groups across states. For example, 33.4% of Black women in Texas reported they went without a doctor visit because of cost compared to 13.4% of Black women in Massachusetts.
- The U.S. disparity score for this indicator was 1.55. State disparity scores ranged from a low of 0.81 in Hawaii to a high of 2.43 in Wisconsin, where minority women in every subgroup reported that they went without care due to cost at twice the rate of White women.
- Figure 2.5 shows four states in the lower quadrants (Hawaii, Maine, Alaska, and West Virginia) with disparity scores that were just lower than 1.00. In these states, the share of White and minority women for whom cost was a barrier to care was similar. In Alaska and West Virginia, greater shares of White women cited cost as a barrier than White women nationally; whereas in Hawaii and Maine, the reverse was true.
- Of the states in the upper left quadrant of Figure 2.5, Wisconsin and Rhode Island hovered above the rest as states with two of the highest disparity scores on this indicator, yet smaller shares of White women went without care due to cost than White women nationally.
- The upper right quadrant includes a cluster of southern states (Oklahoma, Mississippi, Arkansas, and Kentucky) in which the share of White women reporting cost as a barrier was greater than the national average for White women, yet women of color were still at a disadvantage relative to White women in the state.

FIGURE 2.5. State-Level Disparity Scores and Percent of White Women Ages 18–64 Who Did Not See a Doctor in Past Year Due to Cost

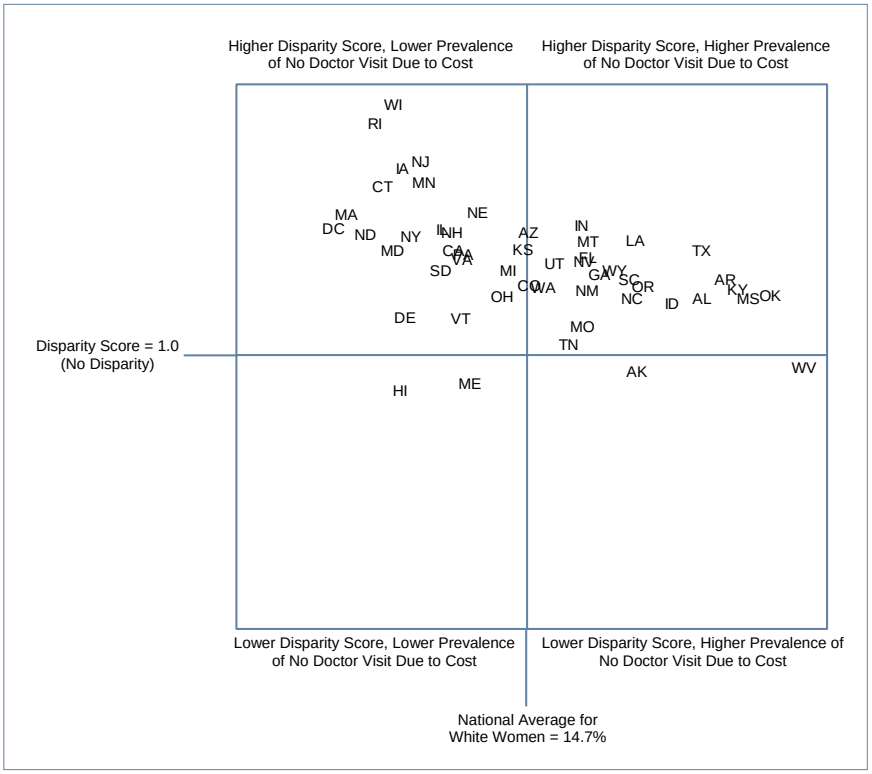


TABLE 2.5. No Doctor Visit in Past Year Due to Cost, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.55**	**17.5%**	**14.7%**	**22.8%**	**21.9%**	**27.4%**	**12.1%**	**25.7%**
Alabama	**1.33**	23.0%	20.8%	27.7%	27.8%			
Alaska	**0.92**	17.9%	18.6%	17.1%		12.1%		15.3%
Arizona	**1.71**	18.6%	14.7%	25.1%	16.2%	29.2%		17.3%
Arkansas	**1.44**	23.5%	21.7%	31.2%	29.8%	38.5%		
California	**1.60**	17.2%	12.1%	19.4%	14.1%	24.9%	9.1%	
Colorado	**1.41**	16.3%	14.8%	20.8%	16.4%	23.3%	8.9%	
Connecticut	**1.96**	11.6%	9.6%	18.8%	15.1%	24.4%	11.0%	
Delaware	**1.22**	11.1%	10.4%	12.8%	14.0%	10.3%		
District of Columbia	**1.73**	11.8%	7.9%	13.7%	13.9%	15.3%	7.1%	
Florida	**1.56**	20.7%	16.8%	26.3%	23.3%	29.3%	22.7%	
Georgia	**1.46**	20.4%	17.3%	25.3%	26.0%	24.4%		
Hawaii	**0.81**	8.9%	10.2%	8.3%		12.4%	7.8%	
Idaho	**1.30**	20.4%	19.8%	25.7%		27.2%		34.4%
Illinois	**1.72**	14.8%	11.7%	20.1%	17.8%	27.3%	11.2%	
Indiana	**1.74**	18.4%	16.6%	28.9%	28.4%	28.6%		
Iowa	**2.07**	11.1%	10.3%	21.3%	21.8%	25.0%		
Kansas	**1.61**	16.2%	14.5%	23.4%	27.9%	26.2%	10.5%	32.8%
Kentucky	**1.39**	23.0%	22.1%	30.6%	27.7%	38.2%		
Louisiana	**1.66**	23.0%	18.5%	30.6%	31.1%	28.0%		
Maine	**0.85**	12.6%	12.7%	10.8%				
Maryland	**1.60**	12.6%	10.0%	16.0%	16.5%	18.6%	9.5%	
Massachusetts	**1.80**	9.8%	8.3%	15.0%	13.4%	18.6%	11.2%	
Michigan	**1.48**	15.6%	14.0%	20.8%	22.3%	20.5%	9.9%	
Minnesota	**1.99**	12.2%	11.0%	22.0%	29.2%			
Mississippi	**1.34**	25.5%	22.5%	30.1%	30.4%	32.5%		
Missouri	**1.18**	17.1%	16.6%	19.6%	18.6%	15.3%		
Montana	**1.65**	17.8%	16.8%	27.8%		28.4%		23.3%
Nebraska	**1.81**	14.3%	13.0%	23.5%	21.1%	25.6%		
Nevada	**1.54**	20.7%	16.7%	25.8%	23.0%	29.5%	18.3%	
New Hampshire	**1.71**	12.6%	12.1%	20.6%		26.0%		
New Jersey	**2.11**	16.2%	11.0%	23.1%	18.2%	32.3%	13.4%	
New Mexico	**1.38**	20.4%	16.8%	23.2%		25.3%		17.4%
New York	**1.68**	13.9%	10.6%	17.8%	13.6%	21.9%	17.6%	
North Carolina	**1.33**	20.5%	18.4%	24.5%	23.7%	29.0%	15.4%	32.5%
North Dakota	**1.69**	9.5%	9.0%	15.3%				16.6%
Ohio	**1.35**	14.6%	13.8%	18.6%	18.0%	22.0%		
Oklahoma	**1.35**	24.4%	23.3%	31.4%	29.4%	32.5%	16.3%	23.0%
Oregon	**1.40**	20.3%	18.8%	26.3%		31.3%	19.0%	34.5%
Pennsylvania	**1.58**	13.7%	12.4%	19.7%	20.8%	20.9%	8.7%	
Rhode Island	**2.32**	11.5%	9.3%	21.7%	16.5%	24.5%		
South Carolina	**1.44**	21.2%	18.3%	26.3%	26.5%	22.3%		
South Dakota	**1.49**	12.2%	11.7%	17.4%		16.7%		18.4%
Tennessee	**1.07**	16.4%	16.1%	17.3%	16.5%			
Texas	**1.60**	27.0%	20.8%	33.4%	33.4%	35.6%	10.5%	
Utah	**1.53**	17.0%	15.7%	24.0%		28.8%	11.1%	
Vermont	**1.22**	12.5%	12.4%	15.1%		13.0%		
Virginia	**1.55**	14.2%	12.4%	19.3%	17.4%	29.5%		
Washington	**1.39**	16.8%	15.3%	21.3%	22.7%	28.1%	14.0%	28.3%
West Virginia	**0.94**	24.5%	24.4%	23.0%	19.6%			
Wisconsin	**2.43**	11.2%	10.0%	24.2%	23.9%	25.7%		
Wyoming	**1.49**	18.6%	17.7%	26.4%		27.0%		23.7%

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

———— Worst state in column

NO MAMMOGRAM IN PAST TWO YEARS

Routine mammography is a critical factor in helping to diagnose breast cancer in its earliest stages, when treatment is most effective. The U.S. Preventive Services Task Force recommends that women ages 40 and older have a mammogram every 1–2 years. After rising for many years, the National Cancer Institute found that screening rates had fallen between 2001 and 2004. Certain populations of women, such as African Americans, have a lower incidence of breast cancer but poorer survival rates when diagnosed.[42,43,44] This could be because the cancer is detected when it is more advanced and more difficult to treat, or, as some theorize, because African American women tend to have a more aggressive type of cancer.

Highlights

- Among women ages 40–64, American Indian and Alaska Native (33.5%), Asian American, Native Hawaiian and Other Pacific Islander (29.2%), and Hispanic (28.8%) women had the highest rates of no recent mammogram, while Black women (24.1%) had the lowest rate, slightly better than the rate for White women (24.9%).
- The share of women who did not get a mammogram ranged from a low of 16.3% in Massachusetts to a high of 37.1% in Idaho. There was also considerable variation within racial and ethnic groups across states. For example, 14.5% of Latinas in Massachusetts did not have a mammogram in the past two years compared to 42.9% of Latinas in Oklahoma.
- The U.S. disparity score for no mammogram in the past two years was 1.09, meaning that rates of no mammogram were just slightly higher among women of color than among White women. State disparity scores ranged from a low of 0.78 in Tennessee to a high of 1.59 in Iowa.
- In Figure 2.6, states were about equally clustered in the upper quadrants, with disparity scores above 1.00. In these states, women of color had higher rates of no mammogram than White women.
- The upper left quadrant includes states in which White women did better than the national average for White women, but women of color fared worse than White women in the state.
- Although Iowa had the highest disparity score (1.59), White women in the state also had lower rates of no mammogram than White women nationally, which is reflected in the state's position in the upper left quadrant in Figure 2.6.
- The upper right quadrant includes states in which White women had higher rates of no mammogram than the national average for White women, yet the rates were even higher among women of color.
- This is one of the few indicators where a sizable minority of states (eight states, four of which are Southern states) fell into the lower quadrants of Figure 2.6, meaning that women of color had lower rates of no recent mammogram than White women in their states.
- Tennessee, in the lower left quadrant, had the lowest disparity score in the nation, which meant that women of color had lower rates of no mammogram than White women in the state. It also meant that White women in the state had a lower rate of no mammograms than White women nationally.

FIGURE 2.6. State-Level Disparity Scores and Percent of White Women Ages 40–64 Who Did Not Have a Mammogram in Past Two Years

TABLE 2.6. No Mammogram in Past Two Years for Women Ages 40–64, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.09**	**25.5%**	**24.9%**	**27.1%**	**24.1%**	**28.8%**	**29.2%**	**33.5%**
Alabama	**1.03**	24.9%	24.6%	25.4%	22.9%			
Alaska	**0.91**	30.3%	31.1%	28.4%				26.0%
Arizona	**1.25**	26.0%	24.8%	31.0%		31.8%		24.7%
Arkansas	**0.99**	32.6%	32.5%	32.2%	26.2%			
California	**1.13**	23.8%	22.4%	25.3%	25.8%	24.9%	25.6%	
Colorado	**1.17**	30.1%	29.4%	34.3%	30.8%	38.4%		
Connecticut	**1.34**	18.2%	17.3%	23.3%	21.5%	21.1%		
Delaware	**0.89**	17.0%	17.5%	15.6%	12.8%			
District of Columbia	**1.03**	19.6%	19.4%	20.0%	19.3%			
Florida	**1.03**	25.8%	25.4%	26.1%	21.2%	30.5%		
Georgia	**1.01**	23.8%	23.6%	23.8%	22.4%			
Hawaii	**1.05**	24.6%	23.9%	25.0%		33.3%	23.9%	
Idaho	**0.93**	37.1%	37.2%	34.7%				
Illinois	**1.01**	24.5%	24.5%	24.8%	23.4%	23.3%		
Indiana	**1.03**	29.9%	29.6%	30.4%	27.7%			
Iowa	**1.59**	23.0%	22.4%	35.7%				
Kansas	**1.26**	25.8%	25.2%	31.7%	26.0%	32.3%		
Kentucky	**1.00**	24.9%	25.0%	25.0%	21.2%			
Louisiana	**0.97**	25.4%	25.7%	24.8%	24.4%	28.8%		
Maine	**1.46**	19.1%	18.8%	27.4%				
Maryland	**1.00**	21.3%	21.3%	21.3%	22.2%			
Massachusetts	**1.33**	16.3%	15.9%	21.1%	22.4%	14.5%		
Michigan	**1.14**	21.5%	20.9%	23.8%	20.9%			
Minnesota	**1.30**	19.5%	19.2%	24.9%				
Mississippi	**1.11**	32.9%	31.6%	35.3%	35.8%			
Missouri	**0.92**	30.2%	30.5%	28.1%	23.6%			
Montana	**1.05**	30.6%	30.5%	32.0%				35.6%
Nebraska	**1.21**	25.1%	24.7%	29.9%		34.6%		
Nevada	**1.01**	30.4%	30.5%	30.9%		31.4%		
New Hampshire	**1.47**	20.6%	20.3%	29.9%				
New Jersey	**1.09**	23.1%	22.5%	24.6%	19.8%	26.2%	29.9%	
New Mexico	**1.12**	31.1%	29.7%	33.3%		33.2%		37.4%
New York	**1.13**	23.2%	22.1%	25.0%	23.8%	22.7%		
North Carolina	**1.18**	22.5%	21.7%	25.7%	20.8%	41.1%		30.8%
North Dakota	**1.35**	26.1%	25.6%	34.6%				
Ohio	**1.04**	27.6%	27.2%	28.2%	24.8%			
Oklahoma	**1.05**	34.1%	34.4%	36.2%	33.8%	42.9%		27.2%
Oregon	**1.29**	27.9%	27.2%	35.1%				
Pennsylvania	**1.22**	26.1%	25.4%	30.9%	32.4%			
Rhode Island	**1.07**	17.0%	16.9%	18.2%		16.2%		
South Carolina	**0.88**	27.8%	28.8%	25.2%	24.3%			
South Dakota	**1.32**	26.7%	26.2%	34.7%				31.1%
Tennessee	**0.78**	21.2%	22.1%	17.2%	17.7%			
Texas	**1.25**	33.3%	30.2%	37.9%	27.1%	41.3%		
Utah	**1.15**	35.4%	35.0%	40.4%		38.3%		
Vermont	**1.35**	22.8%	22.4%	30.3%				
Virginia	**1.01**	26.1%	26.0%	26.3%	24.4%			
Washington	**1.14**	27.2%	26.6%	30.2%	32.9%	31.5%	26.7%	39.0%
West Virginia	**1.07**	26.5%	26.4%	28.1%				
Wisconsin	**1.38**	24.3%	23.7%	32.7%	21.9%			
Wyoming	**1.29**	33.8%	33.1%	42.5%		39.8%		

Note: Among women ages 40–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004 & 2006 (The Women's Health module is only used in even-numbered years).

— — — Best state in column

———— Worst state in column

NO PAP TEST IN PAST THREE YEARS

Cervical cancer is now largely preventable because of the Pap test. In recent years, tremendous progress has been made in improving access to Pap smears for low-income and uninsured women through programs such as the CDC'S National Breast and Cervical Cancer Early Detection Program (NBCCEDP), and by state-level insurance mandates that require insurers to cover screenings. Improvements in Pap screenings, especially for women of color, may also be attributed to other state policies and programs. One study found that Spanish-speaking women in California were more likely than English speakers to have received a Pap test in the past three years.[45] Another study documented that reports of cervical cancer screening were higher among Latina and African American Medicaid beneficiaries in California than among Whites.[46]

The U.S. Preventive Services Task Force recommends that women begin screening within three years of the onset of sexual activity or at age 21 (whichever comes first), and obtain a Pap test at least every three years after a negative result.[47]

Highlights

- Nationally, 13.2% of women had not had a Pap test in the past three years (Table 2.7). Almost one-quarter (24.1%) of Asian American, Native Hawaiian and Other Pacific Islander, 18.2% of American Indian and Alaska Native, and 16.3% of Hispanic women had not had a Pap smear in the past three years. White (12.2%) and African American women (11.0%) had considerably lower rates of no Pap test.
- The share of women who did not get their recommended Pap tests ranged from a low of 8.5% in Maine to a high of 22.6% in Utah. The share of White women who did not get a Pap test ranged from 7.6% in the District of Columbia to 22.4% in Utah.
- The U.S. disparity score for no Pap test was 1.27, meaning that rates were just higher among women of color than among White women. State disparity scores ranged from a low of 0.66 in Maine to a high of 2.08 in Massachusetts, the only state with a disparity score above 2.00. In Maine, the state's relatively small population of minority women had the nation's lowest rate of no Pap tests.
- In Figure 2.7, the distribution of states was most concentrated in the upper left quadrant. In these states, White women had lower rates of no Pap test than both White women nationally and women of color in their state.
- In Massachusetts, the state with the highest disparity score, the share of White women reporting no Pap test in the past three years (7.9%) was lower than the national average for White women (12.2%).
- In Figure 2.7, nine states, primarily in the northeastern and southeastern regions of the U.S., fell into the lower quadrants, which meant that rates of no Pap test among minority women were lower than among White women.
- In Maine, which had the lowest disparity score, a higher share of both White and minority women had Pap tests than White women nationally, but a higher share of minority women had a Pap test than White women in the state.

