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Racial/Ethnic Health Disparities Among Women in California

A PUBLICATION OF THE

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Introduction

For the past twenty years, the goal of the federal government's *Healthy People* program (HP 2000; HP 2010) has been to reduce and ultimately eliminate health disparities. The HP 2020 goal adds equity as a concern; specifically, the new goal is to "achieve health equity, eliminate disparities, and improve the health of all groups."[1] As rigorously documented, inequity based on one's racial/ethnic identity has been linked to disparities in health care access and coverage, and poorer health outcomes.[2,3] In the landmark 2002 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, two main factors were cited as driving the disparities: 1) People of color are subjected to adverse social determinants of health, and 2) People of color are disproportionately represented among the uninsured.[4]

In general, women of color have worse health outcomes than white women, although rates among women of color do vary.[5] Nationally, heart disease death rates are the highest among African-American women; cervical cancer rates among Asian/Pacific Islanders, African Americans, and Latinas are higher than among white women; and African-American women have higher infant, fetal, and perinatal mortality rates than white women.[6]

Using data from the 2011–2012 California Health Interview Survey (CHIS 2011–12), this policy brief describes racial/ethnic health disparities among women for four main health topics: 1) health status; 2) health conditions (arthritis, asthma, diabetes, heart disease, and high blood pressure); 3) health risk factors (smoking and obesity); and 4) health coverage and access. Because health data on Latina and Asian subgroups is often unavailable, a snapshot of their health is also highlighted.[7]

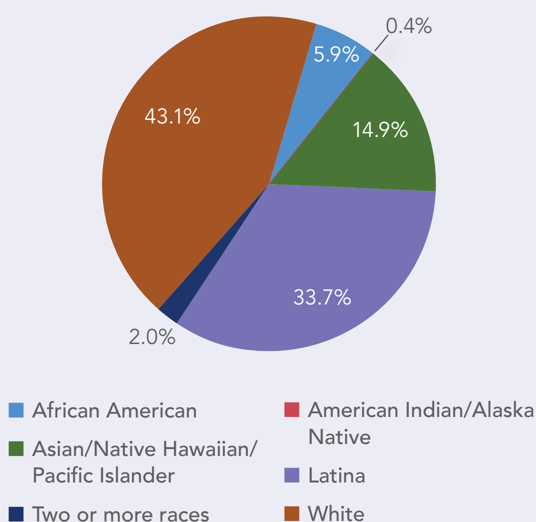
The Healthy People 2020 goal is to "achieve health equity, eliminate disparities, and improve the health of all groups."

More Women of Color in California than White Women

California is one of the most racially/ethnically diverse states; six out of 10 Californians are people of color. The number of adult Latinas (33.7%) is growing, and beginning to approach the number of adult non-Hispanic white women (43.1%) (EXHIBIT 1).[8,9] The third largest group of adult women in California is Asian (14.5%), which when combined with Native Hawaiian/Pacific Islanders (0.4%) totals nearly 15% of all women (Asian/NH/PI). African-American women (5.9%) comprise less than half the number of Asian women. American Indian/Alaska Native women (AI/AN) are less than one percent of Californian women (0.4%). Although women who report being of two or more racial/ethnic groups is growing, the multi-racial group in our analyses is smaller than expected (2.0%) because those who identify with one group more than another are placed in that specified group.[10] Trends indicate that the racial/ethnic diversity of California women will continue to increase, as the majority of infants born statewide are people of color. Currently, people of color make up 72.6% of Californians under the age of 18.[11]

Women of color are more likely than white women to report their health as "fair or poor."

EXHIBIT 1 | Racial/Ethnic Distribution, Women Ages 18 and Older, California, 2011–12



Source: 2011–12 California Health Interview Survey

Asian/Native Hawaiian/Pacific Islander and Latina Women Younger

The age profile of women differs across racial/ethnic groups so it is important to examine since many health conditions vary by age. In California, Latina and Asian/NH/PI women are significantly younger than other groups. Over one-half of African-American (54.1%), AI/AN (72.1%), and white (64.3%) women are 45 years and older. In comparison, just over a third of Latinas (36.9%) and 44.3% of Asian/NH/PI women are 45 years or older (EXHIBIT 2).

