Health care utilization among women on O'ahu: implications for Native Hawaiian women

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Abstract

Women generally seek and use more health care services than do men. Women are also more likely to encounter financial and non-financial barriers to care than do their male counterparts. These differences are accentuated among low income and minority women. We examined health care utilization patterns among women on O'ahu using survey data, and compared those patterns among Native Hawaiian and other ethnic groups. We also provide prevalence rates for several critical women's health issues by ethnic group and explore demographic predictors for health care utilization. Although the vast majority of women have seen health care providers in the last year, ethnic and socioeconomic disparities were identified, especially with respect to our Native Hawaiian female population. A pattern for Native Hawaiian women reveals among the highest rates of depression, as well as sexual/physical/emotional abuse. Alarmingly, Native Hawaiian women are also less likely to have seen a provider in the last year, less likely to have insurance coverage, and more likely to visit emergency departments. Differences by provider type served to reinforce these disparities. In order to reduce barriers to health care utilization for Native Hawaiian women—and for all women in Hawai'i—we recommend universal insurance coverage that includes screening and counseling services. Additionally, training for health care providers is essential in order to improve culturally competent, psychological assessments of health issues for women, particularly Native Hawaiian women.

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Introduction

Women in the United States seek and use more health care services than men of comparable age[1 7]. For example, 83% of women report having a usual source of health care, such as a primary care provider, in comparison to 73% of men who are 18 years of age or over[2]. Women with a usual source of care are more likely than those without to receive preventive, curative, and rehabilitative care[8]. This implies that women without a usual care source may be lacking appropriate preventive, curative, and rehabilitative care. This may well lead to increased costs in terms of dollars and in years of productive life, which in turn, may result in increased costs not only in terms of dollars, but more importantly, in terms of years of productive life. Of note, these trends persist, even after accounting for obstetric uses across all age, ethnicity, and socioeconomic groups.

Women are also significantly more likely than men to encounter barriers to regular health care[1,9]. Women are more likely than men to have limited coverage and to require public insurance, especially Medicaid[10]. Low income and minority women are more likely to be uninsured or publicly insured than women of higher socioeconomic status and men from similar minority groups. A well-documented study on Native Hawaiian health needs established that lack of insurance is a major barrier to health care utilization for Native Hawaiians[11]. Thus, women of Native Hawaiian ancestry who lack insurance may be more vulnerable to such health care system problems, both financial and non-financial.

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Table 1. Sample description (*n* = 332)

		Number of respondents (%)
Response Rate		81.8%
Age	18-24	43 (13.5%)
	25-34	60 (18.8%)
	35-44	85 (26.6%)
	45-54	67 (21.0%)
	55-64	33 (10.3%)
	65 and over	31 (9.7%)
Ethnic Identity	Caucasian	91 (28.5%)
	Filipino	38 (11.9%)
	Hawaiian	59 (18.5%)
	Japanese	69 (21.6%)
	Other	62 (19.4%)
Children		228 (71.7%)
Living Situation	Alone	43 (13.6%)
	Other	28 (8.9%)
	With relatives	78 (24.7%)
	With partner	137 (43.4%)
	With partner and relatives	30 (9.5%)
Education Level	Less than high school	10 (3.0%)
	High school	87 (26.4%)
	College	232 (70.5%)
Employment Status	Not employed	86 (26.1%)
	Employed part-time	69 (21.0%)
	Employed full-time	174 (52.9%)
Monthly Household Income	Less than $1,000	46 (14.3%)
	Between $1,000 and $2,000	76 (23.7%)
	Between $2,000 and $3,000	55 (17.1%)
	More than $3,000	144 (44.9%)

Non-financial barriers, such as lack of services or inappropriate providers, can also impede access to health services[6,9-10]. A major criticism of health treatment for women is its lack of sensitivity to the unique needs of women, including lack of dependable childcare, safe transportation, and adequate hours of operation.

There has been recent interest in increasing service delivery to minority women. These studies, which assert that such delivery requires certain cultural competencies[12-16], could well be extrapolated to apply to Native Hawaiian women. Thus far, such competencies include: (1) understanding cultural strengths and acculturation issues, and (2) recognizing a woman's relational needs and difficulties in initiating treatment. Although not specific to women, the need for increased cultural competency in treating Native Hawaiians was recognized and prioritized as early as 1985 in Hawai'i[11].