FIGURE 2.7. State-Level Disparity Scores and Percent of White Women Ages 18–64 Who Did Not Have a Pap Test in Past Three Years

TABLE 2.7. No Pap Test in Past Three Years, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.27**	**13.2%**	**12.2%**	**15.5%**	**11.0%**	**16.3%**	**24.1%**	**18.2%**
Alabama	**1.00**	12.5%	12.4%	12.5%	11.7%			
Alaska	**1.19**	11.3%	11.1%	13.3%				9.5%
Arizona	**1.88**	13.9%	10.7%	20.0%		17.6%		15.1%
Arkansas	**1.00**	16.5%	16.2%	16.2%	13.8%			
California	**1.33**	14.2%	12.1%	16.0%	10.0%	16.0%	18.7%	
Colorado	**1.03**	11.7%	11.6%	11.9%	9.4%	11.6%		
Connecticut	**1.51**	9.8%	8.9%	13.4%	8.6%	15.2%	25.5%	
Delaware	**1.35**	9.7%	9.0%	12.2%	9.3%			
District of Columbia	**1.37**	9.5%	7.6%	10.4%	9.8%	12.5%		
Florida	**1.35**	14.8%	12.7%	17.2%	13.6%	18.7%		
Georgia	**1.23**	11.1%	10.2%	12.5%	9.7%	24.0%		
Hawaii	**1.27**	16.6%	13.6%	17.3%		16.5%	18.5%	
Idaho	**0.96**	19.6%	19.7%	18.9%		16.5%		
Illinois	**1.06**	12.1%	11.8%	12.6%	8.8%	12.1%	22.6%	
Indiana	**1.06**	15.4%	15.2%	16.0%	15.0%	12.5%		
Iowa	**1.97**	10.9%	10.1%	19.9%		25.1%		
Kansas	**1.32**	12.3%	11.6%	15.3%	11.2%	18.5%		
Kentucky	**1.15**	13.7%	13.5%	15.5%	17.2%			
Louisiana	**1.12**	13.6%	12.7%	14.1%	12.9%	21.4%		
Maine	**0.66**	8.5%	8.6%	5.7%				
Maryland	**1.15**	10.5%	10.0%	11.6%	10.2%	14.8%	16.4%	
Massachusetts	**2.08**	9.2%	7.9%	16.4%	10.5%	16.6%	22.2%	
Michigan	**1.04**	12.5%	12.2%	12.7%	10.3%	10.0%		
Minnesota	**1.30**	10.8%	10.5%	13.6%	14.8%			
Mississippi	**0.79**	13.0%	14.3%	11.3%	11.2%			
Missouri	**0.85**	14.1%	14.4%	12.3%	10.4%			
Montana	**0.85**	14.4%	14.6%	12.5%				14.2%
Nebraska	**1.32**	13.0%	12.6%	16.6%		14.7%		
Nevada	**1.02**	14.7%	14.7%	15.0%		12.8%		
New Hampshire	**1.82**	9.0%	8.6%	15.6%				
New Jersey	**1.23**	12.8%	11.7%	14.4%	9.8%	12.8%	24.3%	
New Mexico	**1.06**	14.0%	13.8%	14.6%		12.9%		21.9%
New York	**1.50**	12.3%	10.7%	16.1%	11.1%	12.2%	33.7%	
North Carolina	**0.97**	10.7%	10.6%	10.3%	8.1%	13.5%	23.0%	8.4%
North Dakota	**1.11**	13.4%	13.3%	14.8%				
Ohio	**0.77**	12.7%	13.1%	10.1%	7.9%	19.8%		
Oklahoma	**1.16**	16.3%	16.1%	18.6%	13.7%	16.9%		16.3%
Oregon	**1.49**	14.3%	13.3%	19.8%		19.6%		
Pennsylvania	**1.38**	13.3%	12.5%	17.2%	15.4%	17.5%		
Rhode Island	**0.95**	8.9%	8.9%	8.4%	8.9%	7.6%		
South Carolina	**0.83**	11.3%	11.7%	9.7%	8.8%	10.6%		
South Dakota	**1.33**	10.7%	10.4%	13.9%				10.9%
Tennessee	**1.06**	10.9%	10.8%	11.4%	8.8%			
Texas	**1.30**	17.6%	15.2%	19.7%	11.7%	20.9%		
Utah	**1.08**	22.6%	22.4%	24.2%		20.9%		
Vermont	**1.83**	9.5%	9.1%	16.7%				
Virginia	**1.07**	11.6%	11.4%	12.2%	10.4%	7.6%		
Washington	**1.53**	13.3%	12.3%	18.8%	19.0%	14.7%	23.5%	15.8%
West Virginia	**1.08**	13.8%	13.7%	14.8%				
Wisconsin	**1.57**	11.5%	10.8%	16.9%	11.3%			
Wyoming	**1.04**	14.7%	14.6%	15.2%		14.8%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: BRFSS, 2004–2006.

— — — Best state in column

———— Worst state in column

LATE INITIATION OF OR NO PRENATAL CARE

Women who receive early prenatal care and maintain a healthy diet during pregnancy are less likely to deliver low or very-low-birthweight babies, and have lower infant mortality rates. In the past two decades there has been significant policy attention to the importance of timely and adequate prenatal care in improving birth and maternal outcomes. State and federal policymakers responded to national reports that recognized the importance of opening financial access to prenatal care by expanding eligibility to Medicaid for low-income pregnant women. Today, Medicaid finances more than 40% of all births in the U.S., and few women are uninsured by the time they deliver. Financial access, however, is only one of many factors that influence early entry into prenatal care. Other factors, such as the availability of health providers in neighborhoods and language accessibility, also affect the timely use of prenatal care services.

This indicator reports the percent of all live births for which women initiated prenatal care after the first trimester, or received no prenatal care at all.

Highlights

- Nationally, 16.2% of women initiated prenatal care late or did not receive prenatal care (Table 2.8). White women (11.1%) had the lowest rate of initiating prenatal care late or receiving no prenatal care, followed by American Indian and Alaska Native (14.7%), Hispanic (22.9%), Black (23.9%), and Asian American, Native Hawaiian and Other Pacific Islander (30.1%) women.
- The share of women initiating prenatal care late or receiving no prenatal care ranged from a low of 9.2% in New Hampshire to a high of 30.9% in New Mexico.
- The U.S. disparity score for prenatal care was 2.04, meaning the share of women with late or no prenatal care was twice as high among women of color than White women. States disparity scores for late initiation of or no prenatal care ranged from a low of 1.39 in Hawaii to a high of 3.04 in the District of Columbia.
- In the District of Columbia, Black and Hispanic women initiated prenatal care late or received no prenatal care at three times the rate of White women, and American Indian and Alaska Native women had a rate of late or no prenatal care that was more than four times as high as the rate for White women.
- In Figure 2.8, all states clustered in the upper quadrants, with disparity scores above 1.00, which meant that in all states women of color had higher rates of late or no prenatal care than White women.
- The states in the upper left quadrant were clustered tightly around the national average for White women, meaning that White women in these states had just slightly lower rates of late/no prenatal care than the national average for White women, but a higher share of women of color than White women in these states had late or no prenatal care.
- In the states in the upper right quadrant, White women had a higher prevalence of late or no prenatal care than the national average for White women, and women of color had higher rates than White women within their state.
- New Mexico stood out from other states in Figure 2.8. Women of all racial and ethnic groups had relatively high rates of late or no prenatal care, which is reflected in the state's position at the far right-hand side of the upper right quadrant.
- No states fell into the lower quadrants, meaning that minorities did not achieve parity with White women in receipt of prenatal care in any state.

FIGURE 2.8. State-Level Disparity Scores and Percent of Births with No or Late Prenatal Care for White Women Ages 18–64

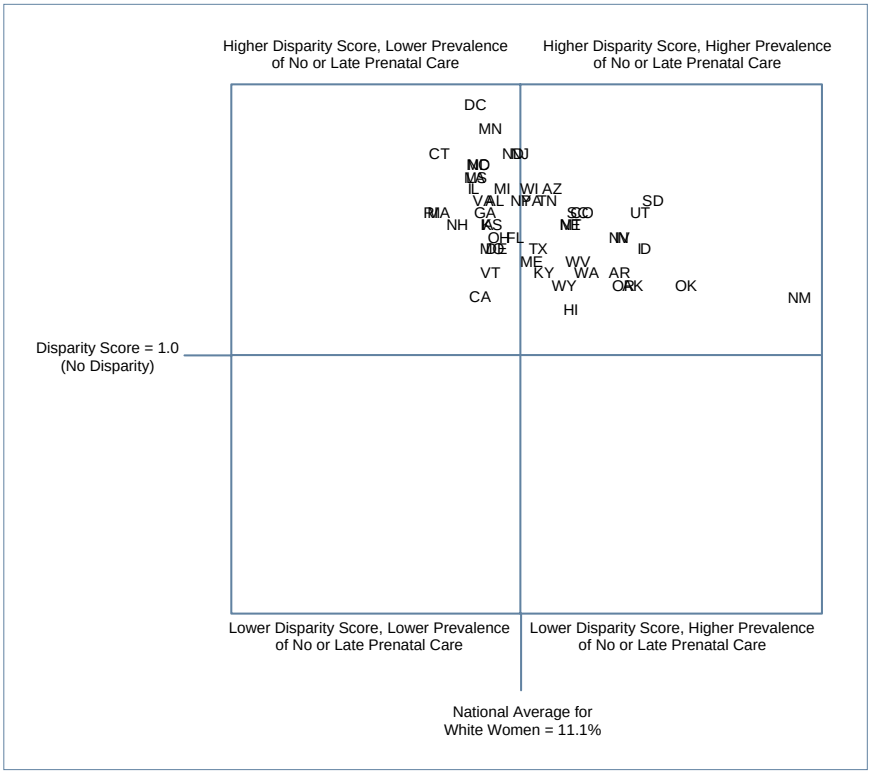


TABLE 2.8. Late Initiation of or No Prenatal Care, by State and Race/Ethnicity

State	Disparity Score	Percent of Live Births with Late or No Prenatal Care: All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**2.04**	**16.2%**	**11.1%**	**22.7%**	**23.9%**	**22.9%**	**14.7%**	**30.1%**
Alabama	**2.68**	16.3%	10.0%	26.8%	24.5%	46.9%	12.6%	18.6%
Alaska	**1.47**	19.8%	16.0%	23.5%	16.3%	21.8%	24.9%	29.7%
Arizona	**2.53**	23.5%	12.5%	31.6%	21.8%	33.2%	15.8%	32.0%
Arkansas	**1.74**	18.9%	15.4%	26.9%	26.7%	29.4%	17.6%	24.6%
California	**1.55**	13.0%	9.4%	14.5%	16.5%	15.2%	11.5%	24.0%
Colorado	**2.22**	20.5%	13.8%	30.6%	28.8%	32.4%	19.2%	32.4%
Connecticut	**2.59**	11.9%	7.6%	19.7%	19.7%	23.1%	12.3%	14.6%
Delaware	**1.98**	14.4%	10.1%	20.0%	18.8%	28.0%	9.9%	12.9%
District of Columbia	**3.04**	23.2%	9.2%	27.9%	28.5%	29.5%	18.3%	38.1%
Florida	**1.94**	16.1%	10.9%	21.2%	26.0%	18.6%	12.2%	35.8%
Georgia	**2.28**	15.8%	9.6%	21.9%	20.9%	29.0%	11.4%	16.5%
Hawaii	**1.39**	17.3%	13.3%	18.5%	9.7%	18.9%	18.8%	18.8%
Idaho	**1.77**	18.9%	16.5%	29.3%	24.1%	33.1%	19.6%	32.5%
Illinois	**2.35**	14.7%	9.1%	21.4%	25.8%	20.4%	11.9%	18.6%
Indiana	**1.98**	18.8%	15.5%	30.7%	30.8%	35.5%	16.5%	29.1%
Iowa	**2.14**	11.3%	9.7%	20.7%	22.9%	24.5%	12.4%	24.1%
Kansas	**2.19**	13.0%	9.9%	21.7%	20.7%	25.9%	13.8%	18.0%
Kentucky	**1.70**	13.3%	12.1%	20.5%	21.3%	31.4%	12.8%	14.8%
Louisiana	**2.48**	15.5%	9.2%	22.9%	24.1%	16.3%	11.7%	15.6%
Maine	**1.75**	12.1%	11.6%	20.3%	23.6%	19.5%	17.9%	22.0%
Maryland	**2.60**	16.6%	9.3%	24.2%	24.5%	31.9%	15.1%	21.3%
Massachusetts	**2.18**	10.2%	7.6%	16.5%	20.0%	17.0%	13.9%	11.5%
Michigan	**2.27**	14.1%	10.3%	23.4%	28.1%	22.1%	11.8%	20.6%
Minnesota	**2.85**	13.9%	9.8%	27.9%	27.8%	30.4%	25.5%	36.0%
Mississippi	**2.47**	15.6%	9.2%	22.7%	22.8%	23.0%	14.1%	27.8%
Missouri	**1.86**	11.8%	9.9%	18.4%	19.7%	20.3%	11.6%	19.6%
Montana	**2.13**	16.2%	13.3%	28.4%	14.8%	19.9%	16.3%	33.9%
Nebraska	**2.04**	16.8%	13.3%	27.1%	28.1%	30.0%	16.3%	31.5%
Nevada	**2.07**	24.4%	15.4%	31.9%	30.0%	35.9%	19.8%	31.4%
New Hampshire	**1.83**	9.2%	8.4%	15.3%	24.3%	19.6%	14.7%	18.1%
New Jersey	**2.71**	20.2%	11.1%	30.0%	36.5%	32.1%	15.2%	32.1%
New Mexico	**1.48**	30.9%	23.2%	34.4%	31.8%	33.3%	23.9%	40.8%
New York	**1.72**	15.0%	11.1%	19.1%	29.4%	26.7%	17.3%	25.2%
North Carolina	**2.66**	15.7%	9.3%	24.8%	23.7%	30.1%	15.0%	19.8%
North Dakota	**2.36**	13.6%	10.8%	25.5%	17.4%	19.5%	12.8%	33.1%
Ohio	**1.90**	12.2%	10.2%	19.3%	21.2%	21.3%	9.7%	19.1%
Oklahoma	**1.67**	22.4%	18.3%	30.6%	29.6%	35.4%	19.7%	29.8%
Oregon	**1.73**	18.9%	15.6%	27.0%	24.4%	29.8%	18.3%	31.1%
Pennsylvania	**2.05**	14.7%	11.6%	23.7%	27.6%	26.5%	18.9%	17.6%
Rhode Island	**1.79**	9.8%	7.2%	12.9%	18.8%	13.2%	18.2%	19.1%
South Carolina	**2.17**	20.3%	13.6%	29.5%	29.6%	38.3%	20.5%	22.6%
South Dakota	**2.38**	22.0%	16.9%	40.2%	36.5%	36.1%	27.7%	42.3%
Tennessee	**2.19**	16.6%	12.3%	27.0%	27.0%	41.5%	16.9%	21.8%
Texas	**1.92**	18.9%	11.9%	22.8%	22.6%	24.0%	11.0%	20.6%
Utah	**2.21**	20.1%	16.3%	36.1%	39.7%	35.9%	34.3%	43.3%
Vermont	**1.82**	10.2%	9.8%	17.8%	27.9%	20.6%	13.1%	14.3%
Virginia	**2.36**	14.6%	9.5%	22.4%	22.4%	28.9%	14.5%	17.9%
Washington	**1.64**	17.1%	14.0%	23.0%	24.2%	28.2%	18.4%	28.0%
West Virginia	**1.73**	14.1%	13.6%	23.5%	25.0%	25.8%	13.9%	30.8%
Wisconsin	**2.38**	15.1%	11.5%	27.4%	26.0%	29.3%	30.0%	28.8%
Wyoming	**1.69**	14.5%	13.0%	22.0%	13.9%	20.4%	15.3%	29.1%

Note: Data are for all live births, regardless of maternal age.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System; Health, United States, 2007.

— — — Best state in column

———— Worst state in column

SOCIAL DETERMINANTS

An individual's health and patterns of health care use are influenced by numerous factors beyond whether or not they have health coverage. While much of the policy focus has been on personal behaviors (e.g., smoking, diet, nutrition, help seeking), there is growing evidence that social factors (e.g., early life experiences, psychosocial work environment, neighborhoods, and housing) can have a direct or indirect influence on health outcomes.

