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Health Disparities Among California's Nearly Four Million Low-Income Nonelderly Adult Women

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While low-income women face many of the same needs as all women in obtaining affordable, quality care, they experience several unique challenges. Their limited resources and higher uninsured rates leave them more exposed financially. They encounter health disparities across a wide range of measures.

One-third of California women ages 18-64 (34%) have low incomes, with family incomes below 200% of the Federal Poverty Level (FPL).¹ This includes nearly 1,919,000 women (17%) whose family incomes are below the federal poverty level (0-99% FPL) and an additional 17% (1,942,000) with family incomes from 100-199% FPL.

This brief, based on data from the 2007 California Health Interview Survey, examines the health issues of nonelderly low-income women ages 18-64 compared to women with higher incomes. While one-third of nonelderly women have low incomes, 43% have family incomes of 400% FPL and above (higher income), and in between, nearly one-quarter of nonelderly women have family incomes from 200-399% FPL (23%).

Low-income women as a group are younger than women with higher incomes. Slightly over one-third of low-income women (36%) are ages 18-29. In contrast, among women with family incomes of 400% FPL and above, just 17% are ages 18-29.

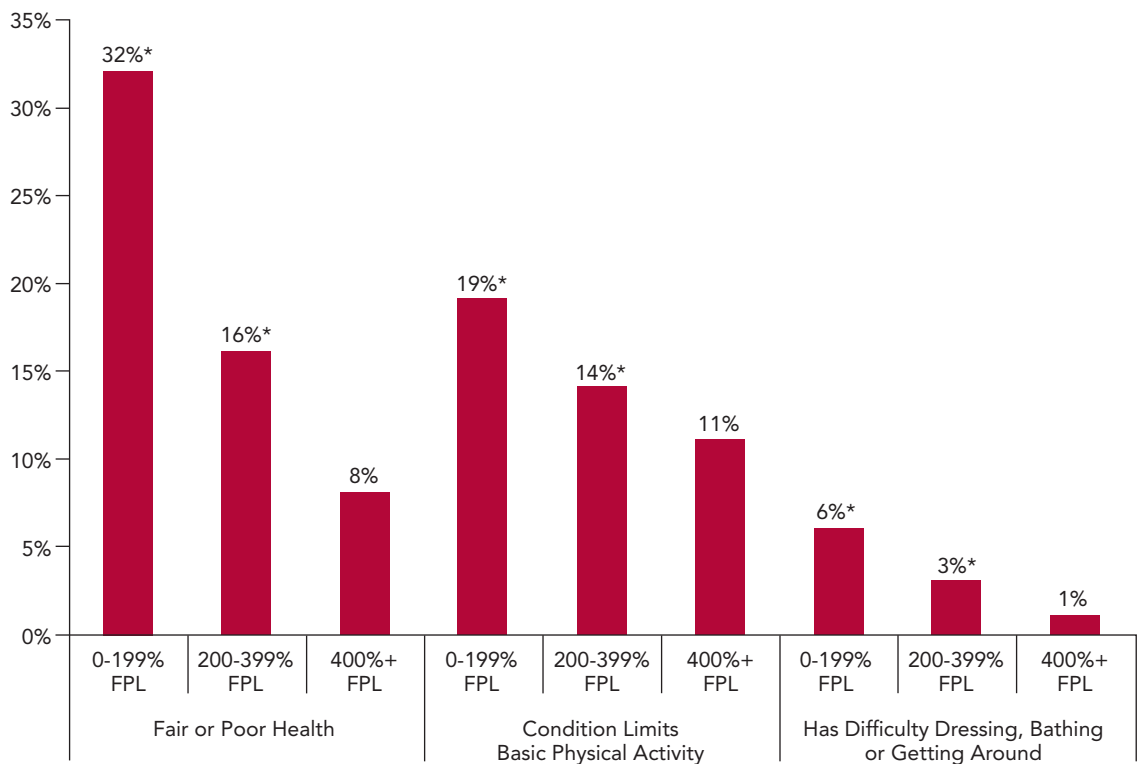
Minority women are more likely to have limited family incomes; nearly six in ten Latinas (58%), 47% of American Indian/Alaska Native women, 41% of African-American women, 28% of Asian/Pacific Islander women and 29% of multiple race women have low incomes. In comparison, 16% of white women are in families with incomes below 200% FPL.

