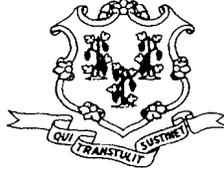


# State of Connecticut

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## PERMANENT COMMISSION ON THE STATUS OF WOMEN

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### Written Testimony of The Permanent Commission on the Status of Women Before the Government Administration and Elections Committee Wednesday, March 12, 2008

#### In Support of: SB 681, AA Establishing a Minority Health Council

Senator Slossberg, Representative Caruso and members of the committee, thank you for this opportunity to provide written testimony on behalf of the Permanent Commission on the Status of Women (PCSW) in support of SB 681, which would establish a Minority Health Council.

In Connecticut, the leading causes of death for women are major cardiovascular disease, cancer, diabetes, chronic lower respiratory, and HIV/AIDS.<sup>1</sup> There is a clear racial and ethnic disparity as African-American and Hispanic women are at a greater risk for these diseases than White women. The extent of the problem with Asian populations is unknown due to lack of sufficient data.

We believe that the lack of workforce diversity, including language barriers, impacts the quality of care for gender, racial and ethnic communities. According to the Center for Women in Politics & Public Policy,<sup>2</sup> Blacks and Hispanics make up more than 18% of the population, but represent less than 5% of doctors, 8% of dentists, and 8% or registered nurses are Black and Hispanic. Although females dominate in the registered

<sup>1</sup> .S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Mortality by State, Race/Ethnicity, Gender, Age and Causes, 1999-2002*, accessed 9/05 at <http://www.cdc.gov/nchs>.

<sup>2</sup> The Center for Women In Politics & Public Policy. *Spotlight on Connecticut*, 2006.

35<sup>th</sup> anniversary  
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nursing and diagnostic fields at 92% and 77% respectively, they represent only 25% of doctors. When race is considered the numbers are even lower for women of color. Of the female healthcare workforce, women of color are 7% of doctors; 4% of dentists; 9 % of registered nurse, and 11% of diagnostic technicians. The only areas in which women of color are significantly represented are as LPNs at 21.7% and health aides at 33.9%.

We believe that the establishment of a Minority Health Advisory Council will ensure that a conscious effort is made to address health disparities in the workforce and quality of care for gender, racial and ethnic communities. We look forward to working with you to address this issue. Thank you for your consideration.



# CONNECTICUT WOMEN'S HEALTH CAMPAIGN

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## Racial & Ethnic Disparities in Healthcare

The Connecticut Women's Health Campaign supports increased education and awareness, early intervention and treatment, and equal access to health care to address racial and ethnic disparities in healthcare.

### *The Problem*

In Connecticut, the leading causes of death for women are major cardiovascular disease, cancer, diabetes, chronic lower respiratory, and HIV/AIDS.<sup>i</sup> There is a clear racial and ethnic disparity as African-American and Hispanic women are at a greater risk for these diseases than White women. The extent of the problem with Asian populations is unknown due to lack of sufficient data.

### Major Cardiovascular Disease

African-Americans are at greater risk for heart disease, stroke and other cardiovascular diseases than Caucasians. The prevalence of these diseases in Black females is 49%, compared to 35% in White females.<sup>ii</sup> High blood pressure is a leading cause of stroke. The rate of high blood pressure for Black/African-American females age 20 and older is 46.6%.<sup>iii</sup> The risk of heart disease and stroke increases with physical inactivity. Physical inactivity is more prevalent in women, African-Americans and Hispanics.

### Cancer

#### *Lung Cancer*

In 1987, lung cancer surpassed breast cancer as the leading cause of cancer-related deaths for women.<sup>iv</sup> African American women have the highest rates of lung cancer incidence, followed by Caucasian, Asian Pacific, Hispanic and American Indian/Native Alaskan women.<sup>v</sup> In the United States, lung cancer is the leading cause of cancer deaths in the Hispanic community.<sup>vi</sup> Between 1999 and 2002 in Connecticut, Hispanic women had a 32% incidence rate of lung cancer.<sup>vii</sup> Smoking is the primary cause of lung cancer, followed by exposure to secondhand smoke.

