Policy brief
Health Policy Institute of Ohio

Unhealthy Differences: Health Disparities between Men and Women in Ohio

SUMMARY

In 2008, Ohio's adult (18-64 years) population was split almost evenly between men (49.43%) and women (50.57%). Based upon data from the 2008 Ohio Family Health Survey (OFHS), the Health Policy Institute of Ohio (HPIO) found important health disparities between men and women. This data brief more closely examines those disparities and the circumstances surrounding them.

Key findings include:

- Men were more likely than women to be uninsured
- Women were more likely than men to live at or below 200% of poverty ($41,304 per year for a family of four)[1]
- Women were more likely than men to have ever been diagnosed with cancer
- Men were more likely than women to have high blood pressure, heart disease, and have had a heart attack

Results presented in this brief highlight key differences (or disparities) found in health behaviors, risk factors, family income, experiences with the health care system, and other key indicators by gender. Policymakers and other decision makers may look to these findings as they shape strategies to build health equity and improve the physical, mental, and social well-being of all Ohioans.

INTRODUCTION

Data from studies such as the National Health Interview Survey (NHIS) provide evidence of gender disparities in health care and health outcomes on a national level.[2] To examine to what extent such disparities exist in Ohio, the Health Policy Institute of Ohio analyzed data from the 2008 Ohio Family Health Survey. HPIO examined trends in health care, health outcomes, health behaviors, and socioeconomic factors in Ohio's working-age adult (ages 18-64) men and women. Findings indicated significant differences between groups on the basis of socioeconomic status, health care system experience, health behaviors, and health outcomes. The sections that follow further break out the data and describe the findings in ways that provide further tools for policymakers to make informed health policy decisions.

This data brief summarizes findings on health disparities between Ohio's men and women.[3] Health disparities also exist among different regions, races and ethnicities, and age groups; these disparities are covered in accompanying briefs.

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1 Federal Registrar, effective April 2007-2008.
2 Data can be found at the website for the National Center for Health Statistics, Center for Disease Control at http://www.cdc.gov/nchs/fastats/Default.htm
3 Because OFHS is self-reported, *gender* is used instead of *sex*. Gender is the social expression of a number of factors, including one's biological sex, and is therefore a social identity rather than a biological category. For the sake of statistical strength of the sample, the only two gender categories examined in this brief are *men* and *women*.

What is meant by "health disparities"

Many definitions of *health disparities* exist in the literature and in practice. Olivia Carter-Pokras and Claudia Baquet, two leading scholars in the field of social epidemiology, describe a disparity as a signpost or indicator of something problematic: "If a disparity is identified and described, then the health community, policymakers, and the public can become more aware of it." (Carter-Pokras and Baquet, *What is a "health disparity"*, 2002)

Inequity and *inequality* are other words with distinct meanings closely related to *disparity*. Many definitions of each of these words also exist and are used to varying degrees by researchers and health policy analysts.

If a disparity is determined to be avoidable, unfair, and actionable, then Carter-Pokras and Baquet consider it to be an "inequity." What is considered to be avoidable and unjust is a product of what is currently known, they add, and will depend on who is making that decision and how it is made. "Inequality," by comparison, is considered to be a more observational term; it does not necessarily imply a value statement about the difference.

Briefs written by the Health Policy Institute of Ohio use these definitions because they are clear, concise, and because they fall in line with definitions used by the World Health Organization.

FINDINGS

According to the 2008 Ohio Family Health Survey, women constitute just over 50% of Ohio's 7.16 million adult (ages 18-64) population. That percentage equates to over 3.62 million women and 3.54 million men. The Health Policy Institute of Ohio analyzed data from the 2008 OFHS to examine trends in health care, health outcomes, and social determinants of health in Ohio's working-age adults (ages 18-64) according to self-reported gender.