Single mothers are also more likely to have low-incomes than women who are married or single without children.

This policy brief is based on data collected in 2007, before the recession that began in 2008. Low-income women are particularly vulnerable to downturns in the economy because of their already limited resources, cutbacks that affect funding for public programs and changes in resources for safety-net providers and other services.

Exhibit 1

Health Status and Functioning by Federal Poverty Level, Women Ages 18-64, California, 2007



Note: The 2007 Federal Poverty Level (FPL) was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

Source: 2007 California Health Interview Survey

*Significantly different from the 400%+ FPL category, $p < .05$.

Poorer Health Status and Physical Limitations More Prevalent for Nonelderly Low-Income Women

Lower income is linked to a wide range of health issues.² There is a four-fold difference in reported fair or poor health status between nonelderly low-income and higher-income women (32% v. 8%; Exhibit 1). Even though as a group they are younger than higher-income women, low-income women are more likely to report they have a health condition that limits one or more of the basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying (19% vs. 11%); and they are more likely to

report having difficulty performing basic daily activities, such as dressing, bathing or getting around the house (6% vs. 1%).

Exhibit 2 shows the rates of selected chronic conditions among all nonelderly women and among those ages 40-64, as these chronic conditions, except for asthma, become more pronounced as women get older.³

While the differences by income are not very pronounced across all nonelderly women, patterns emerge among women ages 40-64, where there are higher prevalence rates and the age differences between groups are

Chronic Health Conditions by Federal Poverty Level, Women Ages 18-64 and 40-64, California, 2007

Exhibit 2

Diagnosed Health Conditions**	Ages 18-64			Ages 40-64		
	0-199% FPL	200-399% FPL	400%+ FPL	0-199% FPL	200-399% FPL	400%+ FPL
Asthma	13%	15%	15%	16%	17%*	14%
Diabetes***	7%*	6%*	4%	15%*	10%*	5%
High Blood Pressure	20%	21%*	18%	33%*	32%*	25%
Heart Disease	5%*	4%	3%	8%*	6%*	4%

Note: The 2007 Federal Poverty Level (FPL) was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

* Significantly different from the 400%+ FPL category, $p < .05$.

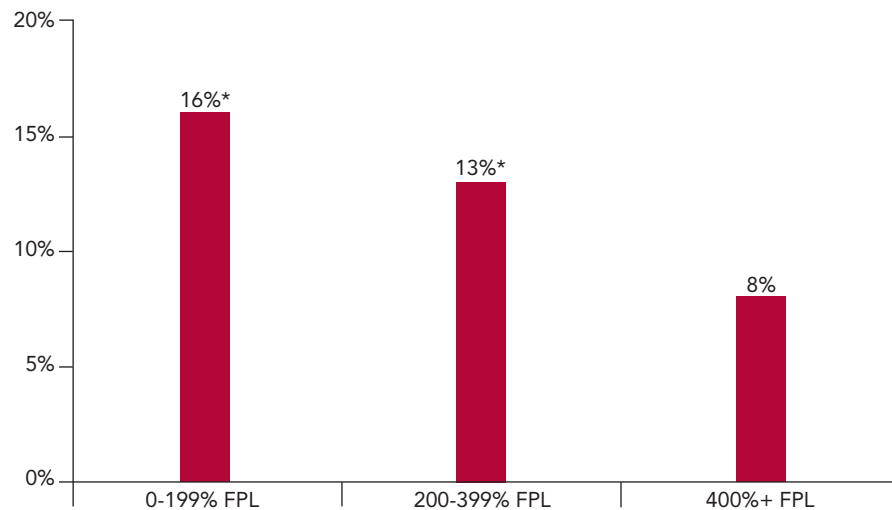
** Health condition is based on women reporting that they have ever been diagnosed with the condition.

*** Diabetes rate excludes gestational diabetes.

Source: 2007 California Health Interview Survey

Experienced Psychological Distress in the Past 12 Months by Federal Poverty Level, Women Ages 18-64, California, 2007

Exhibit 3



Note: The 2007 Federal Poverty Level (FPL) was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low-income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

*Significantly different from the 400%+ FPL category, $p < .05$.

