Health Care Needs of Medically Underserved Women of Color: The Role of the Bureau of Primary Health Care

Marilyn H. Gaston, Sharon E. Barrett, Tamara Lewis Johnson, and Leonard G. Epstein

The Bureau of Primary Health Care (BPHC) was developed to increase access to comprehensive primary and preventive health care and to improve the health status of medically underserved populations. Approximately 43 million Americans fall into this category, and the majority are poor, female, young, and uninsured. Under the Public Health Services Act, BPHC does not provide direct services, but rather assists local communities in identifying populations at risk of poor health outcomes and helps these communities through various programs. One of the newest initiatives of BPHC is the Office of Minority and Women’s Health, developed with a mission to help reduce the disparities in the health status of women of racial and ethnic minority populations. This article outlines these disparities and discusses proposals for reducing them.

Key words
accessibility of services
health care utilization
racial differences
women

The hypotheses, studies, programs, and approaches discussed in this special edition are familiar to social workers in a variety of educational and practice settings. The respective helping professions and the Bureau of Primary Health Care (BPHC) have known and worked closely together with women from Native American, Hispanic American, African American, and Asian American and Pacific Islander backgrounds for decades. The bureau has recently developed a specialized program, Office of Minority and Women’s Health (OMWH), to help address some of the unmet health care needs of women of color. Concomitantly, this new program and its conceptualization have been based on our mutual knowledge that women of color (particularly in the lowest income group) and their children have not received the level of access or quality of physical and mental health care that they require to sustain themselves (Adams, 1995; Bayne-Smith, 1996; Center for Health Economics Research, 1993; Salganicoff, 1997; Schoen, 1997; U.S. Department of Health and Human Services [HHS], 1985; Weaver, 1976; Weiss, 1997). The difficult task for the helping professions and for government has been to determine and agree on the most effective policies, services, and conceptual approaches to support and implement in this new and fluid managed health care environment. However, in the past several years, our knowledge of successful model programs that solve and prevent some health problems has increased significantly (BPHC, 1996a). A number of successful programs developed by BPHC have been based on a clearer understanding of the relationship between the culture of a community and its health status. At the close of the 20th century, we know more about how to assist medically underserved women than ever before in our history (Adams, 1995; Bayne-Smith, 1996). But the research challenge remains urgent to identify more specifically what works well and with which women, under what conditions and in what amounts, to prevent poor health, illness, and early deaths. These are critical issues in our current health care environment, where
human and fiscal resources are limited and where access, cost, quality, and utilization are being managed by new processes (Mauer, Jarvis, Mockler, & Trabin, 1995).

The intent of this article is to describe the role of BPHC, OMWH, and their legislative mission to enhance the health status of underserved and vulnerable women and their children; to briefly review some of the background data on the medically underserved and the particular status of women of color within that population; to identify a series of questions to help frame the policy dialogue for developing services to medically underserved women of color; and to invite dialogue, feedback, and participation with social workers around a number of these key questions and issues that can help guide our collective vision and health care initiatives for the medically underserved over the next several years.

**Mission of the Bureau of Primary Health Care**

One of the most significant problems for underserved populations is their inability to obtain health care services in the marketplace. Where access is severely limited, “people use fewer health services and have worse health outcomes” (Center for Health Economics Research, 1993, p 6). The limited access of medically underserved and vulnerable populations is reflected in their higher mortality rates and increased rates of cancer, heart disease, strokes, and dental disease (Center for Health Economics Research, 1993).

The Bureau of Primary Health Care was developed by the Public Health Service to increase access to comprehensive primary and preventive health care and to improve the health status of populations defined as medically underserved (BPHC, 1996b). Generally, the medically underserved in the United States are defined as individuals and families who lack adequate “access to primary care” (Hawkins & Rosenbaum, 1993, p. 49). Multiple barriers to access exist: low income, lack of health insurance, old age, poor health outcomes, inadequate health infrastructure, and insufficient supply of primary physicians, as well as cultural, attitudinal, and linguistic differences (Hawkins & Rosenbaum, 1993). When gender is added to these characteristics, the risk of limited access increases. A medically underserved woman encounters additional barriers to health care access that result from any combination of the following characteristics including but not limited to poverty: race, ethnicity, and culture; state of mental or physical health; geographic location; and sexual orientation (BPHC, 1996b).

