

Women's Health in California: Examining Age and Income

A PUBLICATION OF THE



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Introduction

This policy brief examines differences in indicators of health status and conditions, health risks, and health insurance coverage and access across women's lifespan in California. While there are no set boundaries for defining specific age cohorts, there are clear differences in economic, social, family, and health indicators across age groups. This analysis compares several common health measures for women in four age groups—18–29, 30–44, 45–64, and 65 and older.¹ It further examines selected indicators within each age group by income, examining disparities for low-income women, a group particularly affected by the recent economic downturn.² An earlier companion brief examined women's health across racial/ethnic groups.³

Data for this policy brief are from the 2011–2012 California Health Interview Survey (CHIS 2011–12).

Women's Social and Economic Profile

Approximately one-half of California women are under age 45 and one-half are over. Specifically, 22.3% of women are ages 18–29, 26.8% ages 30–44, 33.5% ages 45–64, and 17.5% are ages 65 and older.

Women's social and economic profile varies across age groups (data not shown). Younger women are the most likely to be low income, with one-half of women ages 18–29 (50.4%) in families with incomes below 200% of the federal poverty level (FPL),⁴ followed by women ages 30–44 (40.6%), women 65 and older (35.8%),⁵ and women ages 45–64 (31.4%).

From six in 10 to nearly seven in 10 women in the three nonelderly age cohorts currently work in the labor force, in contrast to 14.3% of women ages 65 and older.

Marital and family structure, both of which have a strong effect on income and household resources, also differ by age. Women ages 18–29 are the least likely to be married (18.7%), while women 65 and older are the most likely to be separated, widowed, or divorced (50.3%). Women ages 30–44 are the most likely to be single parents (17.1%), followed by women ages 18–29 (11.7%).

Self-Reported Rates of Fair or Poor Health Increase with Age

As women age, the percent who report their health as "fair or poor" increases, going from 11.9% of young women ages 18–29 to approximately double that rate for women ages 45–64 (24.7%) and 65 years and older (27.2%) (EXHIBIT 1).⁶

Older women are the most likely (38.1%) to report they have a condition that limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying.

Ever-Diagnosed Health Conditions Increase with Age Among Women, Except for Asthma

The increased rates of self-reported fair or poor health and activity limitations parallel an increase by age in the ever-diagnosed rates of the health conditions covered in this brief, with the exception of asthma (EXHIBIT 1).⁷

Arthritis. Approximately one in three (31.0%) women ages 45–64 and 56.3% of women ages 65 and older have ever been diagnosed with arthritis, compared to fewer than one in 10 women in the two younger age cohorts.

As women age, the percent who report their health as "fair or poor" increases.

EXHIBIT 1 | Health Status, Health Conditions, and Health Risks by Age Group, Women Ages 18 and Older, California, 2011–12

	Ages 18–29	Ages 30–44	Ages 45–64	Ages 65 and Older
Health Status				
Fair/Poor Health	11.9%*	17.6%*	24.7%	27.2%*
Condition Limits Basic Physical Activity	6.5%*	10.4%*	23.1%	38.1%*
Health Conditions				
Arthritis	3.1%*	8.9%*	31.0%	56.3%*
Asthma	18.1%	12.6%†	15.5%†	14.2%†
Diabetes	1.7%*	3.7%*	10.9%	17.3%*
Heart Disease	1.2%*	2.0%*	6.1%	16.8%*
High Blood Pressure	6.5%*	14.6%*	34.1%	61.9%*
Health Risks				
BMI=30+ (obesity)	15.3%*	25.3%*	28.6%	23.6%*
Current Smoker	11.5%	11.0%*	13.0%	6.4%*

*Significantly different from women ages 45–64. †Significantly different from women ages 18–29. Health conditions are based on women reporting if they have ever been diagnosed with the condition.
Source: 2011–12 California Health Interview Survey

Asthma. Although asthma affects women across all age cohorts, asthma does not follow the pattern of increases across age groups in ever-diagnosed prevalence. Younger women (ages 18–29) have the highest prevalence of asthma (18.1%).

