

Focus

on Eliminating Disparities for Women of Color



RACIAL ETHNIC MINORITIES IN NEBRASKA

After a steady 17% increase in Nebraska's racial and ethnic minority population during the last decade, Nebraska continues to become more racially and ethnically diverse. According to the 2010 Census, Hispanics accounted for 51% of the minority population, while African Americans, Asians, and American Indians accounted for 25%, 10%, and 5%, respectively. These data apply to both minority women and men.

ABOUT THE REPORT

The 2015 Women's Health Equity Report illustrates that while Nebraska has made progress in recent decades to reduce health disparities by race and ethnicity, health inequities still exist. By comparing current data to data collected between 2007 and 2009*, we are able to see trends in selected social and health indicators, which provide a comprehensive understanding of the underlying disparities among women in Nebraska. Comparing data also facilitates the development of interventions that may reduce disparities.

REDUCING/ELIMINATING DISPARITIES FOR THE FUTURE

To help Nebraska achieve its vision of health equity for all Nebraskans, we must take a proactive approach and enhance our collaboration with partners to make an impact that will improve the health of racial ethnic minorities in Nebraska. It is critical to develop interventions that focus on individual behavior changes, but also those that effect system change at the local, state, and national levels.

As this report demonstrates, there are still notable health disparities among Nebraska's racial/ethnic minorities compared to non-Hispanic White women. It is important to remember that health status is an integral part of our everyday lives. It not only involves physical health, but also our living and working conditions. Therefore, all sectors of our society, including the non-healthcare sector and policy makers, play a huge role in achieving health equity in Nebraska.

90% margin of error was used for ACS data.

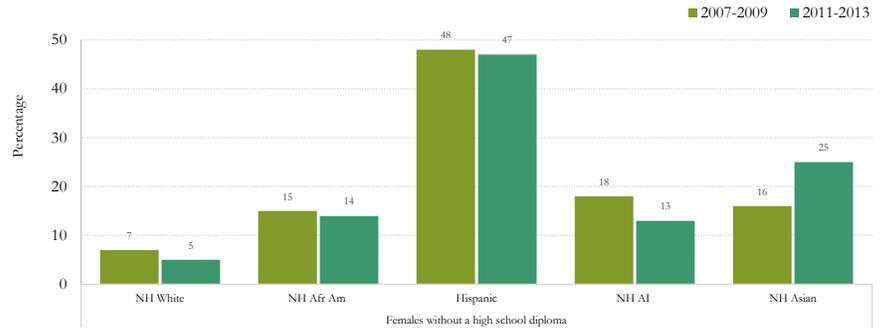
95% confidence intervals were used for other data presented in this report.

FIGURE 1. DISPARITIES IN EDUCATION

Education is an important social determinant of health. Disparities in education can therefore lead to disparities in health. Disparities in education are found persistently across all minority women groups during both three year time periods when compared to non-Hispanic White women. The percentage of women who do not have a high school diploma continued to remain the highest for Hispanic women. Rates for African American, American Indian and Asian women were also higher than that of non-Hispanic White women in Nebraska.

A decrease in the percentage of women who do not have a diploma was seen for non-Hispanic White women between 2007-2009 and 2011-2013. Compared to the 2007-2009 time period, the percentage of Asian women without a high school diploma greatly increased, while African American, Hispanic, and American Indian women saw slight decreases in the percentage of women without a diploma during this time.