When the definition of medically underserved is operationalized to include 12 health status variables (see Hawkins & Rosenbaum, 1993) designed to measure the extent and distribution of vulnerability in state and county populations, the results show that approximately 43 million Americans fall into this category. Of these 43 million who lack access to a primary care physician, the majority are poor, female, young, and uninsured (BPHC, 1996b). Furthermore, survey research shows that these medically underserved populations are found in each state, although the proportionate distribution varies by state and to some extent by region. Proportionately more (eight of 12) of the southern states have populations that are medically underserved compared with other regions of the country. Only seven states have populations in which fewer than 10 percent are medically underserved, whereas 15 states have medically underserved populations that range between 21 percent and 46 percent of the overall population. In 28 states between 11 percent and 20 percent of their populations are medically underserved (BPHC, 1996b).

Under the Public Health Services Act, BPHC does not provide direct services to people in local communities, but rather assists local communities in identifying populations at risk of poor health outcomes and then helps these communities in four primary ways:

1. helps establish and support the Community and Migrant Health Centers and Health Care Programs for the homeless and for public housing residents
2. operates the National Health Services Corps that provides financial support for training and education of culturally competent health care providers in exchange for their provision of health care services in rural and urban areas where there is a shortage of health care professionals
3. identifies and disseminates information about creative and successful health care programs that serve as nationwide models for replication
4. works directly with local communities to establish and build primary care systems and recruit health care clinicians.

BPHC’s 1998 budget appropriation of $977 million supports 17 program initiatives in more than
746 local nonprofit health clinics, in 4,500 related programs, and for more than 5,000 health care providers throughout the United States. Nearly 85 percent of the total appropriation to the bureau is used to support local nonprofit community health centers. The remaining 16 percent of the appropriation is used to support the National Health Services Corps and programs for a number of specialized diseases—black lung, Hansen’s, and Alzheimer’s. The 746 nonprofit health centers provide true safety net services to the medically underserved without regard to their ability to pay or the availability of health insurance.

**BPHC supports primary and preventive health care for 10.3 million (20 percent) of the 43 million medically underserved Americans.**

### Services Supported

BPHC supports primary and preventive health care for 10.3 million (20 percent) of the 43 million medically underserved Americans. In the period between 1990 and 1996, the nonprofit health centers increased the number of uninsured people receiving plenary health care by 46 percent, and there was an increase of only 16 percent in the number of uninsured people receiving similar care nationally from other health care providers (BPHC, 1996b). Between 1995 and 1996, the number of uninsured people receiving primary care from nonprofit health centers increased by nearly 4 million, and the number of Medicaid-insured people receiving care from the health centers declined by almost 3 million. Overall, health centers supported by the bureau had over 33 million total visits in 1996.

The 17 program initiatives supported by the bureau at the local level are designed to enhance the health status of the following underserved populations: uninsured people; underserved mothers and children; inner-city, elderly poor people; women and people of color living in poverty; high-risk pregnant women; homeless families and individuals; people in rural and frontier areas; Native Hawaiians and Pacific Islanders; school children in poor communities; residents of public housing; people who are substance abusers; new immigrants and detained aliens; adolescents; people with Hansen’s disease; migrant farm workers; people with Alzheimer’s disease; and people with HIV/AIDS-related disorders.

Local community health centers supported by BPHC provide primary and preventive care, outreach, and dental care to these populations. In addition, the health centers offer a range of ancillary health services to the medically underserved, including laboratory testing, environmental health, pharmacy services, health education, transportation, translation services, and prenatal care. The health centers also establish collaborative linkages with welfare agencies, Medicaid, substance abuse treatment services, the Supplemental Food Program for Women, Infants, and Children, and related state and local services and agencies. In addition, more than 350 of the health centers are contractually linked to managed care organizations, HMO primary care networks, and state Medicaid managed care networks in their efforts to provide quality care to the medically underserved population.