Diabetes. Diabetes ever-diagnosed rates increase as women age, ranging from 1.7% of women ages 18–29 to 17.3% of women 65 years and older. Each age cohort across the lifespan shows an increase in diabetes prevalence.

Heart Disease. Heart disease is much higher in older women. One in six (16.8%) women ages 65 and older reports ever being diagnosed with heart disease, a rate nearly three times higher than among women ages 45–64, who report the second highest rate (6.1%).

High Blood Pressure. High blood pressure prevalence increases in women as they age. Approximately one-third (34.1%) of women ages 45–64 have ever been diagnosed with hypertension, increasing to six in 10 women ages 65 and older, the age group with the highest rate (61.9%).

Higher Obesity and Smoking Rates Among Women Ages 45–64

Young women have the lowest obesity prevalence (15.3%), while women ages 45–64 have the highest (28.6%), almost twice that of young women (EXHIBIT 1).⁸

Women in the 45–64 age cohort have higher smoking rates (13.0%) than women 30–44 (11.0%) and 65 years and older (6.4%; EXHIBIT 1). While the lowest smoking rate is among older women, they are the most likely to have “ever smoked,” with slightly over one-third (35.5%) former smokers (data not shown). Among young women (ages 18–29), 11.5% currently smoke, while 5.9% are former smokers (data not shown).

Highest Uninsured Rate Is Among Young Women

This section focuses on health insurance coverage of women ages 18–64 (EXHIBIT 2), using CHIS data obtained prior to full implementation of the Affordable Care Act (ACA). (See endnote for information about coverage for women ages 65 and older.⁹)

Uninsured rates. Women ages 18–29 are the most likely to be uninsured, with nearly three in 10 (29.7%) uninsured for all or part of the year. Uninsured rates are slightly lower for women ages 30–44 (26.1%) and are lowest for women ages 45–64 (18.7%).

Employment-based coverage. The higher uninsured rate among young women parallels low employment-based coverage rates. Just over one-third (34.8%) of women ages 18–29 have employment-based coverage during the past year compared to slightly over one-half (52.1%) of women ages 30–44 and nearly six in 10 women ages 45–64 (59.4%).

EXHIBIT 2 | Health Insurance Status by Age Group, Women Ages 18–64, California, 2011–12

	Ages 18–29	Ages 30–44	Ages 45–64
Health Insurance Status			
Uninsured All or Part Year	29.7%	26.1%*	18.7%*
Employment-Based Coverage All Year	34.8%	52.1%*	59.4%*
Medi-Cal All Year	19.0%	14.8%*	9.6%*

*Significantly different from women ages 18–29.

Source: 2011–12 California Health Interview Survey

Medi-Cal coverage. Medi-Cal plays an important role for many women and, prior to the ACA, was based on categorical eligibility.¹⁰ Women ages 18–29 have twice the rate of Medi-Cal coverage during the past year as women ages 45–64 (19.0% and 9.6%, respectively), with women ages 30–44 falling in-between (14.8%).

Younger Women Least Likely to Have a Usual Place for Care

Women ages 18–29 are the least likely to have a regular source of health care (21.5%); they are twice as likely as women ages 45–64 (10.3%) and four times as likely as women 65 and older (4.8%) to lack a regular place where they receive care (EXHIBIT 3).

Women ages 18–29 are also less likely (49.4%) to receive their care through private doctors/health maintenance organizations (HMOs) than women in the other three age groups, and women 65 and

older (85.4%) are the most likely (data not shown). Clinics and health centers play a role in providing care for women of all ages, but this is particularly so for women ages 18–29 and ages 30–44 (26.7% for both groups; data not shown).

