

Gender differences in health-related behaviours: the BRFSS experience

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Gender differences in morbidity and mortality have been a focus of considerable attention and study over the last several decades.^{1,2} There has been less work on differences between men and women in personal or lifestyle behaviours that lead to illness and death, because in contrast to morbidity and mortality registries, data collection systems of this type are a more recent phenomenon.

One such system, the U.S. Behavioral Risk Factor Surveillance System (BRFSS), which has been in operation since 1984, gathers data on behaviours and practices that contribute to the major causes of morbidity and mortality among U.S. adults, primarily heart disease, stroke, cancer, and diabetes.³ Since its inception, gender differences in these behaviours and practices have been evident. In 1999 and 2000, the latest years for which data from the BRFSS are available, we found that males were more likely than females to lack health insurance, to have been told by a health professional they have diabetes, to be a current smoker, to be a chronic or binge drinker, to consume less than five servings of fruits or vegetables per day, to be overweight, not to have had their blood pressure checked within the past two years or their cholesterol checked with the past five years, not to have had a pneumonia shot, and to perceive their HIV risk as medium or high rather than low or none. Conversely, females were more likely than males to perceive their health as fair or poor and to have a greater number of days on average in the past 30 days when their physical or their mental health was not good. Furthermore, women were more likely than men to report no leisure-time physical activity. No gender differences were observed in other behaviours, such as the mean number of days in the past 30 days when activities were limited (i.e., reported activity limitations), flu shots within the past 12 months among those aged 65 or older, and screening for colorectal cancer. Because the BRFSS collects data on a continuing basis, we can also determine

whether the differences between men and women remain the same or change over time.

Although prevalence differed, we found similar patterns of change for men and women for most health risk behaviours and health conditions from 1990 to 2000. As prevalence increased among men, a similar increase occurred among women. A few exceptions were evident. One example was diabetes awareness, that is, being told by a health professional that you had diabetes. Not only does diabetes lead to other serious complications and illnesses, but the prevalence of the condition has increased over time among U.S. adults.⁴ When we compared males to females for adults aged 18 years or older, we found that males (4.0% in 1990) were somewhat less likely than females (5.7% in 1990) to have been told they had diabetes until 1997. The prevalence was almost the same for the next two years, but by 1999 and for 2000, males were slightly more likely than females to have been told they have diabetes (6.1% vs 5.9% in 2000). So, the pattern appears to be reversing. The next step is to explore why these differences occur.

The BRFSS data indicate that important co-factors for diabetes such as being overweight and poor diet could contribute to these changes. While the BRFSS data show that men are significantly more likely than women to be overweight, the prevalence of overweight increased among both men and women from 1990 to 2000 (42.6% in 1990 to 45.1% in 2000 for men; 24.4% in 1990 to 28.5% in 2000 for women). For the four years of data available on the prevalence of consuming five or more servings of fruits and vegetables per day, we found that the consumption of fruits and*

* All respondents aged 18 years or older who report that their body mass index (BMI) is between 25.0 and 29.9. BMI is defined as weight in kilograms divided by height in meters squared.

vegetables, which was relatively low for both men and women, remained fairly constant over time. However, for each year, men (81.1% in 2000) were more likely than women (73.0% in 2000) to not have five or more servings per day.

This is just one example of how data from the BRFSS can be used to identify gender differences and provide insight into the health differentials. Although the BRFSS comparisons of diabetes prevalence to other behaviours are ecological, and as such subject to the strengths, but also the weaknesses inherent in this type of analysis, they suggest hypotheses for additional study. The BRFSS data enable us to further assess these relationships at the individual level to better

understand how behaviours influence health among men and women.

Systems that collect health behaviour data, like the BRFSS, can complement those that track morbidity and mortality. Although a great deal of research has been carried out to investigate gender differences in morbidity and mortality, it is important that these data be analysed in relation to the behaviours and practices that contribute to illness and death, and additionally, in relation to the social and environmental factors that contribute to the behaviours.⁵ Only by continually collecting and analysing such data to identify and understand the differences between men and women, can we intervene most effectively to reduce morbidity and mortality.

References

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