### Population Served

Analysis of user data shows that low-income women of color are the major recipients of services provided in almost all 746 local health centers supported by BPHC (BPHC, 1996b). Of the people served directly in local health center programs, 57 percent are low-income women of color (32 percent are of childbearing age), and 42 percent are children. Slightly more than 65 percent of the total population served are people of color, and 85 percent of these are poor, near poor, and among the sickest and most isolated in the nation (BPHC, 1996b). The remaining 35 percent of the underserved population are white and have incomes that are between 100 percent and 200 percent above the poverty line. Almost 41 percent of the clients served in local health centers are uninsured. Nearly one-third of all health center clients have Medicaid coverage, whereas fewer than 8 percent have Medicare benefits. Fewer than 15 percent of individuals receiving local health center services have private insurance benefits but have limited options for obtaining quality services in their geographic areas.

The proportion of medically underserved males and females receiving services across all local health center program initiatives is evenly distributed up to age 12. However, between ages 13 and 64,
frequency of service utilization by women almost doubles that of men. Similarity in utilization rates by gender is not noted again until both groups exceed age 85.

Women older than age 15 make up 27 percent of the clients served by the Health Care for the Homeless Program. Of the women served in this program, 40 percent are African American, 36 percent are white, 14 percent are Hispanic, 2.3 percent are Asian or Pacific Islander, and 2.1 percent are Native American (BPHC, 1994a, 1994b). In the HIV Early-Intervention Program, 15,000 women over age 13 received services in 1994. Of this number, a disproportionate percentage (51.7) were African American, whereas African American women make up only 6 percent of the total population of the United States (U.S. Bureau of the Census, 1995). Nearly 20 percent of the HIV Early-Intervention Program recipients were white women, and 25 percent were Hispanic. Together, African American and Hispanic women were 77 percent of all of the women older than age 13 treated by local health services for HIV in 1994.

In each key health status initiative offered by local health care centers, the frequency of service utilization by women of color exceeded their expected frequency based on their relatively small representation in the general population. Clearly, the local nonprofit health center programs supported by BPHC constitute the primary health care service system for low-income women and their children who have been medically underserved for a variety of interrelated personal, organizational, financial, and bureaucratic reasons. Although BPHC can and does address the health disparities that affect the lives of low-income women and their children who have been medically underserved for a variety of interrelated personal, organizational, financial, and bureaucratic reasons. Although BPHC can and does address the health disparities that affect the lives of low-income women and their children, these disparities are only symptomatic of more entrenched causes. The frequency of use and the persistence of wide health disparities between low-income women of color and others in the community support the need for a specialized initiative to examine, evaluate, and strategically plan how to reach and provide primary health care to this segment of the population.

The Office of Minority and Women’s Health: Formulating a Vision

One of the newest initiatives within BPHC is the development of OMWH. OMWH was developed in 1994 with a mission to develop and promote specific activities that help reduce the disparities in the health status of women of racial and ethnic minority populations. In addition, OMWH is designed to develop collaborative partnerships to ensure that health services are coordinated and reflective of the cultural and linguistic needs of the population of culturally diverse women that are served. OMWH uses three related strategies to move toward achievement of its mission:

1. promotion of strategies to improve access of members of ethnic minority groups and women to health care
2. development of collaborative linkages between public and private organizations to encourage the sharing of resources
3. gathering and dissemination of information on the health status of women of color and model programs that have been successful in eradicating barriers to health care.

Beginning in 1991 BPHC developed a Women’s Health Workgroup to examine the health status of women of color and the continued disparities in their access to primary health care. The workgroup was asked to review background data on the current health status and access of women of color, identify and evaluate research studies and reports on the health condition of this population, explore historical trends in access and their relationship to the health risks of this population, and examine existing health services programs that have achieved a measure of success in getting women of color access to primary care. The workgroup was also asked to help develop a comprehensive strategic plan by spring 1998 for increasing the access of women of color to primary care.

One of the first tasks for the workgroup was to review existing reports on the disparities in health status and access of women of color to primary care. Several studies over the past 13 years showed clearly the dilemmas of obtaining access to health care and the added risks when the population is poor, of color, and female. Three of these reports were of particular relevance to our strategic planning process.

Research on Underserved Populations

The Heckler Taskforce. One of the first comprehensive reports on the health status of people of color and their children was issued in 1985 (HHS). Margaret Heckler, then secretary of HHS, recognized in her annual report to Congress what she termed “a continuing disparity in the burden of death and illness experienced by black and other minority Americans as compared with our nation’s population as a whole” (p. x). Heckler established
a national taskforce and asked that they examine four interrelated areas of health care for black and other populations of color: (1) current health status, (2) access to the health care system, (3) actual use of health care services, and (4) factors related to disparities in health status.