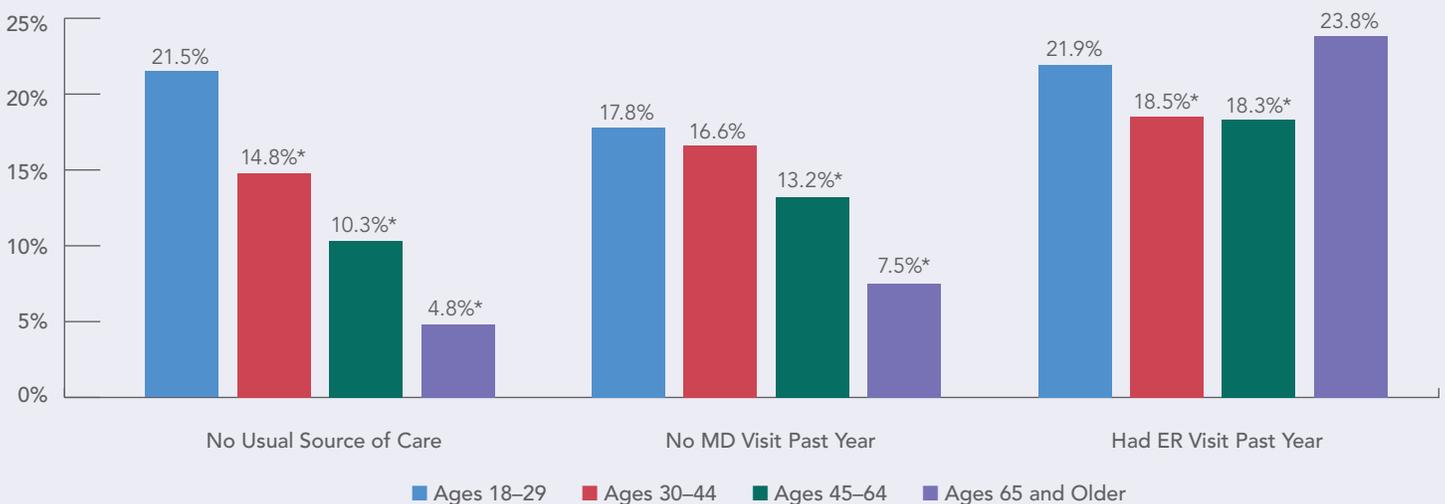
Younger Women Least Likely to Have Recent Doctor Visit

While most women had a health care provider visit in the past year, women in the two youngest age groups are the least likely to have had this type of contact (EXHIBIT 3). About one in six women ages 18–29 (17.8%) and ages 30–44 (16.6%) have not seen a provider in the past year, over twice the rate of women 65 years and older (7.5%).

Younger (21.9%) and older (23.8%) women, the two ends of the age span, report the highest rates of a past-year emergency room visit.

Women ages 18–29 are the least likely to have a regular source of health care (21.5%).

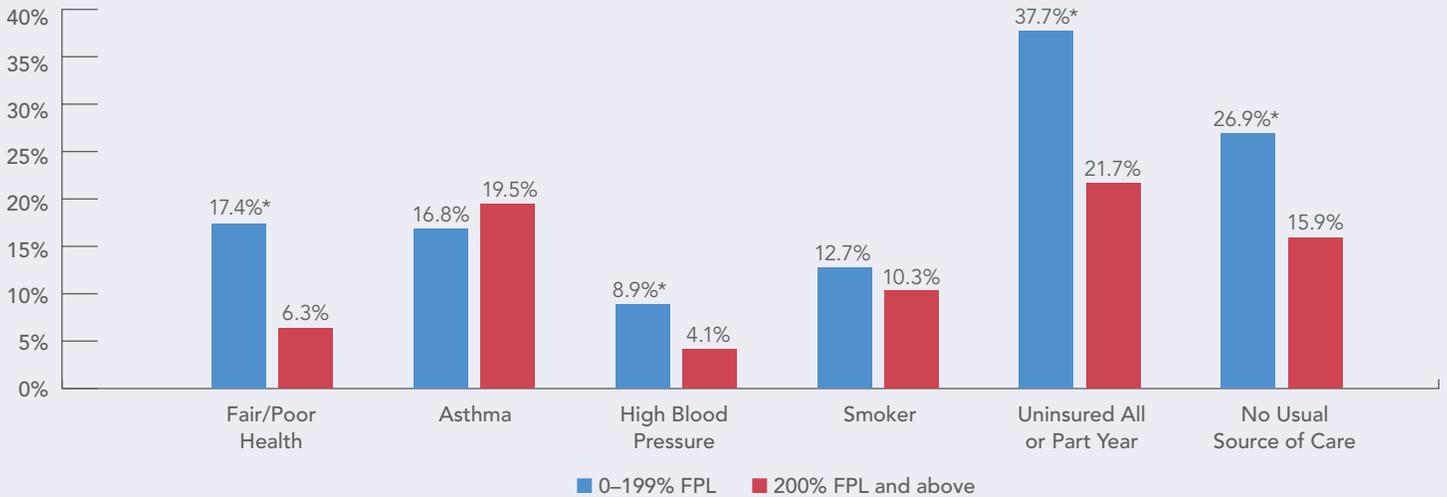
EXHIBIT 3 | Access Measures by Age Group, Women Ages 18 and Older, California, 2011–12