One of the largest social determinants of health and health care use is socioeconomic status, or social class, which is often measured by income, education, and occupation. Women are more likely to live in poverty than men, and women of color are more likely than either White men or White women to live below the poverty line. These differences are related in part to the fact that women continue to shoulder the major responsibility for raising children. Socioeconomic disadvantage, whether defined by income, education, or occupation, is associated with high risk health behaviors, worse access to health care, and poorer health outcomes.

Neighborhood and housing characteristics also have an important impact on health, and more than ever, researchers are focusing their efforts on understanding the relationship between the two. Factors such as crime, the availability of healthy foods, the availability of parks and other athletic facilities, homeownership, and segregation have all been shown to affect health. Neighborhoods that are racially segregated, especially those with a high proportion of African Americans, Latinos, and American Indian and Alaska Natives, tend to have higher concentrations of poverty.[48] Residential segregation has been associated with infant and adult mortality[49] as well as limits on availability of care.[50] Segregated neighborhoods also affect the economic and educational opportunities of their residents.

For some of the social determinants of health and health care use, good state-level and population-based data remain elusive. In the absence of more refined measures, researchers often use proxies to assess their impact on health. For example, the percentage of women living in single-parent households headed by women is a proxy for social support, and for the children of those households, a proxy measure of their early life experiences.

The tables that follow present the indicators that capture some of the social determinants of health and are used to calculate state disparity scores. The indicators included in this dimension are:

1. Percent of Women in Poverty
2. Median Household Income
3. Gender Wage Gap
4. Percent of Women with No High School Diploma
5. Percent of Women Living in Single-Parent, Female-Headed Households
6. Residential Segregation: Index of Dissimilation

SOCIAL DETERMINANTS DIMENSION SCORES

The dimension score is a standardized summary measure that captures the average of the indicator disparity scores along with an adjustment for the relative prevalence of the indicators for women in the state. States were grouped according to whether their dimension score was better than, equal to, or worse than the national average.

- Nationally, 18 states scored better than the national average for the social determinants dimension including many states in the West, and Mid-Atlantic.
  - New Hampshire had the best dimension score. Its better-than-average dimension score was driven by two factors. First, New Hampshire's disparity scores for all social determinants were among the lowest. Minority women in New Hampshire, although few in number, tended to be better educated, more affluent, and better integrated than minority women in other states. Second, White women in New Hampshire had prevalence rates better than the national average on every indicator except the percentage of women living in a household headed by a single female.
- Eleven states had dimension scores that were equal to the national average, including several in the Midwest such as Wyoming, Nebraska, Colorado, New Mexico, and Minnesota.
- Twenty-one states and the District of Columbia, including many in the South Central part of the country such as Louisiana, Mississippi, Arkansas, and Tennessee, had dimension scores for the social determinants dimension that were worse than the national average.
  - Unlike the other states with below-average scores, Montana had very few indicators for which the disparity score was among the highest. However, on most indicators, White women in Montana had prevalence rates worse than the national average.
  - In Rhode Island, South Dakota, and Mississippi, many of the indicator disparity scores for social determinants were among the worst in the country.
- West Virginia, Kentucky, and the District of Columbia were outliers on most of the indicator graphs, but for different reasons.
  - The District of Columbia's dimension score was worse than the national average because the District experienced some of the highest disparity scores across every indicator. As with the health status dimension, White women in D.C. had better prevalence rates than the national average on every indicator except the gender wage gap, whereas White women in Kentucky and West Virginia were worse than average on almost all indicators.
  - West Virginia had a better-than-average dimension score, while the dimension score in Kentucky was worse than the national average. Disparity scores for West Virginia were among the lowest on four of the six indicators in the dimension.
  - In Kentucky, disparity scores were lower than that national average on all indicators, but not as low as West Virginia's. However, the prevalence rates for White women in both states were among the highest, and for some indicators, the worst in the country.
- In New Mexico, with a dimension score on par with the national average, and Utah, with a dimension score above the national average, disparity scores for social determinants were consistently among the best in the nation, but prevalence rates for White women were above the national average. In contrast, disparity scores in Connecticut, which had a dimension score equal to the national average, were consistently below the national average, but prevalence rates for White women were better than the national average.

FIGURE 3.0. Social Determinants Dimension Scores, by State

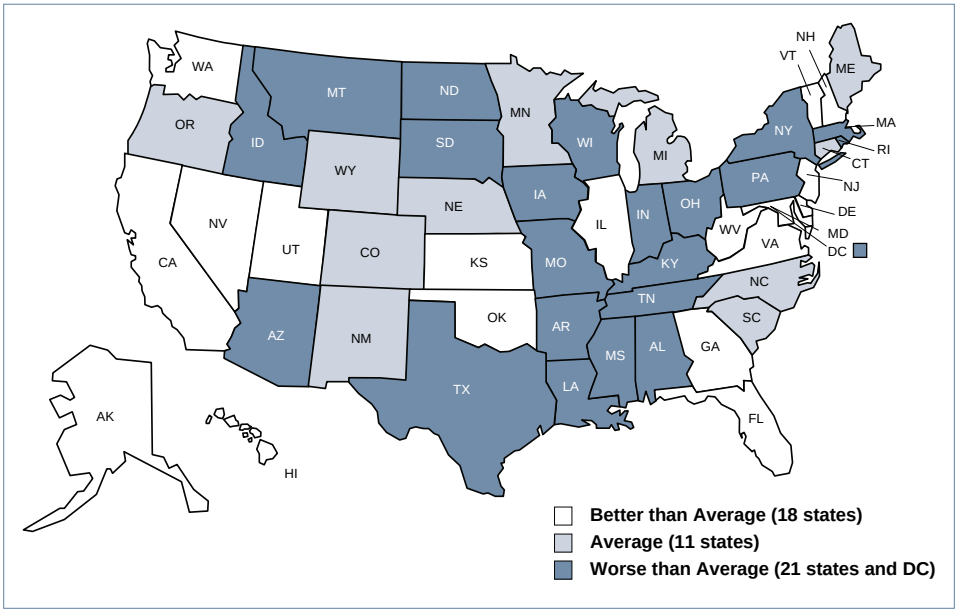


TABLE 3.0. Social Determinants Dimension Scores, by State

	State	Dimension Score
Better than Average	New Hampshire	-1.73
	Hawaii	-1.50
	Vermont	-1.46
	Washington	-0.85
	Delaware	-0.82
	Virginia	-0.80
	Oklahoma	-0.61
	Alaska	-0.56
	Maryland	-0.55
	West Virginia	-0.53
	Nevada	-0.37
	New Jersey	-0.37
	Utah	-0.27
	California	-0.26
	Kansas	-0.25
	Florida	-0.21
	Illinois	-0.19
	Georgia	-0.14
Average	Maine	-0.15
	Oregon	-0.11
	Nebraska	-0.10
	South Carolina	-0.07
	Wyoming	-0.04
	Michigan	-0.04
	Minnesota	-0.03
	Connecticut	-0.03
	North Carolina	0.04
	New Mexico	0.05
	Colorado	0.06
Worse than Average	Massachusetts	0.13
	Missouri	0.13
	Ohio	0.14
	Kentucky	0.18
	Idaho	0.22
	Arizona	0.25
	Arkansas	0.36
	Pennsylvania	0.39
	New York	0.41
	Indiana	0.43
	North Dakota	0.46
	Texas	0.50
	Iowa	0.51
	Wisconsin	0.55
	Tennessee	0.56
	Alabama	0.66
	District of Columbia	0.69
	Mississippi	0.90
	South Dakota	0.91
	Rhode Island	1.01
	Montana	1.28
	Louisiana	1.37

State	Dimension Score
Alabama	0.66
Alaska	-0.56
Arizona	0.25
Arkansas	0.36
California	-0.26
Colorado	0.06
Connecticut	-0.03
Delaware	-0.82
District of Columbia	0.69
Florida	-0.21
Georgia	-0.14
Hawaii	-1.50
Idaho	0.22
Illinois	-0.19
Indiana	0.43
Iowa	0.51
Kansas	-0.25
Kentucky	0.18
Louisiana	1.37
Maine	-0.15
Maryland	-0.55
Massachusetts	0.13
Michigan	-0.04
Minnesota	-0.03
Mississippi	0.90
Missouri	0.13
Montana	1.28
Nebraska	-0.10
Nevada	-0.37
New Hampshire	-1.73
New Jersey	-0.37
New Mexico	0.05
New York	0.41
North Carolina	0.04
North Dakota	0.46
Ohio	0.14
Oklahoma	-0.61
Oregon	-0.11
Pennsylvania	0.39
Rhode Island	1.01
South Carolina	-0.07
South Dakota	0.91
Tennessee	0.56
Texas	0.50
Utah	-0.27
Vermont	-1.46
Virginia	-0.80
Washington	-0.85
West Virginia	-0.53
Wisconsin	0.55
Wyoming	-0.04

— — — Best state in column
——— Worst state in column

POVERTY

The link between income and health is well established.[51,52] Poor individuals are less likely to have access to health coverage, less likely to have a usual source of care, and less likely to have routine screenings and checkups. Poor access is associated with a higher risk of delays in care and potentially poorer health outcomes.[53] Poverty also indirectly affects health through factors such as nutrition and stress. The poverty rates presented here are generated from the Current Population Survey conducted by the Census Bureau. According to poverty guidelines from the U.S. Department of Health and Human Services in 2005, the poverty threshold for a family of four was $19,350.[54]

Highlights

- In the U.S., 16.4% of nonelderly adult women had household incomes below the federal poverty threshold (Table 3.1). Women of color lived in poverty at more than twice the rate of White women (25.8% vs. 11.9%). Of all groups, American Indian and Alaska Native women experienced the highest poverty rates (32.8%), followed by Black (28.5%) and Hispanic (27.4%) women. White women had the lowest poverty rate.
- Women in Southern states, such as Mississippi, Louisiana, and Alabama, had higher poverty rates than women in any other region of the country. Women in parts of New England, such as Vermont, New Hampshire, and Connecticut had lower poverty rates than women in other regions.
- The U.S. disparity score for poverty rate was 2.18. State disparity scores for poverty ranged from a low of 1.41 in West Virginia to a high of 4.09 in South Dakota, meaning that women of color in South Dakota lived in poverty at four times the rate of White women.
- Poverty rates for women of color were higher than those for White women in all states, which resulted in all states having disparity scores above 1.00.
- States with large proportions of American Indian and Alaska Native women, such as North Dakota and South Dakota, had some of the highest disparity scores, largely because poverty rates among American Indian and Alaska Native women were substantially higher than those of White women.
- West Virginia had the lowest disparity score (1.41) in the nation, though this low score was largely attributable to White women in West Virginia experiencing the highest poverty rate of all White women in the country (19.3%), which narrowed the gap between them and women of color.
- Virginia and Kentucky tied for the second-lowest disparity score (1.65). Here, one in three nonelderly women was a racial and ethnic minority, and the poverty rate was below the national average for each racial and ethnic group.
- Though Kentucky and Virginia had the same disparity score (1.65), Kentucky was located at the far right of the upper right quadrant of Figure 3.1. White women in Kentucky had the second-highest poverty rate of all White women (17.5%)—nearly six percentage points higher than White women nationally—which narrowed the disparity between them and women of color, and resulted in one of the lowest disparity scores on this indicator.

FIGURE 3.1. State-Level Disparity Scores and Rates of Poverty for White Women Ages 18–64

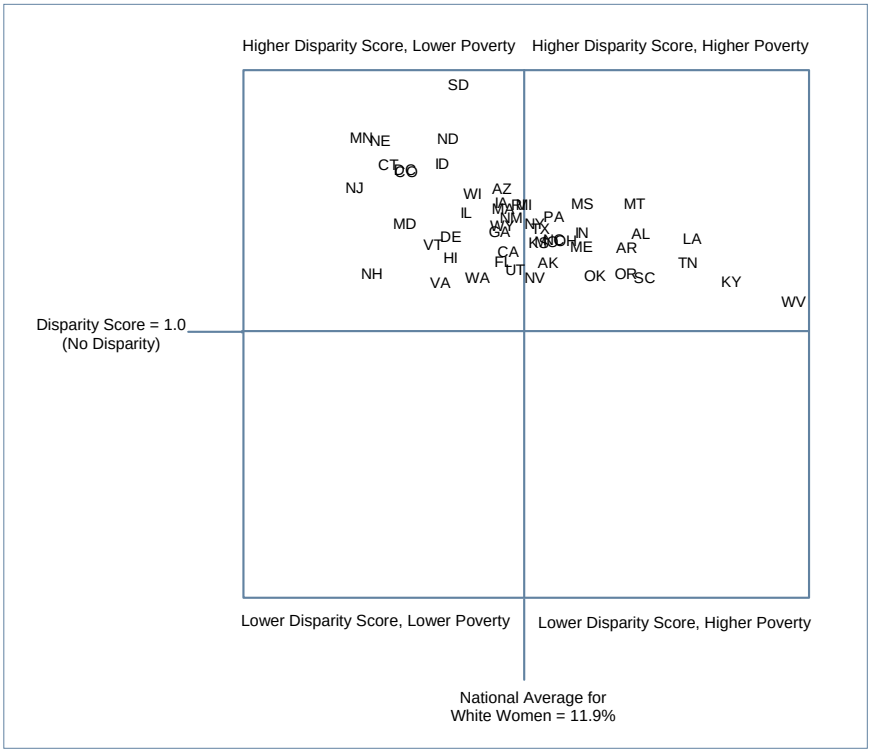


TABLE 3.1. Poverty, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**2.18**	**16.4%**	**11.9%**	**25.8%**	**28.5%**	**27.4%**	**15.0%**	**32.8%**
Alabama	**2.24**	21.0%	15.1%	33.8%	35.0%			
Alaska	**1.89**	15.7%	12.5%	23.7%		20.4%	17.3%	31.4%
Arizona	**2.80**	19.3%	11.3%	31.5%	25.8%	32.1%		40.1%
Arkansas	**2.07**	18.3%	14.7%	30.3%	32.8%	25.1%		
California	**2.01**	17.8%	11.4%	23.0%	26.1%	25.9%	15.2%	
Colorado	**3.01**	12.9%	8.6%	26.0%	23.0%	28.5%	10.5%	
Connecticut	**3.09**	12.3%	8.1%	25.2%	18.4%	35.2%	14.2%	
Delaware	**2.21**	13.6%	9.9%	21.8%	19.6%	32.9%	20.7%	
District of Columbia	**3.03**	19.9%	8.6%	26.1%	27.2%	21.6%		
Florida	**1.91**	15.3%	11.3%	21.6%	25.7%	20.0%	8.0%	
Georgia	**2.26**	16.9%	11.2%	25.3%	25.8%	28.7%	13.5%	
Hawaii	**1.94**	17.2%	9.8%	19.1%		22.4%	16.9%	
Idaho	**3.11**	12.2%	9.6%	29.9%	44.5%	31.0%		
Illinois	**2.51**	15.3%	10.3%	25.8%	32.6%	25.0%	8.4%	
Indiana	**2.26**	15.9%	13.4%	30.4%	33.2%	31.1%		
Iowa	**2.62**	12.9%	11.2%	29.5%		32.5%		
Kansas	**2.14**	14.6%	12.3%	26.3%	30.0%	29.0%		
Kentucky	**1.65**	18.7%	17.5%	28.9%	29.6%			
Louisiana	**2.18**	23.7%	16.5%	36.0%	37.4%			
Maine	**2.08**	14.1%	13.4%	27.9%				
Maryland	**2.36**	13.6%	8.6%	20.4%	22.1%	16.5%	16.4%	
Massachusetts	**2.55**	14.9%	11.3%	28.8%	26.9%	36.5%	22.7%	
Michigan	**2.60**	16.1%	11.8%	30.8%	36.6%	25.4%	9.0%	
Minnesota	**3.43**	9.7%	7.4%	25.5%	36.6%	25.7%	17.8%	
Mississippi	**2.61**	22.5%	13.5%	35.2%	35.8%			
Missouri	**2.15**	14.9%	12.5%	26.9%	28.7%	27.0%		
Montana	**2.61**	16.9%	14.9%	38.8%				48.3%
Nebraska	**3.40**	11.0%	7.9%	26.9%	32.2%	26.7%		
Nevada	**1.70**	15.4%	12.2%	20.6%	29.5%	21.0%	14.0%	
New Hampshire	**1.75**	8.0%	7.7%	13.4%				
New Jersey	**2.81**	12.2%	7.2%	20.3%	22.9%	25.1%	8.1%	
New Mexico	**2.44**	20.8%	11.5%	28.1%		26.3%		40.7%
New York	**2.38**	18.9%	12.1%	28.9%	29.9%	33.3%	18.4%	
North Carolina	**2.17**	17.6%	12.7%	27.5%	28.0%	29.2%	20.4%	30.7%
North Dakota	**3.42**	12.3%	9.8%	33.4%				37.3%
Ohio	**2.16**	15.5%	13.0%	28.1%	32.5%	23.7%		
Oklahoma	**1.72**	16.5%	13.8%	23.8%	24.8%	29.3%		30.9%
Oregon	**1.74**	16.4%	14.6%	25.5%		32.8%	14.0%	
Pennsylvania	**2.46**	15.9%	12.7%	31.2%	34.6%	28.0%	18.0%	
Rhode Island	**2.59**	15.2%	11.7%	30.3%	22.2%	37.1%	25.1%	
South Carolina	**1.71**	19.0%	15.2%	25.9%	26.5%	24.3%		
South Dakota	**4.09**	13.4%	10.1%	41.1%				52.0%
Tennessee	**1.89**	19.7%	16.3%	30.8%	31.0%	36.1%		
Texas	**2.30**	20.6%	12.3%	28.4%	26.6%	30.6%	14.7%	
Utah	**1.80**	13.1%	11.6%	20.8%		21.8%	16.2%	
Vermont	**2.11**	9.9%	9.4%	19.8%				
Virginia	**1.65**	11.5%	9.6%	15.8%	16.4%	19.7%	9.0%	
Washington	**1.70**	12.2%	10.6%	18.0%		21.1%	11.4%	
West Virginia	**1.41**	19.7%	19.3%	27.2%				
Wisconsin	**2.74**	12.8%	10.5%	28.7%	27.0%	28.4%		
Wyoming	**2.33**	12.8%	11.2%	26.2%		26.4%		

Note: Among women ages 18–64.