The taskforce structured its methods and data analysis around the concept of excess deaths to show the extent of differences in health status by income, color, and gender. *Excess deaths* were defined operationally as the number of deaths that would not have taken place had the rates for the ethnic minority populations been equal to that of white Americans. The taskforce found that 80 percent of the excess deaths in these populations resulted from six causes: (1) cancer, (2) cardiovascular disease and stroke, (3) chemical dependency, (4) diabetes, (5) homicide and accidental injuries, and (6) infant mortality. The actual rankings within each population of color varied. The report showed that overall the rates of excess mortality for African American, Native American, and Hispanic American (Mexican origin) females greatly exceeded that of white females. However, data on Asian American female populations concluded that there was an absence of excess deaths in this population. In fact, the rates of actual deaths were significantly lower than for white females in every category.

When the specific causes of deaths were examined comparatively by group, African American females were at considerably higher risk in every category. The risk of excess mortality for African American females from infant mortality, tuberculosis, hypertension, homicide, and diabetes were consistently higher than for all other groups of females. The risk of excess deaths for African American females from tuberculosis was 15 times greater, and their risk of death from hypertension was 13 times greater than for white females. The highest risk of excess deaths for Native American females was from cirrhosis, tuberculosis, and renal disease (HHS, 1985).

On the basis of this report, Heckler proposed a series of national policy strategies that would “end the health disparity” between Americans (HHS, 1985, p. x):

1. an outreach strategy to disseminate health information to increase early detection, health promotion, and intervention
2. development of specific efforts to educate patients and health care providers about the links between health risks and culture
3. development and implementation of flexible models of health care that are culturally competent
4. development of methods to increase the availability of health care programs in ethnic minority communities
5. discovery of ways to increase collaboration within and across various federal branches and departments that affect the availability of health professions in underserved areas
6. an increase in the capacity of the nonfederal sector to address the health problems of people of color
7. improvement in and facilitation of the use of available sources of data
8. development and fostering of a research agenda to ensure health issues of ethnic minority populations are studied scientifically.

*Studies by the Robert Wood Johnson Foundation.* A second major effort to document the health status of populations of color was conducted by the Robert Wood Johnson Foundation between 1991 and 1993. The foundation commissioned three related studies of secondary health care data that included sampling of African American and Hispanic populations. The first report (Robert Wood Johnson Foundation, 1991) focused on health status, human resources, and availability of hospital and nursing home beds. Although the report noted that life expectancy of women of color (particularly African American women) had increased relative to men, the range of disparities by race and Hispanic origin noted in the Heckler report (HHS, 1985) remained. The report cited distressingly high rates of infant mortality, neonatal mortality, low-birthweight babies, deaths from addictive substances, and lower annual physician visits by race and Hispanic origin. The most significant new data in the 1991 Robert Wood Johnson report was information on the development and spread of AIDS. The report indicated that the risk of new cases of AIDS was most pronounced among African American and Hispanic women and their infants.

The second Robert Wood Johnson report (Institute for Health Policy, 1993) focused on substance abuse, with fewer indicators of linkages by race and Hispanic origin. Although the rates of deaths from the ingestion of alcohol and illicit drugs was considerably greater for African American men, the rate of death for African American women (4 per 100,000) noted in the report was two times greater than the rate for white women.
Deaths from alcohol use were found to be lower generally among white, African American, and Hispanic women than men. Data and information on other ethnic groups was not included in the analysis.

The third report in the Robert Wood Johnson series (Center for Health Economics Research, 1993) focused on the relationship between access to health care and health status. The foundation concluded that although the United States had made major gains in health care delivery that were reflected in advances in the health status of the population as a whole, these advances had not trickled down to lower-income African Americans and Hispanics. Data were not available on Native American and Asian American populations.