Source: 2007 California Health Interview Survey

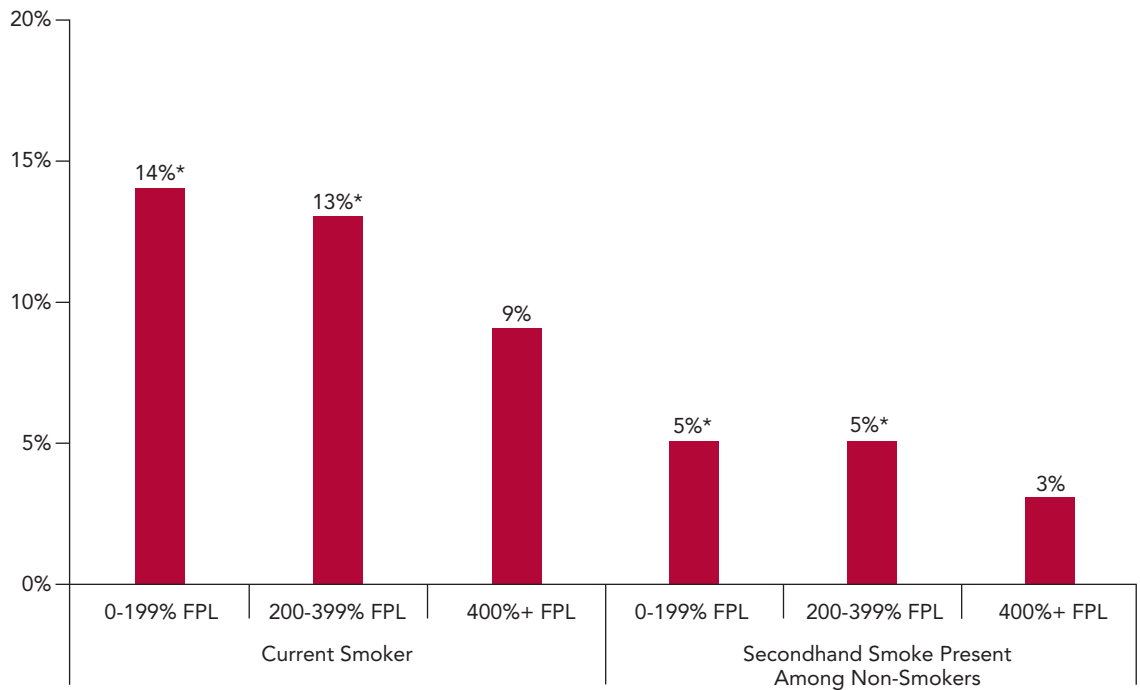
controlled. Low-income women ages 40-64 have higher rates of diabetes, high blood pressure and heart disease than women with family incomes at or above 400% FPL, and a similar rate of asthma. One-third of low-income women in this age group have ever been diagnosed with high blood pressure, 15% with diabetes, 16% with asthma and

8% with heart disease. Women with family incomes 200-399% FPL also have higher rates of these health conditions than higher-income women.

A possible side effect of prolonged economic burden is psychological distress. Among nonelderly women, those with low incomes

Exhibit 4

Current Smoker and Secondhand Smoke in the Home Among Non-Smokers by Federal Poverty Level, Women Ages 18-64, California, 2007



Note: The 2007 Federal Poverty Level (FPL) was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

Source: 2007 California Health Interview Survey

*Significantly different from the 400%+ FPL category, $p < .05$.

are twice as likely to have experienced a degree of psychological distress in the past 12 months compared to higher-income women (16% vs. 8%; Exhibit 3).

Higher Rates of Certain Health Risks Among Nonelderly Low-Income Women

Low-income nonelderly women have higher rates of some common health risks that are associated with health problems and diseases.