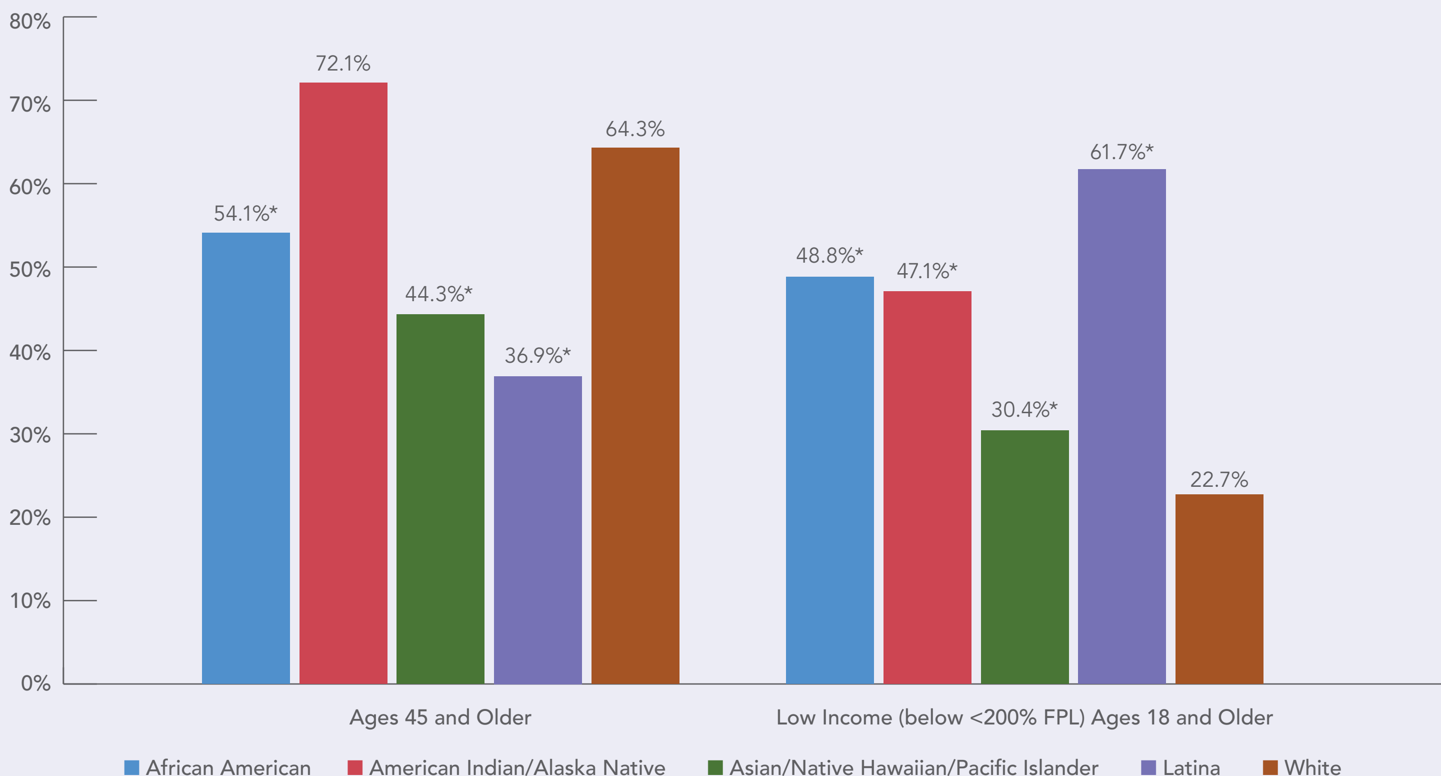
Women of Color More Likely Low Income

Nearly four in 10 (38.9%) California women ages 18 and older are low income, with rates varying across racial/ethnic groups.[12] Women of color are more likely to be low income than white women (22.7%, EXHIBIT 2). Latinas have the highest rate, with approximately six in 10 Latinas (61.7%) living in families with low incomes. About one-half of African-American (48.8%) and AI/AN (47.1%) women are low income, and three in 10 Asian/NH/PI women are (30.4%).

White Women Report Better Health than Other Racial/Ethnic Groups

Notable differences emerge in self-reported current health status among women across racial/ethnic groups.[13] Women of color are more likely than white women to report their health as "fair or poor." Over one-quarter of AI/AN (31.5%), Latina (28.7%), and African-American (26.5%) women, and one in five Asian/NH/PI (19%) women indicate their health status is "fair or poor" compared to 13.6% of white women (EXHIBIT 3).

EXHIBIT 2 | Age and Income Differences by Race/Ethnicity, Women Ages 18 and Older, and Women Ages 45 and Older, California, 2011–12



*Significantly different from white women.

The weighted federal poverty level for a three-person family was $17,916 in 2011 and $18,284 in 2012. A low-income woman (defined as <200% FPL) in a family of three, for example, would have total family income below approximately $35,800 in 2011 and $36,600 in 2012.

Source: 2011–12 California Health Interview Survey

EXHIBIT 3 | Health Status and Conditions by Race/Ethnicity, Women Ages 18 and Older, and Ages 45 and Older, California, 2011–12

	Ages 18 and Older					Ages 45 and Older				
	African American	AI/AN	Asian/ NH/PI	Latina	White	African American	AI/AN	Asian/ NH/PI	Latina	White
Fair/Poor Health	26.5%*	31.5%*	19.0%*	28.7%*	13.6%	32.1%*	35.9%*	29.3%*	42.1%*	16.3%
Arthritis	26.8%*	37.6%	13.4%*	15.9%*	31.9%	45.7%	49.1%	26.7%*	34.4%*	44.1%
Asthma	21.2%	40.1%*	9.9%*	12.4%*	17.5%	23.0%*	44.8%*	10.4%*	12.4%*	15.9%
Diabetes	12.1%*	NR	5.9%	9.7%*	7.0%	18.2%*	NR	11.0%	20.3%*	9.8%
Heart Disease	6.1%	NR	3.2%*	4.3%*	7.6%	11.0%	NR	5.2%*	8.6%*	11.0%
High Blood Pressure	43.1%*	48.3%*	19.9%*	24.1%*	30.9%	60.4%*	55.6%	37.2%*	46.3%*	42.0%

AI/AN= American Indian/Alaska Native; Asian/NH/PI= Asian/Native Hawaiian/Pacific Islander

For all health conditions, respondents were asked by CHIS interviewers if they had ever been diagnosed with the specific condition.

* Significantly different from white women.

NR: Rates for some conditions are “not reported” for AI/AN women because of unstable estimates due to small sample sizes.

Source: 2011–12 California Health Interview Survey

Among women ages 45 and older, both African-American women (60.4%) and Latinas (46.3%) have higher rates of hypertension than white women (42%) while rates are lower for Asian/NH/PI women (37.2%).

