

# American Women and Health Disparities

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In the last century, American women have been given 30 bonus years of life, thanks to such sweeping public health initiatives as sanitation and immunization programs. The America of the next century, however, presents us with new, more complex, and exceedingly interesting public health challenges.

Nearly 40 million of America's 140 million women are now members of racial and ethnic minority groups.<sup>1</sup> These women represent many diverse populations, but encompass 4 major groups: African Americans represent 13% of the total population of US women; Hispanic women, 11%; Asian-American/Pacific Islander women, 4%; and American Indian/Alaska Native women, just under 1%. The remaining 71% of American women are white.<sup>2</sup>

Although these women experience many of the same health problems as white women, as a group, they are in poorer health, use fewer health services, and continue to suffer disproportionately from premature death, disease, and disabilities. Many also face tremendous social, economic, cultural, and other barriers to optimal health.

It is a growing national challenge. The US Census Bureau estimates that by the year 2050, barely 53% of America's women will be classified as non-Hispanic white, and 25% will be Hispanic, 14% non-Hispanic black, 9% Asian and Pacific Islander, and just under 1% American Indian and Alaska Native.<sup>3</sup> Reclassification standards under the new 2000 census have blurred these categories somewhat, but it remains clear that if we are to leave our children and grandchildren a healthier nation, we must address health disparities immediately. The challenge grows more difficult when we consider the aging population. By the year 2050, nearly 1 in 4 adult women

will be 65 years old or older, and an astonishing 1 in 17 will be 85 years old or older.<sup>4</sup>

For public health leaders, the mission of eliminating disparities among a diverse, aging population is daunting. Each group of minority women is made up of subgroups, who have diverse languages, cultures, degrees of acculturation, and histories. African-American women have a common African heritage, but they may also have roots in the United States, Great Britain, the Caribbean, or other countries. Hispanic women, or Latinas, have the distinction of being a multi-racial ethnic group. Many Hispanic women in the United States are recent immigrants; most are of Mexican, Puerto Rican, Cuban, Central American, or South American descent. Asian-American/Pacific Islander women may be of Chinese, Japanese, Vietnamese, Cambodian, Korean, Filipino, Native Hawaiian, or other ancestry. Nearly 75% of this population group are foreign born, including an increasing number of immigrants and refugees from Southeast Asia.<sup>5</sup> American Indian/Alaska Native women are members of more than 500 federally or state-recognized tribes or unrecognized tribal organizations. Major subgroups of this population are American Indians, Eskimos, and Aleuts.<sup>5</sup>

These seemingly impersonal statistics have faces. A potpourri of cultures, traditions, beliefs, challenges, and family styles has always been America's greatest strength. Our challenge for the next century is to close the disparities gap, without compromising the uniqueness and richness of each culture.

We see disparities among these racial and ethnic groups and subgroups in almost every area of health. In breast cancer, for example, white women have a higher incidence rate (114 per 100 000) than African-American women (100), but black women have a higher mortality rate (31 v 25). This likely reflects lower rates of early detection as well as treat-

ment disparities, but there could also be undiscovered physiological factors. Hispanic women have an incidence rate of 69 and a death rate of 15, compared to 75 and 11 for Asian and Pacific Islander women, and 33 and 12 for American Indian women.<sup>6</sup>

For these statistics to be meaningful, we need to take a closer look at each subgroup. Native Hawaiian women, for example, have an unusually high death rate from breast cancer (25 per 100 000), although the overall rate for Asian-American women is lower than average.<sup>6</sup> American Indian women in New Mexico report the lowest incidence (32 per 100 000) and the lowest death rate (9), but much higher rates are reported in many other Indian Health Service areas. There is no clear explanation for this phenomenon.<sup>5 (p74)</sup>

When we look at cervical cancer, we see different trends. The incidence rate of invasive cervical cancer is higher among Asian-American than among white women (10.3 v 8.1 per 100 000). The incidence rate is nearly 5 times higher in Vietnamese women than in white women, yet we cannot explain the causes of this unusually high rate.<sup>6</sup>

If we look at death rates for diseases of the heart, African-American women are clearly at risk, with a staggering 147 deaths per 100 000, compared to 88 for white women, 70 for American Indian/Alaska Native women, and 63 each for Hispanic women and Asian-American/Pacific Islanders. This reflects rates of obesity and the lack of access to preventive health care services, including blood pressure screening and management.<sup>7</sup>

We cannot make assumptions about the health status of any particular racial group. Asian Americans are often viewed as a "model" minority because of their low unemployment and disease rates. Asian-American/Pacific Islander women age 65 and older, however, have the highest death rate from suicide (8 per 100 000) of all women in their age group,

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4 times higher than the rate among elderly black women and twice the rate of white women.<sup>5(p32)</sup>

Disparities are perhaps most striking when we look at the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) rates among women. Twenty percent of Americans currently living with HIV are women, and 77% of those are African American or Hispanic. Many people are shocked to learn that AIDS is the second leading cause of death among African-American women age 25 to 44, their peak childbearing years, which leaves untold numbers of children motherless<sup>8</sup> and affects entire communities.

