



FACT SHEET

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OLDER WOMEN'S HEALTH

Activities and Accomplishments

U.S. Department of Health and Human Services

The U.S. Department of Health and Human Services supports a broad range of activities and programs on older women's health. The following is a listing of agency accomplishments:

Agency for Health Care Policy and Research (AHCPR)

AHCPR provides national leadership for efforts to enhance the quality, appropriateness, and effectiveness of health care services and the improvement of access to those services.

AHCPR facilitates the development of clinical practice guidelines for consumers and clinicians. AHCPR's Clinical Practice Guidelines of interest to older women include:

- * "Quality Determinants of Mammography" which addresses the procedures necessary to obtain a quality mammogram, and
- * "Urinary Incontinence in Adults" which comprehensively discusses the etiology, diagnosis, and treatment of urinary incontinence.

Current grants being supported on health issues that are prevalent in older women include studies to:

- * Compare the determinants and cost-effectiveness of three options for treating local breast cancer in the elderly: modified radical mastectomy, breast conserving surgery with

radiotherapy, and breast conserving surgery without radiotherapy [Hadley/HS 08395]

- * Evaluate the effects of hysterectomy on long-term physical and psychosocial outcomes in upper middle class women age 50-89 [Kritz-Silverstein/HS 06726]
- * Identify barriers to access and use of cervical and breast cancer screening in low income, uninsured minority women [Burnett/HS 07406]

In 1994, a research agenda setting conference was held to examine the effectiveness of hysterectomy and alternative therapies in the treatment of several common, non-cancerous uterine conditions (i.e. leiomyoma, dysfunctional uterine bleeding, uterine prolapse, and endometriosis). The conference examined the scientific evidence as to the effectiveness of treatment for these conditions, and to identify what important research questions need to be answered.

Centers for Disease Control (CDC)

CDC serves as the national focus for public activities aimed at disease prevention and control, environmental health, health promotion, and health education activities.

The Second Supplement of Aging, a supplement to the 1994 National Health Interview Survey, was developed and went into the field for data collection. The data collected from the estimated 10,000 respondents will provide important new information on the health and physical functioning of elderly women and men age 70 years and older, and may serve as a baseline for a longitudinal study of this elderly cohort.

Using data from the Study to Assess Falls Among the Elderly (SAFE), two projects were planned: design, piloting, implementation, and assessment of a self-administered home hazards assessment instrument to be used as the basis for fall intervention and prevention strategies; and assessment of the effect of medication use on hip fracture risk among elderly women.

Food and Drug Administration (FDA)

FDA protects the Nation's health by ensuring that food is safe and wholesome and that human and animal drugs, cosmetics, biological products, therapeutic devices, radiological products, and diagnostic devices are safe and effective.

Osteoporosis

Approval of food claims for foods high in calcium for the prevention of osteoporosis, in accordance with the Nutrition Labeling Education Act of 1993.

Approval of the first collagen-based artificial material for use in acute long bone fractures and traumatic osseous defect. The device is used for women who suffer from osteoporosis.

Approval of two new products that combine estrogen and progestin for hormone replacement therapy. These new products add two more choices for women interested in taking hormone replacement therapy.

Recently an Advisory Committee recommended the approval of calcitonin, a hormone, to be administered as a nasal spray for the treatment of osteoporosis.

Mammography Quality and Technology

The FDA is charged with implementing the Mammography Quality Standards Act (MQSA). MQSA consists of three parts: development of standards, accreditation and certification of mammography facilities, and inspections of mammography facilities.

Incontinence

Approval of an implant used to treat urinary incontinence caused by poor or nonfunctioning bladder outlet mechanisms.

Indian Health Service (IHS)

IHS raises the health status of American Indians/Alaska Natives by providing a comprehensive health services delivery system.

IHS has initiated Women's Clinics with a focus on preventive services for the elderly, i.e. vaccination program, pap smear, breast exams, etc.

National Institutes of Health (NIH)

NIH uncovers new knowledge that will lead to better health for the American public. NIH works toward that goal by conducting research in its own laboratories on the causes, diagnosis, prevention, and cure of human diseases; the process of human growth and development; and the biological effects of environmental contaminants.

- **National Cancer Institute (NCI)**

Breast cancer prevention is a high priority of NCI. The Breast Cancer Prevention Trial (BCPT) is studying the ability of tamoxifen, a hormonal agent long used to treat breast cancer in women at increased risk, including older women. The beneficial effects of tamoxifen in lowering the risk for cardiovascular disease and slowing bone loss are also

being assessed.

- **National Heart, Lung, and Blood Institute (NHLBI)**

Postmenopausal Estrogen/Progestin Interventions (PEPI) Trial

The PEPI Trial evaluated, over a 3-year period, the efficacy and safety of various combinations of sex hormones in improving cardiovascular disease risk factors in postmenopausal women. This study revealed a 10% rate of endometrial hyperplasia, a precursor to malignancy in women who use estrogen alone. This finding confirms the need to take progestins with estrogen to reduce the rate of development of uterine cancer. Women in the study will be followed for an additional 2 years to monitor any untoward effects of their participation in the trial.

Angiographic Trial for Prevention of Coronary Heart Disease (CHD)

The CHD Trial will evaluate the separate and combined effects of hormone replacement therapy and antioxidant vitamin treatment on coronary artery disease in postmenopausal women. This new study is expected to identify therapeutic options and increase understanding of CHD in women.

Evaluation of Ischemic Heart Disease in Women

This evaluation will focus on development of clinically useful approaches to identify women with CHD. Reliable methods for early identification of such patients will assist physicians in determining appropriate treatments for women at risk.

- **National Institutes of Aging (NIA)**

Apolipoprotein E Status as a Predictor of the Development of Alzheimer's Disease

This study revealed that many subjects with mild cognitive impairment progress to Alzheimer's disease and that apolipoprotein E4 allele status appears to be a strong predictor of clinical progression.

Multiple Roles of Middle Generation Caregiving Women

This research examines how well middle generation women, age 35-55 years, who simultaneously occupy multiple roles (e.g. primary caregiver, mother, wife, and employee), adapt to the demands of these multiple roles and how these roles influence women's psychological, social, and physical well-being over time. The effects of stress and role support on women's well-being will be examined and whether these processes affect the caregiver role. Changes in well-being and the effect of role mastery as a

mediator in stress, support, and well-being will be examined. The impact of role change will be evaluated in terms of the nature, type and prior role quality. Three face-to-face interviews will be conducted with 280 women at 12-month intervals.

- **National Institute of Alcohol Abuse and Alcoholism (NIAAA)**

Alcohol Effects in Postmenopausal Women

This project examines the effects of moderate alcoholic beverage use and alcohol abuse on estrogen levels in a group of minority and Native American postmenopausal women. This grant will explore differences in alcohol use and abuse between the various ethnic groups included in the study. In addition, a new approach to recruitment and enrollment of Native American women will be piloted.

- **National Institute of Arthritis and Musculoskeletal and Skin Disease (NIAMS)**

Study of Bone Density and Biochemical Markers in the Tamoxifen Trial Launched

NIAMS and the ORWH are co-funding a study to determine the effectiveness of the drug tamoxifen for preventing osteoporosis in a group of women participating in the Breast Cancer Prevention Trial. The Bone Mineral Density and Biochemical Marker Study, a sub-study of the BCPT, is being conducted at 17 clinical sites and will involve 384 women. Tamoxifen, a drug that antagonizes the action of estrogen on the breast, has been shown in several studies to reduce bone loss in the spine in postmenopausal women with breast cancer. This will be the first study of the effect of the drug in pre-menopausal women and in women without breast cancer.

Some Promising Results for Fluoride

Fluoride has been known for many years to have the potential for promoting the new bone formation in the adult skeleton. However, early studies of individuals taking fluoride showed that although their bone mass increased, the fractures continued at the same rate. One reason may have been the dose and particular form of fluoride used in these older studies. Recent results with a slow release form of fluoride combined with high dietary calcium intake slow prevention of fractures in postmenopausal women. While several new and emerging therapies for osteoporosis appear to arrest bone loss, the goal for treating advanced osteoporosis is new bone formation. New approaches to the use of fluoride both alone and in combination with other agents suggest the exciting possibility of actually restoring lost bone.

Estrogen Replacement Therapy and Fractures in Older Women

Estrogen replacement therapy has become an accepted preventive strategy for osteoporosis

in postmenopausal women. Several epidemiologic studies have shown a statistically significant reduction in hip, wrist, and spine fractures among women taking estrogen. The effectiveness of estrogen in preventing fractures in elderly women has been uncertain. Recently, information on the bone density, fracture incidence and estrogen use in 9,700 women over the age of 65 enrolled in the Study of Osteoporosis Fractures was assessed and reported. Women who currently took either estrogen or estrogen plus progestin and who started using hormone replacement within five years of menopause exhibited the lowest rate of fracture. All fracture sites were affected. However, the results also indicated that this protection persisted only when estrogen continued. Previous intake of estrogen, even for as long as 10 years, failed to provide adequate fracture protection in elderly women.

These results suggest that estrogen replacement therapy should be initiated early in menopause and continued indefinitely to offer optimal prevention of osteoporosis. Further studies are needed to determine the overall risks and benefits of such a regimen.

Consensus Development Conference on Optimal Calcium Intake

The National Institutes of Health convened a Consensus Development Conference on Optimal Calcium Intake on June 6-8, 1994. Conclusions from that meeting include:

- * A large percentage of Americans, especially the elderly, fail to meet currently recommended guidelines for optimal calcium intake.
- * All women and men over 65, daily intake is recommended to be 1,500 mg/day, although further research is needed in this age group. These guidelines are based upon calcium from the diet plus any calcium taken in supplemental form.
- * Adequate vitamin D is essential for optimal calcium absorption. Dietary constituents, hormones, drugs, age and genetic factors influence the amount of calcium required for optimal skeletal health.

● **National Institute of Mental Health (NIMH)**

Relapse and Recurrence in Geriatric Psychotic Depression

The study longitudinally follows a group of depressed women at high risk for relapse of depression to determine whether 1) estrogen influences the course of depression; 2) estrogen influences pharmacokinetic factors in depressed geriatric women under treatment; and 3) estrogen affects cognitive status in older women who have undergone electroconvulsive therapy, a therapy with known effects on cognitive function.