Health Conditions Reflect Varied Racial/Ethnic Disparities

In this section, racial/ethnic differences are described for five key health conditions — arthritis, asthma, diabetes, heart disease, and high blood pressure. As noted earlier, racial/ethnic groups in the state are unevenly distributed by age. Since four of the five conditions are associated with the aging process, these conditions were examined among adult women overall (18 and older) as well as among those ages 45 years and older (EXHIBIT 3).[14]

Arthritis. Latina, Asian/NH/PI and African-American women have lower rates of arthritis (15.9%, 13.4%, and 26.8%, respectively) compared to white women (31.9%). The rate for AI/AN women (37.6%) is not significantly different from that of white women.

Among women 45 years and older, arthritis rates range from 26.7% of Asian/NH/PI women to 49.1% of AI/AN women. The overall pattern between racial/ethnic groups is similar for those 18 and older except that only older Asian/NH/PI (26.7%) and Latina (34.4%) women have significantly lower rates of arthritis than that of older white women (44.1%; EXHIBIT 3).

Asthma. American Indian/Alaska Native women 18 and older have the highest rate of asthma (40.1%) among all groups, with more than two-fifths having ever been diagnosed. Their rate is more than twice that of white women (17.5%). In contrast, Asian/NH/PI (9.9%) and Latina (12.4%) asthma rates are lower than that of white women.

For those aged 45 and older, the picture remains starkly disproportionate, with AI/AN (44.8%) and African-American (23.0%) women much more likely to have asthma compared to white women (15.9%).

Diabetes. When diabetes is considered, the situation for women of color is also mixed. Asian/NH/PI women (5.9%) and white women (7%) have the lowest rates of diabetes. In comparison, 12.1% of African-American women and nearly one in 10 Latinas (9.7%) report being diagnosed with diabetes, rates that are significantly higher than for white women.[15]

Among women 45 and older, both Latina (20.3%) and African-American women (18.2%) are more likely to have diabetes at this stage in their lives compared to white women (9.8%).

Heart Disease. Both Latina (4.3%) and Asian/NH/PI (3.2%) women are less likely to state they have been diagnosed with heart disease compared to white women (7.6%).

Among women 45 years and older, the pattern is the same, with Latinas (8.6%) and Asian/NH/PI women (5.2%) less likely to have heart disease than white women (11.0%). The rate for African-American women (11.0%) is similar to the rate for white women.

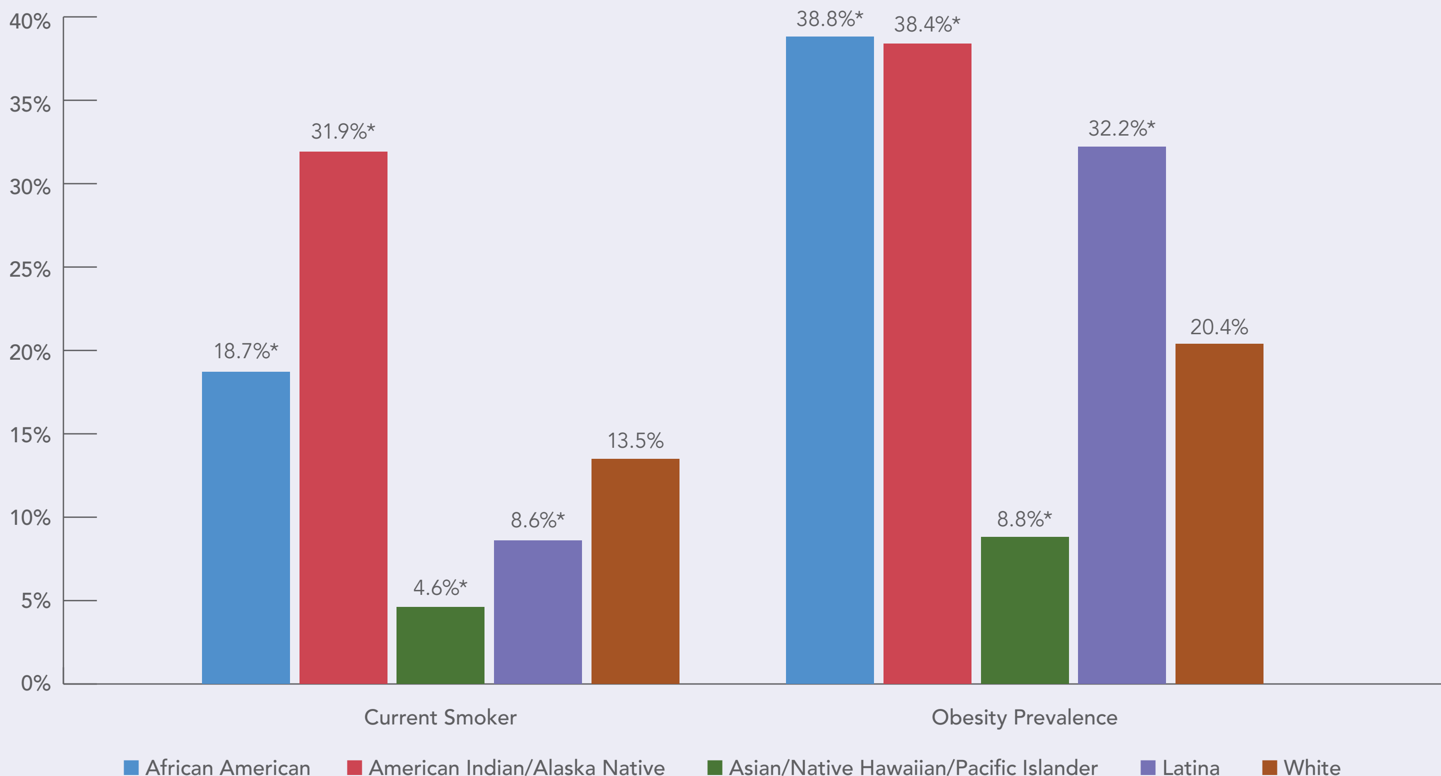
High Blood Pressure. The prevalence of high blood pressure (hypertension) among women 18 and older in California is fairly high, ranging from 19.9% among Asian/NH/PI women to 48.3% among AI/AN women. The rates for white and African-American women fall in between, at 30.9% and 43.1%, respectively. Asian/NH/PI women's rate is significantly lower than that of whites, while the rates for AI/AN and for African-American women are significantly higher.[16]