Health Care System

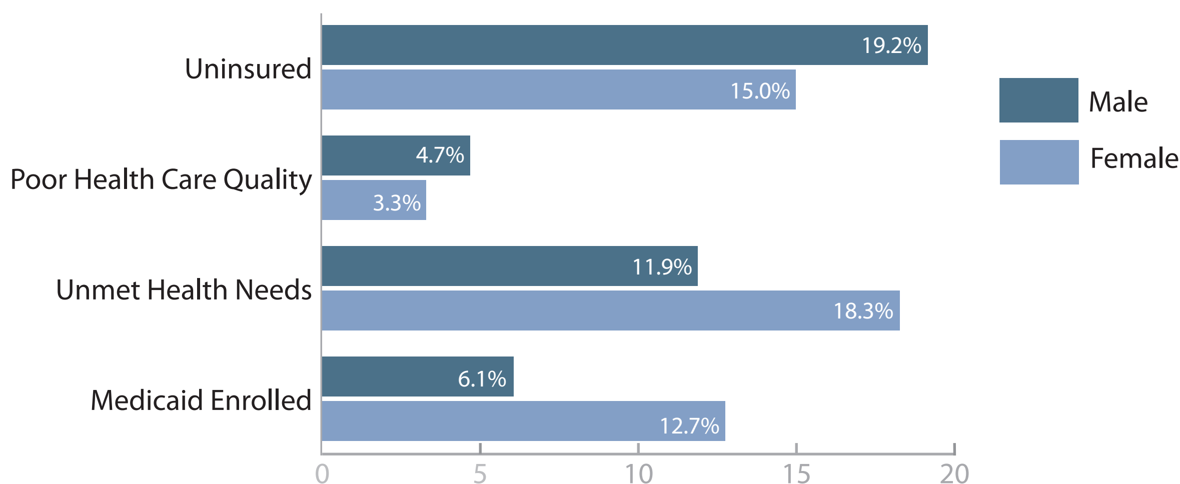
Gender disparities were evident when looking at data pertaining to Ohioans' experiences with the health care system. In the 2008 OFHS, 17% of Ohio's adults – over 1.2 million people – reported that they did not have health insurance.[4] Men were 30% more likely than women to be **uninsured**.

Respondents were asked to rate the **quality** of the health care that they received in the last year on a scale of zero to ten, with zero representing the worst quality, and ten the best. Nearly 4% of Ohio

Fig. 1

Health Care System Factors by Gender

Adults 18-64



4 This percentage refers to adults with *general* health insurance coverage; the reported figure is based on the response of insurance status in the week prior to being surveyed.

adults rated their health care quality as "poor" — a value of zero through four. Men were 40% more likely than women to rate the quality of their care as "poor." Men were 30% less likely than women, however, to report having **unmet health needs**.

More than 675,000 adults (9.4%) were enrolled in the **Medicaid** program at the time of the 2008 OFHS, primarily women. Men were 50% less likely than women to be enrolled in Medicaid.

Health Behaviors and Risks

In the Ohio Family Health Survey, as in similar population surveys, considerations such as health behaviors are typically treated as personal choices and are addressed on an individual level. The 2008 OFHS findings illustrate that there are significant differences in health behaviors and health risk factors between men and women.