- **National Institute of Nursing Research (NINR)**

Menstruation and Menopause Research

Although menopause is a universal phenomenon among women, there is considerable individual variation in the manifestation and severity of a variety of perimenopausal symptoms. NINR investigators have speculated that endocrinologic and metabolic changes associated with the menopause interact with or accelerate events of normal aging to promote increased incidence of metabolic bone disease, heart disease, diabetes, hypertension, breast cancer, osteoarthritis, autoimmune disease, and menstrual bleeding disorders in mid-life. The primary purpose of an NINR-supported, five-year, multisite (seven clinical sites) cooperative agreement is to determine whether menopausal-related changes in hormones or menstrual cycle patterns are associated with changes in joints indicative of arthritis development, loss of bone density, and change in body composition.

- **Office of Research on Women's Health (ORWH)**

Women's Health Initiative (WHI)

- * WHI is a \$625 million study that is being carried out in more than 40 centers across the country. It is the largest prevention-oriented clinical trial for women in U.S. history.
- * The goal of the WHI is to examine the major causes of death, disability, and frailty from cardiovascular disease, breast and colon cancer, and osteoporosis in older women of all races and socioeconomic backgrounds.
- * The WHI will provide essential scientific data to evaluate dietary patterns, supplement use, hormone-replacement therapy, and other medical or behavioral interventions for preventing cardiovascular disease and osteoporosis in postmenopausal women.

Office of HIV/AIDS Policy (OHAP)

OHAP coordinates and integrates PHS efforts in combatting the HIV epidemic.

Collaboration with American Association of Retired Persons' (AARP) - Women's Initiative and the Center for Women Policy Studies in the development of the report, *Midlife & Older Women & HIV/AIDS*, which was published in 1994. Collaborations with AARP are ongoing to continue to highlight the impact of HIV/AIDS on older women.

Office of Minority Health (OMH)

OMH serves as the advocate for and coordinator of health programs and policies addressing minority health issues. In this role, OMH establishes objectives for minority health activities and tracks their progress.

OMH has participated in a cooperative agreement with state, county and local health organizations to develop effective practices for bilingual/bicultural health services delivery.

OMH has assisted the Task Force on Aging Research in the development of a chapter on special populations and ensured the integration of references to minority populations throughout the report, which covered the major diseases disproportionately affecting minority populations.

Office on Women's Health (OWH)

OWH improves the health of women across the life-span by directing, developing, stimulating and coordinating women's health research, health care services, and public and health professional education and training across the agencies and offices of the Public Health Service; and with other government agencies, public and private organizations, and consumer and health care professional groups.

OWH is involved in activities that relate to health issues for older women. The Office co-sponsored the only White House Conference on Aging Mini-Conference that focused on the health care needs of older women. OWH is collaborating with the White House and the Health Care Financing Administration to promote biennial mammography screening covered by Medicare. As the OWH convenes regional summits, conferences, and other fora on the health care needs of women, it will direct particular attention to the health needs of older women.

President's Council on Physical Fitness and Sports (PCPFS)

PCPFS serves as a catalyst to promote, encourage, and motivate the development of physical fitness and sports participation for Americans of all ages. PCPFS provides guidance to the President and the Secretary of Health and Human Services on how to motivate more Americans to be more physically active.

In 1993, PCPFS endorsed the Senior Olympics/Senior Games to encourage older men and women to participate in sports for better health.

PCPFS has put together recommendations for the 1995 White House Conference on Aging to place greater emphasis on an exercise and physical activity message through presentations by the nation's leaders in sports and fitness.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA ensures that research adequately and appropriately addresses the etiology and impact of substance abuse and mental illness on both the health of women and the health and development of their families. Additionally, SAMHSA focuses on incorporating research findings into prevention and treatment strategies.

The Center for Substance Abuse Prevention (CSAP) held a workshop in August 1994 to examine issues related to women in transition. The workshop was intended to provide recommendations to CSAP regarding appropriate substance abuse prevention activities for women experiencing such life transitions as widowhood and divorce.

For Further Information:

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Glossary of Acronyms

AHCPR - Agency for Health Care Policy and Research

CDC - Centers for Disease Control and Prevention

FDA - Food and Drug Administration

IHS - Indian Health Service

NCI - National Cancer Institute

NHLBI - National Heart, Lung, and Blood Institute

NIA - National Institutes of Aging

NIAAA - National Institute on Alcohol Abuse and Alcoholism

NIAMS - National Institute of Arthritis and Musculoskeletal and Skin Disease

NIH - National Institutes of Health

NIMH - National Institute of Mental Health

NINR - National Institute of Nursing Research

OHAP - Office of HIV/AIDS Policy

OMH - Office of Minority Health

ORWH - Office of Research on Women's Health

OWH - Office on Women's Health

PCPFS - President's Council on Physical Fitness and Sports

SAMHSA - Substance Abuse and Mental Health Services Administration

THE WHITE HOUSE
WASHINGTON

OFFICE OF THE FIRST LADY

TO John Spiegel

FROM Jennifer Klein

FAX # 401 - 7321

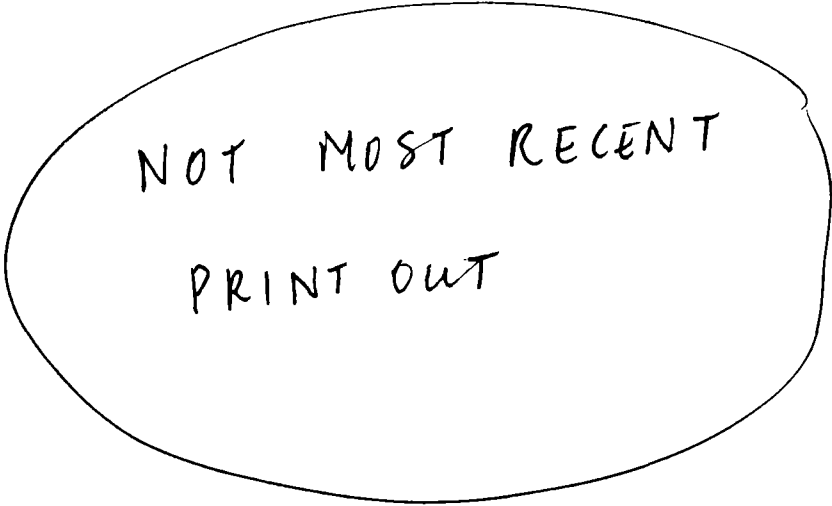
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COMMENTS Here is the latest version of
the older women document.
Could you ask Leslie and Elie to
fill in the remaining holes?
Ignore the impact #s for now.
Thanks!
Happy New Year
P.S. Also please have them check
the form and the substance
of the footnotes.

DRAFT

**THE HEALTH OF AMERICA'S OLDER WOMEN:
A WHITE HOUSE REPORT
ON CURRENT STATUS AND
THE IMPACT OF REPUBLICAN BUDGET CUTS**



NOT MOST RECENT
PRINT OUT

December 20, 1995

A PROFILE OF AMERICA'S OLDER WOMEN

DEMOGRAPHIC TRENDS

The aging of the American population has significant implications for women. Women represent a majority of older Americans and an even larger proportion of the very old, those aged 85 and over.

The Population is Aging. Currently, 13% of the total population in the United States, or 33.2 million Americans, are 65 or older. In the next 35 years, the number of Americans over the age of 65 will more than double, reaching 20% of the total population or 70 million.¹

The Number of Older Women is Growing. About 20 million, or 8% of Americans aged 65 or older, are women. In the next 35 years, that number will nearly double, to 38 million or 10% of the population.²

- Life expectancy for women has increased steadily. In 1960, life expectancy at birth for females was about 73. By 1994, life expectancy increased to 79 years. Average life expectancy is shorter for men than for women. In 1994, when life expectancy at birth was 79 for a female, it was 72.3 for a male.³

Women Over 85 Are One of the Fastest Growing Segments of Society. The number of people over the age of 85 is growing quickly, and women represent an even larger proportion (72%) of this group. Today, 2.5 million are women over 85, a figure that will more than double to 5.7 million by 2030.⁴

¹U.S. Bureau of the Census, Statistical Abstract of the United States, 1995.

²Id.

³U.S. Department of Health and Human Services, PHS, Monthly Vital Statistics Report, October 23, 1995.

⁴Statistical Abstract of the United States, 1995.

Older Women Are Far More Likely Than Men to Live Alone. Forty-two percent of women aged 65 and over lived alone in 1992, compared with just 16% of older men. The proportion of women living alone increases dramatically with age. About one-third (34%) of women aged 65 to 74 lived alone, compared to over half of women aged 85 and over.⁵ Because women have longer life expectancies and many women marry men who are older, the life expectancy for widowed women in the United States is about 17 years beyond the death of their spouses -- years in which increased frailty or disability are generally endured alone.⁶

FINANCIAL STATUS

Older women are typically poorer than older men, and women over 85 and minority women are even more likely to be poor. The most vulnerable group is elderly women living alone.

Older Women Are Poorer Than Older Men. The median income for women 65 or older is \$8,600 a year. The median income for men is about \$15,000, 76% higher than the median for women.⁷

Fifteen percent of older women live in poverty, compared with 8% of older men. Twenty-one percent of women over age 85 have incomes below the federal poverty level.⁸ Forty-one percent of women aged 65 to 74 and 57% of women over 75 live on incomes below twice the poverty line (\$14,000).⁹

Minority Women Are Poorer Still. Minority women have substantially lower incomes. In 1992, the median income of elderly white women (\$8,600) was 38% higher than the median income of black women (\$6,200), and 44% higher than the median income of Hispanic women (\$6,000).¹⁰

⁵National Institute on Aging, Profiles of America's Elderly, November 1993.

⁶C. Costello and A.J. Stone eds. *The American Woman 1994-1995*, Women's Research and Education Institute, 1994.

⁷U.S. Bureau of the Census, Current Population Reports, Series P-60-188, Income, Poverty and Valuation of Noncash Benefits: 1993.

⁸Id.

⁹Id.

¹⁰U.S. Bureau of the Census, Current Population Reports, Series P-60-184, Money Income of Households, Families and Persons in the United States: 1992.