The federal poverty level in 2005 was $19,350 for a family of four.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: CPS, 2004–2006.

— — — Best state in column

——— Worst state in column

MEDIAN HOUSEHOLD INCOME

Median household income is an important indicator of resources available to women and their families. Individuals in lower-income households have fewer resources available to address health issues and are more likely to experience cost-related barriers to care. A lack of resources has a direct impact on health, as poor people are more sensitive to price changes than wealthier people. For example, a change in medication price, even a modest one, can result in people choosing to forgo their medication, or to cut down on how often they take it and how much they take.[55] Research has also demonstrated that individuals living in poorer neighborhoods are more likely to have poor health behaviors[56] and are more likely to experience higher rates of mental illness[57] and cardiovascular disease[58] than those living in neighborhoods with greater resources. The data presented here are derived from the Current Population Survey conducted by the Census Bureau, and to keep the interpretation consistent with other indicators, the disparity score for median household income was calculated as the ratio of White women to minority women.

Highlights

- Nationally, the median household income for women was $45,000, and ranged from a low of $24,000 for American Indian and Alaska Native women, to $26,681 for Black, $27,748 for Hispanic, $52,669 for Asian American, Native Hawaiian and Other Pacific Islander, and $54,536 for White women (Table 3.2). Household incomes tended to be lowest in the South and highest in New England and some Mid-Atlantic states.
- Within racial and ethnic groups, there was variation across states in median household income levels. Among American Indian and Alaska Native women, the median household income in Alaska ($32,017) was more than twice that in Montana ($12,480). For Asian American, Native Hawaiian and Other Pacific Islander women, the median household income in New Jersey ($85,000) was more than twice that in Rhode Island ($33,928).
- Nationally, the disparity score was 1.82, and ranged from 1.14 in New Hampshire to 2.58 in Montana. This meant that in all states White women had greater median household incomes than women of color, resulting in all states being located in the upper quadrants of Figure 3.2. In 18 states and the District of Columbia, the disparity score was 2.00 or higher, indicating that the median household income for White women was more than double that for women of color.
- More than 30 states were located in the upper right quadrant of Figure 3.2, which meant that even though White women in those states had median household incomes that were below those of White women nationally, there was still a disparity between White women and women of color. White women in states such as Montana, Kentucky, and West Virginia (found at the far right of the upper right quadrant) had median household incomes well below the national average for White women.
- Montana's disparity score (2.68) was an outlier because the median household income of minority women, mostly American Indian and Alaska Native women, was only $16,200, which was less than 40% of the median household income of White women in the state.
- New Jersey, at the far left of the upper left quadrant, stood out because the median household income of White women ($80,324) was the highest in the country. While the median household income of minority women was also higher than the national average for minority women, it was still less than half that of White women in the state ($38,420).
- In New Hampshire, another outlier, the median household income of White women ($62,550) was higher than the national average for White women, and the difference between it and that of minority women in the state was relatively small.

FIGURE 3.2. State-Level Disparity Scores and Median Household Income for White Women Ages 18–64

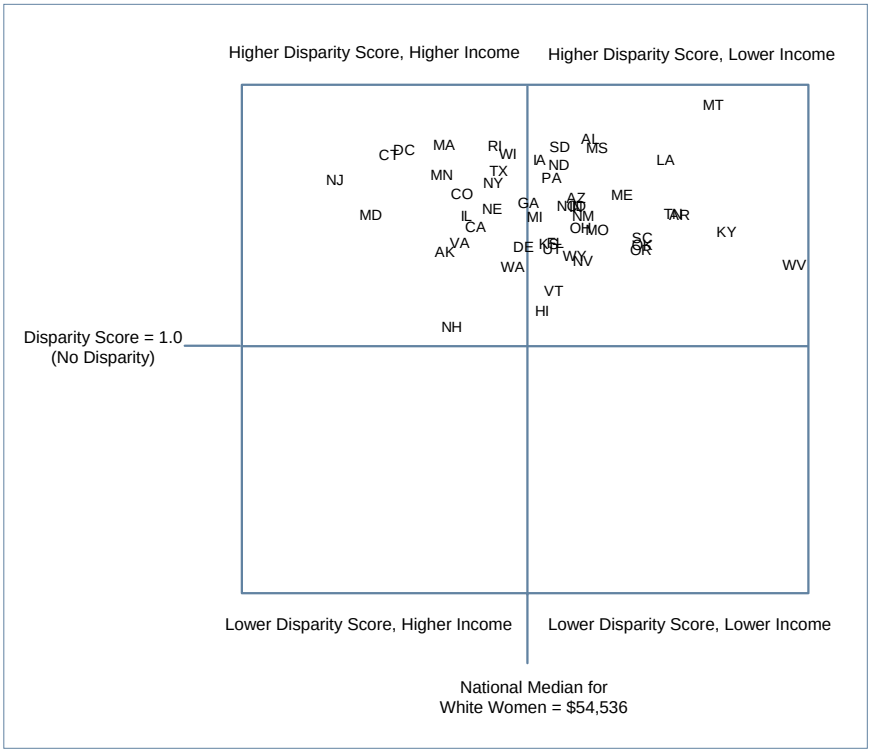


TABLE 3.2. Median Household Income, by State and Race/Ethnicity

State	Disparity Score	Median Income						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.82**	**$45,000**	**$54,536**	**$30,000**	**$26,681**	**$27,748**	**$52,669**	**$24,000**
Alabama	**2.36**	$38,200	$49,460	$21,000	$20,000			
Alaska	**1.62**	$54,431	$63,319	$39,029		$42,002	$45,000	$32,017
Arizona	**1.98**	$39,031	$50,615	$25,614	$29,000	$25,062		$21,810
Arkansas	**1.86**	$37,010	$43,600	$23,400	$21,345	$28,103		
California	**1.78**	$43,000	$59,765	$33,500	$32,000	$29,349	$54,000	
Colorado	**2.00**	$52,015	$61,366	$30,742	$36,286	$28,000	$48,112	
Connecticut	**2.26**	$60,086	$71,086	$31,520	$34,650	$23,360	$66,407	
Delaware	**1.65**	$47,812	$55,000	$33,250	$33,000	$25,866	$52,722	
District of Columbia	**2.29**	$39,573	$68,747	$30,000	$30,000	$30,000		
Florida	**1.68**	$42,003	$52,209	$31,051	$26,681	$32,640	$52,017	
Georgia	**1.95**	$42,000	$54,536	$28,017	$28,000	$25,600	$50,253	
Hawaii	**1.24**	$45,052	$53,378	$43,100		$37,383	$46,890	
Idaho	**1.92**	$46,990	$50,264	$26,148		$25,614		
Illinois	**1.85**	$50,000	$60,862	$32,879	$25,842	$30,000	$74,050	
Indiana	**1.92**	$46,958	$50,610	$26,400	$23,026	$25,000		
Iowa	**2.22**	$50,510	$53,575	$24,087		$24,404		
Kansas	**1.68**	$47,840	$52,739	$31,483	$22,984	$33,084		
Kentucky	**1.75**	$39,880	$41,084	$23,478	$22,435			
Louisiana	**2.22**	$33,000	$44,420	$20,000	$18,000			
Maine	**2.00**	$46,012	$47,217	$23,666				
Maryland	**1.86**	$56,892	$73,788	$39,599	$37,200	$39,500	$48,560	
Massachusetts	**2.32**	$53,700	$63,382	$27,321	$32,017	$20,948	$41,700	
Michigan	**1.85**	$48,025	$54,081	$29,295	$22,000	$35,000	$73,656	
Minnesota	**2.13**	$59,000	$63,800	$30,000	$23,000	$25,000	$48,000	
Mississippi	**2.30**	$34,472	$49,000	$21,288	$20,800			
Missouri	**1.77**	$44,000	$49,000	$27,748	$25,500	$30,020		
Montana	**2.58**	$39,807	$41,794	$16,200				$12,480
Nebraska	**1.90**	$52,983	$58,078	$30,500	$24,000	$29,882		
Nevada	**1.56**	$41,000	$50,000	$32,017	$25,000	$30,000	$48,025	
New Hampshire	**1.14**	$62,100	$62,550	$54,953				
New Jersey	**2.09**	$61,096	$80,324	$38,420	$32,018	$30,000	$85,000	
New Mexico	**1.85**	$35,000	$50,020	$27,000		$28,815		$17,076
New York	**2.07**	$43,080	$58,000	$28,005	$28,200	$24,000	$38,538	
North Carolina	**1.92**	$41,365	$51,227	$26,681	$26,000	$24,333	$45,908	$30,250
North Dakota	**2.19**	$49,093	$51,891	$23,735				$20,832
Ohio	**1.78**	$46,097	$50,261	$28,296	$24,691	$28,922		
Oklahoma	**1.67**	$41,500	$45,891	$27,554	$28,010	$24,546		$22,088
Oregon	**1.64**	$42,010	$46,000	$28,080		$23,400	$52,800	
Pennsylvania	**2.10**	$47,655	$52,500	$25,002	$22,198	$27,748	$55,000	
Rhode Island	**2.32**	$48,835	$57,883	$25,000	$27,562	$20,149	$33,928	
South Carolina	**1.72**	$37,000	$45,860	$26,718	$26,000	$26,112		
South Dakota	**2.31**	$48,645	$51,862	$22,471				$14,560
Tennessee	**1.87**	$38,892	$44,000	$23,479	$23,479	$18,143		
Texas	**2.15**	$39,084	$57,360	$26,681	$26,830	$25,113	$52,935	
Utah	**1.64**	$49,199	$52,509	$32,000		$29,200	$37,405	
Vermont	**1.37**	$52,020	$52,356	$38,152				
Virginia	**1.68**	$52,615	$61,576	$36,640	$33,207	$32,000	$61,979	
Washington	**1.52**	$52,324	$56,030	$36,764		$31,000	$54,000	
West Virginia	**1.54**	$37,353	$37,862	$24,585				
Wisconsin	**2.26**	$52,030	$56,589	$25,080	$24,034	$26,000		
Wyoming	**1.60**	$48,645	$50,700	$31,751		$29,904		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: CPS, 2004–2006.

— — — Best state in column

———— Worst state in column

GENDER WAGE GAP

Despite the Equal Pay Act, which passed more than 40 years ago, women continue to earn less than men.[59] Gender and racial and ethnic disparities in earnings are well documented. These disparities persist even after controlling for years of work, experience, marital status, education, and race.[60] Wages represent one measure of the resources available to cover health care expenditures. With an increasing number of women living alone, and more women having families without getting married, wages matter even more with regard to their impact on health and health care. The gender wage gap represents the ratio of earnings for women of various racial and ethnic groups to those of non-Hispanic White men. Like median household income, a higher number is a better outcome. It means that there is a smaller difference between their earnings and those of White men.

Highlights

- Nationally, the gender wage gap between women and men was 69.2 percent. This means that nonelderly adult women who worked full time, year round earned 69.2 cents for every dollar earned by a non-Hispanic White man (Table 3.3). This number differed significantly by race and ethnicity. For every dollar a White man earned, Hispanic and American Indian and Alaska Native female full-time workers earned 50.9 and 56.5 cents, respectively, compared to 73.3 cents for White and 77.4 cents for Asian American, Native Hawaiian, and Other Pacific Islander women.
- Earnings for female full-time workers also differed by state. Earnings for non-Hispanic White women in Vermont, New York, and Arizona were closest to those of White men, while the gap between White men and White women was the greatest in Wyoming, Utah, and Oregon.
- The national wage gap disparity score was 1.21, ranging from 0.93 in West Virginia to 1.55 in the District of Columbia. West Virginia was the only state where minority women had a smaller wage gap than White women.
- In Michigan, New Hampshire, and Wyoming, there was little to no difference between the wage gaps of White women and women of racial and ethnic minority populations. The difference in the gaps was largest in the District of Columbia, Arizona, and Texas.
- There was a disparity in the wage gap between White women and women of color in most states, as indicated by almost all states being located in the upper quadrants of Figure 3.3. Most states were situated in the upper left quadrant, which meant that there was a disparity between White women and women of color in these states, and wage gaps for White women that were higher than the national average of 73%.
- Wyoming, which fell into the far right of the upper right quadrant, was notable because of its disparity score of 1.06. While the difference in the wage gap between White women and women of color was negligible, both White women and women of color earned much less than White men.
- With the exception of Wyoming, there is very little variation in gender wage gap among White women, as evidenced by clustering around the national average for White women in Figure 3.3. This pattern is different from that of most indicators.

FIGURE 3.3. State-Level Disparity Scores and Gender Wage Gap for White Women Ages 18–64

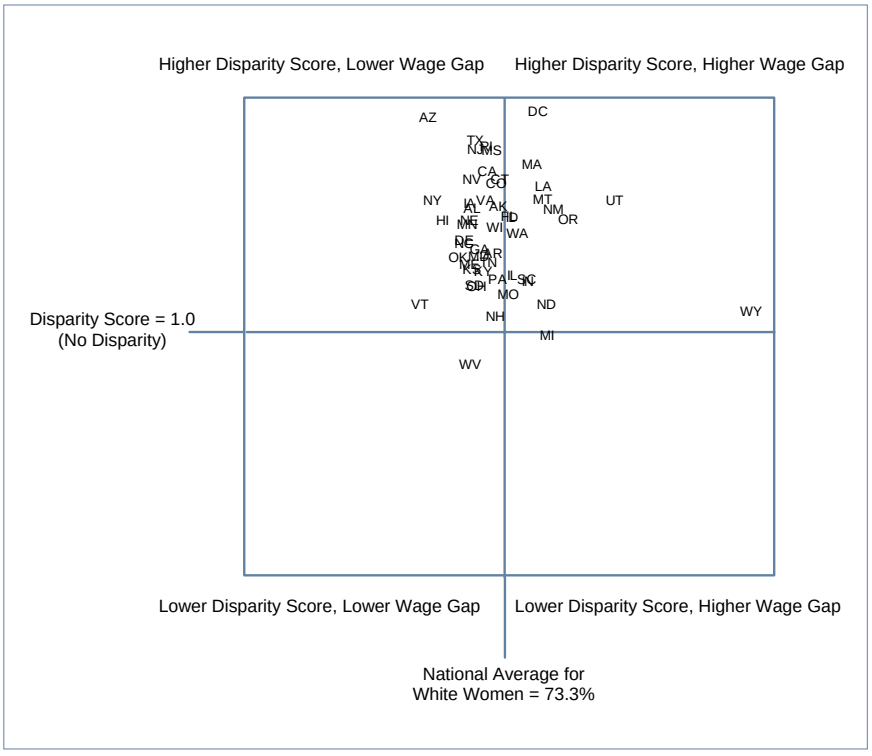


TABLE 3.3. Gender Wage Gap for Women Who Are Full-Time Year-Round Workers Compared to Non-Hispanic White Men, by State and Race/Ethnicity