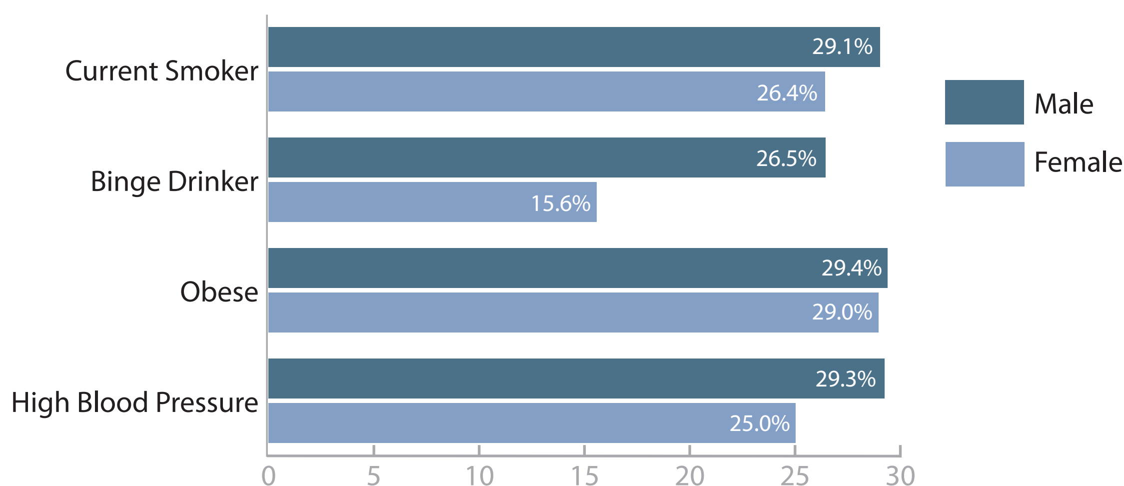
Nearly two million adults (27.7%) reported **smoking** at least one cigarette per day, most or everyday. More than one and a half million (21%) reported at least one incidence of **binge drinking** in the thirty days prior to being surveyed.[5] While men were only 10% more likely than women to be smokers, they were 70% more likely to binge drink.

Obesity and **hypertension** are important predictors of poor medical outcomes. Statewide, 29.2% of adults (more than two million) had a body mass index (BMI) of at least 30 kg/m2 (qualifies as obese) and 27.1% (nearly two million) had been told that s/he had high blood pressure (hypertension). There was no statistically significant difference in obesity rates between men and women. However, men were 20% more likely than women to have high blood pressure.

Fig. 2

Health Risks by Gender

Adults 18-64



An important, yet unmeasured variable that operates both as a risk factor and as an outcome is stress. While it is accepted that all individuals feel stress to some degree, and that stress can take a positive or a negative form, the lack of an appropriate measure prevents public health officials from being able to quantify stress as a population-level outcome. If stress can lead to serious mental, emotional, and physiological problems for an individual, so too may the chronic stress of particular gender roles in society adversely affect men and women. Consideration of stress as a health outcome is important in work on health disparities, as well as in public health in general.

5 Respondent reported drinking at least five (men)/ four (women) alcoholic beverages in one sitting in the thirty days prior to being surveyed.

Health Outcomes

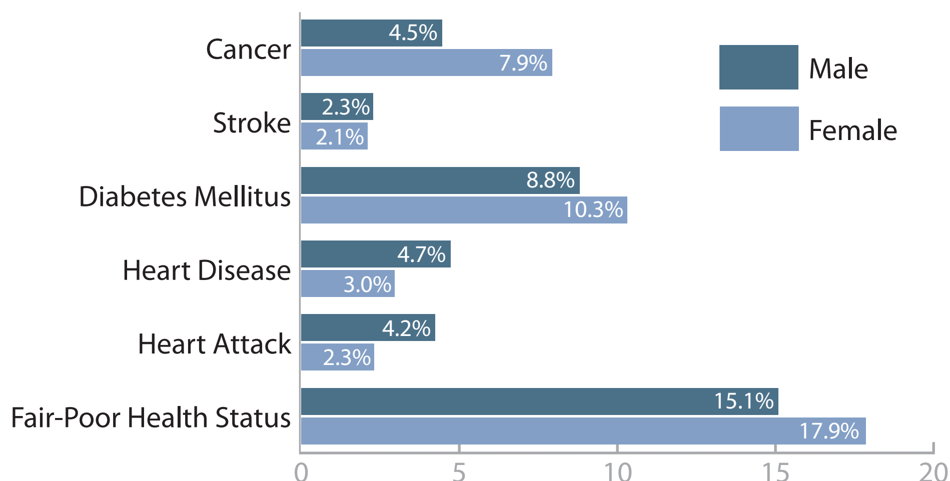
When asked to rate their own **health status** as *poor, fair, good, very good*, or *excellent*, 16.5% of Ohio's adults (nearly 1.2 million) considered themselves to be in only poor or fair health. The 2008 OFHS gathered data on a number of health outcomes that, for many people, may contribute to their self-perception of being unhealthy. Statewide, 3.3% of adults reported having ever had a **heart attack**, 2.2% reported having ever had a **stroke**, 6.2% reported having ever been diagnosed with **cancer**, 3.8% reported having ever been diagnosed with **heart disease**, and 9.6% reported having ever been diagnosed with **type 2 diabetes** (diabetes mellitus).

