WOMEN'S HEALTH INEQUALITIES IN NEW MEXICO: CHALLENGES & POLICY OPTIONS

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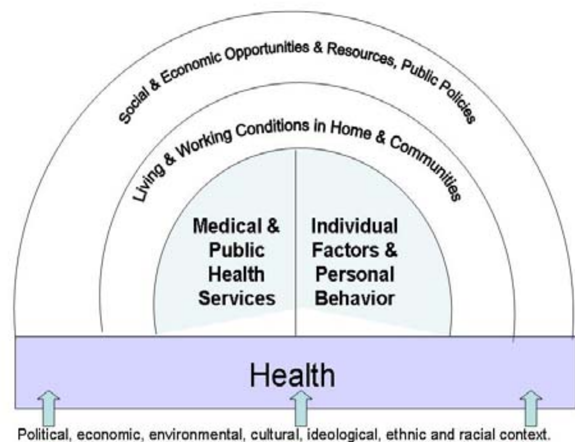
Health inequalities are a growing public health challenge which disproportionately impact women. While increased attention has been given to women's health issues at the federal and state levels over the last 30 years, and the overall health of the US population continues to improve, health inequalities among women who are low income, uninsured, and racial and ethnic minorities persist. This brief reviews the evidence underpinning the determinants of women's health in New Mexico and suggests broad areas of policy options to assure that all women are able to achieve equitable access to health care and a healthy life, regardless of race/ethnicity, gender and socio-economic status[1].

A FRAMEWORK FOR UNDERSTANDING HEALTH

Research demonstrates (Figure 1) that there are multiple dimensions which explain inequalities in health[2], [3], [4], [5]. Factors such as income and education and personal behaviors and access to medical and public health services impact the health of all girls and women. Non-medical factors such as housing, working conditions and support from family and friends also impact poor or good health. Social and economic opportunities and public policies provide access to resources across the lifespan and ultimately affect poor or good health. At any given time, these factors interact to moderate health and well-being within New Mexico's political, economic, environmental, cultural, ideological, ethnic and racial context. In short, a woman's health is shaped by factors within and outside the health care system.

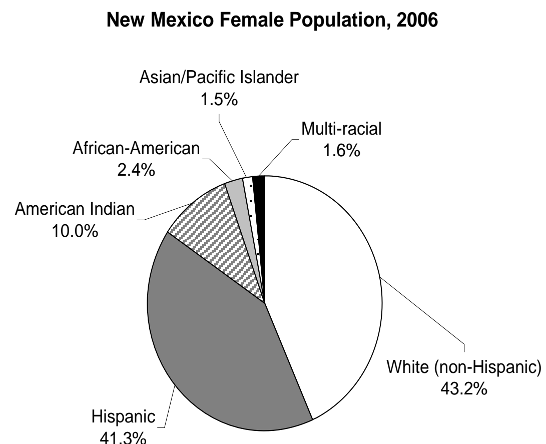
Figure 1:
Framework for Understanding the Causes of Health



Source: Adapted from D. Williams, US Commission on Socio-Determinants of Health. WK Kellogg Symposium, 2007

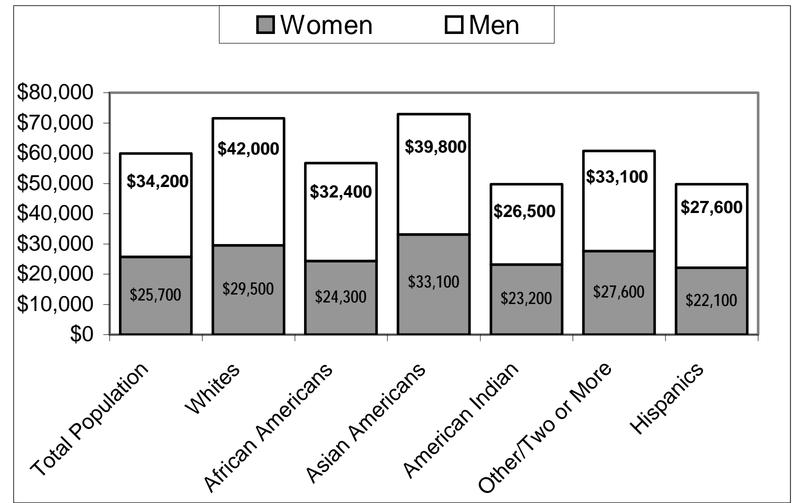
DETERMINANTS OF HEALTH

More than half of women in New Mexico are racial/ethnic minorities (56.8%). Compared to the United States, New Mexico has higher proportions of Hispanic White and American Indian females, and much lower proportions of Black and Non- Hispanic White females. **Racial and ethnic background has profound effects on an individual's health primarily because of the different social and economic experiences – advantages and disadvantages – that go along with race and ethnicity[6]**