Poverty Rates Among Women Living Alone Are Higher. Poverty rates are higher at every age for women who live alone than for men, and the disparity increases with age. In 1993, over 26% of women 65 and over living alone were in poverty (income of about \$6,900), compared to 13.9% of men. Another 15.6% of these women were near poor (income of \$8,700). And the picture was even worse for minority women; 44% of black women and 47% of Hispanic women 65 and older living alone were poor, as compared with 24% of white women.¹¹

Widowhood often drives women into poverty. A study by the National Bureau of Economic Research found that half of poor widows were not poor when their husbands were alive.¹²

Half of All Women on Social Security Would be Poor Without It. As of 1990, 33% of unmarried women age 65 or older who received Social Security depended on it for at least 90% of their income; more than 18% had no other income.¹³ Half of all women beneficiaries would be poor if they did not receive a Social Security benefit.¹⁴

HEALTH STATUS

Despite living, on average, seven years longer than men, women have poorer health outcomes and are more likely to have chronic diseases and disability than men.

Women Suffer from Chronic Health Conditions. Women age 65 or older are more likely than men to suffer from serious chronic conditions. For example, 41% of women over 75 [OR 75 OR OLDER] and only 30% of men suffer from hypertension.¹⁵ In addition, 64% of

¹¹U.S. Bureau of the Census, 1993.

¹²David Wise and Michael Hurd, *Elderly People Living Alone: Aging and the Prospects of Poverty: Executive Summary*, report prepared for The Commonwealth Fund Commission on Elderly People Living Alone (National Bureau of Economic Research, 1987).

¹³American Association of Retired Persons (AARP) Fact Sheet, Facts About Older Women: Income and Poverty, 1995.

¹⁴R. O'Grady-LeShane. Economic Security for Midlife and Older Women. Background paper prepared for the Conference on Women and Aging: An Agenda for Action (sponsored by PHS Office on Women's Health and the National Policy and Resource Center of Women and Aging, Brandeis University), October 30, 1995.

¹⁵NCHS, "Trends in the Health of Older Americans: United States, 1994," Vital and Health Statistics, Series 3, No. 30, April 1995.

women 75 or older and only 36% of men have diabetes.¹⁶ Older women are also more likely to experience non-life-threatening chronic health conditions. Fifty-five percent of women 65 and over suffer from arthritis, compared with 39% of men.¹⁷ These conditions may contribute to a loss of functioning, particularly as women age.

Women 85 And Older Are Even More Vulnerable. These problems become more serious with increasing age. Women over the age of 85 are extremely vulnerable. More than half of all women over age 85 have problems managing basic daily activities like bathing and eating, as compared to only 34% of men in the same age group.¹⁸ In addition, because women generally live longer than men, they are more likely to get diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis.

The following table illustrates the prevalence and risks of particular diseases faced by older women.

[JASON -- INSERT TABLE HERE]

¹⁶National Health Interview Survey, 1993.

¹⁷NCHS, "Trends in the Health of Older Americans: United States, 1994," Vital and Health Statistics, Series 3, No. 30, April 1995.

¹⁸Health Care Financing Administration (HCFA), Medicare: A Profile, February 1995.

MEDICAL NEEDS AND EXPENSES

While all older Americans spend a significant portion of their incomes on health care, elderly women who live alone face the greatest financial burden.

Older Americans Spend A Significant Portion of Their Incomes On Health Care. Older Americans currently spend 21% of their incomes on health care.¹⁹

NO WOMEN V. MEN?

Older Women Rely More Than Men On Long-Term Care. Twenty-two percent of women 65 or older either live in an institution or need help to live at home, compared with 15% of men.²⁰

- **Home Care.** Older women living alone are major users of paid home care services. HHS FILL IN: HOW MUCH HOME CARE DO THEY USE? HOW MUCH DOES IT COST?] About 62% of all women receiving paid home care live alone; another 28% live with adult children or others. Only 10% of women receiving home care are married.²¹
- **Nursing Home Care.** Over 75% of nursing home residents are women. Roughly 28% of all women over 85 live in nursing homes, compared with 16% of men in this age group.²² The average cost of nursing home care is \$38,000 per year -- more than four times the median income for older women. On average, women remain in nursing homes a year longer than men.²³

¹⁹"Coming Up Short: Increasing Out-of-Pocket Health Spending By Older Americans," prepared by AARP Public Policy Institute and the Urban Institute, updated February 1995. Does not include long-term nursing home costs.

²⁰Guralnik and Simonsick, "Physical Disability in Older Americans, *J. Of Gerontology*, Vol. 48 (special issue): 3-10, 1993.

²¹Diane Rowland and Karen Davis. Caring for Women in Older Age, *An Unfinished Revolution: Women and Health Care in America*, DATE????.

²²Bureau of the Census and National Institute on Aging, *Profiles of America's Elderly*, No. 4, November 1993.

²³P. Kemper, et al. A Lifetime Perspective on Proposals for Financing Nursing Home Care, *Inquiry* 28(4):333-344, Winter 1991.

WOMEN AS CAREGIVERS

Women are the primary caregivers for their spouses and parents and also provide a vast majority of the paid long-term care in this country.

- Today, more than 7 million Americans are unpaid caregivers who provide about 75% of all non-medical care to the frail elderly.²⁴ Seven out of ten of these caregivers are women.²⁵ The typical unpaid caregiver is a woman in her middle or older years (average age of 57) providing care to a parent, spouse or other relative. Women provide the care that has helped to alleviate the need for formal supportive services and health care and to forestall costly institutional care for loved ones.
- The role of "unpaid caregiver" has important consequences for women's health. Caregiving can be a significant financial drain, and it is likely to have an even greater emotional and physical impact, particularly as the woman gets older. The stresses and strains of care giving, including the inability to have a break from responsibilities, can lead to depression, reduced immunity levels, poor general health, and lower quality of life.²⁶
- The majority of paid home care workers are also women. [OR IS THIS NURSING HOME AIDES TOO?] According to estimates based on the 1989 Current Population Survey, approximately 197,049 persons work as home care aides. The overwhelming majority (90%) are female [and they are disproportionately from minority groups].²⁷

²⁴Paper presented by Fernando Torres-Gil, Assistant Secretary for Aging, at the Conference on Women and Aging: An Agenda for Action, October 30, 1995.

²⁵House Select Committee on Aging, *Exploding the Myths: Caregiving in America*, January 1987.

²⁶U.S. Public Health Service, Office on Women's Health, *Fact Sheet on Older Women's Health*, 1995.

²⁷S.J. Williams, series ed. *The Continuum of Long-Term Care: An Integrated Systems Approach*, Albany, N.Y.: Delmar Publishers Inc., 1996.

OLDER WOMEN'S DEPENDENCE ON MEDICARE AND MEDICAID

Because they are generally poorer than men, women depend more on Medicare and Medicaid for critical health services.

Number of Women Covered

- **Medicare.** Of the 37 million Medicare beneficiaries, over 20 million, or 57% are women. There are twice as many female beneficiaries over age 85 than men.²⁸
- **Medicaid.** Over 4 million older Americans are covered by Medicaid. 60% of all Medicaid beneficiaries are women.²⁹

Dependence on Medicare and Medicaid

Older Women Are More Likely to Rely on Medicare and Medicaid. Because elderly women typically have lower socioeconomic status and more limited retirement benefits than elderly men, they are more likely than men to be either solely dependent on Medicare or to have coverage under Medicaid, which serves as supplemental insurance to Medicare for eligible low-income elderly people.

- 5 million, or 23% of women age 65 or older, have only Medicare to cover their medical bills.
- An additional 2 million (11%) of older women rely on Medicaid in addition to Medicare.³⁰

Medicare and Medicaid Provide Critical Services for Older Women.

- Medicare covers a range of medical services, including hospital stays, physician visits, skilled nursing care, and some home health care.
- Medicaid also covers essential services for older women, including some that are not covered by Medicare -- like prescription drugs, dental care, eyeglasses, hearing aids, and more extensive long-term care.
 - Medicaid will pay an average of over \$800 for prescription drugs for an older

²⁸HCFA, *Medicare: A Profile*, February 1995.

²⁹HCFA, *Medicaid: On Overview*, September 1995.

³⁰Current Population Survey, March 1995.

woman on Medicaid in 1995.³¹ [HHS average = \$585?]

- Approximately 68% of the nation's one million nursing home residents rely on Medicaid to pay for some or all their care.³² Over 75% of nursing home residents are women.³³
- Medicaid pays Medicare premiums for about 4 million elderly women in poverty. Most of these beneficiaries also receive Medicaid coverage for Medicare coinsurance and deductibles.³⁴

³¹Department of Health and Human Services estimates from aged National Medical Expenditure Survey data, 1995.

³²HCFA, Medicaid: An Overview, September, 1995.

³³Profiles of America's Elderly, November 1993.

³⁴Estimates based on data from: HCFA, Office of Legislation and Intergovernmental Affairs; the 1994 Greenbook, Tables B-11 and 5-1; and G. Chulis et al., "Health Insurance and the Elderly: Data from the MCBS," Health Care Financing Review, Spring 1993: Volume 14, Number 3, pp. 163-181.

THE IMPACT OF THE REPUBLICAN CUTS IN MEDICARE AND MEDICAID

MEDICARE

REDUCED BENEFITS AND INCREASED MEDICARE COSTS

The Republican Medicare Plan Will Reduce Benefits and Increase Health Care Costs for Older Women. The Republican budget cuts Medicare by an unprecedented \$[200] billion. These cuts will reduce the benefit provided by Medicare while increasing direct and indirect costs for beneficiaries.

- **Cuts Benefits.** Federal Medicare spending per beneficiary will be \$[1,700] less than under current law in 2002.
- **Increases Premiums.** The Republican budget increases premiums from 25% of Part B program costs to 31.5%. **In 1996 alone, this change will increase costs for elderly couples by \$[264] and elderly individuals by \$[132].** The President's balanced budget plan maintains current policy and permanently sets premiums at 25% of program costs.
 - Over 19 million elderly women, more than a third of whom are at or near poverty, are currently enrolled in the Medicare Part B program.
 - Over 20%, or \$10.4 billion, of the increase would come from elderly women with incomes below 200% of poverty (\$15,000?).³⁵
- **Allows Doctors to Overcharge.** Under current law, Medicare limits the amount doctors can charge beneficiaries above Medicare payment rates. The Republican Medicare plan creates new, private fee-for-service plans that are similar to Medicare but that allow doctors to overcharge -- so-called "balance billing."
- **Ends Financial Protection for Poor Medicare Beneficiaries.** As many as [---] poor elderly women will lose funding for their Medicare premiums -- just when these premiums are being increased. [NEED TO MAKE CONSISTENT WITH INFO ABOVE.]

³⁵Id.