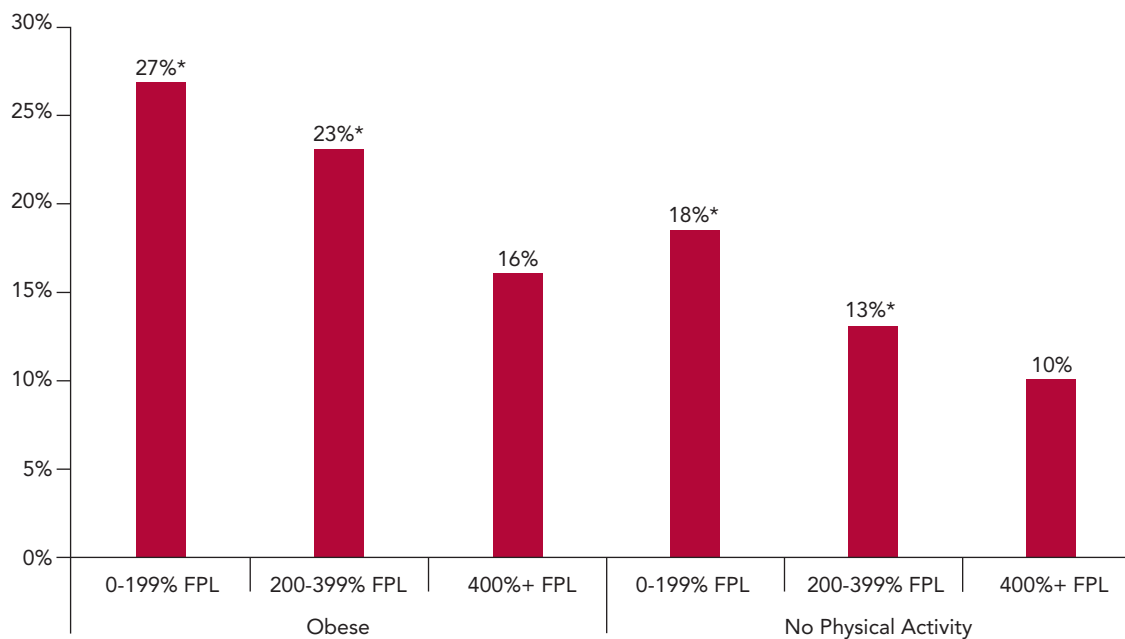
Although smoking rates have decreased for low-income women, they are still more likely to smoke compared to women with higher

incomes. In 2007, 14% of low-income women were smokers, compared to fewer than one in ten higher-income women (9%; Exhibit 4).

Low-income women also face slightly higher exposure to secondhand tobacco smoke in the home.⁴ Among women who do not smoke, low-income women and those at 200-399% FPL have slightly higher rates of secondhand tobacco smoke in their homes (5%) compared to women with family incomes of 400% FPL and above (3%).

Prevalence of Obesity and Lack of Physical Activity by Federal Poverty Level, Women Ages 18-64, California, 2007

Exhibit 5



Notes: The 2007 Federal Poverty Level (FPL) was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

Body Mass Index (BMI) is based on self-reported height and weight. Obese is defined as a BMI of 30 or above.

Source: 2007 California Health Interview Survey

*Significantly different from the 400%+ FPL category, $p < .05$.