*Significantly different from women ages 18–29.

Source: 2011–12 California Health Interview Survey

EXHIBIT 4 | Selected Health Indicators by Family Income, Women Ages 18–29, California, 2011–12



*Significantly different from women with family incomes 200% FPL and above. Health conditions are based on women reporting if they have ever been diagnosed with the condition. Diabetes rates are not reported because of unstable estimates due to small sample sizes.
Source: 2011–12 California Health Interview Survey

Health Differences by Income

Age group comparisons provide an overview of differences in health status, access, and risks across the lifespan. However, within each age group, other factors also impact health disparities, one of the most significant being income. To examine the challenges low-income women face, differences for selected health measures are discussed next for each age group by income.¹¹

Health Disparities by Income Level Among Women Ages 18–29

One-half of women ages 18–29 have household incomes below 200% of the federal poverty level, and several of the health indicators measured in this brief look worse for them when compared to their higher income peers (EXHIBIT 4). Young low-income women are nearly three times more likely to report their health as “fair or poor” compared to those with family incomes 200% FPL and above (17.4% vs. 6.3%, respectively). Low-income young women have higher rates of ever-diagnosed high blood pressure, but not asthma, than young women with higher incomes. Smoking rates do not differ by income for this age group. Differences in access measures are pronounced. Nearly four in 10 (37.7%) young low-income women are uninsured and over one-quarter lack a usual place for care, rates much higher than for young women with family incomes 200% FPL and above.

Health Disparities by Income Level Among Women Ages 30–44

Four in 10 (40.6%) women ages 30–44 are low income. This is also the age group with the highest