Among women 45 and older, rates of high blood pressure range from nearly four in 10 to six in 10 women. Both African-American women (60.4%) and Latinas (46.3%) have higher rates of hypertension than white women (42%), while rates are lower for Asian/NH/PI women (37.2%). Over one-half of AI/AN women in this age group have hypertension, a rate not statistically different than for white women (EXHIBIT 3).

Risk Factors: Smoking and Obesity

Many factors can contribute to poor health; this brief examines two main health risks: smoking and obesity.[17]

EXHIBIT 4 | **Smoking Status and Obesity Prevalence by Race/Ethnicity, Women Ages 18 and Older, California, 2011–12**



*Significantly different from white women.

Source: 2011–12 California Health Interview Survey

Current Smoking. While the smoking rate among all women 18 and older in California is 11%, rates vary among racial/ethnic groups. The highest smoking rate is among American Indian/Alaska Native women, with slightly over three in 10 (31.9%) smoking. In addition to AI/AN women, African-American women (18.7%) have higher smoking rates than white women (13.5%), while Latina (8.6%) and Asian/NH/PI women (4.6%) have lower rates (EXHIBIT 4).

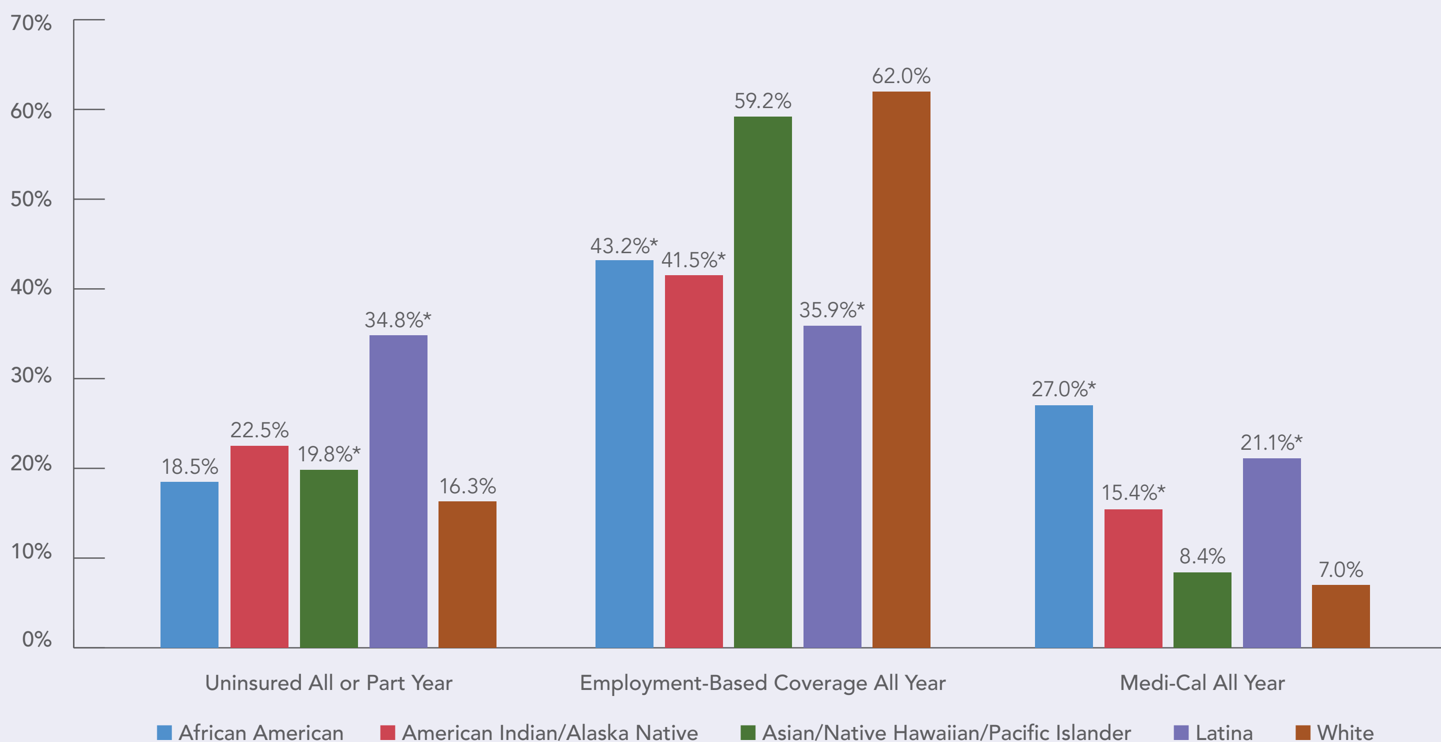
Obesity. Nearly one in four (23.9%) California women meet the criteria for obesity, based on a body mass index (BMI) of 30.0 or greater.[18] Latina (32.2%), African-American (38.8%) and AI/AN (38.4%) women have higher rates of obesity than white women (20.4%), while Asian/NH/PI women (8.8%) have a lower rate (EXHIBIT 4).