Disparities in Education in Nebraska Women 2007-2009 & 2011-2013



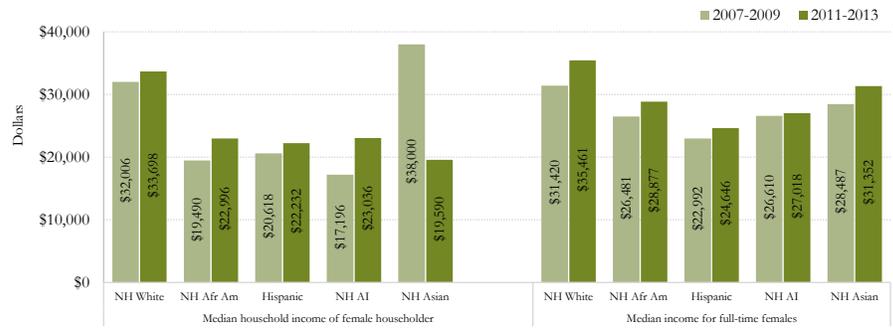
Data source: American Community Survey, US Census Bureau

FIGURE 2. DISPARITIES IN HOUSEHOLD INCOME

Income level is one important socioeconomic factor that directly influences women's health. Substantial disparities in income are observed persistently across all minority women groups when compared to non-Hispanic White women. During the most recent measurement period (2011-2013), both median household incomes of female householders, as well as median incomes for full-time women, were significantly lower for African American, Hispanic, American Indian and Asian women.

The median household income increased for women of all races and ethnicities except Asian women across the two time periods, although the change was not statistically significant from 2007-2009 to 2011-2013 for minority women who worked full-time. The median income for full-time non-Hispanic White women significantly increased during the same period.

Disparities in Household Income in Nebraska Women 2007-2009 & 2011-2013



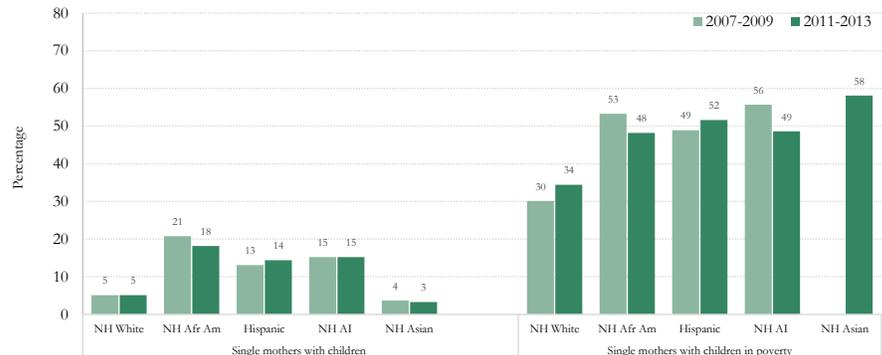
Data source: American Community Survey, US Census Bureau

FIGURE 3. DISPARITIES IN FEMALE HOUSEHOLDS

Single mothers with children, especially those who are racial or ethnic minorities, experience many challenges obtaining quality healthcare. The latest measurement period (2011-2013) indicates that African American, Hispanic, and American Indian women continue to be significantly more likely to be single mothers and to live in poverty than their non-Hispanic White and Asian counterparts are. The percentage of single mothers of Asian descent does not significantly differ from that of non-Hispanic White women; however, the percentage of single Asian mothers in poverty is statistically significantly higher than non-Hispanic White women. The percentage of African American women who are single mothers with children dropped during the 2011 - 2013 time period. Other groups indicated no large changes when comparing the two time periods. The percentage of American Indian and African American women with children in poverty dropped during the 2011-2013 time period.

Combining Figures 1, 2, and 3, we can conclude that compared with White women, minority women are more likely to earn less money, be single parents, live in poverty, and less likely to graduate from high school. The noticeable negative changes in income and education attainment for Asian women from 2007-2009 to 2011-2013 need to be further investigated.