This study examines health care utilization patterns among women in Hawai'i and compares these trends among ethnic groups. The analysis also provides prevalence rates for several critical women's health issues by ethnic group. Additionally, the present study explores demographic predictors for health care utilization. Implications, especially for Native Hawaiian women, are discussed.

Table 2. Prevalence of selected women's health issues, by ethnicity

Health Issue	Prevalence (per 100 women)					
	Overall	Caucasian	Filipina	Hawaiian	Japanese	χ^2, *df*, *p*
Osteoporosis	9.2	5.6	5.3	8.5	13.2	N.S.
Breast Cancer	2.9	2.2	0.1	3.4	7.5	N.S.
Sexually Transmitted Disease	11.9	16.7	7.9	10.3	11.9	N.S.
Physical Abuse	15.1	14.8	21.1	21.8	7.2	Trend ($\chi^2=6.28$, $df=3$, $p=0.098$)
Sexual Assault	13.5	21.3	7.9	19.0	7.5	$\chi^2=7.98$, $df=3$, $p=0.046$
Emotional Abuse	26.1	36.0	18.9	27.6	17.9	Trend ($\chi^2=7.67$, $df=3$, $p=0.053$)
Substance Abuse	10.9	7.8	11.1	13.8	8.8	N.S.
Depression	36.2	49.4	32.4	34.5	23.5	$\chi^2=11.59$, $df=3$, $p=0.009$

N.S. = not significant

Method

Participants

The sample was drawn from major shopping centers using cluster sampling. Eight sites were selected representing the diversity of communities on O'ahu[17]. These areas included Kalihi, Kāne'ohe, Mānoa, Hawai'i Kai, Mililani, Mō'ili'ili, Salt Lake, and Wai'anae. To detect differences among the demographic variables, 37 participants were needed per collection site for a total sample of 296[18].

A total of 332 women completed surveys at one of eight sites (see below) for an overall response rate of 81.8%. The sample description is provided in Table 1.

Measures

Categorical information was collected on site: age (18-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75 years or older); ethnicity (Caucasian, Filipina, Hawaiian, Japanese, other); highest educational level (less than or some high school, high school graduate, some college/graduate); employment status (unemployed, part-time, full-time); income (< \$1000 per month, \$1000-\$2000, \$2000-\$3000, >\$3000 per month); insurance coverage (yes, no); living situation (alone, with partner, with relatives or friends, other); and number of children (none, one, more).

The survey also assessed eight priority health issues among women. Participants were asked to respond to a series of statements on each of these issues, including a statement on prevalence. Participants were asked if they have had in the past, currently have, or think they have each of the women's health conditions. Additionally, several questions were asked about health care utilization. The women were asked if they had seen a health care provider in the last year. They were also asked if they had a usual source of care, and if they did, whether or not they were comfortable with their usual source of care. In addition, the participants were asked if they had seen a primary care provider, emergency department doctor, obstetrician/gynecologist, mental health worker, or other specialist.

Procedures

This cross-sectional survey of women on O'ahu was conducted in October, November, and December of 1999. These data were part of an earlier study by Goebert[19]. Data collection was conducted on Sundays, which is the peak-volume shopping day for the chain of stores accessed. Survey tables were set up near each store and every woman within reasonable earshot was invited to participate in a study on women's health concerns. The purpose of the study was explained to potential participants and verbal consent was obtained. The survey was written at the sixth-grade reading level and took less than 10 minutes to complete. Participants received a \$10 gift certificate for completing the survey.

Data analyses

Descriptive statistics were calculated on the demographic variables. The prevalence rates for each health issue and health care utilization pattern were determined. Chi square analyses were conducted to compare ethnic groups. Regression analyses were conducted to predict health care utilization with demographic and health issue variables.

Results

Table 2 provides the prevalence rates for selected health issues by ethnicity. Again, the problems of Native Hawaiian women surface as we see the highest rates of depression and sexual assault among Hawaiian, Caucasian, and Filipina women. The highest rates for physical/emotional abuse were among Hawaiian women and their Filipina counterparts.