Disparities in Health Coverage Among Women Ages 18–64

This coverage information provides a picture of nonelderly women's (18–64) health insurance status in 2011 and 2012, prior to implementation of the major coverage expansion of the Patient Protection and Affordable Care Act (ACA). CHIS data show considerable variation by race/ethnicity among nonelderly women in access to and sources of coverage (EXHIBIT 5).

Employment-based insurance is the main source of coverage, and white (62%) and Asian/NH/PI (59.2%) women had the highest rates of this type of coverage during the past year. Employment-based coverage rates are lower for the other racial/ethnic groups, with just slightly over one-third of nonelderly Latinas (35.9%) and four in 10

EXHIBIT 5 | Health Insurance Status by Race/Ethnicity, Women Ages 18–64, California, 2011–12



*Significantly different from white women.

Source: 2011–12 California Health Interview Survey

Latinas had the highest uninsured rate with slightly over one-third (34.8%) uninsured for all or part of the past 12 months.

African-American (43.2%) and AI/AN (41.5%) women covered through this source.

Medi-Cal is an important safety net for women, and its role will increase under the Affordable Care Act. Rates of Medi-Cal coverage are higher among African-American women (27.0%), Latinas (21.1%), and AI/AN women (15.4%) than for white women (7.0%; EXHIBIT 5).

Privately purchased insurance, which often is an expensive source of coverage, covers 6.3% of nonelderly women with rates ranging from 3.2% of Latinas to 9.1% of Asian/NH/PI women (data not shown). Other insurance sources, or combination of sources, cover an additional 5.4% of women (data not shown).

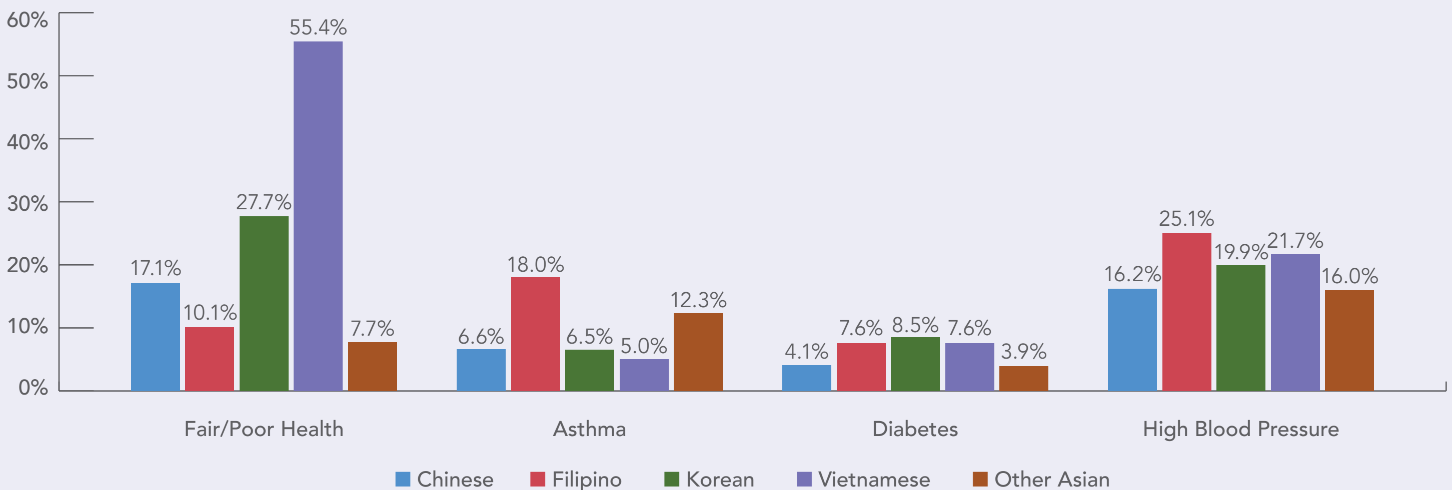
The remaining non-elderly women, 24.1% or approximately 2,835,000 women, were uninsured for all or part of the year (EXHIBIT 5).

Latinas had the highest uninsured rate with slightly over one-third (34.8%) uninsured for all or part of the past 12 months. But all groups faced being uninsured, with rates ranging from 16.3% of white women to approximately one in five African-American (18.5%), Asian/NH/PI (19.8%), and AI/AN (22.5%) women.

Usual Source of Care

A usual place for care assists with access to health care and continuity of care. Although the majority of women report they have a usual source, differences exist by racial/ethnic group in where women receive care and whether they have a usual source (data

EXHIBIT 6 | Health Status and Conditions Among Asian Subgroups, Women Ages 18 and Older, California, 2011–12



Source: 2011–12 California Health Interview Survey

not shown). Latinas (19.5%) are the least likely to have a usual setting where they receive care, followed closely by Asian/NH/PI women (15.3%).[19]

Clinics and health centers are the usual providers for one in five California women (21.1%), with AI/AN women (37.1%), Latina (33.3%) and African-American women (25.3%) most likely to receive care in these settings. White women are more likely to receive care through private doctors/HMOs (77.9%) than Latinas (45.4%), AI/AN (52.2%), African-American (62.8%), and Asian/NH/PI women (65.9%).