#### *Breast Cancer*

In Connecticut, White women have a breast cancer incidence rate of 135.5. This rate is higher than Blacks (121.7), Asian and Pacific Islanders (109.3) and Hispanics (107.2). However, Black women have a higher estimated mortality rate than White women, 33.8 and 25.4 respectively.<sup>viii</sup> The disparity between incidence and mortality rates is attributed to Black women being diagnosed with breast cancer at a later stage, when five-year survival is less likely.<sup>ix</sup> This data strongly suggests that early detection of breast cancer in Black women would reduce the

disproportionately high mortality rates experienced by this group. Additionally, a new study indicates that the differences in mortality rates may be due to a difference in tumor biology between the races.<sup>x</sup> In the study of 2,140 women with breast cancer, findings indicated that African-American women were more likely to have larger tumors and/or different types of breast cancer, such as estrogen receptor negative disease, that is more difficult to treat. In addition to getting regular mammograms the American Cancer Society recommends increased physical activity, minimal alcohol consumption and the avoidance of obesity as ways to reduce the risk of breast cancer.<sup>xi</sup>

### *Ovarian Cancer*

Ovarian cancer is the fifth most common cancer found in American women and occurs in 1 out of 57 women.<sup>xii</sup> In 2004, approximately 25,500 women were diagnosed with ovarian cancer, and about 50 percent of diagnosed women died within five years of cancer detection.<sup>xiii</sup> There are racial disparities connected with this disease. In 2000, the death rate among African American women was 5.9 per 100,000, compared to 3.0 among Asian/Pacific Islanders, and 2.7 among White women.<sup>xiv</sup> The rate of death from ovarian cancer was higher in women who were overweight - the risk went up by 50% in the heaviest women.<sup>xv</sup> Studies have recognized that for women, being overweight or obese in adolescence or young adulthood is linked with an increased risk of being diagnosed with ovarian disease.<sup>xvi</sup>

Additionally, according to a study from the University of California at Berkeley, obese women "...are more likely than non-obese women to delay pap tests, pelvic exams and mammograms, even though they are "moderately" or "very concerned" about cancer."<sup>xvii</sup> They avoid or delay these procedures due to embarrassment, previous humiliating experiences, and lack of proper instruments.

### *Cervical Cancer*

Approximately 14,000 women are diagnosed with cervical cancer each year with more than 3,900 dying as a result of this disease. Risks of cervical cancer include human papilloma virus or HPV and smoking. Similar to ovarian cancer, there are also racial and ethnic health disparities in connection with cervical cancer. For example, in 2001, black women had the highest age-adjusted mortality rate from cervical cancer (4.8 per 100,000), followed by Hispanic women (3.4 per 100,000). From 1992-2000, African American women were less likely to survive cervical cancer five years after diagnosis compared with white women (African American: 62.6%; white: 73.3%) (Health US, 2003, table 54).<sup>xviii</sup>

In addition, knowledge of the advantages of pre-screening, such as pap tests, varies based upon socio-economic status. In 2005, the Guttmacher Institute released data about a study that questioned 338 women undergoing cervical screening via pap testing. The average of correct answers was 8.7 out of 20 questions. The scores were higher among white women (10.2), than among blacks (8.4) and Hispanics (7.4); higher among women with more than a high school education than among women with less education (10.0 vs. 7.9); and higher among women with an annual household income of at least \$10,000 than among those with a lower income (9.3 vs. 8.4).<sup>xix</sup>

### Diabetes

Approximately 9.1 million women in the United States have diabetes. The prevalence of diabetes is at least two to four times higher among African American, Latino, Native American

and Asian/Pacific Islander women than among Caucasian women.<sup>xx</sup> Women with diabetes are at greater risk for heart disease and stroke. According to the Connecticut Department of Public Health, Black and Hispanic women have higher mortality rates due to diabetes and diabetes-related causes than White women. Between 1999 and 2001, Black women died at a rate of 40.2 per 100,000 and Hispanic women at a rate of 28.9, as compared to the rate of 14.1 for White women.<sup>xxi</sup> When analyzing diabetes-related deaths, the rates of death for Black and Hispanic women dramatically increased to a rate of 128.4 and 86.3 per 100,000 respectively, as compared to 53.5 for White women.<sup>xxii</sup>