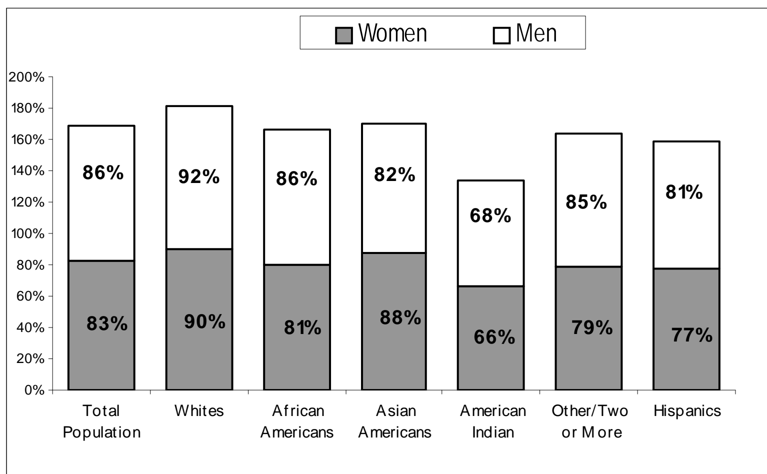
Source: US Census

Figure 3
Median Annual Earnings for Full-Time Year-round Workers, by Race, Ethnicity & Gender
Source: Institute for Women's Policy Research, 2004 & US Census



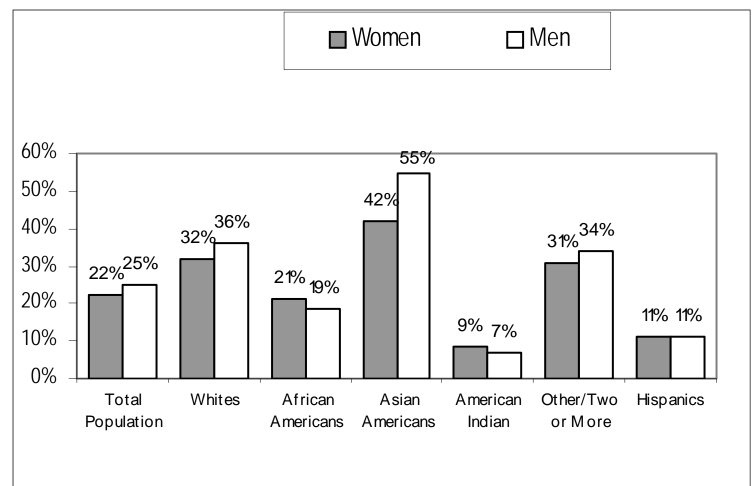
Work is linked to health via social resources, health care insurance coverage, hazardous or risky workplace conditions, and psychosocial characteristics of the work environment[7]. While women have made progress in the workforce since the passage of the 1963 Equal Pay, the closing of the wage gap between men and women has been at a minimal rate of about half a penny a year[8]. Across all sub-groups, the median annual earnings of women are less than men, with Hispanic women having the lowest at $22,100 per year followed by Native Americans at $23,200 and African Americans at $24,300. Low wages are partly explained by the fact that women of color are segregated into non-managerial and professional occupations such as clerical and service work.

Figure 4
Percent Women & Men Aged 16 & Older Living *Above* Poverty by Race & Ethnicity
Source: Institute for Women's Policy Research, 2004 & US Census



New Mexico is, unfortunately, ranked 50th in the nation for the percent of women living in poverty in our state. Almost 20% of New Mexican women and 10.6% of New Mexican men are living in poverty.[9] Research shows that **poverty is linked to ill health[10]**. Whereas, wealth is health by providing people access to economic resources, medical care and quality of life options such as nutritious foods, better child care, safe neighborhoods with good schools, reliable transportation.