- Medicaid currently pays all Medicare premiums, coinsurance and deductibles for people below 100% of poverty (known as QMBs) -- two million of whom are elderly women -- and premiums for people with incomes between 100% and 120% of poverty. The Republican proposal completely eliminates coverage of coinsurance and deductibles for these poor elderly and disabled people. And while Republicans claim to cover premiums, they set aside *less than half* of the money needed to cover their premiums in 2002, denying premium coverage to as many as [-----] poor elderly and disabled women.
- **Could Force the Poor to Leave Fee-For-Service Plans.** Without assistance with premiums, copayments and deductibles, poor Medicare beneficiaries may be forced to leave their fee-for-service plan and enroll in an managed care plan that does not require cost sharing -- if one exists in their area.

INCREASES COSTS FOR BENEFICIARIES WITHOUT EXPANDING BENEFITS OR PREVENTION

- The Republican budget increases beneficiary costs while adding only one new benefit -- coverage of oral nonsteroidal antiestrogen for the treatment of breast cancer.
- Currently, Medicare does not cover the array of preventive benefits now offered by many private plans, particularly managed care plans. These preventive benefits can both increase beneficiary's health and reduce costs.
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The reduction in Federal support of [\$116 billion] in Medicaid spending could force states to deny meaningful coverage for [over 8 million] Americans in 2002 alone, according to estimates by the Department of Health and Human Services.

These people include:

- **[650,000] older women**
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[CHECK -- Over 185,000] women over age 65 would be thrown into poverty, largely as a result of the cuts in Medicare and Medicaid, according to the Department of Health and

³⁶Department of Health and Human Services, 1995.

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Since OBRA '87, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31%.³⁹

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³⁷Department of Health and Human Services, December 1995. Note: In this analysis, poverty is defined more broadly than in official poverty statistics from the Census Bureau. This broader definition includes the effects of Federal tax policies (including the Earned Income Tax Credit), near-cash in-kind assistance programs such as food stamps and housing programs, and out-of-pocket health spending.

³⁸*Improving the Quality of Care in Nursing Homes*, Washington, D.C.: National Academy Press, 1986.

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nursing and rehabilitative services necessary to improve their ability to function.

- Residents would no longer be guaranteed the same comprehensive assessment of their health and functional status now required nationally.
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- The Republican budget also repeals the right of individuals to enforce spousal impoverishment protections in court when they believe they have been wrongfully denied, making the protections unenforceable.

How many individuals in nursing homes have a living spouse? Percentage of men v. women?
Add family financial protections?

⁴⁰Department of Health and Human Services, 1995.

DRAFT

**THE HEALTH OF AMERICA'S OLDER WOMEN:
A WHITE HOUSE REPORT
ON CURRENT STATUS AND
THE IMPACT OF REPUBLICAN BUDGET CUTS**

December 20, 1995

ADD EXECUTIVE SUMMARY

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A PROFILE OF AMERICA'S OLDER WOMEN

DEMOGRAPHIC TRENDS

The aging of the American population has significant implications for women. Women represent the majority of older Americans and an even larger proportion of the very old, those aged 85 and over. Furthermore, the # of older American women is growing quickly

The American Population is Aging. Currently, 13% of the total population in the United States, or 33.2 million Americans, are 65 or older. In the next 35 years, the number of Americans over the age of 65 will more than double, reaching 20% of the total population or 70 million.¹

The Number of Older Women is Growing. About 20 million, or 8% of Americans are women age 65 or older. In the next 35 years, that number will nearly double, to 38 million or 10% of the population.²

- Life expectancy for women has increased steadily. In 1960, life expectancy at birth for females was about 73. By 1994, life expectancy increased to 79 years. Average life expectancy is shorter for men than for women. In 1994, when life expectancy at birth was 79 for a female, it was 72.3 for a male.³

Women Over 85 Are One of the Fastest Growing Segments of Society. The number of people over the age of 85 is growing quickly, and women represent an even larger proportion of this group. While women constitute 59% of the overall elderly population, they account for 72% of the very old. Today, 2.5 million women are over 85, a figure that will more than double to 5.7 million by 2030.⁴

¹U.S. Bureau of the Census, *Statistical Abstract of the United States*, (115th edition) Washington D.C., September 1995.

²Id.

³G.K. Singh, T.J. Matthews, S.C. Clark et al., "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1994." *Monthly Vital Statistics Report*, Vol. 43, No. 13, Hyattsville, MD: National Center for Health Statistics (NCHS), October 1995.

⁴U.S. Bureau of the Census, 1995.

Older Women Are Far More Likely Than Men to Live Alone. Forty-two percent of women aged 65 and over lived alone in 1992 compared with just 16% of older men. The proportion of women living alone increases dramatically with age. About one-third (34%) of women aged 65 to 74 lived alone, compared to over half of women aged 85 and over.⁵ Because women have longer life expectancies and many women marry men who are older, the life expectancy for widowed women in the United States is about 17 years beyond the death of their spouses -- years in which increased frailty or disability are generally endured alone.⁶ - implication?

this
doesn't
really make
sense
here

FINANCIAL STATUS

Older women are typically poorer than older men, and women over 85 and women of color are even more likely to be poor. Elderly women living alone, however, are the most vulnerable to poverty. The number of elderly women in poverty would increase without social security benefits

Older Women Are Poorer Than Older Men. The median income for women 65 or older is \$8,200 a year. The median income for men is \$14,600, 78% higher than the median for women.⁷

Fifteen percent of older women live in poverty compared with 8% of older men. Twenty-one percent of women over age 85 have incomes below the federal poverty level.⁸ Forty percent of women aged 65 to 74 and 56% of women over 75 live on incomes ~~below twice~~ the poverty line (about \$14,000).⁹

twice below
or not times

⁵U.S. Bureau of the Census and National Institute on Aging, "Living Arrangements of the Elderly," *Profiles of America's Elderly*, No. 4, November 1993.

⁶C. Costello and A.J. Stone, eds, for the Women's Research and Education Institute, *The American Woman: 1994-1995*, New York, NY : W.W.

⁷U.S. Bureau of the Census, Current Population Reports, Series P60-184, *Money Income of Households, Families and Persons in the United States: 1992*, Washington D.C., September 1993.

⁸Id.

⁹Id.

Women of Color Are Poorer Still. Older women of color have ~~even~~ substantially lower incomes ~~than~~ ^{elderly white women}. In 1992, the median income (\$8,600) of elderly white women was 38% higher than the median income (\$6,200) of elderly black women, and 44% higher than the median income (\$6,000) of elderly Hispanic women.¹⁰

Poverty Rates Among Women Living Alone Are Higher. Poverty rates are higher at every age for women who live alone than for men, and the disparity increases with age. In 1993, over 26% of women 65 and older living alone were in poverty (income of about \$6,900), compared to 13.9% of men. Another 15.6% of these women were near ^{poverty} ~~poor~~ (income of \$8,700). And the picture was even worse for women of color; 44% of black women and 47% of Hispanic women 65 and older living alone were poor, as compared with 24% of white women.¹¹

or poverty?

or  Widowed often drives women into poverty. A study by the National Bureau of Economic Research found that half of poor widows were not poor when their husbands were alive.¹²

insert section on older women being more likely than men to live alone (pg. 5)

Half of All Women on Social Security Would be Poor Without It. As of 1990, 33% of unmarried women age 65 or older who received Social Security depended on it for at least 90% of their income; more than 18% had no other income.¹³ Half of all women Social Security beneficiaries would be poor if they did not receive a Social Security benefit.¹⁴

¹⁰Id.

¹¹U.S. Bureau of the Census, Current Population Reports, Series P60-188, *Income, Poverty, and Valuation of Noncash Benefits: 1993*, Washington, D.C., February 1995.

¹² Wise and Hurd, *Elderly People Living Alone: Aging and the Prospects of Poverty: Executive Summary*, report prepared for The Commonwealth Fund Commission on Elderly People Living Alone, (National Bureau of Economic Research, 1987).

¹³American Association of Retired Persons (AARP) Fact Sheet, *Facts About Older Women: Income and Poverty*, 1995.

¹⁴R. O'Grady-LeShane, Economic Security for Midlife and Older Women. Background paper prepared for the Conference on Women and Aging: An Agenda for Action (sponsored by Public Health Service Office on Women's Health and the National Policy and Resource Center of Women and Aging, Brandeis University), October 30, 1995.

HEALTH STATUS

Despite living, on average, seven years longer than men, ^{older} women have poorer health outcomes and are more likely to have chronic diseases and disability than men.

Women Suffer from Chronic Conditions. Women age 65 or older are more likely than men to suffer from serious chronic conditions. For example, 41% of women age 75 or older, but only 30% of men suffer from hypertension.¹⁵ In addition, 64% of women 75 or older, but only 36% of men have diabetes.¹⁶ Older women are also more likely to experience non-life-threatening chronic conditions. Fifty-five percent of women 65 and over suffer from arthritis compared with 39% of men.¹⁷ These conditions may contribute to a loss of functioning, particularly as women age.

Women 85 And Older Are Even More Vulnerable. These problems become more serious with increasing age. Women over the age of 85 are extremely vulnerable. More than half of all women over age 85 have problems managing basic daily activities like bathing and eating, as compared to only 34% of men in the same age group.¹⁸ In addition, because women generally live longer than men, they are more likely to get diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis.

The following table illustrates the prevalence and risks of particular diseases faced by older women.

[JASON -- INSERT TABLE HERE]

¹⁵R.A. Cohen and J.F. Van Nostrand, "Trends in the Health of Older Americans: United States, 1994," *Vital and Health Statistics*, (3)30, Hyattsville, MD: National Center for Health and Statistics, April 1995.

¹⁶NHCS, National Health Interview Survey, 1993.

¹⁷Cohen and Van Nostrand, 1995.

¹⁸Health Care Financing Administration (HCFA), *Medicare: A Profile*, February 1995.

MEDICAL NEEDS AND EXPENSES

Although all older Americans spend a significant portion of their incomes on health care, elderly women who live alone face the greatest financial burden. ~~Women who live alone~~

Older Americans Spend A Substantial Portion of Their Incomes On Health Care. Older Americans currently spend 21% of their incomes on health care.¹⁹

Because older women have lower incomes than older men, their health care costs take a larger toll. Women over age 65 spend nearly one quarter (24%) of their income on health care, whereas elderly men spend only 17% of their income for this purpose.