Health Status and Conditions Among Racial/Ethnic Subgroups

Asian Racial/Ethnic Subgroups

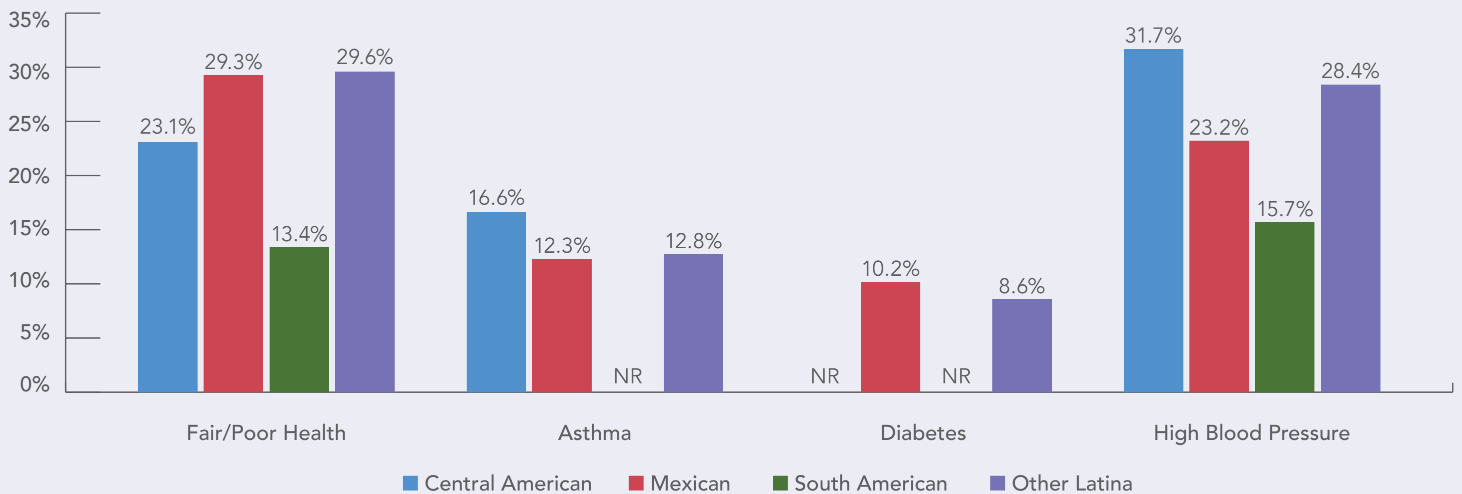
Because the CHIS survey has a large sample size and is administered in multiple languages, we are able to provide data on Asian subgroups. For CHIS 2011–12, sample sizes of Chinese, Korean, Filipino, Vietnamese, and "Other Asian" Californians were large enough to provide stable results for health status and most health conditions for women 18 and older.

Fair/Poor Health Status. Over half of Vietnamese women in California report having fair or poor health (55.4%), a rate much higher than that for other Asian subgroups.[20] The rate among Vietnamese women is also higher than the rate for Asian/NH/PI women as a whole (19.0%). Over one-fourth of Korean women report having fair/poor health (27.7%), followed by Chinese women (17.1%) and Filipinas (10.1%). All rates are different between the Asian subgroups, with the exception of the "fair/poor" health rates for Filipinas versus "Other Asian" (7.7%) women (EXHIBIT 6).

Asthma. Filipinas have close to three times the rate of diagnosed asthma (18.0%) compared to Chinese (6.6%), Korean (6.5%) and Vietnamese women (5.0%); all of those rates are significantly lower than the rate for Filipinas. The asthma rate for "Other Asian" women (12.3%) is about twice as high as the rate for Vietnamese women.

Diabetes. Chinese women (4.1%) and "Other Asian" women (3.9%) have fairly low rates of diabetes. While it appears that the level of diabetes among Chinese women is lower than the rates reported by Korean (8.5%), Filipina (7.6%) or Vietnamese

EXHIBIT 7 | Health Status and Conditions Among Latina Subgroups, Women Ages 18 and Older, California, 2011–12



NR: Rates for diabetes are "not reported" for Central or South American women because of unstable estimates due to small sample sizes.

NR: Rate for asthma is "not reported" for South American women because of unstable estimate due to small sample size.

Source: 2011–12 California Health Interview Survey

women (7.6%), none is significantly different. "Other Asian" women are less likely to have diabetes than Vietnamese women or Filipinas, however.

High Blood Pressure. High blood pressure or hypertension for women ranges from 16.0% (Other Asian) to 25.1% (Filipinas) among Asian subgroups. Filipinas are more likely to have hypertension compared to Chinese (16.2%) or "Other Asian" women (EXHIBIT 6).

Latina Racial/Ethnic Subgroups

For CHIS 2011–12, sample sizes were also sufficient to provide stable results for Mexican, Central American, South American, and "Other Latina/Hispanic" women ages 18 and older for health status and for most health conditions.

Fair/Poor Health Status. South American women report their health status as being "fair or poor" (13.4%) at a rate much lower than that for Mexican women (29.3%) or "Other Latinas" (29.6%). The rate for Central American women (23.1%) is not statistically different than those of Mexican or South American women (EXHIBIT 7).

Asthma. Asthma rates among Central American (16.6%), "Other Latina" (12.8%), and Mexican women (12.3%) are not statistically different from each other. Rates of asthma were unstable for South American women and not reportable.

Diabetes. Because sample sizes for diabetes diagnoses are small for the Latina subgroups, stable rates are only reportable for Mexican women (10.2%) and for "Other Latinas" (8.6%). The rates for the two groups do not differ.

High Blood Pressure. Over three in 10 Central American women (31.7%) have high blood pressure, followed by "Other Latinas" (28.4%), Mexican women (23.2%), and women of South American ancestry (15.7%). South American women are less likely to have hypertension than "Other Latinas" or Mexican women. Mexican women are less likely to have hypertension than "Other Latinas" (EXHIBIT 7).

Summary

A focus on the health status, strengths and disparities of each of the racial/ethnic groups separately provides further understanding of the overall health status of each group.