Disparities in Female Households in Nebraska 2007-2009 & 2011-2013



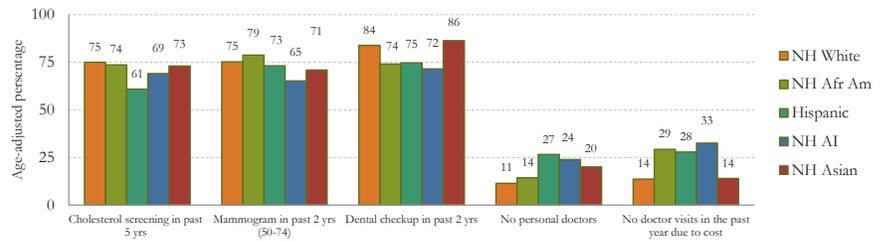
* no comparison data is available for NH Asian 2007-2009 due to unstable rates or insufficient numbers

Data source: American Community Survey, US Census Bureau

FIGURE 4. DISPARITIES IN PREVENTIVE CARE AND HEALTH CARE ACCESS AND UTILIZATION

Health care access and utilization are strongly related to improved health outcomes. In Nebraska, considerable gaps between non-Hispanic White and minority women persist when accessing and utilizing health care services. In contrast to non-Hispanic White women during 2011-2013, American Indian women are the least likely to have had a mammogram or dental checkup in the last two years, and were most likely to not have visited a doctor in the past year due to cost. Hispanic women are the least likely to have cholesterol screening in the past five years and the least likely to have a personal doctor. Additionally, the percentage of Hispanic, American Indian, and Asian women who reported not having a personal doctor and the percentage of African American, Hispanic, and American Indian women who reported not seeing doctors in the past year due to cost are statistically significantly higher than those for non-Hispanic White women. The percentage of African American and Hispanic women who reported having a dental checkup in the past two years is statistically significantly lower than that for non-Hispanic White women.

Disparities in Preventive Care and Health Care Access and Utilization in Nebraska Women 2011-2013

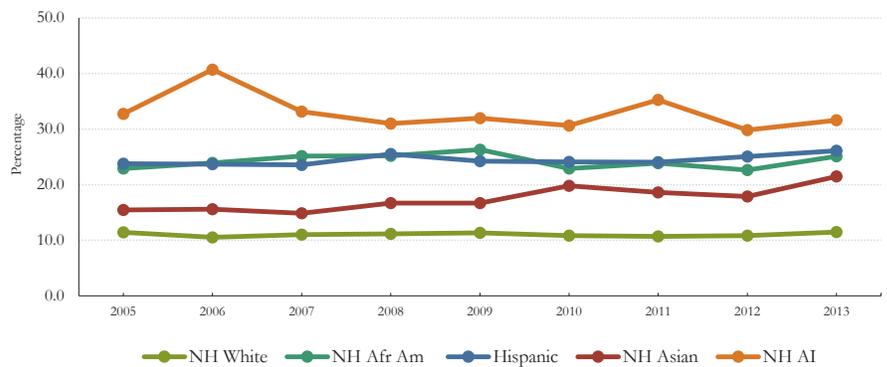


Data source: Nebraska Behavioral Risk Factor Surveillance System

FIGURE 5. DISPARITIES IN INADEQUATE PRENATAL CARE

Substantial racial and ethnic disparities in prenatal care continue to persist in Nebraska. Racial and ethnic minority women are less likely than non-Hispanic White women to have adequate prenatal care from 2005 to 2013. American Indian women are most likely to have inadequate prenatal care. The percentage of Asian women who received inadequate prenatal care increased slightly over time, while the percentage of women from other racial/ethnic groups who received inadequate prenatal care appears to be relatively stable from 2005 to 2013.