Figure 5
Percent New Mexico's Women Aged 25 & Over with Four-Year College Degree or More
Source: Institute for Women's Policy Research, 2004 & US Census



Educational status in New Mexico varies by race/ethnicity and sex. Asian Americans, both men and women are more likely to have a four-year college degree or more. Whereas, American Indian men (7%) and women (9%) are less likely to have a college degree, followed by Hispanic men and women at 11%. **Education is tightly linked with income and wealth which in turn are tightly linked with women's health**. For example, more schooling yields opportunities for more rewarding jobs with healthier working conditions.[11]

Political participation

Higher **political participation by women is correlated with lower female mortality rates**[12]. Additionally, increased **representation of women in elected positions at the federal, state and local levels has implications for the development of health policies that are importance to women** such as expansions in coverage, improvements in access to care, and reproductive health promotion.[13] In 2007, 52% of women and 51% of men voted in the general election.[14] While women comprise 51% of New Mexico's population, they are less likely to be represented in elected offices. In 2004, one woman served in the U.S. House of representatives, 3 women served in statewide elected executive offices (1 White and 2 Hispanics) and 33 women served in the state legislature (18 White, 2 African American and 13 Hispanics). During that year, no Native American women were represented at the state or Congressional levels.

Other Determinants of Health

Context matters for health. Health and health disparities are embedded in larger historical, geographic, sociocultural, economic and political contexts[15]. Factors such as environmental racism, violence against women, access to transportation, language barriers, immigration status, health literacy, gender and social discrimination, aging and disability, sexual minority status (lesbian/bi/transgender) are other intersecting issues that impact differences in health status and access to care. "Clues to current and changing population patterns of health, including social disparities in health, are to be found chiefly in the dynamic social, material, and ecological contexts into which we are born, develop, interact, and endeavor to live meaningful lives"[16].

DIFFERENCES IN HEALTH INSURANCE COVERAGE, ACCESS & STATUS

Health insurance coverage is a critical factor in making health care accessible to women. Women with health coverage are more likely to obtain needed preventive, primary, and specialty care services, and have better access to many of the new advances in women's health[17]. Among the sources of coverage, Hispanic and American Indian women are least likely to have private coverage and employment-based coverage than non-Hispanic White women. American Indian/Alaska Native women are almost three times likely to be uninsured and Hispanic women almost twice as likely to be uninsured than Non-Hispanic White women (Figure 6). Among the 43% of low-income (less than 200% of the poverty threshold) women in New Mexico, only 20% are covered by Medicaid, 44% are uninsured, and 36% have other private (including Medicare or military related coverage) or employer-based coverage.[18]

Figure 6

Health Insurance Coverage of NM Women by Race/Ethnicity, Ages 18-64, 2003-05

Source: U.S. Census Annual Social and Economic Supplement (ASEC), KFF

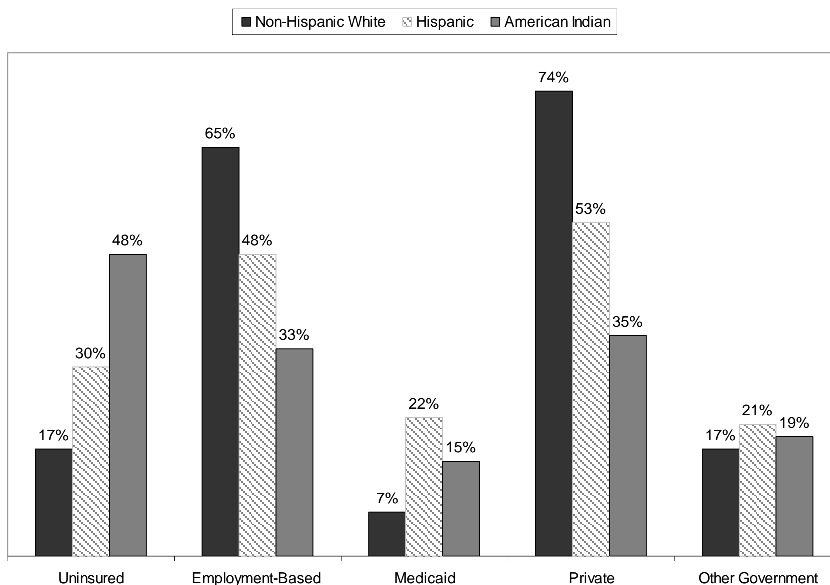


Figure 7

Late or no prenatal care (Prenatal care beginning after the third trimester or no prenatal care)