Almost 1.25 million Connecticut adults are at increased risk of developing diabetes because they are overweight, have a sedentary lifestyle, or have a history of gestational diabetes, all of which are known risk factors.<sup>xxiii</sup>

### HIV/AIDS

Racial and ethnic populations have been disproportionately affected by the HIV/AIDS epidemic in Connecticut. Although Blacks/African-Americans and Hispanics represent 9.1% and 9.4% of Connecticut's population,<sup>xxiv</sup> 62.3% of reported AIDS cases and 65.9% of reported HIV infections are among these populations.<sup>xxv</sup> Among women, the disparities are even more dramatic, with Black/African-American and Hispanic women representing 70.2% of females with AIDS, and 72.3% of females with HIV infection.<sup>xxvi</sup>

### *The Causes*

Two common risk factors for all of the above mentioned diseases, except HIV/AIDS, are obesity and smoking.

### Obesity

Throughout the United States, obesity has increased in people of all ethnic groups, ages and genders. This is not an isolated threat to health, nor one limited to a particular population group. However, among some racial, ethnic and socioeconomic groups, the prevalence of obesity and many obesity-related risk factors are especially high.

Obesity is more common among African-American and Hispanic women and children. Among adult women, obesity is highest among African American and Mexican American women. Of females ages 20 and older, 77.3% of Black/African-American women,<sup>xxvii</sup> and 71.7% of Mexican-American women are overweight or obese.<sup>xxviii</sup> According to a national study conducted between 1986 and 1998, overweight prevalence rose more than 120% among African Americans and Hispanic children, compared to 50% among Whites.<sup>xxix</sup>

While personal choice plays a role in the rise of obesity, it alone is not responsible for the epidemic we face today. In some groups, lower incomes are associated with higher prevalence of obesity. Some low-income neighborhoods have many fast food restaurants, but few have stores or markets that sell nutritious foods. Women of lower socioeconomic status (incomes less than 130% of poverty threshold or \$22,660 – \$24,258 for a family of four) are about 50% more likely to be obese than those of higher socioeconomic status.<sup>xxx</sup>

Many lack access to safe places to play and be active. Communities with a higher percentage of African American residents tend to have fewer available parks and green spaces. Of African-American females age 18 and older, 55.2% are inactive, compared to 36.2% of White females.<sup>xxxi</sup>

Black and Hispanic children are significantly less likely than White children to report involvement in organized physical activity, as are children with parents who have lower income and educational levels.<sup>xxxii</sup> In addition, many Americans of limited economic resources simply cannot purchase healthy food, join health clubs, or participate in organized sports or physical activity programs.

### Smoking

Tobacco use has been a women's health issue dating back to the 1920's when tobacco companies recognized women as a target for their product. Since the 1980's there has been a dramatic increase in smoking related illnesses among women, including lung cancer and heart disease.<sup>xxxiii</sup>

In Connecticut, 18% of women smoke (283,100 women) and 7% are pregnant women.<sup>xxxiv</sup> The smoking rates in African-American and Hispanic communities continue to increase as tobacco companies continue to market to young African American and Hispanic women. Nationally, 19% of African American women,<sup>xxxv</sup> and 11% of Hispanic women are current smokers.<sup>xxxvi</sup> Overall, in the United States, 20% of women smoke.<sup>xxxvii</sup>

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<sup>i</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Mortality by State, Race/Ethnicity, Gender, Age and Causes, 1999-2002*, accessed 9/05 at <http://www.cdc.gov/nchs>.

<sup>ii</sup> American Heart Association. *Heart Disease and Stroke Statistics – 2007 Update (based on 2004 figures)*.