African-American Women. Demographically, African-American women in California comprise a small proportion of all women (5.9%), and over half are 45 years and older. Nearly half are low income, a rate higher than that for white women. One in five African-American women has asthma, and over a quarter self-report having "fair/poor" health status and arthritis. The rate of diabetes goes from 12.1% to 18.2% when all adults are compared to those ages 45 years and older. Smoking rates are higher than among white women, and nearly two-fifths are obese. Medi-Cal is an important safety net for this group, although nearly one in five African-American women ages 18–64 were uninsured all or part of the year.

American Indian/Alaska Native Women. While less than one percent of the adult female population, this group represents diverse tribal groups in rural and urban areas of the state. Nearly three-fourths are 45 years and older, exacerbating their exposure to age-related health conditions, and just under half are low income. American Indian/Alaska Native adult women have one of the highest rates of asthma and high blood pressure among the racial/ethnic groups. With slightly over three in 10 AI/AN women current smokers, and an obesity prevalence of nearly four in ten, they face many health challenges. Over one in five (22.5%) AI/AN women ages 18–64 are uninsured, affecting access to health care.

Asian/Native Hawaiian/Pacific Islander Women. Among women of color, Asian/Native Hawaiian/Pacific Islander women also represent a wide range of different subgroups. Along with their Latina counterparts, they tend to be a younger group (i.e., 55.7% are 44 years or younger), and represent approximately 15% of the population of women statewide. Three in 10 are low income. Among Asian subgroups, those reporting having "fair or poor" health range from approximately one in 10 Filipinas and "Other Asian" women to over half of Vietnamese women (55.4%). Asian/NH/PI women have lower rates of arthritis than white women regardless of age group examined, and lower rates of asthma. Drilling down, however, Filipinas have three times the rate of asthma compared to Chinese, Korean or Vietnamese women. The rate of hypertension is lower than white women's rate. Twenty percent are uninsured and 15% lack a usual source for health care.

Latinas. Latinas form the second largest group of women in California. They are younger than other groups, with 63.1% under 45 years. Latinas have the highest rate of low income households (61.7%), and they are more likely to say their health is "fair or poor" (28.7%) compared to white women. Among the Latina subgroups, Mexican women are more likely to report fair/poor health than South American women. Latinas are less likely to report having asthma, but more likely to report having diabetes compared to white women. Latinas ages 18 and older are less likely to have high blood pressure or arthritis; rates remain lower than among white women when those 45 years and older are the focus. While fewer Latinas smoke than white women, they are more likely to be obese. Latinas have the highest uninsured rate, with over one-third uninsured during the past 12 months, and nearly one in five has no usual source of care.

White Women. Demographically, white women compose the largest proportion among racial/ethnic groups of adult females in California. They are increasingly an aging population, with 64.3% ages 45 years or older. They are the least likely to be low income of all the racial/ethnic groups (22.7%); still over one in five falls into that category. White women are less likely to report having "fair or poor" health compared to women of color. However, one-third of adult white women have arthritis, a

A focus on the health status, strengths and disparities of each of the racial/ethnic groups separately provides further understanding of the overall health status of each group.

rate that climbs to 44.1% for those 45 years and older, and a rate higher than for Latinas or Asian/NH/PI women. Asthma rates are considerably lower than for AI/AN women. Diabetes is found among 7.0% of white women, a lower rate than for Latinas or African-American women. Hypertension rates are higher for white women than for Latinas and Asian/NH/PI women. With nearly one out of seven white women smoking, and one in five obese, they are exposed to risk factors that can contribute to poor health. One in six white women is uninsured. They are more likely to receive their care from private doctors and HMOs compared to other groups.

Discussion

Despite laws prohibiting overt racial/ethnic discrimination both nationally and in California, many of the social and economic structures that historically created such inequities remain.[21] Efforts to eliminate inequity based on race/ethnicity, age, gender, immigrant status, as well as other elements of personal identity can help level the playing field, enhancing economic, political, social and educational opportunities for vulnerable groups, which in turn can help eliminate health disparities.[22]

The social determinants of health play a key role in contributing to many of the health disparities covered in this brief, with economic status most notable. Beyond providing economic and educational opportunities for all racial/ethnic groups and subgroups of women in California, specific health policies can help decrease exposure to and prevalence of health conditions. These include policies impacting clean air and water, expanding access to health coverage and care for the immigrant population, augmenting preventive health efforts such as screening, and providing for nutritious food and physical activity. In addition, affordable and equitable health care coverage statewide can help reduce disparities. With the 2014 full implementation of the Patient Protection and Affordable Care Act (ACA), health providers, advocates, and policymakers have new opportunities to reduce racial/ethnic health inequities and disparities by assisting such groups to attain the promises of increased health care access, utilization and insurance coverage.

The social determinants of health play a key role in contributing to many of the health disparities covered in this brief.

Data Source and Methods

Data for this policy brief is drawn from the 2011–12 California Health Interview Survey (CHIS 2011–12), a random-digit-dial telephone survey of the California population living in households, and the largest statewide survey conducted in the U.S. CHIS interviewed 25,087 women ages 18 and older in 2011–12. Sampling tolerances at the 95% confidence level were used to calculate statistically significant differences between groups. All differences between groups reported in the policy brief are statistically different at the $p<.05$ unless otherwise noted. The determination of adequate sample size to report data was based on analysis of the coefficient of variation (CV), using a criterion of 30. For more CHIS information, please visit www.chis.ucla.edu.

Author Information

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Funder Information

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Endnotes

1 For further information about the effort to eliminate health disparities, go to the Healthy People 2020 Disparities site online at http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx.