The report (Center for Health Economics Research, 1993) identified a number of factors that were related to access to health care. Most notable among the factors that determined both limited access to health care and poor health status were low income, the maldistribution of health services in the community, absence of culturally competent services providers, and the unavailability of health insurance. The report noted that the uninsured tended to be young, low-income African American and Hispanic women and their children. In addition, the data showed that there were limited improvements or changes in several areas of health care noted in the Heckler report (HHS, 1985): continued high rate of neonatal deaths, low-birthweight babies, and limited access to prenatal care for most underserved women of color. Furthermore, the report found that although more than 75 percent of white women obtained prenatal care, only 65 percent of African American and Hispanic women received such care. Part of the reasons for the differences in access to prenatal and postnatal care by race and Hispanic origin is the difficulty Hispanic and African American women reported in obtaining care and the limited number of health care providers located in their communities or the limited number who accepted Medicaid payments. Overall, the report concluded that a central issue that continued to produce negative health outcomes for women of color was limited access to quality health care.

Studies on Asian and Pacific Islander Populations. Few of the research reports produced over the past several decades provide adequate data on Asian American and Pacific Islander populations and issues of health care. Where data has been available, the quality of this data has been questioned (Zane, Takeuchi, & Young, 1994). Gardner (1994) provided an overview of critical health care issues for Asian American and Pacific Islander populations that allowed for comparisons with white, African American, and Hispanic populations of key causes of mortality. Gardner examined crude death rates for various populations between 1940 and 1980. In comparison to other populations, the rates for Asian American and Pacific Islanders for all causes of death were lowest. Recent figures (Gardner, 1994) on life expectancy show that Asian American and Pacific Islander populations tend to have life spans equal to that of white and African American females. Infant mortality rates and the proportion of low-birthweight babies of Asian American and Pacific Islanders are the lowest of all population groups in the United States. Although Asian American and Pacific Islander women die from the same six causes as women in other populations, the rates of deaths and percentages of death by cause are lower than for other groups of American women. For example, whereas the death rate from all causes per 100,000 for white females in 1980 was 405 and the rate for African American women was 611, the rate for Asian American women was only 244 per 100,000 (Gardner, 1994). The leading causes of death for Asian American women in 1980 were cancer and heart disease. However, these rates per 100,000 population were twice as low as those for other female populations.

Conclusions of the Women’s Health Workgroup

The Women’s Health Workgroup concluded from their review of studies that one primary cause of dismal health outcomes for low-income women of color was limited access to primary health care at critical stages of their lives. Low-income women of color in many underserved areas have great difficulty finding day-to-day health care for themselves and their families. The reasons for this situation are both complex and long standing.

The workgroup believed that a special initiative aimed at women of color, supported by BPHC and implemented at the local level, could increase access to primary care by low-income women of color and their families. The workgroup noted that experiences in delivering health care to these populations at the local level over the past several years suggested that such an approach could be successful. Progress in two health care indicators were cited as examples. In their efforts to eliminate systemic barriers to care, health center programs supported
by BPHC have developed and implemented innovative primary and preventive services for underserved women in their own communities. These health center programs have exceeded two Healthy People 2000 objectives (mammograms and Pap smears) for women and surpassed national averages, despite the challenges inherent in serving predominantly underserved populations. Compared with the general population, women who received health care services from health centers supported by BPHC had more up-to-date Pap smears and mammograms and prenatal care. These local health center programs have been successful in getting high-risk women into care and maintaining their linkages because these programs meet their needs and help reduce barriers to health care and related services.

Despite these and related achievements, the workgroup noted that the majority of BPHC health services and health data collected on women served by BPHC programs focused primarily on women in their reproductive years and less on the broader range of systemic health and social issues that women experience throughout their lives (for example, women and health issues across the life cycle and gender and ethnocultural issues and their relationship to access). The workgroup believed that additional efforts and resources must be made to address life span issues for women of color. It is important to recognize that many of the underlying social and health issues that negatively affect the lives of these women have existed for decades (HHS, 1985; Rice & Jones, 1990).

Although women of color are more likely than men of color to receive medical and mental health care, the workgroup noted they are underrepresented in all aspects of biomedical research (Glied & Kofman, 1995). There is an even greater shortage of research data on the health status of underserved women and women of color (Weiss, 1997). In many instances the workgroup noted that the nation and the helping professions are unclear about how low-income women of color conceptualize health or disease or what factors determine how they decide when and how to seek help for themselves or their children. Consequently, the workgroup concluded that there is not sufficient information on many important aspects of the health status of women of color and the methods of intervening early to prevent ill health or disease.