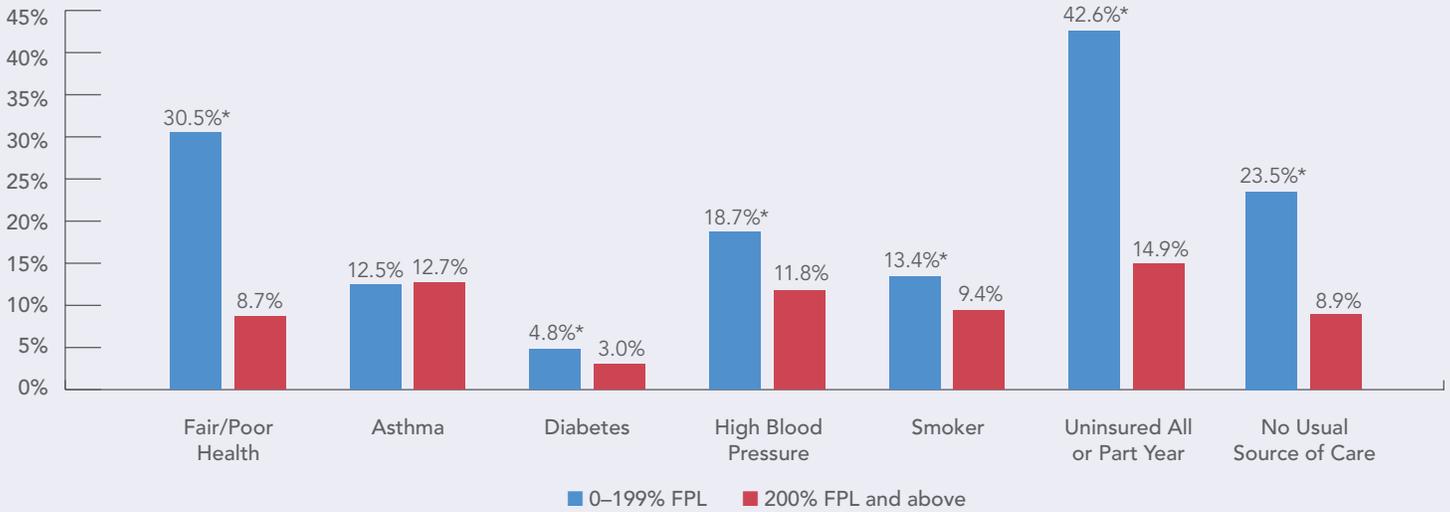
proportion of single mothers (17.1%). One in three low-income women in this age group reports her health as “fair or poor” (30.5%), three times the rate of same-age women with incomes 200% FPL and above (8.7%) (EXHIBIT 5). Low-income women ages 30–44 also have higher rates of ever-diagnosed diabetes and high blood pressure, but not asthma, than their higher income peers. Their smoking rate is also higher. Over four in 10 (42.6%) low-income women ages 30–44 were uninsured for all or part of the past year, compared to 14.9% of higher income peers, and 23.5% report no usual source of health care.

Health Disparities by Income Level Among Women Ages 45–64

Among women ages 45–64, three in 10 (31.4%) are low income. This age group faces emerging health-related issues, which are more prominent for those with low incomes. Nearly one-half of low-income women in this age group (47.7%) report their health as “fair or poor,” in contrast to only 14.1% of those with incomes 200% FPL and above (EXHIBIT 6). Both ever-diagnosed diabetes and high blood pressure rates are higher for low-income women in this age group, compared to their higher income peers, however asthma rates do not differ by income. Nearly one in five (18.2%) low-income women ages 45–64 smokes, adding to their health challenges. Slightly over one-third (36.1%) of low-income women were uninsured for all or part of the year, three times the rate of higher income women (10.7%). Further, nearly one in five (19.0%) low-income women ages 45–64 does not have a usual source of care.

Nearly one in five (18.2%) low-income women ages 45–64 smokes, adding to their health challenges.

EXHIBIT 5 | Selected Health Indicators by Family Income, Women Ages 30–44, California, 2011–12