Men were 20% less likely than women to rate their health status as fair or poor, 10% less likely to have ever been diagnosed with type 2 diabetes, and 40% less likely to have ever been diagnosed with cancer. However, men were 60% more likely than women to have heart disease and 80% more likely to have had a heart attack.[6]

Fig. 3

Health Outcomes by Gender

Adults 18-64



Socioeconomics

When examining the issues of health disparities, it is essential to keep in mind that there are structural and social factors that affect how individuals and populations manage their health and interact with the health care system. The circumstances in which people are born, grow, live, work and age, as well as how they interact with a very complex health care system, are referred to by researchers as *social determinants of health*.[7] The OFHS gathered data on one of the most influential social determinants of health – socioeconomic status.

Socioeconomic status (SES) is a complex concept. It includes factors that directly or indirectly relate to an individual's financial solvency, stability, and growth potential. In the 2008 Ohio Family Health Survey, these factors included annual income, educational attainment, employment, and Medicaid enrollment. Although not measured by the 2008 OFHS, other SES components traditionally include wealth, assets, family size, parental occupation, and group associations. Income, education, and employment are considered separately in the sections that follow.

6 There was no statistical evidence of a difference in having ever had a stroke between men and women.

7 Whitehead M. The concepts and principles of equity and health. Copenhagen: WHO/EURO; 1991.

What is meant by "social determinants of health"

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," (WHO Constitution, 1946) implying that characteristics outside of the biological realm impact human health.
To that end, the World Health Organization, its affiliates, and the CDC have recognized and adopted twelve contributing factors that describe "social determinants of health":

Income and social status
Social support networks
Education and literacy
Employment and working conditions
Social environments
Physical environments
Health services
Personal health practices and coping skills
Healthy child development
Biology and genetic endowment
Culture
Gender

Income was evaluated by comparing federal poverty guidelines with 2008 OFHS data (which captured a survey respondent's annual gross income for calendar year 2007). The following table details 2007-2008 Federal Poverty Guidelines (FPL).[8]

Federal Poverty Guidelines*

Annual Gross Income as Percent of the Federal Poverty Line

Family Size	100% FPL	200% FPL	300% FPL
1	$10,212	$20,424	$30,636
2	$13,692	$27,384	$41,706
3	$17,172	$34,344	$51,516
4	$20,652	$41,304	$61,956

*Federal Register, effective April 2007-2008

HPIO found that 34% or over 2.4 million adults were living at or below 200% of poverty. Men were 20% less likely than women to live at or below 200% of poverty. While the 2008 OFHS did not collect data on wealth and assets (two additional measures of SES), annual income is an easily quantified financial measure that provides insight into whether adults are covered by other government assistance programs (such as Medicaid, Food Stamps, and Welfare-to-Work) that may impact health status and health behaviors.

Educational attainment considered whether or not the respondent had received his/her high school diploma or equivalent at the time of the survey. Statewide, nearly 750,000 adults (10.4%) did not have a high school diploma, with men being 20% more likely than women not to have a diploma.