Disparities in Inadequate Prenatal Care 2005-2013

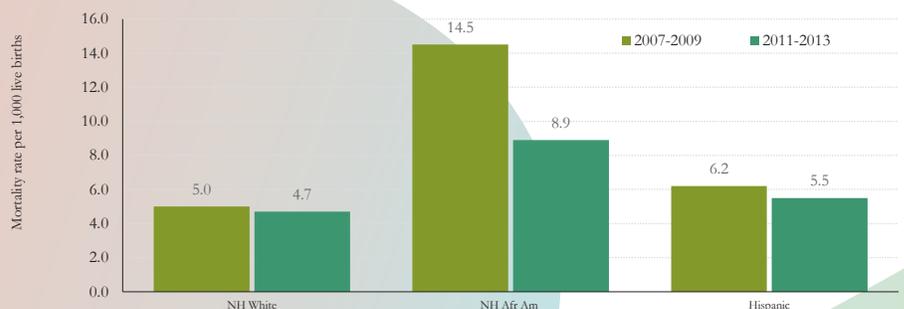


Data source: Vital Records, NHHS

FIGURE 6. DISPARITIES IN INFANT DEATHS

Infant mortality is an important indicator of health in a community and is associated with maternal health, quality of and access to medical care, socioeconomic, and public health practices. Racial and ethnic disparities are identified in infant deaths in Nebraska. The mortality rate for African American infants has greatly decreased since 2007-2009, but significant disparity still exists when compared to Hispanic infants and non-Hispanic White infants; African American infants continue to be more likely to die than non-Hispanic White and Hispanic infants. The infant death rates for Hispanic and non-Hispanic White infants declined from 2007-2009 to 2011-2013, but the declines were not statistically significant.

Disparities in Infant Deaths in Nebraska 2007-2009 & 2011-2013



Data source: Vital Records, NHHS

* no comparison data is available for NH American Indian or NH Asian due to unstable rates or insufficient numbers

FIGURE 7. DISPARITIES IN HEALTH OUTCOMES AND THEIR RISK FACTORS

Racial and ethnic differences in health outcomes and their risk factors continue to exist in Nebraska women. The rate of hypertension is significantly higher for African American and American Indian women when compared to non-Hispanic White women. The rate of diabetes, when compared to non-Hispanic White women, is higher across all racial and ethnic groups. The percentages of African American, Hispanic, and American Indian women who are overweight and reported a lack of physical activity are also higher than non-Hispanic White women. The rate of smoking is significantly higher for African American and American Indian women when compared to non-Hispanic White women.

Compared with White women, African American and American Indian women are more likely to be smokers, lack physical activity, be overweight, and have hypertension and diabetes; Hispanic women are more likely to lack physical activity, be overweight, and have diabetes; Asian women are more likely to have diabetes than White women.

FIGURE 8. DISPARITIES IN CANCER DEATHS

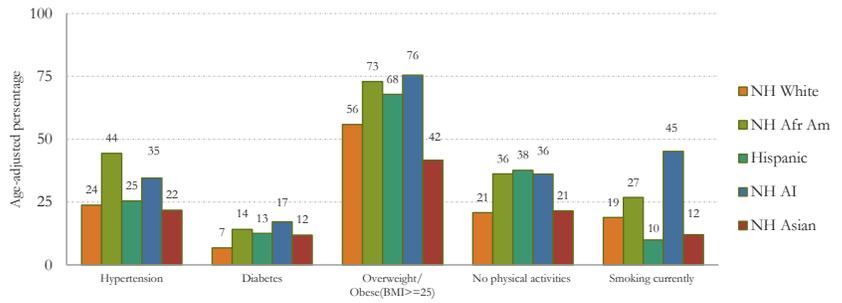
In 2007-2009, African American, Hispanic, and Asian women had cancer mortality rates that were significantly different than non-Hispanic White women. Since that time, the data shows that the disparities have leveled off. African American women had the highest rate of cancer mortality among all women during the 2007-2009 time period while American Indian women had the highest rate cancer mortality rates among all women in Nebraska during the 2011-2013 time period. During the 2011-2013 time period, African American cancer mortality rates declined from the 2007-2009 time period, while the rates for American Indian and Asian women increased. During both three year time periods, African American and American Indian women had a higher rate of cancer mortality compared to non-Hispanic White women. Hispanic women continue to have significantly lower cancer mortality rates than non-Hispanic White women, but there are no statistically significant differences between any other minority women populations and non-Hispanic white women.