Older Women Rely More Than Men On Long-Term Care. Twenty-two percent of women 65 or older either live in an institution or need help to live at home, compared with 15% of men.²⁰

- **Home Care.** Older women living alone are major users of paid home care services. In particular, disabled elderly women who live alone are more likely to need home care services. According to the 1989 National Long-Term Care Survey, elderly women living alone who have mild functional limitations (e.g. difficulty doing light housework, laundry, meal preparation, shopping) have on average about 22 home health visits annually, costing about \$1,140. However, elderly women living alone who have greater difficulty with activities of daily living (e.g., bathing, dressing, eating) have on average 45 home health visits annually, costing about \$2,100. Overall, elderly women living alone who have either mild or severe limitations in functional status have on average 33 home health visits annually at a cost of about \$1,6000. About 62% of all women receiving paid home care live alone; another 28% live with adult children or others. Only 10% of women receiving home care are married.²¹

¹⁹ AARP Public Policy Institute and the Urban Institute. "Coming Up Short: Increasing Out-of-Pocket Health Spending By Older Americans," February 1995. Excludes long-term nursing home costs.

²⁰J.M. Guralnik and E.M. Simonsick, "Physical Disability in Older Americans, *J. of Gerontology*, Vol. 48 (special issue): 3-10, 1993.

²¹Diane Rowland and Karen Davis. *Caring for Women in Older Age, An Unfinished Revolution: Women and Health Care in America*, 1994.

- **Nursing Home Care.** Over 75% of nursing home residents are women. Roughly 28% of all women over 85 live in nursing homes, compared with 16% of men in this age group.²² The average cost of nursing home care is \$38,000 per year -- more than four times the median income for older women. On average, women remain in nursing homes a year longer than men.²³

WOMEN AS CAREGIVERS

Women are the primary ^{unpaid} caregivers for their spouses and parents and also provide a vast majority of the paid long-term care in this country.

- Today, more than 7 million Americans are unpaid caregivers who provide about 75% of all non-medical care to the frail elderly.²⁴ Seven out of ten of these caregivers are women.²⁵ The typical unpaid caregiver is a woman in her middle or older years (average age of 57) providing care to a parent, spouse or other relative. Women provide the care that has helped to alleviate the need for formal supportive services and health care and to forestall costly institutional care for loved ones.
- The role of "unpaid caregiver" has important consequences for women's health. Caregiving can be a significant financial drain, and it is likely to have an even greater emotional and physical impact, particularly as the woman gets older. The stresses and strains of care giving, including the inability to have a break from responsibilities, can lead to depression, reduced immunity levels, poor general health, and lower quality of life.²⁶

²²U.S. Bureau of the Census and National Institute on Aging, 1993. *Profiles of America's Elderly*.

²³P. Kemper, B.C. Spillman, and C.M. Murlaugh. "A Lifetime Perspective on Proposals for Financing Nursing Home Care," *Inquiry* 28(4):333-344, Winter 1991.

²⁴Paper presented by Fernando Torres-Gil, Assistant Secretary for Aging, at the Conference on Women and Aging: An Agenda for Action, October 30, 1995.

²⁵United States Congress House Select Committee on Aging, *Exploding the Myths: Caregiving in America*, January 1987.

²⁶U.S. Public Health Service, Office on Women's Health, *Fact Sheet on Older Women's Health*, 1995.

- The majority of paid home care workers and nursing home aides are also women. The overwhelming majority of nursing home aides (95%) and home health aides (93%) are female, and they are disproportionately from minority groups.²⁷

OLDER WOMEN'S DEPENDENCE ON MEDICARE AND MEDICAID

Because they are generally poorer and use more health ^{care} services than men, women depend more on Medicare and Medicaid for critical health services.

Number of Women Covered

- **Medicare.** Of the 37 million Medicare beneficiaries, over 20 million, or 57% are women. The proportion of female beneficiaries over age 85 is nearly double that of male Medicare beneficiaries.²⁸
- **Medicaid.** Over 4 million older Americans are covered by Medicaid. 60% of all Medicaid beneficiaries are women.²⁹

Dependence on Medicare and Medicaid

Older Women Are More Likely to Rely on Medicare and Medicaid. Because elderly women typically have lower socioeconomic status and more limited retirement benefits than elderly men, they are more likely than men to be either solely dependent on Medicare or to have coverage under Medicaid, which serves as supplemental insurance to Medicare for eligible low-income elderly people.

- Almost 5 million, or 23% of women age 65 or older, have only Medicare to cover their medical bills.
- An additional 4 million (about 20%) of older women rely on Medicaid in addition to Medicare. Of these women, about 2 million receive only assistance in paying for Medicare premiums, coinsurance, and deductibles.³⁰

²⁷S.J. Williams, series ed. *The Continuum of Long-Term Care: An Integrated Systems Approach*, Albany, N.Y.: Delmar Publishers Inc., 1996.

²⁸HCFA, *Medicare: A Profile*, February 1995.

²⁹HCFA, *Medicaid Statistics: Program and Financial Statistics Fiscal Year 1993*. HCFA Pub No. 10129. October 1994.

³⁰Current Population Survey, March 1995.

Medicare and Medicaid Provide Critical Services for Older Women.

- Medicare covers a range of medical services, including hospital stays, physician visits, skilled nursing care, and some home health care.
- Medicaid also covers essential services for older women, including some that are not covered by Medicare -- like prescription drugs, dental care, eyeglasses, hearing aids, and more extensive long-term care.
 - Medicaid will pay an average of over \$800 for prescription drugs for an older woman on Medicaid in 1995.³¹ [HHS average = \$585?]
 - Approximately 68% of the nation's 1.5 million nursing home residents rely on Medicaid to pay for some or all their care.³² Over 75% of nursing home residents are women.³³
 - Medicaid pays Medicare premiums for about 4 million elderly women in poverty. Most of these beneficiaries also receive Medicaid coverage for Medicare coinsurance and deductibles.³⁴

³¹U.S. Department of Health and Human Services estimates from aged National Medical Expenditure Survey data, 1995.

³²HCFA, *Medicaid: An Overview*, September, 1995.

³³U.S. Bureau of the Census and National Institute on Aging. 1993.

³⁴Estimates based on data from: HCFA, Office of Legislation and Intergovernmental Affairs; the 1994 Greenbook, Tables B-11 and 5-1; and G. Chulis et al., "Health Insurance and the Elderly: Data from the MCBS," *Health Care Financing Review*, 14(3):163-181, Spring 1993.

THE IMPACT OF THE REPUBLICAN CUTS IN MEDICARE AND MEDICAID

MEDICARE

REDUCED BENEFITS AND INCREASED MEDICARE COSTS

The Republican Medicare Plan Will Reduce Benefits and Increase Health Care Costs for Older Women. The Republican budget cuts Medicare by an unprecedented \$200 billion. These cuts will reduce the benefit provided by Medicare while increasing direct and indirect costs for beneficiaries.

- **Cuts Benefits.** Federal Medicare spending per beneficiary will be \$1,700 less than under current law in 2002.
- **Increases Premiums.** The Republican budget increases premiums from 25% of Part B program costs to 31.5%. This amounts to a premium increase of more than \$40 billion over the next seven years. In 2002, this translates into \$84.60 per month -- \$14.20 per month per person more than the President's plan -- \$170.40 per year and \$340.80 per couple per year. The President's balanced budget plan maintains current policy and permanently sets premiums at 25% of program costs.
 - Over 19 million elderly women, more than a third of whom are at or near poverty, are currently enrolled in the Medicare-Part B program.
 - Over 20%, or \$10.4 billion, of the increase in premiums would come from elderly women with incomes below 200% of poverty (\$15,000).³⁵
- **Allows Doctors to Increase Charges to Beneficiaries.** Under current law, Medicare limits the amount doctors can charge beneficiaries above Medicare payment rates. The Republican Medicare plan creates new, private fee-for-service plans that are similar to Medicare but that allow doctors to increase their fees and charge beneficiaries the difference above what Medicare pays -- so-called "balance billing."
- **Ends Financial Protection for Poor Medicare Beneficiaries.** As many as ___ poor elderly women will lose funding for their Medicare premiums -- just when these premiums are being increased. [NEED TO MAKE CONSISTENT WITH INFO

³⁵Id.

ABOVE.]

- Medicaid currently pays all Medicare premiums, coinsurance and deductibles for people below 100% of poverty (known as Qualified Medicare Beneficiaries or QMBs) -- two million of whom are elderly women -- and premiums for people with incomes between 100% and 120% of poverty. The Republican proposal completely eliminates coverage of coinsurance and deductibles for these poor elderly and disabled people. And while Republicans claim to cover premiums, they set aside *less than half* of the money needed to cover premiums in 2002.
- **Could Force the Poor to Leave Fee-For-Service Plans.** Without assistance with premiums, copayments and deductibles, poor Medicare beneficiaries may be forced to leave their fee-for-service plan and enroll in a managed care plan that does not require cost sharing -- if one exists in their area.

INCREASES COSTS FOR BENEFICIARIES WITHOUT EXPANDING BENEFITS OR PREVENTION

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Add family financial protections? -no b/c this is about the ~~is~~ affect on elderly women.

⁴⁰ U.S. Department of Health and Human Services, 1995.



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SOUNDING BOARD

ON BEHALF OF OLDER WOMEN

Another Reason to Protect Medicare and Medicaid

OLD age is a territory populated largely by women. Because women outlive men by an average of seven years, the ratio of women to men increases sharply among the elderly. For every 100 men 65 years of age and older, there are about 150 women. By the age of 85, this ratio becomes about 100 to 250. Longer survival brings women greater risks of living alone and in poverty, of having chronic illness, becoming frail, and being hospitalized and institutionalized.¹ Now, for political reasons, older women face the possible loss of medical coverage that they have depended on and that has facilitated their survival. Proposals to curtail Medicare and Medicaid, if enacted, could leave beneficiaries, the majority of whom are women, paying more out of pocket for what may be less medical care.

Of some 32 million elderly Medicare beneficiaries, 19 million are women and 13 million are men. Women depend on Medicare longer, using the benefits of that program for about 15 years on average, as compared with 7 years for men. Women are also more likely than men to be Medicaid beneficiaries, because of their greater poverty and need for long-term care. At the age of 65, a man has one chance in seven of residing in a nursing home for a year or more during his remaining years, whereas a woman at the age of 65 has one chance in three. Medicare and Medicaid could easily be called "women's programs" for the very old subgroup of the general older population, those 80 years of age and older. This is the fastest-growing age group, the one most prone to illness and disability, and the one most in need of geriatric and long-term care.