<sup>iii</sup> *Ibid.*

<sup>iv</sup> American Cancer Society. *Cancer, Facts and Figures 2005*. Atlanta, GA: American Cancer Society.

<sup>v</sup> *Ibid.*

<sup>vi</sup> Campaign for Tobacco Free Kids. *Tobacco Use and Hispanics, 2006*.

<http://www.tobaccofreekids.org/research/factsheets/pdf/0134.pdf>.

<sup>vii</sup> Centers for Disease Control and Prevention and National Cancer Institute. U.S. Cancer Statistics Working Group, 2005. *United States Cancer Statistics: 1999–2002 Incidence and Mortality Web-based Report*. Available at: [www.cdc.gov/cancer/npcr/uscs](http://www.cdc.gov/cancer/npcr/uscs).

<sup>viii</sup> National Cancer Institute. *State Cancer Profiles 2002*, <http://statecancerprofiles.cancer.gov/incidencerates/incidencerates.html>

<sup>ix</sup> Ries L.A.G., Eisner M.P., Kosary C.L., et al (eds). 2001. *SEER Cancer Statistics Review, 1973-1998* Bethesda, MD: National Cancer Institute.

<sup>x</sup> Bakalar, Nicholas. "Tumor Types May Explain Survival Rates for Cancer," *New York Times*, October 24, 2006.

<sup>xi</sup> American Cancer Society. *Breast Cancer Facts and Figures 2001-2002*. Atlanta, GA: American Cancer Society.

<sup>xii</sup> *General Ovarian Cancer Statistics: Ovarian Cancer is a Serious and Under-Recognized Threat to Women's Health*.

<http://www.ovariancancer.org/index.cfm?fuseaction=Page.viewPage&pageId=509&parentID=508&grandparentID=522&nodeID=1>

<sup>xiii</sup> *Ibid.*

<sup>xiv</sup> Centers for Disease Control and Prevention, National Center for Health Statistics, *Healthy Women: State Trends in Health and Mortality*. <http://www.4woman.gov/pub/steps/Cancer.htm>

<sup>xv</sup> *Overview: Ovarian Cancer. What Causes Ovarian Cancer?*

[http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_2\\_2X\\_What\\_causes\\_ovarian\\_cancer\\_33.asp?rnav=cri](http://www.cancer.org/docroot/CRI/content/CRI_2_2_2X_What_causes_ovarian_cancer_33.asp?rnav=cri)

<sup>xvi</sup> National Cancer Institute. *Obesity and Cancer: Questions and Answers*.

<http://www.cancer.gov/newscenter/obesity1>

<sup>xvii</sup> North American Association for the Study of Obesity (NAASO). <http://www.naaso.org/news/20051017a.asp>

<sup>xviii</sup> Centers for Disease Control. <http://www.cdc.gov/omh/Highlights/2005/HJan05.htm>

<sup>xix</sup> Breitkopf, Carmen R., Pearson, Heidi C., and Breitkopf, Daniel M. "Poor Knowledge Regarding the Pap Test Among Low-Income Women Undergoing Routine Screening." *Perspectives on Sexual and Reproductive Health*, Volume 37, Number 2, June 2005.

<sup>xx</sup> American Diabetes Association. [www.diabetes.org/uedocuments/WomenFinal.pdf](http://www.diabetes.org/uedocuments/WomenFinal.pdf)