State	Disparity Score	Gender Wage Gap						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.21**	**69.2%**	**73.3%**	**60.8%**	**61.1%**	**50.9%**	**77.4%**	**56.5%**
Alabama	**1.31**	69.4%	76.2%	58.0%	55.8%			
Alaska	**1.32**	69.4%	73.9%	56.0%		54.3%	55.5%	50.5%
Arizona	**1.54**	72.1%	80.5%	52.4%	68.3%	50.0%		64.1%
Arkansas	**1.20**	71.1%	74.4%	61.8%	62.1%	46.2%		
California	**1.41**	62.2%	74.8%	53.2%	64.0%	41.9%	69.8%	
Colorado	**1.38**	69.3%	74.1%	53.8%	59.5%	48.1%	66.3%	
Connecticut	**1.38**	70.0%	73.8%	53.4%	60.8%	44.4%	66.8%	
Delaware	**1.23**	72.5%	76.9%	62.3%	66.5%	49.9%	66.6%	
District of Columbia	**1.55**	53.8%	70.6%	45.5%	45.8%	30.8%		
Florida	**1.29**	66.7%	73.0%	56.5%	58.3%	52.1%	68.9%	
Georgia	**1.21**	68.7%	75.5%	62.2%	62.4%	41.6%	72.8%	
Hawaii	**1.28**	63.9%	79.0%	61.6%		57.8%	61.6%	
Idaho	**1.29**	70.2%	72.7%	56.3%	29.5%	49.9%		
Illinois	**1.15**	69.3%	72.7%	63.3%	63.4%	51.4%	85.5%	
Indiana	**1.13**	71.4%	71.4%	63.0%	66.9%	45.7%		
Iowa	**1.33**	76.2%	76.4%	57.6%		55.2%		
Kansas	**1.16**	75.0%	76.2%	65.6%	62.3%	65.0%		
Kentucky	**1.16**	75.0%	75.3%	65.0%	69.3%			
Louisiana	**1.37**	63.0%	70.2%	51.4%	51.4%			
Maine	**1.18**	75.8%	76.5%	65.0%				
Maryland	**1.19**	69.5%	75.6%	63.3%	64.5%	45.9%	68.0%	
Massachusetts	**1.42**	66.7%	71.1%	50.0%	56.2%	41.7%	64.5%	
Michigan	**1.00**	70.0%	70.0%	70.0%	69.2%	57.8%	76.4%	
Minnesota	**1.27**	74.7%	76.7%	60.2%	65.6%	48.0%	68.3%	
Mississippi	**1.46**	64.5%	74.4%	51.2%	51.2%			
Missouri	**1.10**	72.0%	73.1%	66.3%		61.0%		
Montana	**1.34**	69.1%	70.3%	52.6%	42.1%			47.2%
Nebraska	**1.28**	74.8%	76.4%	59.6%	67.3%	54.8%		
Nevada	**1.38**	67.3%	76.2%	55.1%	60.7%	49.0%	71.4%	
New Hampshire	**1.05**	74.0%	74.2%	70.8%				
New Jersey	**1.46**	66.4%	75.9%	52.0%	53.2%	41.7%	79.2%	
New Mexico	**1.31**	60.4%	69.5%	53.0%		54.3%		45.8%
New York	**1.33**	70.4%	80.0%	60.0%	64.0%	53.3%	66.0%	
North Carolina	**1.23**	73.4%	76.9%	62.7%	65.3%	46.6%	62.2%	77.5%
North Dakota	**1.08**	70.0%	70.0%	65.0%				67.0%
Ohio	**1.12**	74.5%	75.8%	67.7%	67.7%	59.2%		
Oklahoma	**1.19**	74.9%	77.4%	64.9%	75.0%	49.9%		59.9%
Oregon	**1.28**	65.6%	68.4%	53.2%		47.2%	66.7%	
Pennsylvania	**1.14**	71.7%	73.9%	64.9%	64.9%	60.5%	87.7%	
Rhode Island	**1.46**	71.1%	75.0%	51.2%	57.7%	41.0%	55.8%	
South Carolina	**1.14**	68.6%	71.5%	62.8%	62.0%	57.1%		
South Dakota	**1.12**	76.0%	76.0%	67.6%				76.0%
Tennessee	**1.18**	74.7%	74.7%	63.3%	67.8%	44.8%		
Texas	**1.48**	63.9%	75.8%	51.2%	59.9%	46.7%	68.2%	
Utah	**1.33**	61.3%	65.2%	48.9%		44.4%	56.2%	
Vermont	**1.08**	81.1%	81.2%	75.4%				
Virginia	**1.33**	66.7%	75.0%	56.3%	56.2%	50.6%	63.0%	
Washington	**1.25**	68.9%	72.3%	57.7%		55.7%	56.3%	
West Virginia	**0.93**	76.3%	76.3%	82.1%				
Wisconsin	**1.27**	71.7%	74.3%	58.7%	60.8%	58.5%		
Wyoming	**1.06**	57.1%	57.3%	54.1%		53.1%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: CPS, 2004–2006.

— — — Best state in column

——— Worst state in column

WOMEN WITH NO HIGH SCHOOL DIPLOMA

Educational attainment influences health in direct and indirect ways. Education is related to the types of jobs an individual can obtain and to income, both of which affect opportunities for healthier living and the ability to access health care. Individuals with less than a high school education tend to work in lower paying jobs. A woman working full time and year-round with at least a high school education makes almost twice as much as a woman who has not earned her high school diploma.[61] Educational attainment is also correlated with health literacy, which impacts an individual's ability to communicate with health providers, understand and follow instructions, and navigate the health system. Nearly 75% of adults with less than a high school education have basic or below-basic health literacy, meaning they are unable to read a prescription label to determine when to take their medication.[62] Women with less than a high school education also have poorer health outcomes, including higher rates of infant mortality,[63] smoking, and diabetes than women with a high school diploma.[64,65]

Highlights

- Nearly one in eight (12.4%) nonelderly adult women lacked a high school diploma (Table 3.4). More than one in three Hispanic (35.8%) and one in six American Indian and Alaska Native (18.1%) women had not completed high school, compared to nearly 1 in 15 White women (7.3%).
- In four states (Minnesota, New Hampshire, North Dakota, and Vermont) fewer than 7% of women lacked a high school diploma, while in three states (Arizona, California and Texas), more than 16% of women lacked a high school diploma.
- Among White women, eight states had rates of women without a high school diploma greater than 10%, seven of which were located in the South, and nine states and the District of Columbia had rates below 5%. By comparison, 49 states had rates greater than 10% for all minority women.
- Within racial groups, there was significant variation in high school completion rates. There was nearly a ten-fold difference between White women in Kentucky and those in the District of Columbia, and nearly a six-fold difference between Hispanic women in Iowa and those in Hawaii.
- The national disparity score was 3.11, reflecting that the share of minority women without a high school diploma was slightly more than three times that of White women, but as with prevalence rates, disparities varied greatly across states. In West Virginia and Kentucky, disparity scores were less than 1.00, indicating that White women lacked a high school diploma at a higher rate than women of color. However, in Arizona, Nebraska, Colorado, and the District of Columbia, disparity scores were greater than 6.00, and another eight states had disparity scores between 5.00 and 6.00.
- The majority of states (30) clustered in the upper left quadrant of Figure 3.4, which meant that the percentage of minority women without a high school diploma was greater than the percentage of White women, but in those states, the percentage of White women who lacked a high school diploma was lower than the national average for White women.
- States in the South tended to cluster in the upper right quadrant because White women living there had lower high school completion rates than the national average for White women. The District of Columbia stood alone at the top of the upper left quadrant, because only 1.5% of White women in the District had not completed high school and, despite being comparable to the national average, the rate for minority women was nearly 12 times that of White women.
- In Kentucky, another outlier state at the far right of the upper right quadrant, though minority women and White women had nearly equal diploma rates, the percentage of White women who lacked a high school diploma was the highest in the nation, just over two times the national average for White women.

FIGURE 3.4. State-Level Disparity Scores and Percent of White Women Ages 18–64 with No High School Diploma

TABLE 3.4. Women with No High School Diploma, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**3.11**	**12.4%**	**7.3%**	**22.8%**	**14.9%**	**35.8%**	**10.9%**	**18.1%**
Alabama	**1.34**	13.3%	12.0%	16.1%	16.5%			
Alaska	**3.23**	7.5%	4.6%	14.9%		17.8%	19.2%	16.7%
Arizona	**6.43**	16.1%	5.1%	32.7%	13.1%	39.8%		17.9%
Arkansas	**2.09**	13.7%	10.9%	22.7%	18.3%	43.7%		
California	**5.24**	17.8%	5.4%	28.1%	9.6%	40.1%	10.1%	
Colorado	**6.91**	10.4%	4.2%	29.2%	11.9%	36.9%	11.8%	
Connecticut	**3.79**	9.5%	5.6%	21.2%	11.5%	32.9%	13.5%	
Delaware	**1.92**	10.7%	8.3%	15.9%	11.1	41.3%	8.4%	
District of Columbia	**11.76**	11.6%	1.5%	17.2%	14.4%	42.5%		
Florida	**2.85**	11.2%	6.5%	18.6%	17.9%	20.5%	10.2%	
Georgia	**1.98**	11.8%	8.5%	16.7%	14.2%	33.5%	8.6%	
Hawaii	**2.40**	7.1%	3.3%	8.0%		9.1%	9.0%	
Idaho	**5.29**	9.2%	5.9%	31.4%		42.2%		
Illinois	**3.20**	11.0%	6.4%	20.6%	14.4%	36.9%	5.8%	
Indiana	**2.02**	12.2%	10.7%	21.6%	15.9%	42.9%		
Iowa	**5.48**	8.4%	6.0%	32.6%		50.7%		
Kansas	**3.22**	8.3%	6.0%	19.4%	16.0%	30.4%		
Kentucky	**0.93**	14.6%	14.7%	13.7%	12.2%			
Louisiana	**2.50**	15.1%	9.7%	24.3%	24.8%			
Maine	**2.63**	8.0%	7.4%	19.6%				
Maryland	**2.12**	9.8%	6.6%	14.1%	11.1%	34.5%	11.2%	
Massachusetts	**3.21**	8.6%	5.9%	19.1%	11.0%	31.8%	13.5%	
Michigan	**2.09**	8.3%	6.7%	14.0%	13.3%	22.6%	8.1%	
Minnesota	**5.72**	6.3%	4.0%	22.7%	18.9%	41.9%	14.4%	
Mississippi	**1.90**	15.6%	11.3%	21.5%	20.7%			
Missouri	**1.21**	10.0%	9.6%	11.6%	11.0%	19.0%		
Montana	**3.83**	7.7%	6.2%	23.7%				29.8%
Nebraska	**6.62**	7.4%	3.9%	25.6%	10.9%	41.6%		
Nevada	**3.68**	14.1%	6.9%	25.5%	16.2%	38.3%	5.4%	
New Hampshire	**2.39**	5.6%	5.2%	12.5%				
New Jersey	**3.87**	10.0%	4.8%	18.4%	14.1%	28.8%	7.0%	
New Mexico	**5.00**	15.3%	4.8%	23.8%		26.4%		21.8%
New York	**3.52**	12.9%	6.4%	22.6%	16.9%	31.2%	18.0%	
North Carolina	**2.33**	13.0%	9.0%	21.0%	16.5%	45.7%	12.9%	18.3%
North Dakota	**5.39**	6.1%	4.2%	22.5%				23.0%
Ohio	**1.90**	9.7%	8.5%	16.1%	15.1%	28.8%		
Oklahoma	**1.93**	9.4%	7.5%	14.6%	11.7%	29.5%		10.8%
Oregon	**4.03**	9.6%	6.4%	25.6%		41.3%	12.3%	
Pennsylvania	**2.55**	9.6%	7.6%	19.3%	17.3%	29.8%	12.2%	
Rhode Island	**4.37**	12.7%	7.7%	33.9%	25.6%	44.3%	18.7%	
South Carolina	**1.42**	13.6%	11.8%	16.8%	15.9%	26.5%		
South Dakota	**5.29**	7.0%	4.8%	25.3%				26.5%
Tennessee	**1.47**	13.3%	12.0%	17.7%	12.7%	47.7%		
Texas	**4.11**	19.4%	7.5%	30.7%	12.0%	40.2%	9.1%	
Utah	**4.59**	9.4%	5.9%	27.2%		35.6%	12.3%	
Vermont	**2.13**	6.4%	6.1%	12.9%				
Virginia	**2.04**	10.7%	8.1%	16.6%	13.2%	38.5%	7.9%	
Washington	**2.93**	8.8%	6.2%	18.2%		34.3%	12.8%	
West Virginia	**0.63**	11.9%	12.1%	7.6%				
Wisconsin	**5.32**	7.7%	5.0%	26.4%	20.0%	35.2%		
Wyoming	**3.70**	7.9%	6.2%	23.0%		30.3%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: CPS, 2004–2006.

— — — Best state in column

———— Worst state in column

WOMEN IN FEMALE-HEADED HOUSEHOLDS WITH CHILDREN

In 2006, nearly 13 million households were headed by single parents, and the overwhelming majority (10.4 million), were headed by single women.[66] Households headed by single women are more likely to be poor, which impacts the physical, mental, and educational outcomes of the children raised in these homes. Parents with limited economic resources face many obstacles to healthy living and opportunities for learning. The effects of living in a single-parent household go beyond the children; the mothers are also affected. Single mothers report higher levels of psychological distress,[67] lower levels of perceived social support,[68] and poorer eating habits,[69] all of which affect their ability to parent.

Highlights

- Approximately 22% of nonelderly adult women lived in a female-headed household (Table 3.5). In Utah, 13.9% of women lived in female-headed households, while at the other end of the spectrum, 41.6% of women in the District of Columbia did.
- Higher shares of African American (45%) and American Indian and Alaska Native (32.9%) women lived in a female-headed household, whereas fewer Asian American, Native Hawaiian and Other Pacific Islander (9.2%) and White (17.4%) women lived in this household arrangement.
- African American women living in single-parent households ranged from 36.7% in Virginia to 62.3% in Kansas. Among Hispanic women the percentage ranged from a low of 14.9% in Nebraska to a high of 49.7% in West Virginia.
- The national disparity score was 1.70, and ranged from a low of 0.82 in New Hampshire to a high of 4.79 in the District of Columbia. In addition to New Hampshire, disparity scores were either below or equal to 1.00 in Vermont (0.94) and Oregon (1.00), reflecting the fact that White women lived in single-parent households at similar rates to minority women.
- Minority women in the District of Columbia, 81% of whom were African American, lived in a female-headed household at nearly five times the rate of White women. The disparity score in the District of Columbia, aside from being the highest in the nation, is also 1.5 times higher than that of Alabama, the state with the second-highest disparity score.
- States appear equally distributed across the upper two quadrants of Figure 3.5. Most states in the upper left quadrant clustered near the national average for White women, with the exception of New Jersey, the District of Columbia, Mississippi, Connecticut, Utah, Hawaii, and Alabama, where the percentage of White women who lived in female-headed households was noticeably lower than the national average for White women.
- States in the upper right quadrant were less clustered. Outliers in this quadrant included Kentucky and Nevada, where the percentage of White women in female-headed households was 1.4 and 1.3 times the national average for White women, respectively.

FIGURE 3.5. State-Level Disparity Scores and Percent of White Women Ages 18–64 in Female-Headed Households with Children

TABLE 3.5. Women in Female-Headed Households with Children, by State and Race/Ethnicity

State	Disparity Score	Prevalence						
		All Women	White	All Minority*	Black	Hispanic	Asian and NHPI	American Indian/ Alaska Native
All States	**1.70**	**22.1%**	**17.4%**	**29.6%**	**45.0%**	**23.0%**	**9.2%**	**32.9%**
Alabama	**3.17**	25.5%	14.5%	45.8%	49.5%			
Alaska	**1.77**	20.0%	16.0%	28.2%		23.5%	11.3%	39.4%
Arizona	**1.34**	22.9%	19.6%	26.4%		23.6%		
Arkansas	**1.70**	22.2%	18.5%	31.6%	39.4%			
California	**1.11**	19.9%	18.5%	20.7%	42.1%	19.4%	12.1%	
Colorado	**1.58**	17.7%	14.8%	23.5%		21.9%		
Connecticut	**2.98**	21.8%	13.6%	40.6%	42.2%	47.1%		
Delaware	**1.86**	22.4%	17.1%	31.8%	40.0%	24.2%		
District of Columbia	**4.79**	41.6%	10.4%	49.9%	55.2%	24.0%		
Florida	**1.54**	23.5%	18.8%	28.9%	43.3%	20.0%	6.8%	
Georgia	**2.19**	25.5%	16.7%	36.6%	44.0%	16.8%		
Hawaii	**1.21**	15.1%	12.8%	15.5%		28.4%	11.9%	
Idaho	**1.55**	16.6%	15.2%	23.6%		18.9%		
Illinois	**1.88**	20.2%	15.2%	28.5%	46.2%	19.4%	3.0%	
Indiana	**2.06**	23.7%	20.0%	41.3%	54.8%	26.2%		
Iowa	**1.61**	19.7%	18.4%	29.7%		19.5%		
Kansas	**1.80**	21.2%	18.2%	32.8%	62.3%	28.8%		
Kentucky	**1.64**	26.5%	24.6%	40.2%	52.7%			
Louisiana	**2.57**	25.7%	15.6%	40.2%	42.8%			
Maine	**1.81**	21.4%	20.6%	37.2%				
Maryland	**1.82**	22.9%	16.5%	30.2%	37.9%	16.5%	2.0%	
Massachusetts	**1.80**	20.0%	16.8%	30.2%		38.5%	11.0%	
Michigan	**2.55**	23.3%	16.8%	42.7%	53.8%	31.9%		
Minnesota	**2.23**	17.9%	14.9%	33.2%	54.6%		11.7%	
Mississippi	**3.05**	25.4%	12.6%	38.6%	41.0%			
Missouri	**2.30**	26.1%	21.1%	48.3%	58.8%			
Montana	**1.61**	21.1%	19.8%	31.9%		28.8%		
Nebraska	**1.37**	17.9%	16.7%	22.8%		14.9%		
Nevada	**1.20**	24.6%	22.4%	27.0%	58.1%	21.8%	10.2%	
New Hampshire	**0.82**	17.9%	18.2%	14.9%				
New Jersey	**2.69**	17.8%	10.3%	27.6%	37.5%	30.5%	6.8%	
New Mexico	**1.51**	26.5%	20.2%	30.4%		30.3%		35.5%
New York	**2.08**	25.1%	16.8%	34.9%	47.0%	35.5%	6.2%	
North Carolina	**2.30**	23.8%	15.9%	36.6%	45.1%	20.1%		
North Dakota	**2.09**	21.9%	18.9%	39.5%				41.1%
Ohio	**2.53**	24.7%	19.0%	48.0%	57.5%			
Oklahoma	**1.81**	21.1%	16.8%	30.4%	40.8%	15.0%		
Oregon	**1.00**	20.0%	20.0%	20.0%		24.4%		
Pennsylvania	**2.25**	22.3%	18.0%	40.5%	45.7%	40.8%		
Rhode Island	**1.94**	26.7%	21.7%	42.1%		45.0%		
South Carolina	**2.33**	25.6%	16.7%	38.9%	42.1%			
South Dakota	**2.07**	21.5%	18.7%	38.7%				47.1%
Tennessee	**2.37**	24.4%	17.8%	42.3%	49.0%			
Texas	**1.60**	21.0%	15.5%	24.8%	41.7%	21.6%	4.9%	
Utah	**1.39**	13.9%	12.9%	17.9%		18.3%		
Vermont	**0.94**	20.6%	20.7%	19.5%				
Virginia	**1.61**	20.7%	17.1%	27.4%	36.7%	19.0%	8.7%	
Washington	**1.09**	20.3%	19.8%	21.6%		19.5%	10.5%	
West Virginia	**1.78**	22.2%	21.4%	38.1%		49.7%		
Wisconsin	**1.91**	20.5%	17.8%	34.0%	46.4%	23.6%		
Wyoming	**1.82**	18.7%	16.9%	30.7%		30.0%		

Note: Among women ages 18–64.