2 Kressin NR, Petersen LA. (2001). Racial differences in the use of invasive cardiovascular procedures: Review of the literature and prescription for future research. *Annals of Internal Medicine* 135(5):352–366.

3 Mayberry RM, Mili F, Ofili E. (2000). Racial and ethnic differences in access to medical care. *Medical Care Research and Review* 57(1):108–45.

4 Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The National Academies Press, 2002, accessed at www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx.

5 Racial and Ethnic Disparities in Women's Health Coverage *Findings from the 2001 Kaiser Women's Health Survey*, The Henry J. Kaiser Family Foundation, March 2004, http://Kaiserfamilyfoundation.files.wordpress.com/2013/01/racial-and-ethnic-disparities-in-women's-health-coverage-and-access-to-care.pdf; accessed November 21, 2013; James CV, Salganicoff A, Thomas M, Ranji U, Lillie-Blanton M, and Wyn R. *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*. Kaiser Family Foundation, 2009.

6 American College of Obstetricians and Gynecologists. Racial and Ethnic Disparities in Women's Health, *Obstet Gynecol* No. 317, 2005:106:889–92, accessed at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee on Health Care for Underserved Women/Racial-and-Ethnic-Disparities-in-Women's-Health.aspx.

7 An important association with racial/ethnic health disparities is immigrant status. While limited space precludes inclusion of this topic in this brief, some CHIS publications focus solely on this key issue. See Wallace SP, Torres JM, Nobari TZ, and Pourat N. *Undocumented and Uninsured: Barriers to Affordable Care for Immigrant Populations*. Los Angeles, California: UCLA Center for Health Policy Research, The Commonwealth Fund, August 2013.

8 Distribution is based on the California Department of Finance, Office of Management and Budget statistics and definitions, 2011–12 California Health Interview Survey, Extracted on October 29, 2013, http://www.ask.chis.ucla.edu/CHIS online data tool.

9 2010 Census Summary File 1, Table PCT12 by Race/Ethnicity, California and Counties, Extracted on July 22, 2010; California State Data Center, http://www.dof.ca/gov/research/demographic.

10 This practice is similar for CHIS as well as for the U.S. Census. See Racial/Ethnic Distribution of Population Under Age 18 (California, 2010), U.S. Census, 2010 U.S. Census Bureau. Regarding CHIS definitions, CHIS interviewers initially ask respondents to name all of the racial/ethnic groups they identify with. If a respondent names more than one racial/ethnic group, they are then asked if they identify with any one group specifically. If they then specify a group they identify with more than another, they are combined with others of that group; if they do not, they are then placed with the "two or more racial/ethnic group" category.

11 Racial/Ethnic Distribution of Population Under Age 18 (California, 2010), U.S. Census, 2010 U.S. Census Bureau.

12 The weighted federal poverty level (FPL) for a three-person family was $17,916 in 2011 and $18,284 in 2012. A low-income woman (defined as <200% FPL) in a family of three would have family income below approximately $35,800 in 2011 and $36,600 in 2012.

13 For measuring health status, respondents were asked if their health was "excellent, very good, good, fair or poor."

14 For each health condition, respondents were asked if they had ever been diagnosed with the specific condition, which requires access to the health care system. Women with limited or inconsistent access to care, such as women with low incomes or who are uninsured, may be less likely to see a provider and therefore less likely to be diagnosed with a health condition.

15 The rate of diabetes was unstable for AI/AN women due to small sample size and not reportable.

16 The confidence interval for the estimate for "hypertension" for AI/AN women is 35.3% – 61.4%, indicating that one can be 95% confident that the true estimate (48.3%) is within that range.

17 Mental health also impacts overall health status. A CHIS policy brief on mental health status among women with chronic conditions is planned for 2014.

18 Body mass index (BMI) is a measure of body fat based on a person's height and weight. It is calculated by weight in pounds divided by height in inches squared and multiplied by a conversion factor of 703. The standard weight status categories are: below 18.5 is underweight, 18.5–24.9 is normal weight, 25.0–29.9 is overweight, and a BMI of 30.0 and above is obese.

19 The estimate for no usual source of care for American Indian/Alaska Native women was not reported due to small sample size.

20 The confidence interval for the estimate for "fair/poor health" status for Vietnamese women is 46.7% – 64.0%, indicating that one can be 95% confident that the true estimate (55.4%) is within that range, which is still significantly higher than the rates for the other Asian subgroups. Although the diagnosed condition rates are similar to other subgroups, Vietnamese women are more likely to judge their health to be fair or poor.

21 See *Promoting Equity through the Practice of Health Impact Assessment*. Oakland, CA: PolicyLink, 2013, accessed at www.policylink.org/atf/cf/{97c6d565-6b43-406d-a6d5-eca36bf35af0}/PROMOTINGEQUITYHIA_FINAL.PDF.

22 For further information on the health issues affecting the immigrant population, see Ponce N, Lavarreda SA and Cabezas T. *The Impact of Health Care Reform on California's Children in Immigrant Families*. Los Angeles, CA: UCLA Center for Health Policy Research, 2011; Kominski GF, Reifman C, Cameron ME and Roby DH. *Language Barriers Pose a Risk for California HMO Enrollees*. Los Angeles, CA: UCLA Center for Health Policy Research, May 2006.

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The Public Health Institute (PHI), an independent nonprofit organization based in Oakland, California, is dedicated to promoting health, well-being and quality of life for people throughout California, across the nation and around the world. PHI's primary methods for achieving these goals include: sharing evidence developed through quality research and evaluation; conducting public policy analysis and advocacy; providing training and technical assistance; and promoting successful prevention strategies to policymakers, communities and individuals.

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