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- <sup>xxi</sup> CT Department of Public Health. *Connecticut Resident Mortality Summary Tables by Gender, Race & Hispanic Ethnicity, 1999-2001*. Diabetes Deaths: All females 83.2; Black females 40.2; Hispanic Females 28.9, White females: 14.1.
- <sup>xxii</sup> *Ibid.* Diabetes-Related Deaths: All females 268.2; Black females 128.4; Hispanic Females 86.3, White females: 53.5.
- <sup>xxiii</sup> CT Department of Public Health. *Diabetes Fact Sheet* [www.dph.state.ct.us/BCH/HEI/diabetes.htm](http://www.dph.state.ct.us/BCH/HEI/diabetes.htm)
- <sup>xxiv</sup> U.S. Census Bureau, Census 2000, *Table DP-a. Profile of General Demographic Characteristics*.
- <sup>xxv</sup> CT Department of Public Health. *CT HIV/AIDS Statistics through December 31, 2004*, available at [www.dph.state.ct.us/BCH/infectiousdise/2003/final%20pages/topic\\_index\\_X.htm](http://www.dph.state.ct.us/BCH/infectiousdise/2003/final%20pages/topic_index_X.htm), accessed on 1/19/06. AIDS Cases: Total 13,889, White 5,178, Black 5,130, Hispanic 3,518, and Other 63. HIV Cases: Total 1,031; White 340, Black 281, Hispanic 398, and Other 12.
- <sup>xxvi</sup> *Ibid.* Females with AIDS: Total 3,840, White 1,130, Black 1,605, Hispanic 1,090, and Other 15. Females with HIV: Total 382; White 102, Black 122, Hispanic 154, and Other 4.
- <sup>xxvii</sup> See, endnote ii.
- <sup>xxviii</sup> Hedley AA et. al. *Prevalence of overweight and obesity among US children, adolescents and adults, 1999-2002*. *Jama* 2004;291:2847-50 and *Vital Health Stats*, Feb 200, Series 10, No.219.
- <sup>xxix</sup> *Ibid.*
- <sup>xxx</sup> Dept HHS, *Healthy People 2010 2<sup>nd</sup> ed.*
- <sup>xxxi</sup> See, endnote ii.
- <sup>xxxii</sup> *Physical activity levels among children aged 9 – 13 years, United States, 2002*. *MMWR* 2003; 52 (33): 785-8.
- <sup>xxxiii</sup> Campaign for Tobacco Free Kids. *Background on Women and Girls and Tobacco, 2004*.  
<http://www.tobaccofreekids.org/research/factsheets/pdf/0137.pdf>
- <sup>xxxiv</sup> Campaign for Tobacco Free Kids. *Mother's Day Data on Smoking Moms and Related Harms, 2005*.  
<http://www.tobaccofreekids.org/research/factsheets/pdf/0257.pdf>
- <sup>xxxv</sup> Campaign for Tobacco Free Kids. *Tobacco Use Among African Americans, 2004*.  
<http://www.tobaccofreekids.org/research/factsheets/pdf/0006.pdf>
- <sup>xxxvi</sup> See, endnote v.
- <sup>xxxvii</sup> See, endnote xxxiv.

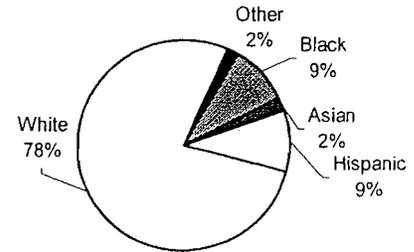


# Spotlight on Connecticut

## Gender & Race in CT: A Snapshot

- In 2000, CT's population was 9.4% Hispanic, 9.1% Black and 2.4% Asian (see Fig 1a).
- CT's urban areas have growing and substantially larger minority populations than the state as a whole. Both Hartford and New Haven's populations were 38% Black and 40% Hispanic, followed by Bridgeport at 31% Black and 32% Hispanic. New Haven and Bridgeport also have substantially higher Asian populations (3.9% and 3.3% respectively).
- Minority women make up approximately 9% of CT's workforce.