Medicare and Medicaid together cover approximately two thirds of health care expenditures for older persons. Both programs are now under intense review. Indeed, uncertainties about the reliability of Medicaid have been raised by proposals to transfer the program to the states in the form of block grants, thereby effectively ending Medicaid as an entitlement and, in the

process, quite probably reducing care for the frail elderly.² The current debates about these programs did not arise from concern about health care reform issues in themselves, however. Nor did they arise out of a need to reassess geriatric care in the United States and the quality of that care. Instead, they arose because political leaders want to balance the federal budget during the next seven years while giving some Americans a tax cut. Congressional leaders have proposed slashing expected growth in Medicare and Medicaid spending by as much as \$435 billion in seven years; \$245 billion in tax cuts would be enacted during the same time.

The movement to reduce Medicare spending has been building for quite a while. For years, the typical Medicare beneficiary has been portrayed as wealthy enough to pay a greater share of the cost of his or her health care. Actually, only 1 in 20 Medicare beneficiaries has an annual income exceeding \$50,000 per year. Eighty-three percent of Medicare's outlays goes to Americans with annual incomes of \$25,000 or less, according to the president of the Commonwealth Fund, Karen Davis.² The average person receiving Medicare benefits spends \$2,750 each year out of pocket on Medicare premiums, deductibles, and copayments and on services that are not covered, such as prescription drugs, eyeglasses, hearing aids, dental care, and long-term care. Supplementary (Medigap) insurance may cover some of these expenses, but the premiums may be \$1,000 or more per year. About 12 percent of Medicare beneficiaries, typically women with incomes under \$10,000 per year, do not have such supplementary insurance. They may have Medicaid coverage of Medicare copayments and premiums, but only if they meet state criteria for being poor. Medicare pays only 45 percent of the health care bills of enrollees, so the oldest and sickest beneficiaries pay even higher shares of their incomes for out-of-pocket expenses. On average, older households spend 12 percent of their income on out-of-pocket health care costs, as compared with 3.7 percent spent by younger households.

Three quarters of older people have incomes of less than \$25,000 per year. The median annual income of older people in 1993 was \$14,983 for men living alone and 44 percent less for women living alone, or \$8,499.

More than one fifth of all older women live on incomes below the stringent poverty line — \$6,729 per year for a person living alone. The longer women live, the greater the likelihood that they will become poor. Whereas 28 percent of women 65 to 69 years of age are poor or nearly poor (defined as having incomes between 100 and 125 percent of the poverty threshold), 58 percent of women 85 and over are poor or nearly poor. Minority women among them fare even worse: 33 percent of black women 65 to 74 years of age are poor, 44 percent of those 75 and over are poor, and many more are nearly poor.¹

Many women become impoverished for the first time in old age, often after the deaths of their husbands. Older women are far less likely than older men to have either public or private pensions of their own, because they are more likely to have discontinuous work histories, part-time employment, or employment in low-paying jobs. For the current generation of older women at least, it was assumed that they would gain old-age security through marriage. But when a husband dies, the surviving widow must rely on "spouse and dependent benefits." Whether provided by pensions or by Social Security, these benefits are generally lower than benefits directly earned and do not support the living standards the women had while their husbands were alive. The surviving wife of a Social Security beneficiary can choose to receive either half of her deceased husband's benefit or the benefit based on her own work history, whichever is higher. Benefits from private pensions may disappear totally with the death of the husband, if he elected to receive higher benefits during his lifetime instead of lower benefits that would also cover his widow's lifetime. In the past, this choice was often made by husbands without the consent of their wives. A federal law now requires the written consent of wives to the husbands' choice.

Against this backdrop of either real or potential poverty among older women, cuts in Medicare have been proposed. In 1996 the deductible for hospital care under Medicare Part A is \$736, the Part B deductible (covering physicians' services) is \$100, and the premium is \$42.50 per month. Under the present joint Congressional budget committee agreement, by the year 2002 Medicare's Part A deductible would become \$1,100 per year, and Part B monthly premiums would nearly double. We do not know whether the president would sign such legislation. It is clear, however, that these increases, if enacted, would cause hardship for many Medicare recipients, especially old and frail women living alone.

Research has shown that people who cannot afford to pay for health care often go without it.² A recent study¹ showed that older women with low incomes are less likely to receive preventive services such as Pap smears and mammograms, because they cannot afford the copayments. It is possible that current efforts to enroll Medicare beneficiaries in managed-care programs, if successful, would mitigate some of the difficulties that have been involved in delivering preventive services to low-income older women, if the women are actively re-

cruited and are willing to leave their customary doctors. However, the stability and quality of services provided by managed-care organizations, as well as patients' satisfaction with them, are uncertain.

The dependence of many older women on Medicaid is at least as great as their dependence on Medicare, and the political threat to Medicaid is greater. Poor older women often depend on Medicaid for all their preventive, short-term, and long-term health care needs. Medicaid pays Part B Medicare premiums and Part A hospital deductibles for qualified Medicare beneficiaries who cannot afford them. Medicaid enters the lives of older women living alone who need nursing home care and have little income and few assets. When they "spend down" their assets and incomes, they may qualify for Medicaid-supported nursing home care. A full three quarters of nursing home residents are women, and half the costs of long-term care in the United States are paid for by Medicaid.

If Medicaid programs are restricted by narrowing eligibility and benefits, low-income women will face larger out-of-pocket costs, and physicians and other providers will be hard pressed to accept Medicaid patients. With federal aid capped through block grants, individual states could stint on Medicaid spending for long-term care in nursing homes and in community-based programs, thereby placing further burdens on women, both as patients and as care givers.

The average life expectancy at the age of 65 for both men and women is longer today than it was in 1965, when Medicare and Medicaid were enacted. Now, at the age of 65, men on average can expect to reach 80 and women 84. According to a recent study,³ the increase in life expectancy over the past 30 years is due in large part to the access to services provided through the Medicare program. Among industrialized nations, the increase in life expectancy from a base age of 80 was found to be greatest in the United States. According to the two major published histories of Medicare,^{6,7} the enactment of this program was supported not only by older people but also by their middle-aged children. Both groups feared the impact of uncovered medical and hospital costs on families. Medicare is still a popular program on which millions of older people, disabled people, and their families depend. Opinion polls show little public support for cutting the Medicare program.

This is not to say that the current Medicare program is perfect. For example, Medicare still remains in the shadow of the acute care model of employer-based health insurance; the program was designed as if its beneficiaries were adult male breadwinners. In reality, its beneficiaries are older people who are more likely than younger adults to have multiple complex, interacting, acute and chronic physical and psychosocial problems and to need long-term care and outpatient drug therapy, neither of which is covered by Medicare. Medicaid provides for these major exclusions from Medicare, but Medicaid comes to the rescue only after impoverishment. Medicare could be improved by the addition of comprehensive geriatric assessment, coordination of

care, and integration of short-term and long-term care. In the process, we might find that more appropriate forms of care could be delivered at a lower price. A recent study⁸ showed that comprehensive geriatric assessment of older people living in the community has already proved to be clinically effective and less costly than conventional care, since it helps reduce the need for nursing home admissions and other forms of expensive care.

As the debate about Medicare continues, lawmakers should be thinking about ways to balance the budget fairly, without overburdening one segment of the population — older women. It has been suggested that a bipartisan commission on Medicare be created to resolve the issues raised by both Republicans and Democrats. This approach would allow all sides to discuss the future of this program in a more detached way. The commission could provide the opportunity to consider thoughtfully the role that managed care could have in restructuring health care for older people, including ways to avoid "cream-skimming" by health maintenance organizations — that is, enrollment of only healthy people. It could evaluate the risks of the proposed medical savings accounts, since they might attract only the healthy and wealthy and undermine the basic concept of insurance as a pool to cover the full range of risks. And the commission could take the opportunity to ask

geriatricians about making Medicare a more fiscally responsible and clinically effective program. No one — not the electorate, not health professionals, not public or medical policy makers — should ignore the problems of old age and their concentration in the female population.

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ROBERT N. BUTLER, M.D.