The workgroup also noted that there is an urgent need to broaden the scope of women’s health research and services to include programs, services, and data that will have a more effective and lasting impact on the health status of underserved women. The group recognized that to truly improve the health status of underserved women, it is necessary to develop and implement services that address related gender and psychosocial factors within the individual’s culture that have an influence on women’s health status.

OMWH and the Women’s Health Workgroup are attempting to develop a policy and program agenda that flows from a set of experiential principles concerning women’s health needs, their caregiving roles and responsibilities, and their health practices. In the past, the failure to articulate the values that women bring to health care has produced policies and programs that impair rather than improve the health of underserved women. The following 10 basic questions form the foundation of the strategic planning proposals for women’s health policy and program development:

1. How do we address women’s health issues throughout their life span?
2. How do we integrate knowledge and understanding of culture and gender roles into effective health services delivery for women?
3. How can BPHC advocate for health promotion and for prevention and treatment of disease for all underserved populations?
4. How does the bureau incorporate the diverse values of women into service design and delivery?
5. What role can complementary and alternative medicine play in helping underserved women promote and maintain health and wellness?
6. How can BPHC-supported programs forge partnerships with the women they serve, providing care with, not for, their clients?
7. How do we integrate a holistic, biopsychosocial approach to health care in the lives of underserved women and avoid the isolation of medical issues?
8. How do we collect, analyze, and disseminate information and knowledge about this underserved population?
9. What kind of leadership strategies are needed to develop and move new policies and services that preserve the viability of bureau programs and other safety net providers for underserved women?
10. How do we link our efforts with those of social work practitioners and professional schools?
The Women’s Health Workgroup also proposed that cultural competence, as defined by Cross, Bazron, Dennis, and Isaacs (1989) be considered as a conceptual framework for organizing services to the large number of racial, ethnic, and linguistic minority groups that receive services from BPHC-funded agencies. The shortage of linguistically and culturally appropriate services for ethnically, racially, and culturally diverse populations is a significant health disparity issue for these populations in the continental United States and U.S.-associated jurisdictions (Davis, 1997). Although many Americans receive linguistically and culturally appropriate health services as a matter of course, a sizable proportion do not. Title VI of the Civil Rights Act and the Disadvantaged Minority Health Improvement Act of 1990 (P.L. 101-527) mandates that HHS provide equal access to its programs and services to ethnically, racially, and culturally diverse populations and to people with limited English skills. Americans whose language and culture of orientation are not within the dominant Western European–American mainstream experience severe health service disparities. As a result, the workgroup believes that cultural competence offers health services an overarching conceptual frame of reference to organize the delivery of services to the underserved populations (Davis, in press).

The strategic planning process established by OMWH is ongoing. The Women’s Health Workgroup will continue to meet to develop and help implement a series of steps at the local level to remove the barriers to care that have been a consistent impediment to access for low-income women of color.

**Implications for Social Work**

Although social workers and many other professions have known about and worked for decades to resolve the disparities in health status that mark communities of color, it is clearer than ever before that women of color continue to die at unexpectedly higher rates than other populations from new and old diseases: AIDS, violence, breast cancer, cervical cancer, liver cancer, cardiovascular disease, and cirrhosis. Their risks of excess deaths are higher. Their resources and choices of care are lower. The children of low-income women of color, too, continue to die at rates that are more expected in countries of lesser wealth than the United States. Some of the implications of these disparities for the nation as a whole and for health care professionals and universities are obvious.

To reduce and eventually resolve these disparities and the factors that have sustained them for decades requires that the nation and the helping professions collaborate in efforts to put the health of ethnic minority populations in all of its forms (physical, mental, and social) high on the national agenda, high on the agenda of social workers, and high on the agendas of the President of the United States and Congress.

In one of his weekly radio addresses, President Clinton (1998) pointed out the disturbing presence of major disparities in health status for African Americans, Asian Americans, Hispanic Americans, and Native Americans compared with other Americans. Mr. Clinton indicated that although the reasons for these disparities may not be as clear as we as a nation would like, it is clear that “racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all” (Clinton, 1998, p. 2). In response to these issues, the president established the following goal: “By the year 2010, we must eliminate racial and ethnic disparities in health status” (Clinton, p. 2). To work toward this goal, Clinton earmarked $400 million in his 1998 budget submission to Congress for this purpose. Clinton’s goal identifies the second implication for social work: Social workers must identify how the profession will contribute to achieving this most important national social justice goal to equalize health status and access.