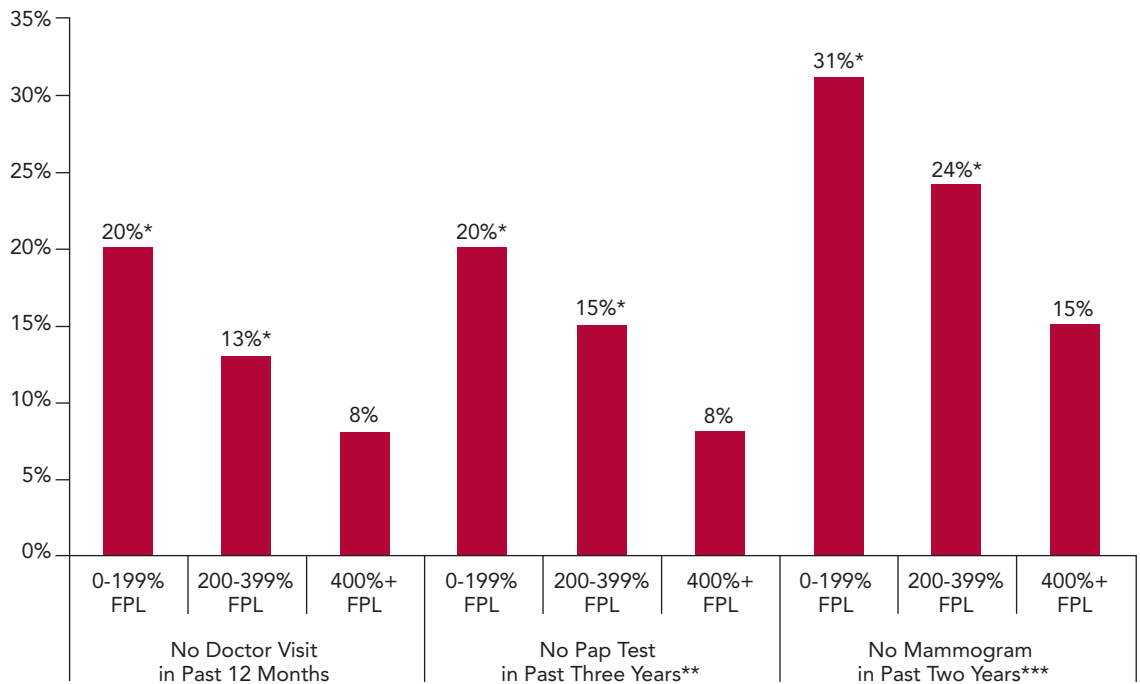
Obesity is associated with several health diseases and conditions, such as diabetes, hypertension and heart disease.⁵ As defined by a Body Mass Index (BMI) of 30 or above, low-income women have obesity rates nearly two times higher than higher-income women (27% vs. 16%; Exhibit 5).⁶ An additional 32% of low-income women are overweight.

Another health area that has received recent attention is physical activity. Regular physical activity is recommended to help improve cardiovascular health, prevent certain health

conditions and maintain a healthy body weight.⁷ Approximately two in ten low-income women (18%) get no physical activity (i.e., they do not get at least 10 minutes of physical activity at any one time during the week), nearly double the rate of higher-income women (Exhibit 5). And while most low-income women perform some level of physical activity for at least 10 minutes each week, they are less likely than higher-income women to get recommended amounts of “regular activity.”

Exhibit 6

Lack Of Doctor Visit and Timely Screenings by Federal Poverty Level, Women Ages 18-64, California, 2007



Note: The 2007 Federal Poverty Level was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

Source: 2007 California Health Interview Survey

* Significantly different from the 400%+ FPL category, $p < .05$.

** Pap test estimates exclude women who have had a hysterectomy.

*** Mammogram rates are for women ages 40-64.

Gaps in Access for Nonelderly Low-Income Women

Even though they report poorer health status than women with higher incomes, nonelderly low-income women are less likely to have seen a physician in the past year. One in five low-income women (20%) report no physician visit in the past year, compared to 8% of higher-income women (Exhibit 6).

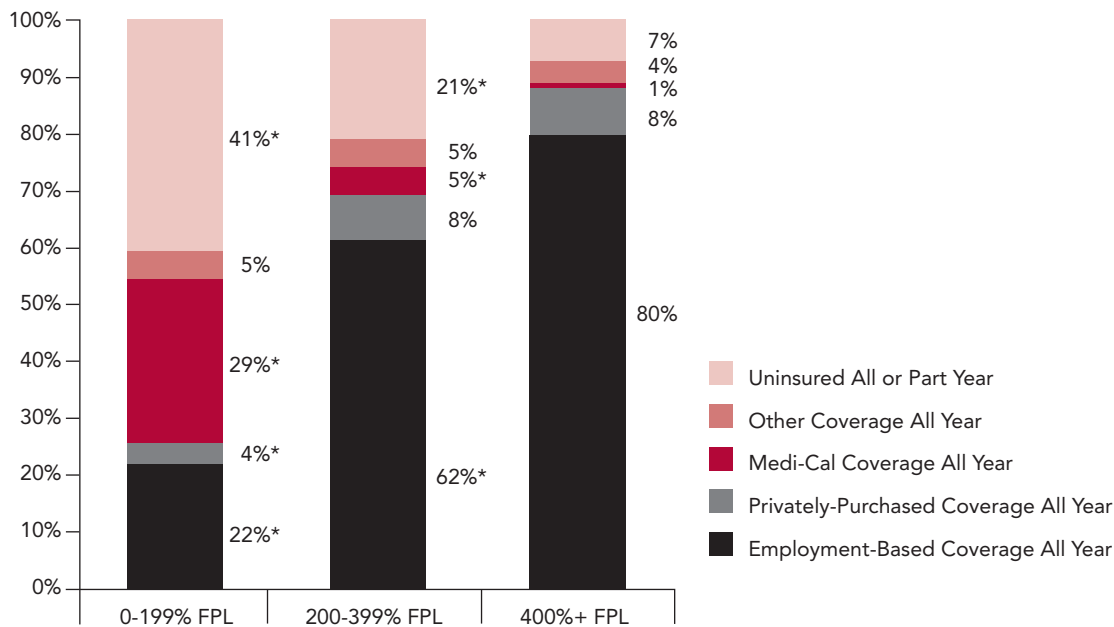
Preventive screening rates also vary by family income (Exhibit 6). Low-income women are the least likely to be screened for cervical and breast cancer, while screening rates increase among higher-income women.