FIGURE 9. DISPARITIES IN HEART DISEASE, STROKE, AND DIABETES DEATHS

Heart disease, stroke, and diabetes continue to be predominant causes of death in Nebraska women. Some disparity gaps persist when comparing the 2007-2009 and the 2011-2013 time periods. African American women continue to have higher mortality rates from heart disease, stroke, and diabetes than non-Hispanic White women. Additionally, Hispanic women have higher mortality rates from Diabetes than non-Hispanic White women. Stroke rates during both three-year time periods were higher for African American women than non-Hispanic Whites.

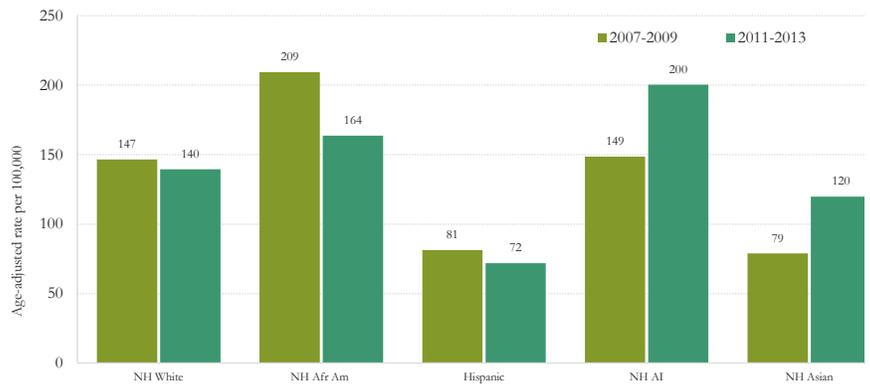


Disparities in Health Outcomes and Their Risk Factors in Nebraska Women 2011-2013



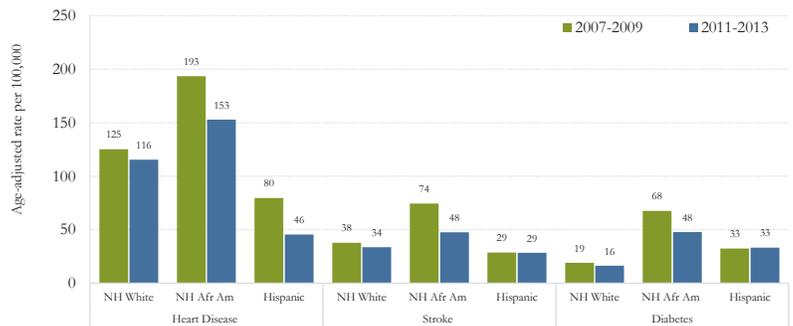
Data source: Nebraska Behavioral Risk Factor Surveillance System

Disparities in Cancer Deaths in Nebraska Women 2007-2009 & 2011-2013



Data source: Vital Records, NHHS

Disparities in Heart Disease, Stroke, and Diabetes Deaths in Nebraska Women 2007-2009 & 2011-2013



Data source: Vital Records, NHHS

* no comparison data is available for NH American Indian or NH Asian due to unstable rates or insufficient numbers

SOURCES:

1. CDC. CDC Health Disparities and Inequalities Report-U.S. 2013 (2013). Morbidity and Mortality Weekly Report (MMWR), 62(Supplement No.3): 1-184.
2. CDC. QuickStats: Health Insurance Coverage Among Adults Aged 55-64 Years, by Type of Coverage-National Health Interview Survey, United States, 2002-2003 and 2012-2013 (2015). Morbidity and Mortality Weekly Report (MMWR), 64(18): 511-511.
3. Beckles, Gloria L. MD, Truman, Benedict I. MD (2013). Education and Income-United States, 2009 and 2011. Morbidity and Mortality Weekly Report (MMWR), 63 (3): 9-15.
4. The Nebraska Statewide Health Needs Assessment (2013). The Office of Community and Rural Health Division of Public Health, DHHS.
5. Nebraska Women's Health Equity Report 2012 - Focus on Eliminating Disparities for Women of Color (2012). The Women's and Men's Health Program, DHHS.