Figure 1a Connecticut Population, by Race/Hispanic Origin, 2000



Source: US Census 2000

Table 1a: Selected Occupations,<sup>1</sup> by Race/Ethnicity for Connecticut & New England, 2000, (number (%))

		Connecticut		New England	
		Female	Male	Female	Male
Physicians/ Surgeons	White	2140 (18.9)	6830 (60.1)	10,990 (23.2)	27,695 (58.5)
	Black	75 (0.7)	195 (1.72)	350 (0.74)	665 (1.4)
	Hispanic	110 (1.0)	245 (2.2)	398 (0.84)	915 (1.93)
	Asian	570 (5.0)	970 (8.6)	2,210 (4.67)	3,520 (7.44)
	Dentists	White	190 (8.1)	1890 (80.1)	1,065 (11.9)
	Black	30 (1.3)	80 (3.39)	65 (0.73)	95 (1.06)
	Hispanic	25 (1.1)	65 (2.8)	65 (0.73)	128 (1.43)
	Asian	45 (1.9)	20 (0.8)	180 (2.01)	214 (2.39)
RNs	White	27,610 (82.8)	1680 (5.0)	126,165 (87.1)	7,545 (6.08)
	Black	1795 (5.4)	135 (0.4)	4504 (3.11)	475 (0.33)
	Hispanic	555 (1.7)	85 (0.25)	1,620 (1.12)	232 (0.16)
	Asian	845 (2.5)	185 (0.55)	2,275 (1.57)	365 (0.25)
	Diagnostic & Medical Technologists & Technicians	White	7898 (65.6)	1959 (16.3)	35,275 (69.8)
Black		715 (5.9)	210 (1.74)	1,325 (2.62)	544 (1.08)
Hispanic		439 (3.6)	213 (1.77)	1,003 (1.98)	509 (1.01)
Asian		274 (2.3)	124 (1.0)	1,258 (2.49)	785 (1.55)

Source: US Census 2001. Employment by Census Occupation Codes: www.census.gov/eo2000.

## Healthcare Workforce Diversity Issues in Connecticut

1. According to a 2003 Connecticut Health Foundation special panel, the "lack of diversity among the health care workforce in Connecticut has a substantial, negative impact on the level of trust and the quality of care for racial and ethnic communities."<sup>2</sup> Additionally, the lack of bilingual health workers is a significant barrier to quality care.
2. Connecticut, like other states is expected to experience a shortage of health support staff in the future and will need to rely more and more on minority workers.<sup>3</sup>

### In Connecticut, while Blacks and Hispanics make up more than 18 % of the population:

- Less than 5% of doctors and 8% dentists are Black and Hispanic. Statewide there are only 185 Black and Hispanic female doctors and 55 dentists.
- Less than 8% of RNs are Black and Hispanic. With only 2% representation there is a particular shortage of Hispanic RNs.
- Only 28 (2.5%) EMTs are Black or Hispanic—all of whom are men.
- Only 39 pharmacists are Black or Hispanic, 34 of whom are women.
- More than 32% of health aides are minority women.

Table 1a (Continued)		Connecticut		New England	
LPNs	White	4495 (70.5)	290 (4.5)	20,985 (79.5)	1,460 (5.53)
	Black	1105 (17.3)	35 (0.55)	2,215 (8.39)	145 (0.55)
	Hispanic	200 (3.1)	50 (0.8)	523 (1.98)	104 (0.39)
	Asian	80 (1.3)	4 (0.06)	233 (0.88)	89 (0.13)
Aides/Medical Assistants	White	19,060 (49.8)	2725 (7.1)	91,475 (66.2)	12,320 (8.91)
	Black	8980 (23.5)	1325 (3.5)	19,560 (14.2)	3,809 (2.75)
	Hispanic	3555 (9.3)	450 (1.2)	8,843 (6.40)	1,375 (0.99)
	Asian	425 (1.1)	0225 (0.6)	1,790 (1.29)	570 (0.41)