Overall, 20% of nonelderly low-income women have not received a Pap test in the past three years, a proportion twice that of women with family incomes of 400% FPL and over. This includes 6% of low-income women who had their last screening over three years ago, 14% who have never had a Pap test, and 80% who were screened within the past three years, which is the general recommendation for timely screening (data not shown).

Low-income women were also the least likely to have received a timely mammogram. In 2007, 31% of low-income women ages

Health Insurance Coverage During Past 12 Months by Federal Poverty Level, Women Ages 18-64, California, 2007

Exhibit 7



Notes: The 2007 Federal Poverty Level (FPL) was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Numbers may not add up to 100% because of rounding.

Source: 2007 California Health Interview Survey

*Significantly different from the 400%+ FPL category, $p < .05$.

40-64 had not received a mammogram within the past two years, a proportion twice that of higher-income women (Exhibit 6). Overall, 15% of low-income women ages 40-64 have never had a mammogram, 16% had their last screening over two years ago, and 69% had a mammogram within the past two years (data not shown).

Screening rates were lower among low-income women ages 40-49 than those ages 50-64 (35% vs. 26% not screened within the past two years, respectively) possibly because the recommendation and message of screening every two years has been less consistent for women ages 40-49 (data not shown).

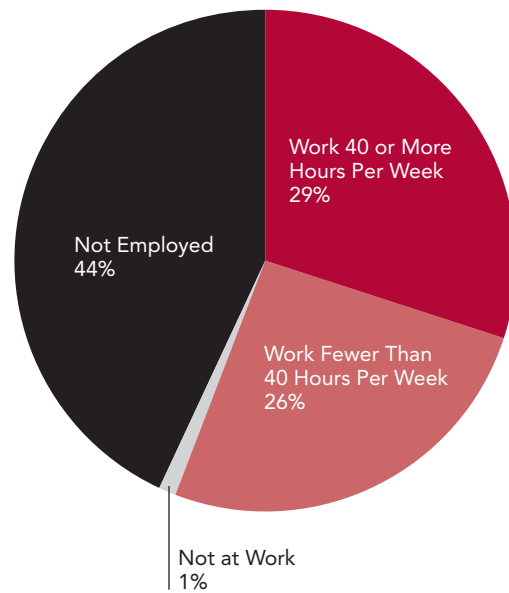
Four in Ten Nonelderly Low-Income Women Uninsured All or Part of the Year

Whether or not a nonelderly woman has health insurance coverage and the source of that coverage varies markedly by family income. Four in ten low-income women (41%) were uninsured for all or part of 2007, nearly six times the rate of women with family incomes of 400% FPL and above (7%) and double the rate of women with family incomes of 200-399% FPL (21%; Exhibit 7).

This disparity in uninsured rates is in part due to the differences in access to employment-based coverage, the main

Exhibit 8

Work Status Among Low-Income Women Currently Uninsured, Ages 18-64, California, 2007



Note: The 2007 Federal Poverty Level was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

Source: 2007 California Health Interview Survey

source of coverage for most women. Two in ten low-income women (22%) were covered by employment-based coverage during all of the past 12 months, in contrast to 80% of women with family incomes of 400% FPL and above and 62% of women with family incomes of 200-399% FPL.