*All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same.

Source: CPS, 2004–2006.

— — — Best state in column

———— Worst state in column

RESIDENTIAL SEGREGATION: INDEX OF DISSIMILATION

The socioeconomic and racial segregation of neighborhoods can have strong effects on both neighborhood conditions and the health of residents living there. Individuals from racial and ethnic minority groups are more likely than Whites to live in socioeconomically disadvantaged neighborhoods. Residents of such neighborhoods often have reduced access to public resources and spending, fewer employment opportunities, and greater exposure to hazardous health conditions, like poor air and water quality.[70] Individuals living in racially segregated neighborhoods (e.g., high concentrations of African Americans) are more likely to rate their health as fair or poor,[71] and are more likely to deliver low-birthweight infants than individuals living in less segregated neighborhoods.[72]

The index of dissimilation is a commonly used measure of neighborhood segregation. It is a ratio of the proportion of a given population to the reference group, in this case non-Hispanic White men and women. The resulting number corresponds to the proportion of the Whites that would need to move in order for the neighborhood to no longer be segregated. As the index of dissimilarity is already a ratio, a calculation of a disparity score using the same methodology as other indicators is not possible.

Highlights

- Across the United States, nearly one in three Whites needed to move in order for the population to be fully integrated.
- People of color in Arizona, Delaware, and Vermont lived in the least segregated states, while people of color in the District of Columbia, Louisiana, New York, and Tennessee lived in the most segregated states.
- The index of dissimilarity for the District of Columbia was the highest, and was 1.5 times that of Louisiana, the next highest state, and more than nine times that of Arizona, the lowest state.
- African Americans tended to live in the most segregated neighborhoods, followed by Asian American, Native Hawaiian and Other Pacific Islanders and Hispanics.
- African Americans in the District of Columbia and Wisconsin lived in the most segregated communities, whereas African Americans in Delaware and Arizona lived in the least segregated. The index of dissimilarity in the District of Columbia was eight times that of Delaware.
- For Asians, Native Hawaiians and Other Pacific Islanders, Connecticut and Arizona were the least segregated states, and New York and Virginia were the most segregated.
- Hispanics in Hawaii were the least segregated of all Hispanics, while they were most segregated in the District of Columbia.
- The indices of dissimilarity comparing Hispanics to Whites varied the most of all groups. Residential segregation for Hispanics in the District of Columbia was 15 times that of Hawaii.

TABLE 3.6. Neighborhood Segregation: Index of Dissimilation

State	All Minority*-White Dissimilarity	Black-White Dissimilarity	Hispanic-White Dissimilarity	Asian and NHPI - White Dissimilarity
All States	**0.30**	**0.38**	**0.29**	**0.31**
Alabama	0.31	0.36	0.22	0.36
Alaska	0.25	0.34	0.22	0.32
Arizona	0.08	0.13	0.09	0.13
Arkansas	0.37	0.56	0.37	0.37
California	0.21	0.33	0.26	0.29
Colorado	0.27	0.47	0.32	0.25
Connecticut	0.17	0.20	0.19	0.11
Delaware	0.10	0.10	0.11	0.23
District of Columbia†	0.75	0.82	0.60	0.31
Florida	0.35	0.32	0.46	0.26
Georgia	0.30	0.36	0.36	0.42
Hawaii	0.14	0.32	0.04	0.17
Idaho	0.23	0.31	0.34	0.26
Illinois	0.37	0.46	0.40	0.38
Indiana	0.39	0.51	0.39	0.33
Iowa	0.30	0.43	0.36	0.37
Kansas	0.31	0.41	0.38	0.35
Kentucky	0.38	0.45	0.31	0.40
Louisiana	0.49	0.26	0.28	0.35
Maine	0.14	0.31	0.12	0.18
Maryland	0.41	0.49	0.47	0.42
Massachusetts	0.22	0.36	0.34	0.31
Michigan	0.34	0.48	0.28	0.36
Minnesota	0.30	0.46	0.29	0.36
Mississippi	0.32	0.35	0.21	0.35
Missouri	0.42	0.55	0.32	0.35
Montana	0.35	0.31	0.17	0.21
Nebraska	0.31	0.52	0.33	0.34
Nevada	0.17	0.29	0.15	0.19
New Hampshire	0.21	0.24	0.29	0.20
New Jersey	0.30	0.37	0.35	0.32
New Mexico	0.16	0.22	0.16	0.24
New York	0.46	0.45	0.49	0.49
North Carolina	0.28	0.32	0.23	0.39
North Dakota	0.33	0.39	0.22	0.31
Ohio	0.36	0.44	0.33	0.34
Oklahoma	0.18	0.38	0.29	0.35
Oregon	0.23	0.45	0.25	0.34
Pennsylvania	0.39	0.52	0.44	0.38
Rhode Island	0.32	0.34	0.39	0.20
South Carolina	0.29	0.34	0.25	0.25
South Dakota	0.42	0.39	0.30	0.27
Tennessee	0.46	0.54	0.34	0.39
Texas	0.34	0.32	0.40	0.36
Utah	0.19	0.26	0.20	0.26
Vermont	0.13	0.23	0.12	0.30
Virginia	0.21	0.25	0.35	0.43
Washington	0.21	0.36	0.30	0.32
West Virginia	0.29	0.38	0.23	0.30
Wisconsin	0.42	0.65	0.39	0.32
Wyoming	0.24	0.43	0.23	0.29

Note: *All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races.

† For DC Data, W. Frey and D. Myers' analysis of Census 2000; and the Social Science Data Analysis Network (SSDAN).

Data: SC-EST2007-alldata6: Annual State Population Estimates by Demographic Characteristics with 6 Race Groups (5 Race Alone Groups and One Group with Two or more Race Groups): April 1, 2000 to July 1, 2007.

Source: Population Division, U.S. Census Bureau. http://www.census.gov/popest/datasets.html

— — — Best state in column

——— Worst state in column

HEALTH CARE PAYMENTS AND WORKFORCE

The indicators studied in this report are shaped by a broad range of factors, many of which are determined by policies made at the state level. State-level policies help establish the context for the operation of the private health care marketplace, the role of public payers and providers, and ultimately women's experiences in the health care system. The characteristics of the providers serving communities, the availability of public funding sources that serve low-income populations, and policies that can enhance or limit access to services all affect the accessibility and availability of care for women of color.

This chapter examines health care workforce measures: health professional shortage areas, mental health professional shortage areas, and the physician diversity ratio, which is a measure of how well the racial and ethnic composition of the physician population reflects the diversity of the state's population. A patient's recognition of symptoms, ability to communicate those symptoms, and adherence to treatment plans may be influenced by socio-cultural factors.[73] A health care workforce that is representative of the population it serves is an important factor in assuring more accessible, quality health care for minority populations.[74]

This report also examines three measures of Medicaid policy, an area in which states have a major role. Under broad federal guidelines, each state operates its own program, determining eligibility, payment, and benefit levels. As a result, there is tremendous variation among states in terms of eligibility, scope of benefits, access to providers, and administrative requirements. Women comprise the vast majority of the adult population on Medicaid since they are more likely to qualify for the program's income and categorical requirements. On average, women have lower incomes and are generally more likely to have responsibility for raising children, compared to men. The Medicaid measures examined in this report include the Medicaid-to-Medicare fee index, income eligibility level for working parents, and the income eligibility level for pregnant women.

States also play a large role in establishing policies that affect access to reproductive health services. Family planning and abortion services encompass some of the medical services most commonly used by women. Resources states dedicate to family planning programs and policies that affect abortion access can directly affect the range of reproductive care that is available and accessible to women. In this report, we looked at three such measures—whether there is a mandatory waiting period for an abortion, whether there is Medicaid funding for an abortion, and the percentage of women who live in counties with no abortion provider.

The tables that follow present indicators that describe state policies that affect health care availability, financing, and infrastructure. The indicators included in this chapter are:

1. Physician Diversity Ratio
2. Primary Care Health Professional Shortage Area
3. Mental Health Professional Shortage Area
4. Medicaid-to-Medicare Fee Index
5. Medicaid Income Eligibility for Working Parents
6. Medicaid/SCHIP Income Eligibility for Pregnant Women
7. Family Planning Funding
8. Abortion Access Policies

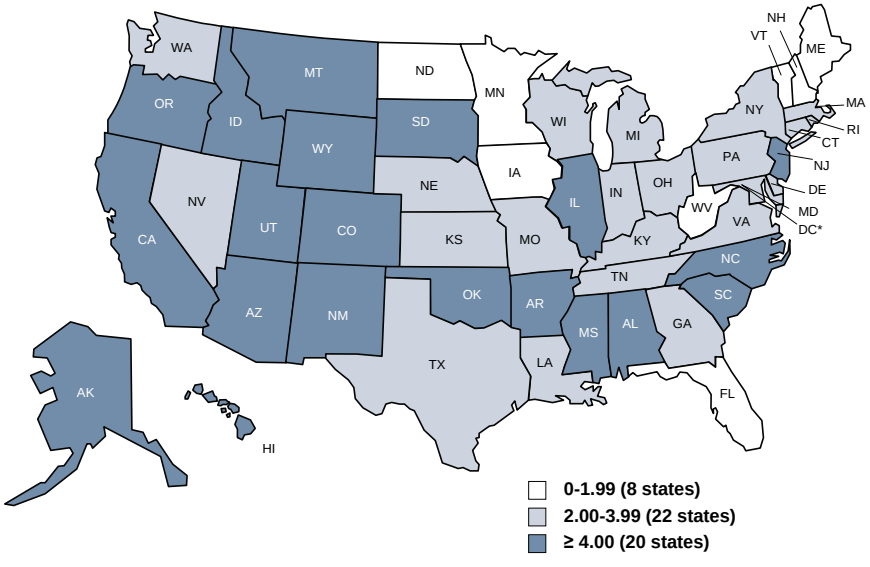
PHYSICIAN DIVERSITY RATIO

Having a health care workforce that reflects the racial and ethnic composition of the population it serves plays an important role in creating a delivery system that is culturally competent and more responsive to the health and social needs of the community.[75] Although the number of physicians of color has been growing in recent years, African Americans, Latinos, and American Indian and Alaska Natives are still underrepresented in the physician workforce. Analysts have also emphasized the importance of increasing the diversity of the broader health care workforce, including nurses, dentists, mental health providers, and other health professionals. As the nation's population becomes more diverse, developing the pipeline of a more diverse health workforce for the future could become even more important.

The physician diversity ratio was created to measure the degree to which a state's physician workforce is representative of the racial and ethnic composition of the state's population.[76] Using the 2000 U.S. Census and the AMA Physician Masterfile, this indicator represents the factor by which the physician workforce would need to be changed so that the ratio of minority physicians to the minority population would match the ratio of White physicians to the White population living in the state.

- There are significant state variations in the racial and ethnic composition of the physician workforce and how closely it matches the state's own demographics. The physician diversity ratio ranged from 0.91 in West Virginia, where the physician workforce was more diverse than the population, to 11.53 in Illinois, where the proportion of physicians who were White far exceeded the proportion of residents. In order to have a physician workforce that matches its population, Illinois would need to increase its current number of underrepresented minority physicians 11 times.
- States with very large White populations (West Virginia, Maine, and New Hampshire) had a diversity ratio near 1.00, meaning their physician composition closely reflected their demographic distribution.
- States with the largest population of minorities tended to have physician workforces that were the least reflective of their demographic composition. Mostly clustered in the West (Alaska, Hawaii, California, and Oregon) and South (Alabama, Mississippi, Arkansas, Oklahoma, South Carolina, and North Carolina), twenty states would need to increase the number of underrepresented minority physicians four-fold or more in order to reach population parity with White physicians.

FIGURE 4.1. Physician Diversity Ratio, by State



Note: The physician diversity ratio is the factor by which underrepresented minority physicians must increase to reach population parity with white physicians. *The physician diversity ratio for District of Columbia was not included.
Source: Trivedi AN et al. Creating a state minority health policy report card. *Health Affairs,* 24(2). 2005.

TABLE 4.1. Physician Diversity Ratio, by State

State	Physician Diversity Ratio
Alabama	4.27
Alaska	6.93
Arizona	5.70
Arkansas	4.29
California	5.60
Colorado	6.49
Connecticut	3.47
Delaware	2.47
Florida	1.34
Georgia	2.96
Hawaii	6.51
Idaho	6.38
Illinois	11.53
Indiana	2.25
Iowa	1.61
Kansas	2.34
Kentucky	2.30
Louisiana	3.69
Maine	0.94
Maryland	2.64
Massachusetts	2.34
Michigan	2.04
Minnesota	1.91
Mississippi	6.71
Missouri	2.36
Montana	4.00
Nebraska	2.80
Nevada	3.93
New Hampshire	1.09
New Jersey	5.63
New Mexico	4.66
New York	3.28
North Carolina	4.56
North Dakota	1.44
Ohio	2.01
Oklahoma	4.49
Oregon	4.69
Pennsylvania	2.54
Rhode Island	2.70
South Carolina	6.87
South Dakota	6.43
Tennessee	2.73
Texas	3.15
Utah	6.47
Vermont	1.35
Virginia	3.21
Washington	3.94
West Virginia	0.91
Wisconsin	3.09
Wyoming	6.14

Note: The physician diversity ratio for the District of Columbia was not calculated.
Source: Trivedi AN et al. Creating a state minority health policy report card. *Health Affairs*, 24(2).

— — — Best state in column

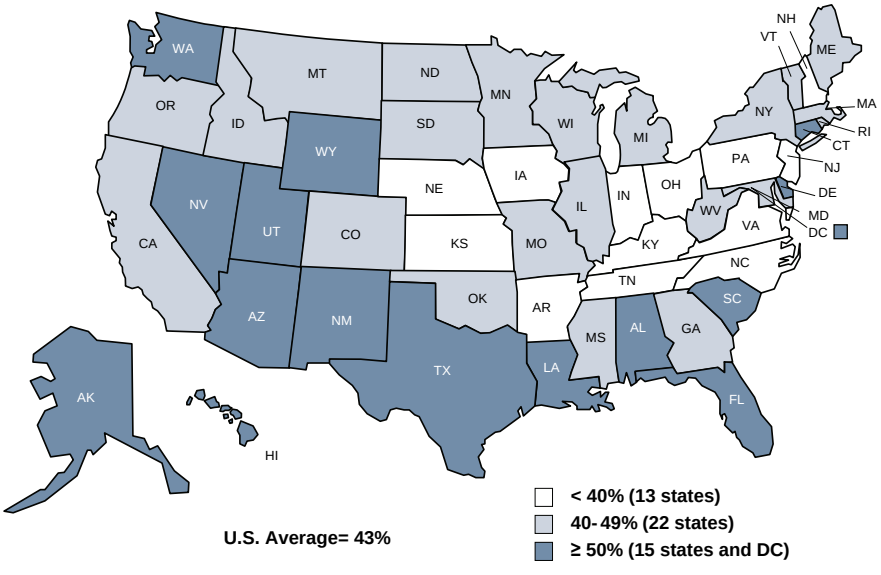
——— Worst state in column

PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREA

Primary care is an essential component of the health care delivery system, particularly in medically underserved communities. Primary care providers can address a wide range of health care needs and guide patients through the health care system, which is particularly critical for women due to more frequent interactions with the health care system, roles in their family's health as mothers and caregivers, and unique reproductive health needs. Access to primary care services, especially for the poor, has resulted in improved preventive care such as higher rates of screenings and immunizations.[77] With poorer access to primary care health providers, patients may resort to emergency departments, which can be more costly. Evidence suggests that a shortage of primary care workforce and services contributes to poorer health outcomes, wider health disparities and an increase in health care costs.[78] Using the Health Resources and Services Administration's (HRSA) 2004 Area Resource File, this indicator measures the proportion of women living in a primary care health professional shortage area, based on the criteria developed by HRSA's Bureau of Primary Health Care.

- Almost half of women (43%) nationwide lived in an area where there is a shortage of primary care providers. The percentages ranged from a low of 22% of women in Virginia to 61% in New Mexico.
- In 15 states and the District of Columbia, the percentage of women who lived in areas with a shortage of primary care providers was 50% or greater.
- Western and Southern states tended to have larger primary care workforce shortages. These states had a disproportionate number of isolated and low-income rural communities, where health care providers are in short supply.