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Morning Mist

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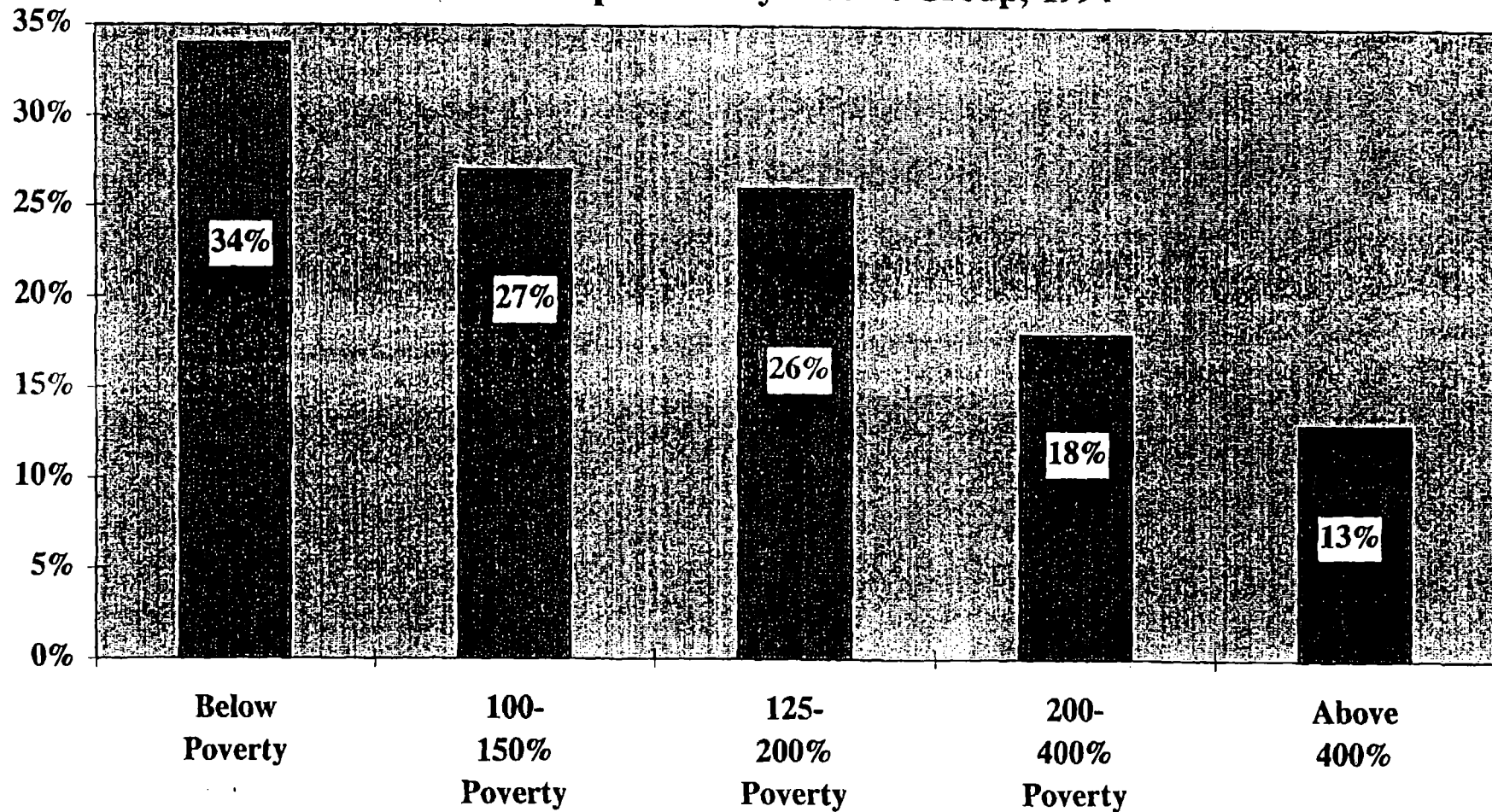
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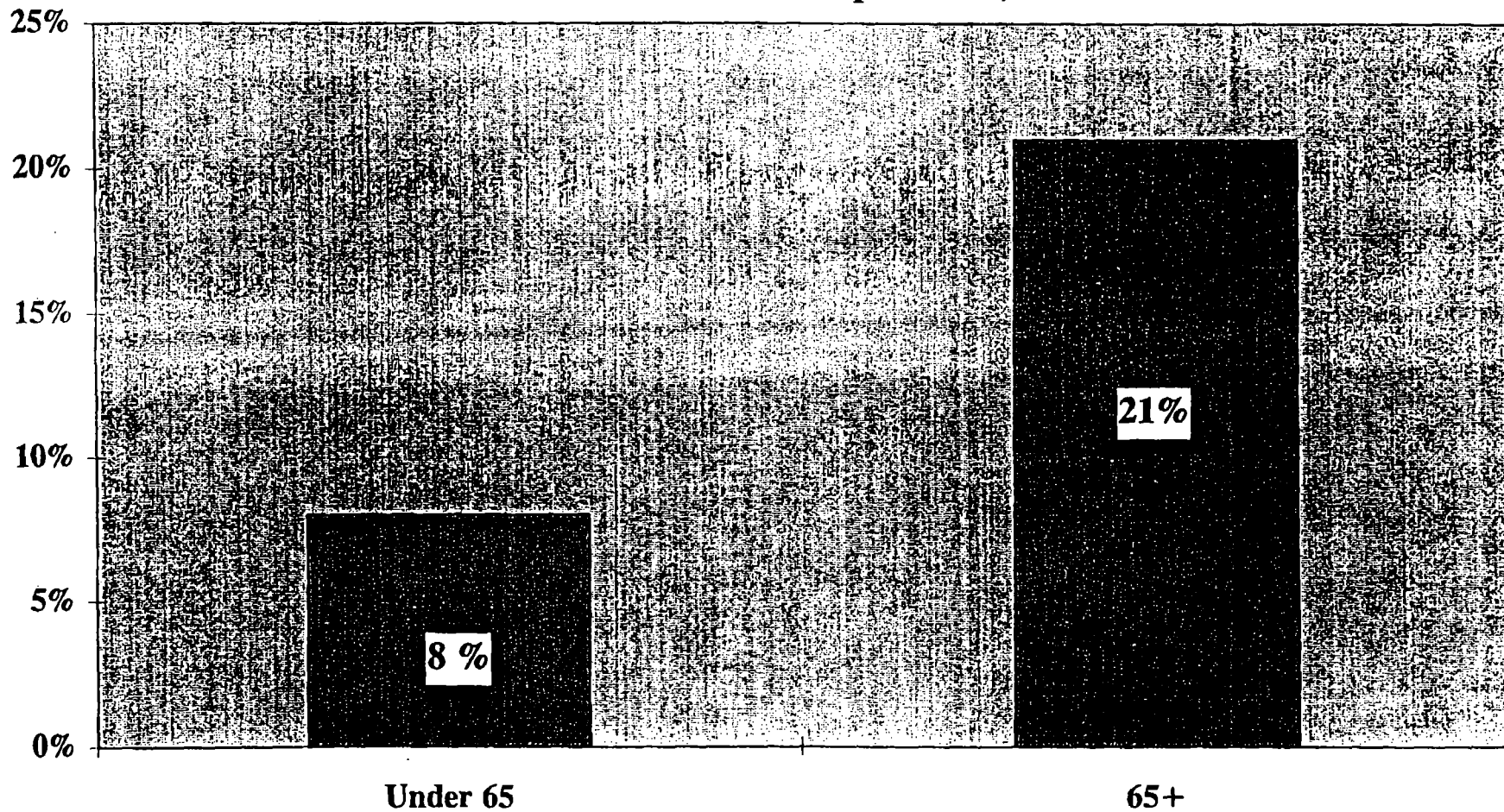
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Older Americans Already Spend A Large Percent of Their Incomes On Out-of-Pocket Health Costs

Out-of-Pocket Health Costs As A Percent of Income
for 65+ and Under-65 Populations, 1994



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Women on the Front Lines

Meeting the Challenge of
an Aging America

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This analysis
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52 Women on the Front Lines

female caregivers are much more likely to be economically disadvantaged than their peers in the general population (Select Committee on Aging 1988).

A recent study of female workers who care for elderly dependents underscored the difficulties of women who carry responsibilities as both breadwinners and caregivers. The researchers studied 40 women (daughters and daughters-in-law) who were primary caregivers for dependant elderly family members over the age of 70. These family members also received some home-care services from agencies in Massachusetts (Gibeau 1989). The researchers reported the following findings:

- ☐ As primary caregivers, the women spent an average of 12 hours per week caring for elderly family members and 26 hours per week caring for their homes, in addition to holding full-time jobs. If the elderly disabled person lived with the caregivers, the combined work of caring for the home and the elderly family member averaged 35 hours weekly.
- ☐ Most of these women had been in the labor force before assuming the caregiving responsibilities. Most had worked over 20 years, and most had cared for the elderly relative for at least five years.
- ☐ The major conflicts with work reported by these women were having to leave or miss work to help arrange medical care, and the general level of emotional strain and fatigue. Over half of the women in the sample had missed work an average of seven times within the last year.

For some of the caregivers, the cumulative hours amounted to three full time jobs (Gibeau 1989). Most women in the study reported that if they were unable to receive any help outside the family for dependant care, they would have to quit their jobs. They ranked the availability of cafeteria-style benefits for eldercare as their highest priority for additional help, if it could be provided.

Paid Caregivers

Although most eldercare is provided by "informal" caregivers, a growing amount of care is the work of paid caregivers, most of whom are middle-aged women. According to a report published by the Older Women's League and the American Federation of State, County and Municipal Employees (AFSCME), about 1.5 million paid caregivers work in more than 25,000 nursing homes and 12,000 home health agencies (Quinlan 1988).

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American Women and the Nation's Caregiving Crisis 53

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In just a decade, the number of nursing aides grew by over 300,000 workers (see table 3.1). Women make up 90 percent of these workers; over 30 percent of these workers are black and nearly 7 percent are Hispanic. In 1987, the labor force as a whole was about 45 percent female, 10 percent black, and 7 percent Hispanic. There were about 300,000 home health aides working in the United States (Silvestri and Lukasiewicz 1992). Over 90 percent of them are female, and they are also disproportionately from minority groups (Quinlan 1988).

As stated, most paid caregivers are middle-aged. The average age of home health workers has ranged from about 47 to the mid-fifties in several studies. Nursing aides in long-term care facilities are in their mid-thirties on average. Most have only a high school education or less, and have worked in the caregiving field about five years (Quinlan 1988).

In general, nursing aides and other paid caregivers, such as home health aides, work for low wages. In a 1987 study, average hourly wages of nursing aides were reported in the \$4-\$5 per hour range in most of the metropolitan areas studied. Wages in rural areas are probably lower. About three-quarters of home health aides earned less than \$10,000 per year (Quinlan 1988). Many paid caregivers work part-time, and do not receive health coverage or pension benefits. Because wages are low and caregiving is a difficult job, turnover among paid caregivers is high. According to Quinlan (1988: 17), "among nursing home workers, . . . it is not uncommon for half the aides to leave their

Table 3.1 SELECTED CHARACTERISTICS OF NURSING AIDES, ORDERLIES, AND ATTENDANTS IN THE UNITED STATES: 1977-87

Year	Number Employed	Women (%)	Black (%)	Hispanic (%)
1987	1,324,000	90.4	30.8	6.6
1986	1,299,000	90.5	29.5	5.0
1985	1,242,000	89.9	28.2	4.9
1984	1,235,000	90.4	29.0	4.9
1983	1,360,000	88.7	27.3	4.7
1982	1,136,000	87.1	31.3	
1981	1,116,000	86.6	28.3	
1980	1,090,000	87.5	28.8	
1979	1,024,000	87.6	30.6	
1978	1,037,000	87.0	27.6	
1977	1,008,000	86.3	26.5	

Source: U.S. Department of Labor, 1978-89, "Employed Persons by Detailed Occupation, Sex, and Race" (annual averages). In *Employment and Earnings*, vols. 25-35 (Washington, D.C.: U.S. Government Printing Office).

a. Designated "black and other" through 1982.

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Diane Rowland
and
Barbara Lyons

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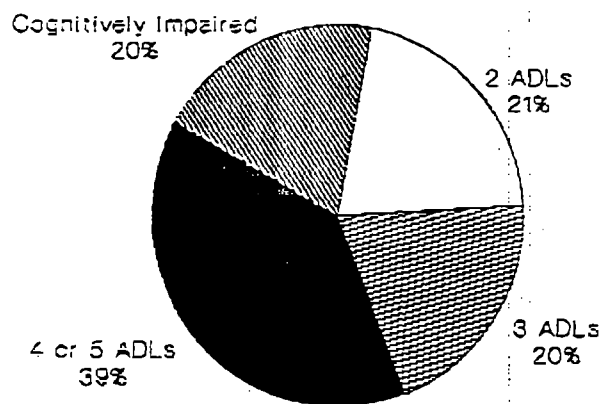
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From "Financing Home Care"

The Elderly Population in Need of Home Care

21



Total Severely Disabled Using Paid Services = 488,000

Figure 1.9 Distribution of the severely disabled elderly population using paid home care services, by disability level, 1989. Source: Data from Lewin/ICF and Brookings (1989), based on 1982 national long-term care survey.

formal care have severe physical limitations (figure 1.9). Individuals with four or five ADL limitations represent close to 40 percent of formal care, even though they constitute only one-fourth of the disabled population. Similarly, those who live alone are also overrepresented among users of formal care: they represent only 17 percent of the total disabled population but account for 28 percent of the users of formal care (Lewin/ICF and Brookings, 1989).