Medi-Cal prevents the income gap in coverage from being even larger by covering eligible low-income women who do not have access to or cannot afford employment-based or other forms of coverage. Approximately three in ten low-income women (29%) were covered by Medi-Cal for the entire year in 2007. This includes 37% of women with

family incomes below poverty (0-99% FPL) and 20% of women with family incomes of 100-199% FPL (data not shown).

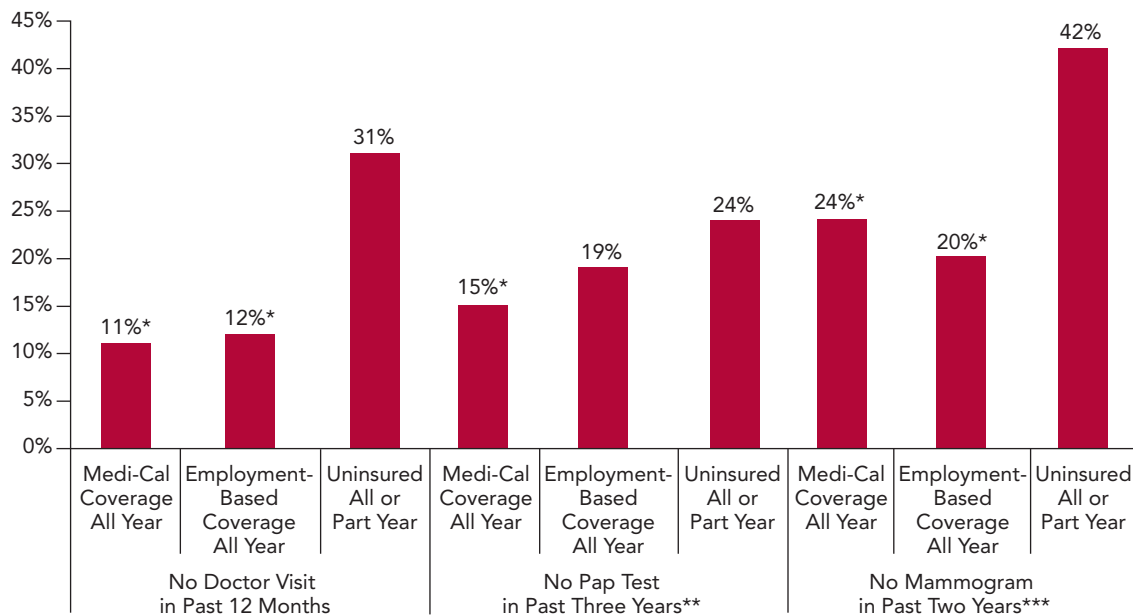
Few low-income women can afford to purchase health insurance coverage on their own through the private market, contributing to just 4% with privately-purchased coverage.

Many Uninsured Nonelderly Low-Income Women Work

The majority of uninsured low-income women work (56%; Exhibit 8). Of those uninsured at the time of the survey, nearly

Access to Care by Health Insurance Coverage During Past 12 Months, Low-Income Women, Ages 18-64, California, 2007

Exhibit 9



Notes: The 2007 Federal Poverty Level was \$10,787 for one person, \$13,954 for a two-person family and \$16,530 for a three-person family. Per our definition of low income, a woman with a family of three living at 0-199% FPL had a 2007 family income between no income to approximately \$33,000.

The Medi-Cal category includes a small percent of women (<1%) who received Healthy Families all year.

Source: 2007 California Health Interview Survey

* Significantly different from the uninsured all or part year category, $p < .05$.

** Pap test estimates exclude women who have had a hysterectomy.

*** Mammography rates are for women ages 40-64.

one in three (29%) were working full time (40 or more hours per week), 26% were working part time (fewer than 40 hours per week), and 1% were employed, but not currently at work.

Low-income working women have less access to employment-based coverage than higher-income women. Among low-income women working 40 or more hours per week, 41% reported they currently had employment-based insurance compared to 92% of women with family incomes of 400% FPL and above and 82% of women with family incomes of 200-399% FPL (data not shown).