<sup>1</sup> **SELECTED OCCUPATIONS EXPLAINED:** Physicians & Surgeons (306) SOC 29-1060 (does not include Ophthalmologists, Podiatrists, or Chiropractors); Dentists (301) SOC 29-1020; RNs (313) SOC 29-1111; LPNs Licensed Practical and Licensed Vocational Nurses (350) SOC 29-2061; Pharmacists (305) SOC 29-1051. Technologists/Technicians include: Clinical Laboratory Technologists and Technicians (330) SOC 29-2010; Diagnostic Related Technologists and Technicians (332) SOC 29-2030; Health Diagnosing and Treating Practitioner Support Technicians (341) SOC 29-2050; Health Diagnosing and Treating Practitioners, All Other (326) SOC 29-1199; and Miscellaneous Health Technologists and Technicians (353) SOC 29-2090; Dental Assistants (364) SOC 31-9091 and Dental Hygienists (331) SOC 29-2021; Physician Assistants (311) SOC 29-1071. The category "Aides/Medical Assistants" includes: Nursing, Psychiatric, and Home Health Aides (360) SOC 31-1010 and Medical Assistants and Other Healthcare Support Occupations (365) SOC 31-909X; Dietitians and Nutritionists (303) SOC 29-1031

<sup>2</sup> Connecticut Health Foundation, "PATHWAYS TO EQUAL HEALTH: Eliminating Racial and Ethnic Health Disparities in Connecticut." New Britain, CT: Connecticut Health Foundation, March 2005, p. 33. Downloaded on 5/31/06 from <http://www.cthealth.org/matnarch/documents/raciaethnicpanel.pdf>

<sup>3</sup> Connecticut Department of Public Health, "Toward Solving Connecticut's Health Care Workforce Shortages," Unpublished report by the Office of Public Health Workforce Development, May 2002.