Not surprisingly, we also see disparities in key risk factors for disease. *The Surgeon General's Report on Women and Smoking*, released March 2001, reported that Alaska Native women have the highest rate of smoking at a discouraging 35%, compared to 24% for white women, 22% for African-American women, 14% for Hispanic women, and 11% for Asian and Pacific Islander women.<sup>9</sup>

In obesity, another major risk factor, we see significant disparities that clearly affect rates of disease. Non-Hispanic black women have the highest rate of obesity, 38%, compared to 35% for Mexican-American women, and 22% for non-Hispanic whites.<sup>7(p247)</sup> We know that cultural and lifestyle factors play a role in these disparities.

We have begun to address these differences through Healthy People 2010, the nation's health agenda for the next decade. Healthy People 2010 has 2 overarching goals: to increase the quality and years of life and to eliminate health disparities. Healthy People 2010 has 220 objectives relevant to women's health, including cancer, heart disease, stroke, diabetes, and access to quality health services. Goals for most ethnic groups are equal, even though some are starting from different baselines. For example, we want to reduce the death rate from breast cancer to 22.3 per 100 000, regardless of baseline disparities.

At the heart of Healthy People 2010 is improved access to such clinical preventive services as mammography and Papanicolaou tests. We also need improved access to high-quality health

education and mental health and support services at the community level, so specific ethnic and cultural needs can be addressed. Health providers must use the clinical setting to better educate underserved women about risk factors they can modify, such as smoking and obesity, using culturally and linguistically appropriate approaches.

This cannot be done without change in the structure of the US health care system, including the increasing influence of market forces, changes in payment and delivery systems, and welfare reform. Reinventing health care delivery is nearly useless without evaluating how these systemic changes will affect the most vulnerable and at-risk populations. Federal, state, and local public health agencies must redouble their efforts to address language and other access barriers and reduce disparities for these underserved Americans.

Throughout the federal health agencies, strategies are being developed to address health disparities. One model to watch is the Breast and Cervical Cancer Early Detection Program sponsored by the Centers for Disease Control and Prevention. It has grown from 8 states in 1991 to 50 states, 6 US territories, the District of Columbia, and 12 American Indian/Alaska Native organizations in 2000. More than 2.7 million breast and cervical cancer screening tests have been provided to more than 1.7 million underserved women from inception through March 2000. Federal and state programs now are addressing how to provide appropriate treatment for the women who are screened.

We have also increased our educational efforts. In 1998 the Health and Human Services Office on Women's Health (OWH) launched the National Women's Health Information Center Website and toll-free telephone service ([www.4woman.gov](http://www.4woman.gov) or 1-800-994WOMAN, TDD: 1-888-220-5446). Women who cannot use the Internet can call information specialists, including Spanish-speaking experts, to get referrals to public and private organizations that can offer culturally appropriate information about specific health problems. The OWH has also launched an educational campaign that specifically targets women of each

racial and ethnic group. *Pick Your Path to Health* offers simple-to-understand, culturally appropriate, weekly action steps to improve health status.<sup>10</sup>

The OWH-sponsored National Centers of Excellence in Women's Health<sup>11</sup> and Community Centers of Excellence in Women's Health<sup>12</sup> have taken a leadership role in developing model minority outreach programs and services.

Another good model is the work being done at the National Cancer Institute (NCI). Last spring the NCI launched a special populations network to address the unequal burden of cancer; 18 grants at 17 institutions will create or implement cancer control programs in minority and underserved populations.<sup>13</sup> The NCI, as well as many other institutes at the National Institutes of Health, have created centers and offices designed specifically to reduce health disparities.<sup>14</sup>

Another innovative program is the Reducing Health Care Disparities National Project at the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration), which works at the state level to reduce health care disparities.<sup>15</sup> Descriptions and details of many other health disparities programs can be found on the websites of individual health agencies. I also recommend the *Women of Color Health Data Book*<sup>5</sup>; it is rich with information on the health, lives, and backgrounds of many ethnic groups of women.

Of course, when we discuss the elimination of health disparities, it must be emphasized that disparities take many forms: racial, ethnic, gender, geographic, income, educational, cultural, and others. Many of these disparities are interlinked. For example, some of the worst health outcomes are experienced by poor, undereducated, African-American women in the rural southern United States. Looking at data from specific racial and ethnic groups, however, is an important place to start as we develop strategies to encourage state and local health care experts to focus on our Healthy People 2010 objectives. Clearly, the one-size-fits-all approach to public health that was so effective for expanding the lifespan of women in the last century will not meet the challenges of the new century. ■

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