Health Insurance Coverage Equalizes Access to Care Among Nonelderly Low-Income Women

Nonelderly low-income women without insurance coverage were the most likely to have been without a physician visit in the past year (31%), had not had a timely mammogram (42%), and had not had a timely Pap test when compared to women with Medi-Cal (24%; Exhibit 9). The gap between uninsured and insured women was not as large for Pap tests as for the other indicators, possibly because of public programs to increase cervical cancer screening or the relatively lower cost of Pap tests.

For each of the three indicators, low-income women receiving Medi-Cal had much better access to these services than those without coverage and had rates that were equivalent to women with employment-based coverage.

Discussion

Low-income women face several health disparities. Even though they are a younger population than women with higher incomes, low-income women have worse general health status and functioning. And mid-life, low-income women have a higher prevalence of three of the four chronic health conditions examined—diabetes, high blood pressure and heart disease.

Preventive practices can be an important safeguard against health problems. Low-income women have lower rates of the health promoting practices examined in this report, such as maintaining a healthy weight, not smoking, and engaging in some physical activities. While these practices are implemented individually, they are often shaped or constrained by social and physical environments.^{8,9} Proactive policies and programs that promote healthy environments can remove some of the obstacles.

Despite their poorer health, low-income women have the highest uninsured rate and the lowest rate of employment-based insurance. Working, even full time, does not ensure available and affordable coverage for this group of women. A recent affordability study that looked at the costs of basic necessities and health care expenses concluded that families with incomes below 200% FPL have few or no resources available to contribute to premiums or out-of-pocket costs and would require full subsidies.¹⁰

Health insurance coverage makes a difference for all women, and especially for low-income women. Those with Medi-Cal or employment-based coverage had more timely preventive screenings and physician visits than women without coverage.

Even before the downturn in the economy in 2007 when these data were collected, low-income women experienced numerous health disparities. Low-income women are particularly vulnerable during economic recessions to reduced access to public benefits and programs. Their limited discretionary income combined with their poorer health status reinforces the urgency of effective and consistent health insurance coverage and access to health services for all.

Data Source

This brief is based on data from the 2007 California Health Interview Survey (CHIS 2007). The California Health Interview Survey is a biennial telephone survey of the California population living in households. Sampling tolerances at the 95% confidence level were used to calculate statistically significant differences between populations. For more information on the California Health Interview Survey, please visit www.chis.ucla.edu.

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Endnotes

- 1 The Federal Poverty Level (FPL) varies by family income and family size. In 2007, the federal poverty level was \$10,787 for one person, \$13,954 for a family of two and \$16,530 for a family of three. We define "low-income women" as women living between 0-199% FPL. This would translate for a family of three to a yearly income between no income to approximately \$33,000, for example.
- 2 Adler N, Newman K. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*. 2002; 21:60-76.
- 3 Health condition prevalence is based on women reporting that they have ever been diagnosed with asthma, diabetes, high blood pressure or heart disease.
- 4 U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006.
- 5 National Task Force on the Prevention and Treatment of Obesity. Overweight, Obesity, and Health Risk. *Archives of Internal Medicine*. 2000; 160(7):898-904.
- 6 Body Mass Index (BMI) is calculated by dividing weight in pounds by height in inches squared and multiplied by a conversion factor of 703 based on respondent's self report of height and weight. Obesity is a BMI of 30 or above.
- 7 U.S. Department of Health and Human Services. *Physical Activity and Health*. A Report of the Surgeon General, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1996.
- 8 Adler N, Newman K. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*. 2002; 21:60-76.
- 9 Babey S, Diamant A, Hastert T, Goldstein H, Harvey S, Banthia R, Flournoy R, Rubin V, Treuhaft S. *Designed for Disease: The Link Between Local Food Environments and Obesity and Diabetes*. California Center for Public Health Advocacy, PolicyLink, and the UCLA Center for Health Policy Research, 2008.
- 10 Carroll D, Roby DH, Ross J, Snavely M, Brown ER, Kominski GF. *What Does it Take for a Family to Afford to Pay for Health Care?* Los Angeles, CA: UCLA Center for Health Policy Research, 2007.



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