FIGURE 4.2. Percent of Women Living in a Primary Care Health Professional Shortage Area, by State



Source: Area Resource File, 2004.

TABLE 4.2. Primary Care Health Professional Shortage Area, by State

State	Percent of Women Living in a Primary Care Health Professional Shortage Area
All States	**43%**
Alabama	55%
Alaska	50%
Arizona	51%
Arkansas	34%
California	49%
Colorado	42%
Connecticut	50%
Delaware	50%
District of Columbia	50%
Florida	51%
Georgia	41%
Hawaii	50%
Idaho	40%
Illinois	48%
Indiana	34%
Iowa	34%
Kansas	36%
Kentucky	36%
Louisiana	51%
Maine	47%
Maryland	40%
Massachusetts	45%
Michigan	43%
Minnesota	41%
Mississippi	46%
Missouri	49%
Montana	47%
Nebraska	31%
Nevada	52%
New Hampshire	28%
New Jersey	29%
New Mexico	61%
New York	40%
North Carolina	28%
North Dakota	40%
Ohio	38%
Oklahoma	47%
Oregon	43%
Pennsylvania	37%
Rhode Island	40%
South Carolina	51%
South Dakota	47%
Tennessee	38%
Texas	50%
Utah	52%
Vermont	41%
Virginia	22%
Washington	51%
West Virginia	44%
Wisconsin	45%
Wyoming	54%

Source: Area Resource File, 2004.

— — — Best state in column

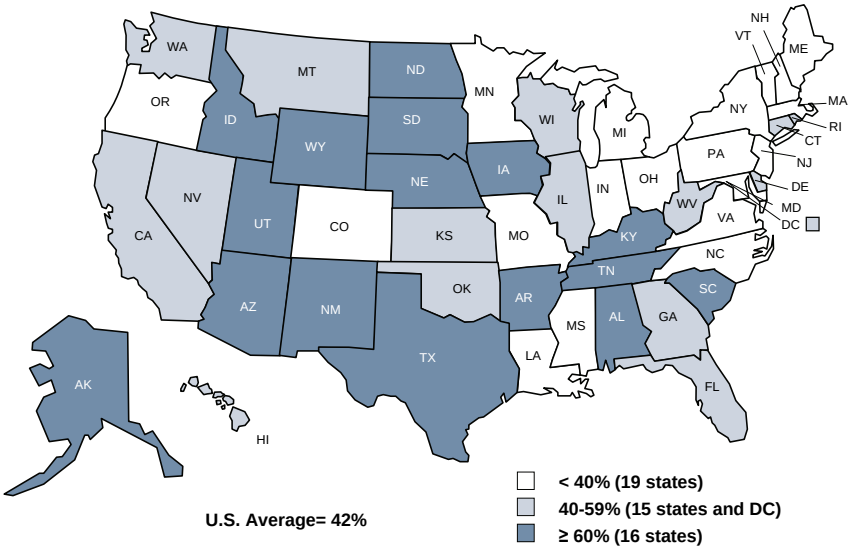
——— Worst state in column

MENTAL HEALTH PROFESSIONAL SHORTAGE AREA

Mental health is essential to overall health and well-being. Women have higher rates of depression, anxiety, and eating disorders than men. Geographic variations in the availability of mental health services contribute to disparities in access to mental health services. Limitations in private and public sources of insurance to cover mental health services also contribute to these disparities. Access to mental health providers and services is particularly critical in low-income areas where people with mental health needs have fewer financial resources to seek care outside their communities. Using the Health Resources and Services Administration's (HRSA) 2004 Area Resource File, this indicator measures the proportion of women living in a mental health professional shortage area, based on criteria developed by HRSA's Bureau of Primary Health Care.

- More than four in ten women (42%) nationwide lived in an area with a shortage of mental health providers. The percentages ranged from a low of 4% of women in Mississippi to all of the women in Idaho and Wyoming.
- As with primary care professional shortages, Western and Southern regions tended to have a greater shortage of mental health workforce likely due to the higher concentration of rural communities.
- Women in the Northeastern states lived in areas with higher numbers of mental health care providers, but even in some of these states, one-third of women lived in mental health professional shortage areas.

FIGURE 4.3. Percent of Women Living in a Mental Health Professional Shortage Area, by State



Source: Area Resource File, 2004.

TABLE 4.3. Mental Health Professional Shortage Area, by State

State	Percent of Women Living in a Mental Health Professional Shortage Area
All States	**42%**
Alabama	78%
Alaska	68%
Arizona	60%
Arkansas	68%
California	50%
Colorado	37%
Connecticut	45%
Delaware	40%
District of Columbia	50%
Florida	47%
Georgia	46%
Hawaii	50%
Idaho	100%
Illinois	45%
Indiana	22%
Iowa	62%
Kansas	43%
Kentucky	61%
Louisiana	18%
Maine	35%
Maryland	10%
Massachusetts	35%
Michigan	32%
Minnesota	39%
Mississippi	4%
Missouri	37%
Montana	58%
Nebraska	74%
Nevada	44%
New Hampshire	12%
New Jersey	17%
New Mexico	73%
New York	36%
North Carolina	16%
North Dakota	62%
Ohio	18%
Oklahoma	59%
Oregon	36%
Pennsylvania	28%
Rhode Island	43%
South Carolina	61%
South Dakota	69%
Tennessee	60%
Texas	60%
Utah	65%
Vermont	31%
Virginia	22%
Washington	50%
West Virginia	40%
Wisconsin	53%
Wyoming	100%

Source: Area Resource File, 2004.

— — — Best state in column

——— Worst state in column

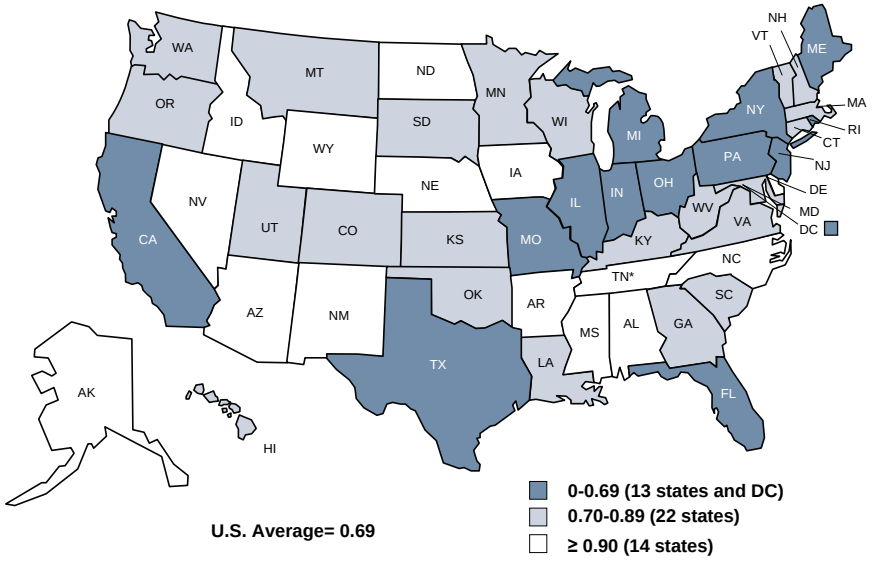
MEDICAID-TO-MEDICARE FEE INDEX

Health care providers' willingness to accept public coverage like Medicaid is affected by the level of payment that they receive from the program. Medicaid historically has had low rates of provider participation, due in large part to lower reimbursement levels relative to Medicare and private insurers. These low rates have prompted many providers to restrict the number of Medicaid patients they see or to drop Medicaid patients altogether, and has made access to care, particularly specialty care, a problem for Medicaid beneficiaries whose health and social needs are often quite complex.

The Medicaid-to-Medicare fee index measures each state's Medicaid fee-for-service physician fees relative to Medicare fees in the state. The Medicaid-to-Medicare fee index is a weighted sum of the ratios of each state's Medicaid fee for a given service to the Medicare fee, using expenditure weights from the year 2000.[79] This index provides a measure of states' reimbursement levels in the fee-for-service marketplace, and thus can serve as a marker for providers' willingness to participate in Medicaid.

- In general, Medicaid physician fees for all services lagged behind Medicare fees by nearly a third; nationally overall, Medicaid fees averaged 69% of Medicare fees. Medicaid fees for primary care averaged slightly lower than for overall services, at 62% of the Medicare rate. Conversely, Medicaid fees for obstetric services were higher than Medicaid fees for other services, but still lower than Medicare, averaging 84% of Medicare fees.
- Since states set their own Medicaid physician fee levels, there is considerable variation across states. Average Medicaid physician fees for services overall ranged from a low of 35% of Medicare fees in New Jersey to a high of 137% in Alaska. For primary care, the range was 34% of Medicare fees in New Jersey and Rhode Island to 138% in Alaska. For obstetric care, fees ranged from 31% in New Jersey to 160% in South Carolina.
- The Northeastern region had lower Medicaid physician fees relative to Medicare physician fees than other regions of the country.
- In most states, physician fees were lower in Medicaid compared to Medicare for all services as well as primary and obstetric care. Medicaid physician fees relative to Medicare were lower in all but four states for overall services and lower in every state but three for primary care. By comparison, Medicaid fees for obstetric services were at least as high as Medicare fees in many more states. Yet, in the majority of states, Medicaid fees for obstetric services remained below those of Medicare.

FIGURE 4.4. Medicaid-to-Medicare Fee Index, by State



Note: This map is the overall Medicaid-to-Medicare fee index, which includes primary care, obstetric care, and other services.
*Tennessee does not have a fee-for-service (FFS) component in their Medicaid programs.
Source: Zuckerman S, McFeeters J, Cunningham P et al. Exhibit 2, Medicaid fee indexes and Medicaid-to-Medicare Fee Indexes, 2003. *Health Affairs*. 2004.

TABLE 4.4. Medicaid-to-Medicare Fee Index, by State

State	Overall	Primary Care	Obstetric Care
United States	**0.69**	**0.62**	**0.84**
Alabama	0.90	0.82	1.19
Alaska	1.37	1.38	1.38
Arizona	1.06	1.01	1.17
Arkansas	0.95	0.96	0.78
California	0.59	0.51	0.65
Colorado	0.74	0.68	0.86
Connecticut	0.83	0.74	1.16
Delaware	1.01	1.00	1.02
District of Columbia	0.52	0.35	0.94
Florida	0.65	0.60	0.82
Georgia	0.81	0.68	1.00
Hawaii	0.74	0.71	0.79
Idaho	0.92	0.89	0.99
Illinois	0.63	0.54	0.84
Indiana	0.68	0.60	0.77
Iowa	0.97	0.94	1.01
Kansas	0.75	0.63	0.92
Kentucky	0.76	0.63	1.11
Louisiana	0.73	0.70	0.89
Maine	0.65	0.54	0.84
Maryland	0.80	0.76	1.03
Massachusetts	0.80	0.72	0.98
Michigan	0.62	0.63	0.60
Minnesota	0.79	0.64	0.82
Mississippi	0.91	0.90	0.85
Missouri	0.56	0.50	0.71
Montana	0.86	0.75	0.97
Nebraska	0.95	0.78	0.94
Nevada	0.98	0.71	1.30
New Hampshire	0.72	0.67	0.96
New Jersey	0.35	0.34	0.31
New Mexico	0.95	0.93	0.95
New York	0.45	0.40	0.65
North Carolina	0.97	0.96	1.01
North Dakota	0.91	0.90	0.94
Ohio	0.68	0.66	0.79
Oklahoma	0.72	0.67	0.81
Oregon	0.86	0.75	1.17
Pennsylvania	0.52	0.43	0.90
Rhode Island	0.42	0.34	0.50
South Carolina	0.89	0.75	1.60
South Dakota	0.83	0.68	0.88
Tennessee*	N/A	N/A	N/A
Texas	0.69	0.62	0.82
Utah	0.73	0.66	0.86
Vermont	0.83	0.64	1.14
Virginia	0.77	0.73	0.84
Washington	0.87	0.79	1.22
West Virginia	0.88	0.82	1.19
Wisconsin	0.87	0.73	1.01
Wyoming	1.03	0.96	1.07

Note: The 'Overall' Medicaid-to-Medicare fee index includes primary care, obstetric care, and other services. *Tennessee does not have a fee-for-service (FFS) component in their Medicaid programs.

Source: S. Zuckerman, J. McFeeters, P. Cunningham, and L. Nichols, "Changes In Medicaid Physician Fees, 1998–2003: Implications For Physician Participation," Health Affairs, June 2004, W4-374-W4-384.

— — — Best state in column
———— Worst state in column

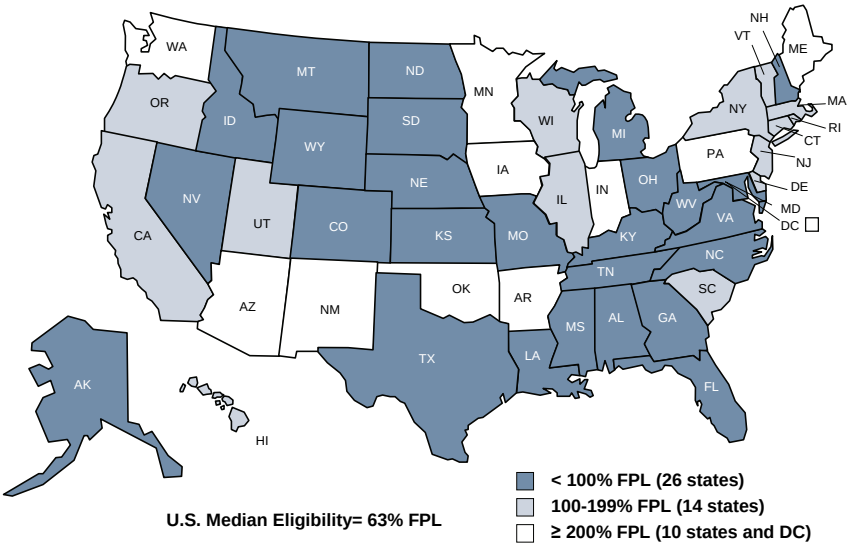
MEDICAID INCOME ELIGIBILITY FOR WORKING PARENTS

Under federal guidelines, states determine Medicaid income eligibility levels for the various populations the program serves according to minimum thresholds established by the federal government. For working parents, the threshold is very low—states need to cover only working parents with incomes below the welfare levels that were in effect in July 1996 (when the formal welfare link with Medicaid was severed and the program was fundamentally changed by federal law).

States can expand their income eligibility thresholds beyond these low levels to extend coverage to more low-income people, and many do. There are several strategies states can employ to do this; for example, they can simply raise the qualifying income thresholds or they can disregard a portion of employed parents' earnings when determining eligibility. While several states have expanded health coverage for parents through a variety of measures, Medicaid coverage for parents in most states is still quite restrictive compared to coverage for children.[80]

- There were large state variations in Medicaid income eligibility levels for working parents, ranging from 20% of the federal poverty level (FPL) in Louisiana (less than $4,000/yr for a family of three in 2008) to 409% FPL in New Mexico.
- About half of the states and the District of Columbia (24 states and DC) covered working parents with incomes at or above the poverty line ($17,600 for a family of three). Many states in the South and Central Plains regions still had eligibility thresholds that were below the federal poverty guidelines.

FIGURE 4.5. Medicaid Income Eligibility for Working Parents as a Percent of Federal Poverty Level, by State



Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

TABLE 4.5. Medicaid Income Eligibility for Working Parents, by State

State	Medicaid Income Eligibility for Working Parents as a Percent of Federal Poverty Level
United States	**63%**
Alabama	26%
Alaska	81%
Arizona	200%
Arkansas	200%
California	106%
Colorado	66%
Connecticut	191%
Delaware	106%
District of Columbia	207%
Florida	56%
Georgia	53%
Hawaii	100%
Idaho	42%
Illinois	191%
Indiana	200%
Iowa	250%
Kansas	34%
Kentucky	64%
Louisiana	20%
Maine	206%
Maryland	37%
Massachusetts	133%
Michigan	61%
Minnesota	275%
Mississippi	32%
Missouri	39%
Montana	60%
Nebraska	59%
Nevada	94%
New Hampshire	55%
New Jersey	133%
New Mexico	409%
New York	150%
North Carolina	52%
North Dakota	63%
Ohio	90%
Oklahoma	200%
Oregon	100%
Pennsylvania	200%
Rhode Island	191%
South Carolina	100%
South Dakota	56%
Tennessee	80%
Texas	28%
Utah	150%
Vermont	191%
Virginia	31%
Washington	200%
West Virginia	35%
Wisconsin	191%
Wyoming	55%

Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

— — — Best state in column
——— Worst state in column

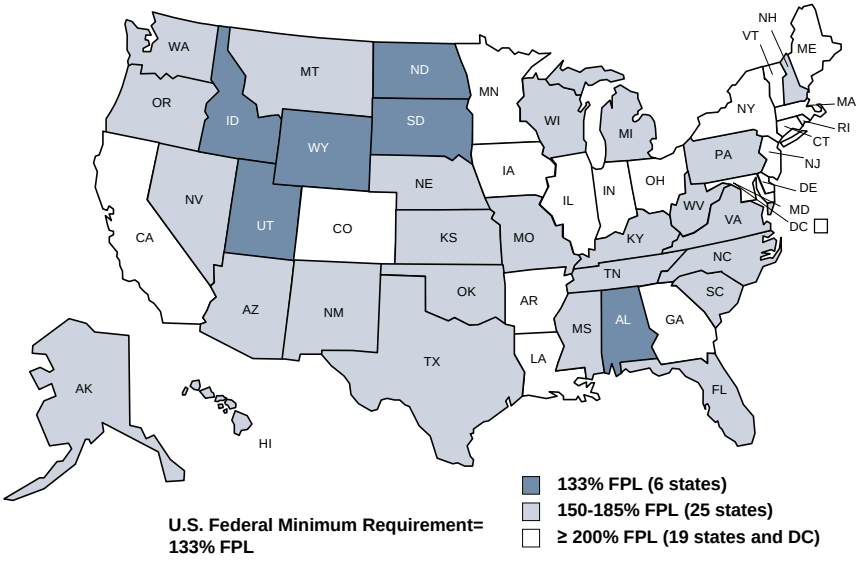
MEDICAID/SCHIP INCOME ELIGIBILITY FOR PREGNANT WOMEN

Medicaid is a major source of financing for maternity care in the U.S., paying for approximately four out of ten births nationally.[81] Medicaid coverage promotes access to prenatal care for beneficiaries, who tend to be younger, poorer, and in worse health than the general population, reducing their risk for problems such as low birthweight babies and other health complications. Under federal law, states must provide Medicaid for pregnancy-related care to pregnant women with incomes at or below 133% of the FPL. States have the option of going beyond the federal law and expanding eligibility to pregnant women with incomes up to 185% of the FPL and beyond. States may expand Medicaid coverage for pregnant women above the 185% threshold by disregarding a set amount of each applicant's income, such as the first $50.