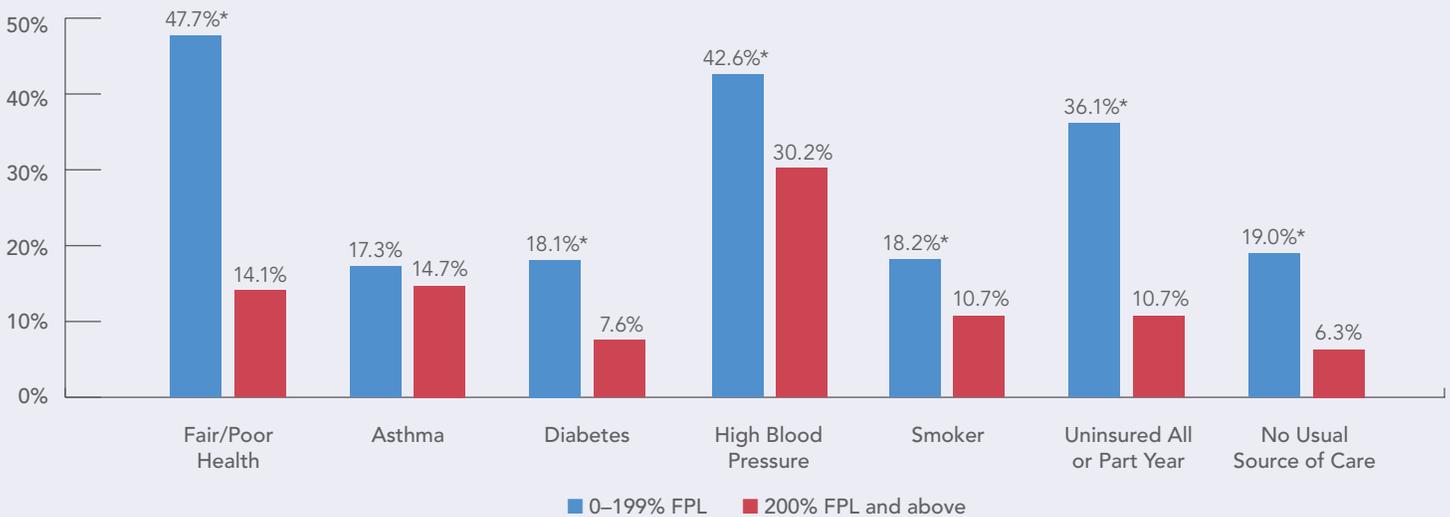
*Significantly different from women with family incomes 200% FPL and above. Health conditions are based on women reporting if they have ever been diagnosed with the condition. Source: 2011–12 California Health Interview Survey

Health Disparities by Income Level Among Women Ages 65 and Older

Slightly over one-third (35.8%) of women 65 and older are low income. Older women with low incomes are more than twice as likely to report their health as “fair or poor” (44.1%) than are women with incomes 200% FPL and above (17.9%) (EXHIBIT 7). Ever-diagnosed rates of health conditions, except for asthma, were higher in

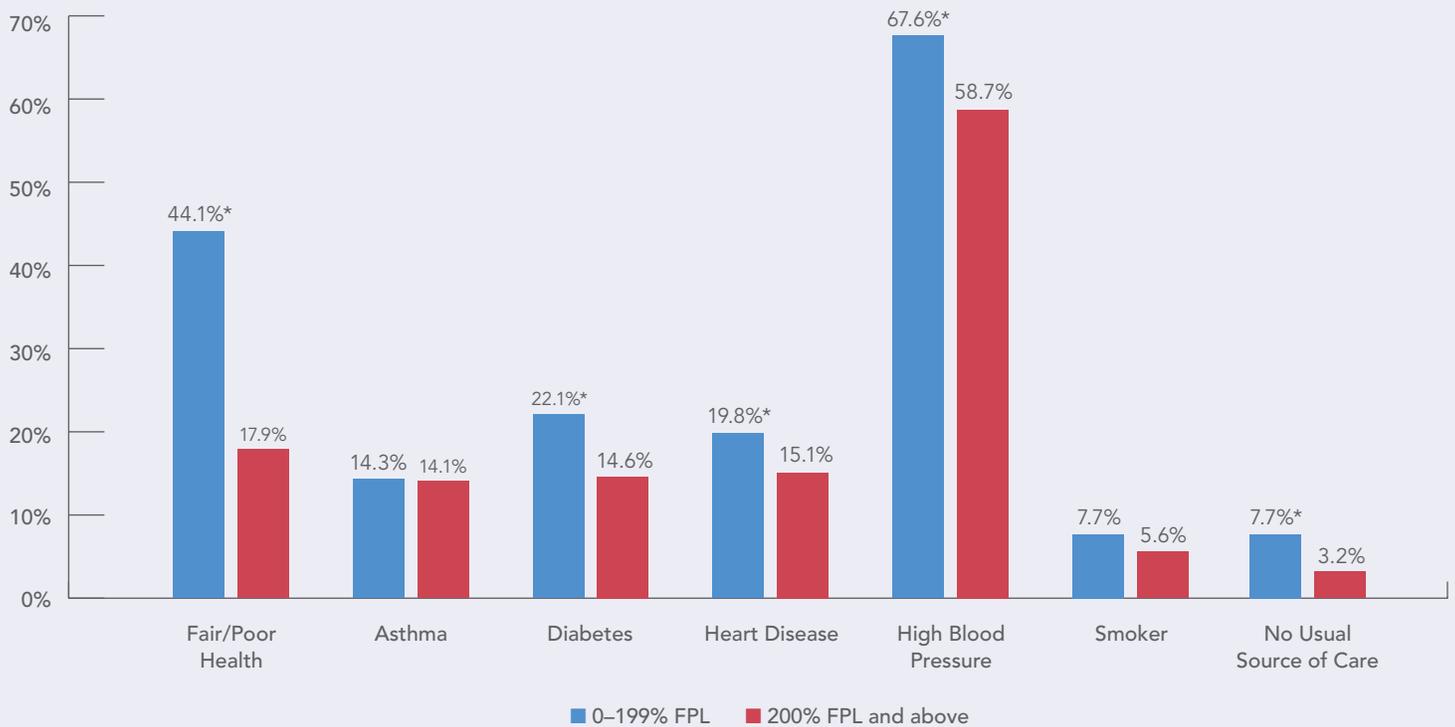
low-income women, including diabetes (22.1% vs. 14.6%), heart disease (19.8% vs. 15.1%), and high blood pressure (67.6% vs. 58.7%). Smoking rates do not differ by income for this age group. While the vast majority of older women have a usual place they receive care, those with low incomes are twice as likely to report no usual source of care compared to those with higher incomes (7.7% vs. 3.2%).