## Notes

- <sup>1</sup> Sullivan Commission on Diversity in the Healthcare Workforce. "Missing Persons: Minorities in the Health Professions." (Atlanta, GA: Sullivan Commission, Sept. 2004, 1).
- <sup>2</sup> Aetna, "Broker and Consultant E-Briefing, Special Report." Accessed from [www.aetna.com/producer/BeB\\_SI/2004-06/si\\_div\\_extent.html](http://www.aetna.com/producer/BeB_SI/2004-06/si_div_extent.html) on 4/5/06.
- <sup>3</sup> Diagnostic Technicians include cardiovascular technologists, and radiologic technicians and technologists (including mammographers), and Support Technicians including dietetic technicians, psychiatric technicians, respiratory therapy technicians and surgical technologists.
- <sup>4</sup> Population figures are from U.S. Census, Annual Estimates of the Population by Sex, Race and Hispanic or Latino Origin for New England States: April 1, 2000 to July 1, 2004 (SC-EST2004-03-25). Release date: August 11, 2005.
- <sup>5</sup> These include home health aides, medical assistants, physician assistants, physical therapy assistants, dental hygienists, dental assistants, and personal and home health aides.
- <sup>6</sup> Rohr, Monica. "Haitian Nursing Assistants Need Workplace Respect." *The Boston Globe*, 11/9/2003. Note: official data on immigrant workers in the health care professions are difficult to obtain.
- <sup>7</sup> Eaton, Susan, Claudia Green, Randall Wilson, and Theresa Osypuk. "Extended Care Career Ladder Initiative (ECCLI): Baseline Evaluation Report of a Massachusetts Nursing Home Initiative." (Cambridge, MA: Kennedy School of Government, 2001, 44).
- <sup>8</sup> Especially for home health aides, medical assistants, physician assistants, physical therapy assistants, dental hygienists, dental assistants, personal and home health aides. US Bureau of Labor. "Employment by occupation, 2004 and projected 2014." (Washington, DC: Bureau of Labor Statistics, 2005). Accessed from <http://www.bls.gov/emp/emptab21.htm> on 4/20/06.
- <sup>9</sup> US Census Bureau. "Projected State Populations, by Sex, Race, and Hispanic Origin: 1995-2025." Accessed from <http://www.census.gov/population/projections/state/stprace.txt> on 3/24/06.
- <sup>10</sup> Note: even in the states that are less diverse overall, there are cities with substantial and growing minority populations. Nashua, NH, for example, was 11% minority in 2000.
- <sup>11</sup> Sullivan Commission on Diversity in the Healthcare Workforce. "Missing Persons: Minorities in the Health Professions." (Atlanta, GA: Sullivan Commission, Sept. 2004, 6).
- <sup>12</sup> Association of American Medical Colleges (AAMC). *Minorities in Medical Education: Facts and Figures 2005*. (Washington, DC: AAMC, 45).
- <sup>13</sup> Conversation with Peter Torres at UMass Boston, Bringing the Best to Nursing
- <sup>14</sup> US Bureau of Labor. "Employment by occupation, 2004 and projected 2014." (Washington, DC: Bureau of Labor Statistics, 2005). Accessed from <http://www.bls.gov/emp/emptab21.htm> on 4/20/06.
- <sup>15</sup> Sullivan Commission, p. 63.
- <sup>16</sup> US Bureau of Labor. "Employment by occupation, 2004 and projected 2014." (Washington, DC: Bureau of Labor Statistics, 2005). Accessed from <http://www.bls.gov/emp/emptab21.htm> on 4/20/06.
- <sup>17</sup> US Department of Health and Human Services, Health Resources and Services Administration. "Projected Supply, Demand, and Shortages for Registered Nurses: 2000-2020." (Washington, DC: HRSA, July 2002). Accessed from <http://bhpr.hrsa.gov/healthworkforce/reports/rnproject/report.htm> on 4/21/06.
- <sup>18</sup> Sullivan Commission, p. 50.
- <sup>19</sup> Sullivan Commission, p. 47.
- <sup>20</sup> Sullivan Commission, p. 51.
- <sup>21</sup> US Department of Health and Human Services, Health Resources and Services Administration. HRSA State Health Workforce Profiles: Massachusetts. (Washington, DC: HRSA, 10, 13, 15). Accessed from <ftp://ftp.hrsa.gov/bhpr/workforceprofiles/MA.pdf> on 4/20/06.
- <sup>22</sup> US Bureau of the Census. "Employment by Census Occupation Codes." Accessed from [www.census.gov/eeo2000](http://www.census.gov/eeo2000) on 3/24/06; anecdotally many non-minority immigrant women also fill these roles.
- <sup>23</sup> US Bureau of Labor Statistics, "Employment by occupation, 2004 and projected 2014." Accessed from <http://www.bls.gov/emp/emptabapp.htm> on 4/20/06.
- <sup>24</sup> U.S. Census, "EEO Data Tool: Massachusetts Females by Selected Healthcare Occupations by Race, 2000."
- <sup>25</sup> HRSA reports on the difficulty of accurately estimating the number of direct care workers because (1) many are thought to work in a "gray market" where there is little formal record keeping about their numbers, training, hours, or wages; and (2) different agencies in the state and federal governments use different classifications for home health aides and nursing aides. They are variously described as direct care paraprofessionals, direct care workers, or members of health support occupations.
- <sup>26</sup> Bureau of Labor Statistics. "Occupational Outlook Handbook, 2004-05 Edition. Nursing, Psychiatric and Home Health Aides." Accessed from <http://www.bls.gov/oco/ocos165.htm> on 3/4/05.
- <sup>27</sup> Stacey, Clare. Chapter 6 in *Serving Care: Home Health Aides in the New Economy*. Draft manuscript (forthcoming).
- <sup>28</sup> Stacey (forthcoming).
- <sup>29</sup> Bureau of Labor Statistics. "Occupational Outlook Handbook, 2004-05 Edition. Nursing, Psychiatric and Home Health Aides." Accessed from <http://www.bls.gov/oco/ocos165.htm> on 3/4/05; "Occupational Employment and Wages, May 2003," Sept. 2004; Bulletin 2567. Accessed from [http://www.bls.gov/oes/oes\\_pub\\_2003\\_m.htm](http://www.bls.gov/oes/oes_pub_2003_m.htm) on 4/5/05.
- <sup>30</sup> US Department of Health and Human Services, Health Resources and Services Administration. HRSA State Health Workforce Profiles: Massachusetts. (Washington, DC: HRSA, 2000). Accessed from <ftp://ftp.hrsa.gov/bhpr/workforceprofiles/MA.pdf> on 4/20/06.



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