	2002-2004	2003-2005	2004-2006
African-American	31.9	30.9	28.6
American Indian or Alaska Native	40.8	40.6	40.3
Asian or Pacific Islander	23.9	**22.5**	19.4
Hispanic	33.2	32.5	30.1
White	23.3	22.7	21.2
New Mexico	30.9	30.4	28.6
United States	16.3	15.9	16.1

Source: 2007 NM Racial and Ethnic Health Disparities Report Card

All women in New Mexico have higher rates of starting prenatal care after the first trimester of pregnancy or not receiving any prenatal care than the national rate. American Indian women consistently have the highest rates of late or no prenatal care (Figure 7).

Figure 8
2006 Percent New Mexico Women 40 and older who had Mammogram within past 2 years (BRFSS)

By Race/Ethnicity	
All Races	70
White	72.2
Hispanic	67.1
Other	65.8
By Income	
<15,000	57.6
15,000-24,999	61
25,000-34,999	66.8
35,000-49,999	70.9
50,000 and above	81.1

Many women of color do not avail themselves of health screening tests such as Pap smears and mammograms on a regular basis due to a variety of factors (availability of insurance coverage, accessibility of facilities, cultural beliefs, and lack of information)[19]. The data by income in Figure 8 illustrates the importance of socio-economic status in obtaining the recommended screenings with a link between income and mammograms.

Source: CDC, BRFSS, NM 2006, http://apps.nccd.cdc.gov/brfss/display.asp

Infectious Disease

Chlamydia is the most common sexually transmitted infection in the United States. From 2001 through 2006, New Mexico has ranked among the top seven states nationally for incidence of chlamydia. The majority of cases occur among females ages15-24. The trend for this age group by age and ethnicity is illustrated by Figure 9.

Figure 9
Chlamydia

	2002-2004	2003-2005	2004-2006
African-American	2865.4	2918.1	3167.8
American Indian or Alaska Native	3075.8	2788.5	2621.6
Asian or Pacific Islander	549.4	410.3	293.1
Hispanic	3390.9	3511.2	3828.5
White	1556.1	1880.6	2249.3
New Mexico	3241.2	3256.1	3385.8
United States	2591.9	2663.9	2743.7

Source: NM Department of Health, STD program

Reproductive Health

Figure 10

Fertility rate	2001	2002	2003	2004	2005	2006*
US rate	65.3	64.8	66.1	66.3	66.7	68.5
NM rate	68.8	69.9	69.6	70.8	71.3	73.2
NM American Indian	71.1	72.1	72.4	71.2	71.4	75.0
NM Asian/Pacific Islander	50.8	51.6	48.2	48.5	53.3	65.4
NM Black	53.9	52.1	52	44.6	45.5	49.3
NM Hispanic	81.9	83.0	82.1	83.6	85.8	87.6
NM White	55.6	56.4	56.4	58.7	56.7	57.2

The fertility rate is the number of all New Mexico births divided by the female population ages 15-44. New Mexico rate is consistently higher than the US rate. Hispanics have the highest fertility rates followed by American Indians (Figure 10).

*2006 preliminary data
Source: 2001-2005 data New Mexico Selected Health Statistics Annual Report 2005;
New Mexico 2006 Natality Summary; Births, Preliminary Data for 2006, National Vital Statistics Reports, CDC/NCHS, Dec 5, 2007

Figure 11
Birth rates to NM teens ages 15-17 by race/ethnicity
New Mexico 2000-2006

	2000	2001	2002	2003	2004	2005	2006*
New Mexico	38.9	36.9	37.7	35.6	36.6	35.7	34.3
African-American	34.9	31.4	21.4	17.8	18.6	24.3	22.0
American Indian	35.6	32.6	34.8	34.5	35.2	29.4	29.5
Asian/PI	9.7	5.6	9.2	9.2	5.5	4.2	7.9
Hispanic	56.3	56.1	57.5	55.7	55.8	56.2	53.6
White	19.5	16.1	14.8	12.4	14.0	13.2	12.6
United States	26.9	24.7	23.2	22.4	22.1	21.4	22

New Mexico consistently has one of the highest teen birth rates in the United States. Hispanic teens continue to have the highest birth rates and show the least decrease over time (Figure 11).