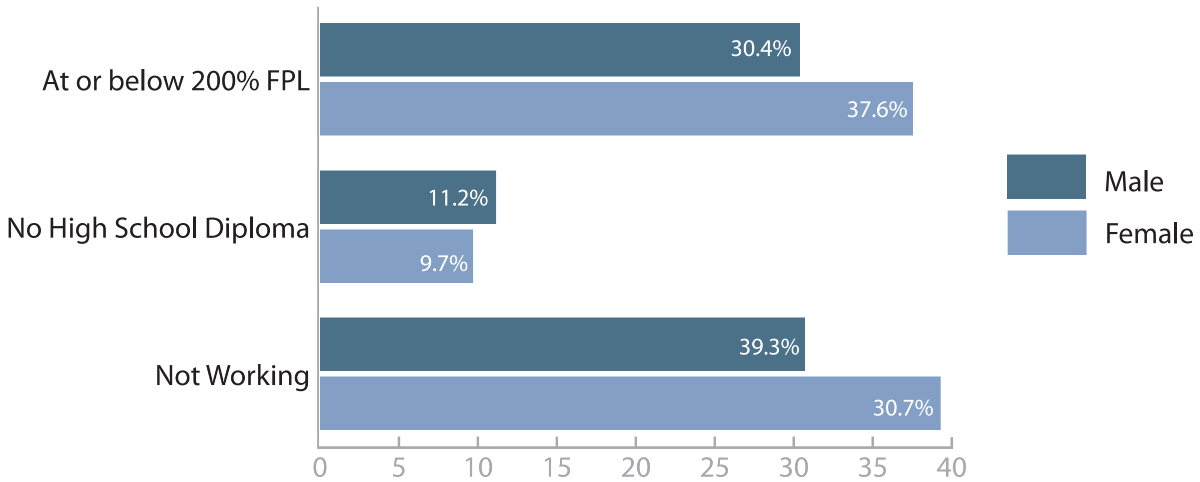
Official **unemployment** numbers, as compiled by the U.S. Bureau of Labor Statistics, are complex. They include information on length of time spent looking for work, type of work, and other details. The OFHS focused on factors associated with employment (income, insurance, etc.) rather than the reasons an individual may or may not be working. Therefore, employment was recorded by whether or not the respondent was working (full- or part-time) in the week prior to being surveyed. By this simple measure, 35% of adults (just over 2.5 million) were not working at the time of the 2008 OFHS. A greater proportion of women were not working than men; men were 20% less likely than women not to be working.

8 The 200% FPL cutoff is used for three key reasons: 1) The US Census Bureau's most recent poverty threshold for the state of Ohio was identified as 200% FPL. 2) The Economic Policy Institute, a national economic think-tank, indexed the 2007 national family budget as $48,778 for a family of four, a number more than twice the value of the federal poverty line. This family budget estimation includes funds for food, housing and utilities, non-recreational transportation, health care, child care, taxes and necessary household items. 3) At the time this analysis was conducted, the 200% FPL cutoff had been proposed as the new income level for adult Medicaid eligibility (it has since been amended to 133% FPL).

Fig. 4

Socioeconomic Factors by Gender

Adults 18-64



Conclusion

Data from the 2008 OFHS indicate that Ohio's men and women differed from one another on many measures of individual health, health care coverage, access to health care, and use of health care. Men were more likely to be uninsured, not to have a high school diploma, more likely to have high blood pressure, heart disease, and have had a heart attack. Women were more likely to live in poverty, be enrolled in Medicaid, and not to be working. They were also more likely to have ever been diagnosed with cancer. These results provide evidence for community actors to shape their understanding of health and health care needs of different populations. Additionally, the data may inform strategies for reaching these populations in communities and improving their health. Concrete data on health disparities contributes to dialogue where policymakers and decision makers think meaningfully about healthy equity, equality, and social determinants of health.

ABOUT HPIO

The Health Policy Institute of Ohio is an independent, nonpartisan organization that forecasts health trends, analyzes key health issues, and communicates current research to Ohio policymakers, legislators, and others. For additional copies of this publication visit www.healthpolicyohio.org or call (614) 224-4950.

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