EXHIBIT 6 | Selected Health Indicators by Family Income, Women Ages 45–64, California, 2011–12



*Significantly different from women with family incomes 200% FPL and above. Health conditions are based on women reporting if they have ever been diagnosed with the condition. Source: 2011–12 California Health Interview Survey

EXHIBIT 7 | Selected Health Indicators by Family Income, Women Ages 65 and Older, California, 2011–12



*Significantly different from women with family incomes 200% FPL and above. Health conditions are based on women reporting if they have ever been diagnosed with the condition.
Source: 2011–12 California Health Interview Survey

For most of the measures examined, low-income women had worse health and access indicators than their higher income counterparts.

Discussion

Examining similar health issues across women’s lifespan provides insight into how such issues are manifested and might be addressed by health care providers and policy advocates. Key findings uncovered that younger women and, to a slightly less extent, women ages 30–44 have higher uninsured rates and less connection to the health care system than women ages 45 and older. Also seen was a pattern of worsening health status, ever-diagnosed health conditions, and health limitations beginning in the 45–64 age cohort and persisting among women ages 65 and older. Asthma was the exception to this pattern.

Persistent within each age cohort is the stark health disparity between low-income and higher income women in California (0–199% FPL vs. 200% FPL and above). For most of the measures examined, low-income women had worse health and access indicators than their higher income counterparts. This pattern was seen across all age cohorts, reinforcing the need for and importance

of statewide and local programs and services that maximize health access and affordability.

The Affordable Care Act (ACA) provides an important opportunity to expand coverage and access to services in the state to most but not all women,¹² and to enhance preventive and intervention services.¹³

An important component of the ACA makes preventive health services more affordable and thus more accessible.¹⁴ The ACA requires private plans (with the exclusion of grandfathered plans) to cover an array of preventive screenings, many directly related to women’s health, without cost-sharing.¹⁵ Additional provisions of the ACA expand Medi-Cal eligibility and benefits and expand prescription drug and preventive service coverage in Medicare.^{16,17} Women with historically limited access and associated health problems, such as low-income women, should find increased assistance and benefits through ACA implementation, especially under the expanded Medi-Cal provisions.