Source: Births (New Mexico - Vital Records and Health Statistics birth files; US - Births:
National Center for Health Statistics New Mexico Population: Bureau of Business and Economic Research: University of NM
Chart prepared by Division of Policy and Performance, NM Department of Health

Chronic Disease

Figure 12

Cancer (2000-2004)		
Incidence per 100000	**Breast**	**Cervical**
All Races	127.8	8.7
White	133.1	8.6
Hispanic	91	9.7
American Indian	44.4	7.8*
Black	69.5*	6.2*

*age-adjusted rate based on less than 20 cases
Source: New Mexico Tumor Registry http://hsc.unm.edu/som/nmtr/cancer_statistics.shtml

Figure 12 illustrate the nature of cancer in New Mexico. White women are more likely to be diagnosed with breast cancer but are also more likely to receive the recommended screening of mammograms.

Behavioral Health
Mental health is crucial to women's overall well being. Some of the most common mental disorders, including depression and certain anxiety disorders, strike approximately twice as many women as men. Socio-cultural and environmental risk factors affect a woman's mental health and well-being such as sexual and other physical abuse, anxiety from having multiple roles as caregivers and wage earners, dead-end employment or unemployment, low educational attainment, and life stressors such as divorce, caregiving and social isolation.

POLICY OPTIONS

Sex, gender, racial, ethnic, socio-economic, and cultural factors must be taken into account in the design and implementation of programmatic, clinical and policy interventions that address women's health.[20] Active engagement and sustained efforts of all stakeholders including federal entities, academic and research institutions, state and tribal governments, faith- and community-based organizations, private industry, philanthropies and many others are needed to solve the pressing women's health issues. The following **policy options are adopted from several national reports and initiatives and are provided as ideas for women's health policy discussions.**[21], [22] , [23], [24]

Health Conditions
A women's health model could be integrated into the state's efforts to address priority areas such as reproductive health, infectious diseases, chronic diseases (stroke, cancer, diabetes), and behavioral health. New Mexico can address inequalities by improving research, surveillance, monitoring and evaluation. Reduction of risks factors can be achieved by including education and outreach for minority communities (girls, Native American, women aging and living with disabilities), enhancing screening and prevention programs, and increasing accessibility and delivery of mental health services and prenatal care.

Investing in State Infrastructure and Health Reform
Unique opportunities exist for states to act as laboratories for eliminating inequalities in women's health by moving towards universal health coverage, expanding eligibility policies and providing innovative enrollment and outreach strategies, fostering a gender, culturally, and linguistically competent workforce and affecting systems-wide change by

setting and monitoring performance standards. Health Coverage Authorities that span across state agencies, programs and commissions could also set minimal performance standards for reducing disparities in access and health status for populations served under public funds. Public and private health plans, hospitals, and providers should collaborate with state agencies to collect demographic information (i.e. race/ethnicity, language preference) in order to analyze utilization patterns, track health outcomes, and develop solutions to eliminate disparities.

Education and Work

Education and work policies and programs that focus on improving the conditions of women are the cornerstone to promoting and protecting intergenerational health and well-being. Since education is a vehicle for securing employment and attaining economic security, programs that prepare girls early in life for school success and continue to support academic engagement are critical for future health.[25] Targeted efforts to close the pay gap between women and men are needed, especially for economically deprived and low income geographic areas in New Mexico. The protection of rights to equally participate in the labor market through monitoring and compliance of federal Equal Employment Opportunity laws, the guarantee of minimum living wages and provision of employer sponsored health insurance are the basis for self-determination and health for women and women of color.

Political Will and Civic Engagement

Public policies to address health inequalities are more likely to be effective if they include women leaders in communities of color whose knowledge and values are consistent with community needs and concerns[26]. Ultimately, women's health disparity reduction strategies rely on building the political momentum and civic engagement of diverse communities and multiple stakeholders in order to move a comprehensive women's health agenda from low relative importance to the forefront.

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[1] This issue brief is adapted from a presentation by L. Cacari Stone to the 2007 Governor's Women's Health Advisory Council Policy Forum, *Gender and Health Disparities : Implications for Women's Health Policy and Leadership*.
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