Infants who are born to women on Medicaid are guaranteed coverage for the full year. In contrast, the mother is covered through 60 days postpartum or through the last day of the month in which the 60 days expire unless she qualifies through another pathway such as a parent. If she doesn't qualify for Medicaid, she often becomes uninsured.

- The variation was smaller for Medicaid income eligibility for pregnant women than for working parents. It ranged from 133% FPL (the Federal minimum requirement) in six states (Alabama, Idaho, North Dakota, South Dakota, Utah, and Wyoming) to 300% of the FPL in the District of Columbia.
- Most states expanded eligibility to at least 185% FPL; only four states (Connecticut, Maryland, Minnesota, and Rhode Island) and the District of Columbia exceeded 200% FPL.

FIGURE 4.6. Medicaid/SCHIP Income Eligibility for Pregnant Women as a Percent of Federal Poverty Level, by State



Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

TABLE 4.6. Medicaid/SCHIP Income Eligibility for Pregnant Women, by State

State	Medicaid/SCHIP Income Eligibility for Pregnant Women as a Percent of Federal Poverty Level
United States	**133%**
Alabama	133%
Alaska	175%
Arizona	150%
Arkansas	200%
California	200%
Colorado	200%
Connecticut	250%
Delaware	200%
District of Columbia	300%
Florida	185%
Georgia	200%
Hawaii	185%
Idaho	133%
Illinois	200%
Indiana	200%
Iowa	200%
Kansas	150%
Kentucky	185%
Louisiana	200%
Maine	200%
Maryland	250%
Massachusetts	200%
Michigan	185%
Minnesota	275%
Mississippi	185%
Missouri	185%
Montana	150%
Nebraska	185%
Nevada	185%
New Hampshire	185%
New Jersey	200%
New Mexico	185%
New York	200%
North Carolina	185%
North Dakota	133%
Ohio	200%
Oklahoma	185%
Oregon	185%
Pennsylvania	185%
Rhode Island	250%
South Carolina	185%
South Dakota	133%
Tennessee	185%
Texas	185%
Utah	133%
Vermont	200%
Virginia	185%
Washington	185%
West Virginia	150%
Wisconsin	185%
Wyoming	133%

Note: Data as of January 2008. The Federal Poverty Level (FPL) for a family of three in 2008 was $17,600 per year.
Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

— — — Best state in column

——— Worst state in column

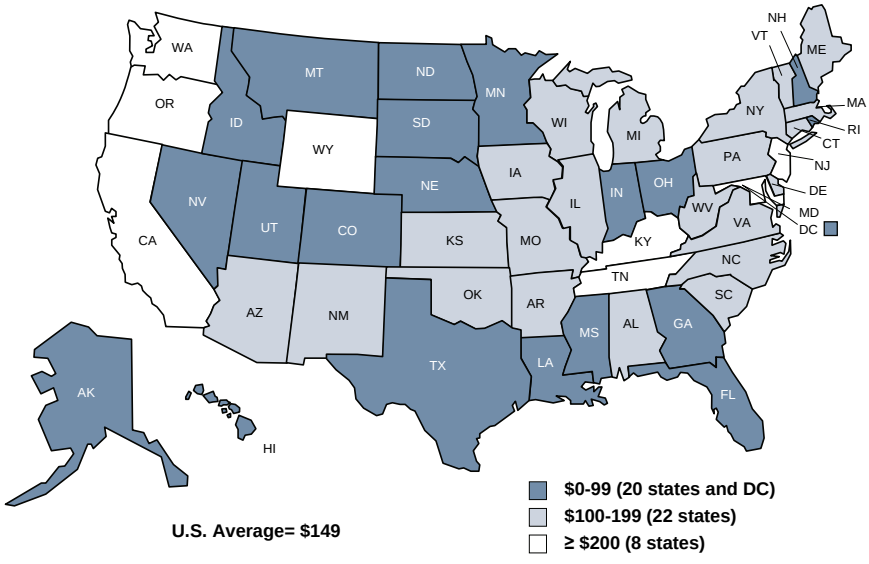
FAMILY PLANNING FUNDING

Access to contraceptive services is an important element to health care for women of reproductive age. Programs like Title X, the federally funded family planning program, and Medicaid provide low-income women with the financial means to obtain not only contraceptive services, but also screening for cervical cancer and sexually transmitted infections. For many women, a family planning provider is their only source of care.

This indicator measures the amount of per capita funding available in a state for family planning services for low-income women who are considered in need of contraceptive services. Expenditures allocated by the state include state-only funds and all non-Medicaid federal funds including the Maternal and Child Health (MCH) and Social Services block grants, and Temporary Assistance for Needy Families (TANF) for contraceptive services, outreach and education. These appropriations are classified as state allocations because the state has discretion over whether such funding is spent on family planning services or for other health care services. Women needing publicly-supported contraceptive services and supplies are defined as those in need of such services who either are aged 20–44 and have a family income that is below 250% FPL ($50,000 for a family of four in 2006) or are younger than 20. The indicator is adjusted for the health care cost of living in each state.

- State funding for women who were in need of publicly supported family planning services varied substantially, ranging from a low of $28 per woman in Hawaii to a high of $368 per woman in Oregon.
- The U.S. average was $149 per woman. Twenty states and the District of Columbia contributed less than $100 to family planning funding per woman in need, while eight states (California, Kentucky, Maryland, New Jersey, Oregon, Tennessee, Washington, and Wyoming) contributed more than $200.

FIGURE 4.7. Family Planning Funding for Women with Incomes Below 250% of Federal Poverty Level, by State



Sources: Calculations based on Sonfield A, Arlich C & Gold R. *Public funding for family planning, sterilization and abortion services, FY 1980-2006.* 2008.; Guttmacher Institute. *Women in need of contraceptive services and supplies, 2006.* 2008.

TABLE 4.7. Family Planning Funding for Women with Incomes Below 250% FPL, by State

State	Family Planning Funding Per Woman in Need
All States	**$149**
Alabama*	$166
Alaska	$71
Arizona*	$124
Arkansas*	$154
California*	$218
Colorado	$46
Connecticut	$164
Delaware*	$181
District of Columbia	$53
Florida*	$92
Georgia	$47
Hawaii	$28
Idaho	$99
Illinois*	$107
Indiana	$40
Iowa*	$123
Kansas	$138
Kentucky	$359
Louisiana*	$95
Maine	$134
Maryland*	$252
Massachusetts	$143
Michigan*	$102
Minnesota*	$64
Mississippi*	$95
Missouri*	$121
Montana	$72
Nebraska	$73
Nevada	$55
New Hampshire	$65
New Jersey	$223
New Mexico*	$111
New York*	$175
North Carolina*	$159
North Dakota	$80
Ohio	$72
Oklahoma*	$187
Oregon*	$368
Pennsylvania*	$170
Rhode Island*	$84
South Carolina*	$176
South Dakota	$61
Tennessee	$224
Texas*	$81
Utah	$34
Vermont	$130
Virginia*	$197
Washington*	$326
West Virginia	$125
Wisconsin*	$199
Wyoming	$322

Note: * States with Medicaid family planning waiver programs. Data as of 2006. The Federal Poverty Level (FPL) for a family of three in 2006 was $16,600 per year.
Source: Calculations based on Sonfield A, Arlich C & Gold R. *Public funding for family planning, sterilization and abortion services, FY 1980-2006* . 2008.; Guttmacher Institute. *Women in need of contraceptive services and supplies, 2006* . 2008.

— — — Best state in column

——— Worst state in column

ABORTION ACCESS

Abortion rates have been declining among all racial and ethnic groups; however, approximately one-fifth of pregnancies in the U.S. end in abortion each year. In recent years, state and federal policies have increasingly restricted access to abortion services for women. Certain policies have a disproportionate effect on low-income women and women of color. While there are many policies that states can enact to restrict abortion access, this report looks at three that are likely to have a greater impact on women of color.

At the federal level, the Hyde Amendment explicitly bans the use of federal funds to pay for abortions unless the pregnancy is a result of rape or incest or if the pregnancy is considered to be a threat to the life of the mother. In the case of Medicaid beneficiaries, states can use their own funding to cover other "medically necessary" abortions, usually to protect the physical or mental health of the women.

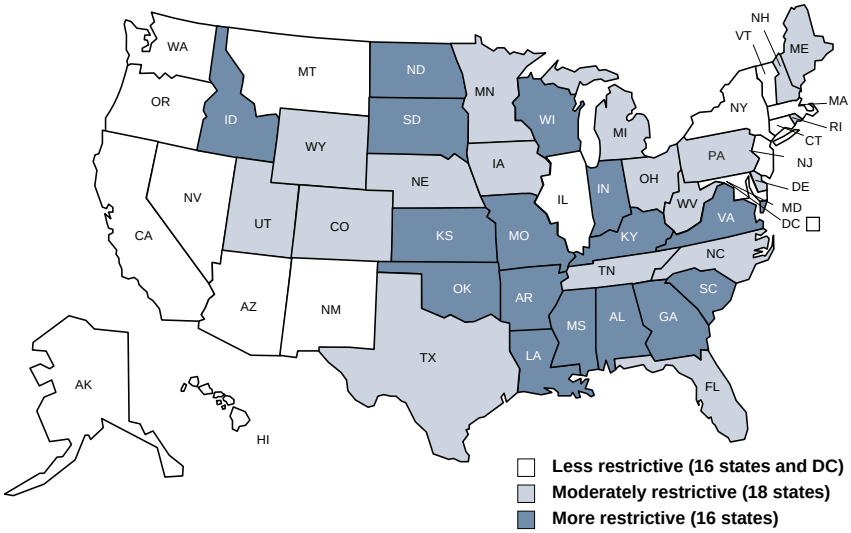
The lack of an abortion provider within easy traveling distance is a critical barrier for many women. These women must often travel long distances to obtain this medical service, which can place an undue burden on low-income women.

Another barrier that has a disproportionate effect on low-income women is a mandatory waiting period that requires women to wait some period of time between state-mandated counseling and the abortion procedure. These waiting period results in multiple trips for women, who then have to take extra time off from work, arrange for child care, and pay higher transportation costs.

To construct this composite index, each of the three component indicators (mandatory waiting period, no use of state-only funds to cover "medically necessary" abortions, and percentage of women who live in counties without an abortion provider) was rated on a scale of 0 to 1 and assigned a weight of 1/3.

- State policies affecting access to abortion were less restrictive in the Pacific Western and Northeastern regions. In Hawaii, the least restrictive state, the state provided Medicaid funding to low-income women for "medically necessary" abortions, there was no waiting period, and all women lived in counties with an abortion provider. California, New York, Connecticut and New Jersey also had less restrictive policies regarding access to abortion.
- Southern states tended to have more restrictive policies affecting access to abortion. Mississippi was the most restrictive in that it did not use state-only funds for "medically necessary" abortions for Medicaid recipients, it had a waiting period, and 91% of women lived in counties without an abortion provider. South Dakota, Arkansas, North Dakota, and Kentucky also had more restrictive policies regarding access to abortion.
- Seventeen states used their own funds to cover all or most "medically necessary" abortions for Medicaid beneficiaries. Thirty-two states and the District of Columbia followed federal Medicaid abortion funding restrictions, which limit publicly funded abortion to cases of rape, incest or life endangerment. South Dakota covered abortions only in cases of life endangerment, which does not comply with the minimum federal requirements under the Hyde Amendment.
- Nationally, 35% of women lived in counties without an abortion provider. The percentage of women who lived in counties without an abortion provider ranged from 0% in Hawaii to 96% in Wyoming.
- Twenty-eight states required women to wait a specified amount of time (usually 24 hours) between counseling and the abortion procedure. This mandatory waiting period policy was not in effect however in four of these states (Delaware, Massachusetts, Montana, and Tennessee) pending legal review.

FIGURE 4.8. Abortion Access, by State



Note: Composite measure of state policies on mandatory waiting periods, Medicaid funding and the availability of abortion providers. States are categorized based on total scores in Table 4.8 as follows: 0.00-0.38 = less restrictive; 0.39-0.85= moderately restrictive; 0.86-0.97 = more restrictive.
Sources: Guttmacher Institute. *Overview of State Abortion Law.* 2008; Jones R et al. Abortion in the United States: Incidence and Access to Services, 2005. *Perspectives on Sexual and Reproductive Health*, 40(1). 2008.

TABLE 4.8. Abortion Access, by State

State	Mandatory Waiting Period for Abortion: 1=Yes, 0=No (Weight:1/3)	Medicaid Funding of Abortion: 1=No, 0=Yes (Weight:1/3)	% of Women in Counties with No Abortion Provider (Weight:1/3)	Total Score* (0=Least Restrictive, 1=Most Restrictive)
Alabama	Yes	No	61%	0.87
Alaska	No	Yes	15%	0.05
Arizona	No	Yes	16%	0.05
Arkansas	Yes	No	79%	0.93
California	No	Yes	4%	0.01
Colorado	No	No	23%	0.41
Connecticut	No	Yes	10%	0.03
Delaware	No	No	18%	0.39
District of Columbia	No	No	0%	0.33
Florida	No	No	20%	0.40
Georgia	Yes	No	62%	0.87
Hawaii	No	Yes	0%	0.00
Idaho	Yes	No	68%	0.89
Illinois	No	Yes	34%	0.11
Indiana	Yes	No	63%	0.88
Iowa	No	No	56%	0.52
Kansas	Yes	No	57%	0.86
Kentucky	Yes	No	77%	0.92
Louisiana	Yes	No	62%	0.87
Maine	No	No	46%	0.49
Maryland	No	Yes	19%	0.06
Massachusetts	No	Yes	7%	0.02
Michigan	Yes	No	33%	0.78
Minnesota	Yes	Yes	62%	0.54
Mississippi	Yes	No	91%	0.97
Missouri	Yes	No	68%	0.89
Montana	No	Yes	49%	0.16
Nebraska	Yes	No	45%	0.82
Nevada	No	No	12%	0.37
New Hampshire	No	No	19%	0.40
New Jersey	No	Yes	10%	0.03
New Mexico	No	Yes	47%	0.16
New York	No	Yes	7%	0.02
North Carolina	No	No	48%	0.49
North Dakota	Yes	No	75%	0.92
Ohio	Yes	No	51%	0.84
Oklahoma	Yes	No	57%	0.86
Oregon	No	Yes	26%	0.09
Pennsylvania	Yes	No	40%	0.80
Rhode Island	No	No	39%	0.46
South Carolina	Yes	No	72%	0.91
South Dakota	Yes	No	78%	0.93
Tennessee	No	No	59%	0.53
Texas	Yes	No	35%	0.78
Utah	Yes	No	55%	0.85
Vermont	No	Yes	24%	0.08
Virginia	Yes	No	57%	0.86
Washington	No	Yes	14%	0.05
West Virginia	Yes	Yes	84%	0.61
Wisconsin	Yes	No	63%	0.88
Wyoming	No	No	96%	0.65

Note: *Composite measure of state policies on mandatory waiting periods, Medicaid funding and the availability of abortion providers.
Source: Guttmacher Institute. *Overview of State Abortion Law*. 2008; Jones R et al. Abortion in the United States: Incidence and Access to Services. *Perspectives on Sexual and Reproductive Health* , 40(1). 2008.

— — — Best state in column

——— Worst state in column

CONCLUSION

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

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

STATE-LEVEL HIGHLIGHTS

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

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

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

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

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

POPULATION HIGHLIGHTS

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

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

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

INDICATOR AND POLICY HIGHLIGHTS

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

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

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

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

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

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

■ ■ ■ ■ ■

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

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

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

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

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