The social work profession must help find ways to assist the health care industry in recognizing and valuing the central role culture plays in women’s health-related behavior. Cultural diversity has a pervasive influence on the level and quality of health care services provided to women of color, who represent some of the most underserved populations by local health care and assistance programs. Racism affects both the resources devoted to serving women and the willingness of women to seek care. Culture, language, and gender affect all facets of health status for underserved women from personal health behaviors to the shortage of health resources in medically underserved communities. The cultural diversity and cultural competence of administrators and providers influence both the quality of and access to care.

Social workers need to strengthen the emphasis on prevention in the social work curriculum. Many illnesses prevalent among women today are preventable, either through changes in lifestyles (for example, improved diet, increased exercise, or...
smoking cessation) or preventive health care (for example, mammograms and Pap smears). Programs that enhance women’s understanding of the effects of their own behavior can result in dramatic improvements in health outcomes. Assessing women's knowledge of daily life skills is important in understanding healthy behavior.

Lifestyle issues are particularly relevant for teenagers, pregnant women, and older women. Good health care choices must also be woven into the cultural traditions of a people. Intergenerational improvement of health behaviors may also serve to ameliorate persistent health beliefs and practices that are deleterious to women’s health. Women gather strength and resilience from relationships, and those relationships are central to encouraging women to lead healthy lifestyles, seek appropriate health services, and work with clinicians to manage illness. Health promotion and illness prevention and treatment programs need to recognize the importance of establishing relational ties with the women they want to serve and of nurturing those relationships that lead to prevention.

There are clear implications that social workers must continue to gather and use information and data about the medically underserved to engage policymakers and government representatives in the development of legislation and policies that show promise of increasing low-income women’s access to primary care. Part of this data gathering and analysis can and should be done by social work scholars in collaboration with BPHC and its hundreds of local programs.

**Conclusion**

The major disparities in health care that pervade the lives of medically underserved women of color, their families, and communities have plagued the United States and all health care professions for decades. The brief overview of data on this population in this and other articles in the special issue of *Health & Social Work* makes clear the continuing dilemma the nation faces; although women are central figures in maintaining the health of their families and communities, medically underserved women are less likely to be able to fulfill this role. Women of color are often unable to carry out this critical role in their families and communities for a variety of reasons: racist, economic, bureaucratic, institutional, cultural, and political, as well as scientific. Medically underserved women need the human services professions to assist in removing fundamental barriers that restrict their ability to maintain their health, the health of their families, and their communities. Part of that responsibility rests with BPHC and OMWH.

The bureau and its programs have a critical role to play in researching and analyzing health care outcomes in relation to underserved women. The bureau must work in partnership with other federal agencies as well as state and local agencies and private, nonprofit, and community-based organizations to promote and support research programs that seek to improve health care services and health outcomes for underserved women. Here too, there are important roles for social work schools and researchers to play. Collaborative efforts between BPHC, the hundreds of local programs it supports, and the field of social work can and should identify existing national- and state-based data sources and areas where additional data collection are needed. More than any other factor, it may be our ability to collaborate that will allow us as a nation and as professional groups to help mitigate the numerous problems and barriers that have caused and sustained the unjust disparities in health care for medically underserved women, their families, and communities.

There is also a need to work with other partners who have established relationships with women, such as schools, faith-based organizations, and social services agencies, to draw women into the health care system and provide comprehensive care. The role women play in caring for their families and their communities must be recognized, supported, and nurtured. At the same time, women must be empowered to care effectively for themselves, something that women may neglect while caring for others. Healthy women build healthy communities.

**References**


Bureau of Primary Health Care. (1996a). *Models that work: Compendium of innovative primary health care programs for underserved and vulnerable*
Health Care Needs of Medically Underserved Women of Color


About the Authors

Marilyn H. Gaston, MD, is associate administrator for primary health care, Health Resources and Services Administration, Bureau of Primary Health Care (BPHC), and Assistant Surgeon General of the United States; Sharon E. Barrett, MS, is associate director, BPHC, Office of Minority and Women's Health (OMWH); Tamara Lewis Johnson, MBA, MPH, is senior public health analyst, OMWH; and Leonard G. Epstein, MSW, is senior coordinator for cultural competency programs, OMWH.

Accepted March 20, 1998