Data Source and Methods

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

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Endnotes

- 1 For additional information on women-focused measures, such as contraception, hormone replacement therapy, and mammograms, see Data Points 2009 based on the California Women's Health Survey at www.dhcs.ca.gov/dataandstats/Pages/cwhs.aspx.
- 2 Ross J. *Falling Behind: The Impact of the Great Recession and the Budget Crisis on California's Women and Their Families*, California Budget Project, February 2012.
- 3 Zahnd E and Wyn R. *Racial/Ethnic Health Disparities Among Women in California*, Oakland, CA: Public Health Institute, January 2014.
- 4 The federal poverty level cutoffs are based on family income and size. It is updated annually by the U.S. Census Bureau (and formally referred to as poverty thresholds) and used for statistical purposes. The weighted federal poverty level for a three-person family was \$17,916 in 2011 and \$18,284 in 2012. A low-income woman (<200% FPL) in a family of three would have income below approximately \$35,800 in 2011 and \$36,600 in 2012.
- 5 For further information about the economic issues faced by many Californians ages 65 and older, see Wallace SP and Smith SE. *Half a Million Older Californians Living Alone Unable to Make Ends Meet*. Los Angeles, CA: UCLA Center for Health Policy Research, February 2009.
- 6 To measure health status, respondents were asked if their health was excellent, very good, good, fair, or poor.
- 7 CHIS respondents were asked "has a doctor ever told you that you have [specific health condition]," which requires health care access. Women with limited or inconsistent access to care may be less likely to have seen a health care provider and therefore less likely to have been diagnosed with a health condition.
- 8 Body mass index (BMI) is a measure of body fat based on a person's height and weight. It is calculated by weight in pounds divided by height in inches squared and multiplied by a conversion factor of 703. Standard weight status categories are: below 18.5 is underweight, 18.5–24.9 is normal weight, 25.0–29.9 is overweight, and a BMI of 30.0 and above is obese.
- 9 This section focuses on women ages 18–64, since nearly all women 65 and older have Medicare. According to CHIS 2011–12, the majority (73.6%) of women 65 and older have Medicare and another coverage source, while 16.4% have Medicare and Medi-Cal. Smaller proportions have Medicare only (5.4%) or other coverage (3.9%).
- 10 For a discussion of Medicaid's categorical coverage of women, see Kaiser Family Foundation, *Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act*, Issue Brief, December 2012.
- 11 See Citation 4 for an explanation of income cutoffs.
- 12 Undocumented immigrants are not eligible for coverage under the ACA. For a discussion of barriers to care for this group, see Wallace SP, Torres JM, Nobari TZ, and Pourat N. *Undocumented and Uninsured: Barriers to Affordable Care for Immigrant Populations*. Los Angeles, California: UCLA Center for Health Policy Research; The Commonwealth Fund, August 2013.
- 13 Kaiser Family Foundation, *Health Reform: Implications for Women's Access to Coverage and Care*, Issue Brief, August 2013.
- 14 National Women's Law Center, *Women's Preventive Services in the Affordable Care Act: Frequently Asked Questions*, Fact Sheet, May 13, 2013, accessed at <http://www.nwlc.org/resource/women%E2%80%99s-preventive-services-affordable-care-act-frequently-asked-questions>.
- 15 For a list of the prevention services covered under the ACA, see Kaiser Family Foundation, *Preventive Services Covered by Private Health Plans under the Affordable Care Act*, September 2011.
- 16 Cassidy A and Dentzer S. Health Policy Brief: "Health Reform's Changes in Medicare," *Health Affairs*, May 20, 2010, accessed at www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=17.
- 17 See California Department of Health Care Services, *Medi-Cal Expansion: Covering More Californians*, accessed at www.dhcs.ca.gov/Pages/Medi-CalExpansionInformation.aspx; Kaiser Family Foundation, *Health Reform: Implications for Women's Access to Coverage and Care*, Issue Brief, August 2013.



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