The use of formal care varies within the severely disabled elderly population (table 1.6). The likelihood of the disabled elderly population using formal care is highest for those in the oldest age group. More severely disabled women than men use paid services, undoubtedly reflecting the longer life expectancy of women. More whites than other races use formal services. Use of formal care by living arrangement is striking. Among the severely disabled, half of those who live alone purchase some formal assistance, compared to only one-quarter of those living with a spouse or others. The disabled elderly who live alone are more likely to need paid assistance. Among the severely disabled elderly population who use formal care services, 49 percent of those living alone—compared to 19 percent of those living with spouses and 33 percent of those living with others—had seven or more paid home care visits per week (Lewin/ICF and Brookings, 1989). However, the high proportion of disabled elderly who live alone, despite their severe disability and limited formal care assistance, is a measure of the strength of the informal network assisting them.

Among those using formal services, the distribution of the number of paid care visits is fairly uniform. One-third of the users of paid care have seven or more visits per week (figure 1.10). They use care on a daily basis or have

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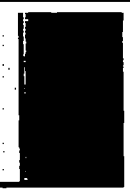


Table 1.6 The Disabled Elderly in the Community Using Formal Home Care, by Disability Level and Selected Characteristics, 1989 (percent)

Characteristic	Total Disabled Elderly Population	Elderly Population with Severe Cognitive Impairment	Elderly Population with Severe Physical Limitations			
			Total	2 ADLs	3 ADLs	4 or 5 ADLs
Users of formal home care	30	19	35	26	35	41
Characteristics of those using formal home care						
65-74 years of age	28	15	31	24	28	40
75-84 years of age	29	12	35	26	37	42
85+ years of age	33	23	39	32	44	42
Male	23	13	28	20	32	33
Female	34	23	39	31	37	46
White	31	20	35	27	36	42
Black or other	26	17	31	25	29	38
Living alone	49	32	72	26	76	64
Living with spouse	25	12	28	21	26	36
Living with others	26	16	33	18	35	42
Poor	28	21	32	19	25	46
Near poor	31	18	37	29	45	40
Modest	25	17	40	34	44	42
Nonpoor	28	17	30	26	28	33

Source: Data from Lewin/ICF and Brookings (1989), estimates based on 1982 NLTC survey.

Note: ADL = activity of daily living. See table 1.2 for definitions of income levels.

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The Elderly Population in Need of Home Care

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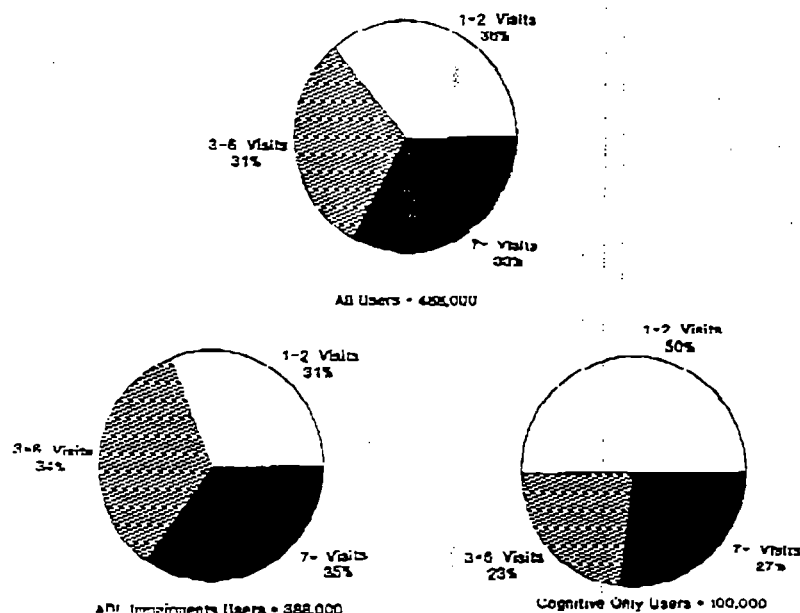


Figure 1.10 Disabled elderly users of formal home care, by number of visits per week, 1989. Source: Data from Lewin/ICF and Brookings (1989), based on 1982 national long-term care survey.

purchased by those who use formal care, with somewhat higher levels of use for those with four or five ADL restrictions (Lewin/ICF and Brookings, 1989). The cognitively impaired who purchase care tend to use care less frequently during the week than the ADL-limited population. The nature of the formal care provided to the cognitively impaired population in one or two visits per week is likely to relate to household management and tasks rather than personal care.

As a result of limited public and private financing, functional disability results in out-of-pocket expenses for home care use (chapter 3). Persons with the highest ADL limitations have out-of-pocket expenses three times higher than the average out-of-pocket spending by all disabled persons who purchase care. Similarly, the use of nursing, therapy, and home health aide services, which are paid by Medicare, increase directly with more ADL limitations.

The cost of paid long-term care climbs steeply as the level of disability increases, and out-of-pocket spending is often substantial. For the disabled with high levels of dependency, out-of-pocket spending was estimated at \$7,800 in 1989, in contrast to \$1,500 to \$2,000 for those with lower levels of dependency (figure 1.11). Expenditures for home care were 17 percent of monthly income for disabled elderly people (Rowland and Lyons, 1990). For those living alone

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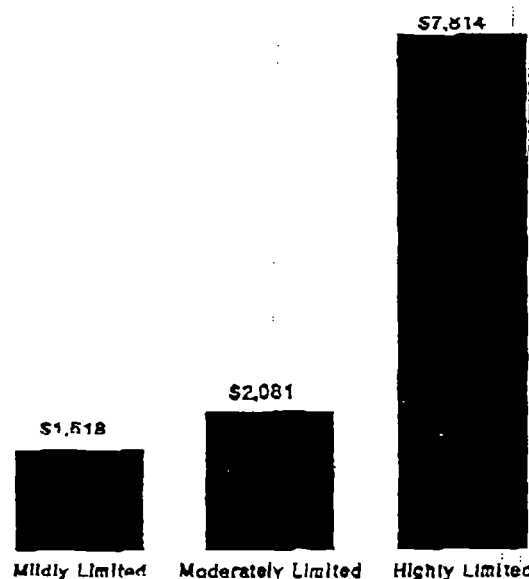


Figure 1.11 Annual out-of-pocket payments for disabled elderly persons purchasing home care, by limitation, 1989. Source: Data from Liu, Manton, and Liu (1983), based on 1982 national long-term care survey and adjusted to 1989 rate of inflation

with high levels of disability, the burden averages about half of monthly income.

The expenses shown in figure 1.11 are only the cost of purchased formal care by those who have the financial resources or insurance to pay for it. These expenses do not include the lost revenues to families when a worker leaves employment to become a full time or part-time caregiver. These spending levels also fail to account for the needs that go unmet because the impaired elderly population cannot afford to purchase care. Improving the financing of home care would address both current burdens and unmet needs.

Summary

This chapter has presented a profile of the severely disabled elderly population living in the community. The 1.6 million severely physically and cognitively disabled elderly people living in the community need extended health, social, and personal care services to assist them in their daily lives. Compared with the total elderly population, the severely disabled are disproportionately likely to be female, of minority race, aged eighty-five and older, and poor. Disability

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Home Care

Current Problems and Future Solutions

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Table 1.3. Use of Home Health Care Services: Percent of Persons Receiving Home Health Visits and Mean Number of Visits and Providers Used, by Demographic Characteristics, United States, 1987.

Population Characteristics	Total U.S. population (in thousands)	Percent Receiving at Least One Home Health Visit	Mean per Person with Visits	
			Visits from All Providers	Particular Providers Used
Total	239,393	2.5	44.0	1.5
Age in years				
Under 40	153,128	1.1	15.0	1.2
Under 6	24,838	2.5	4.3	1.1
6-17	41,950	0.6	"	"
18-39	86,340	1.0	22.8	1.2
40-64	59,744	2.0	37.9	1.5
65-74	16,373	7.1	55.7	1.6
75-84	8,111	14.5	56.9	1.8
85 and older	2,032	30.9	70.6	1.8
Sex				
Male	115,861	1.6	30.7	1.4
Female	123,532	3.3	49.8	1.6
Ethnic/racial background				
White	185,396	2.6	44.2	1.5
Black	28,567	2.4	54.2	1.5
Hispanic	19,186	1.8	"	"
Marital status				
Married	103,589	2.0	31.3	1.4
Widowed	13,762	12.6	70.0	1.7
Divorced/separated	19,542	3.4	61.1	1.8
Never married	40,861	1.5	43.5	1.4
Living arrangement				
Alone	35,210	6.2	70.4	1.7
With others	204,163	1.6	28.5	1.4
ADL/IADL difficulties				
None	127,004	1.2	12.8	1.1
ADL difficulties only	4,910	17.7	43.4	1.6

Elite/medial background				
White	183,395	2.6	44.2	1.5
Black	28,567	2.4	54.2	1.6
Hispanic	19,185	1.8	"	"
Marital status ^a				
Married	101,589	2.0	31.8	1.4
Widowed	13,762	12.6	70.0	1.7
Divorced/separated	19,542	3.4	61.1	1.3
Never married	40,881	1.5	43.5	1.4

Living arrangement				
Alone	35,230	6.2	70.4	1.7
With others	204,163	1.8	28.5	1.4
ADL/IADL difficulties				
None	227,004	1.2	12.3	1.1
IADL difficulties only	4,910	17.7	43.4	1.6
1-2 ADL difficulties	4,625	22.9	61.0	1.7
3 or more ADL difficulties	2,854	41.4	102.0	2.1
Place of residence				
MSA	178,539	2.4	42.4	1.5
Other	60,854	2.6	43.1	1.4
Census region				
Northeast	47,921	2.8	44.3	1.7
Midwest	60,478	2.8	33.5	1.4
South	83,766	1.9	47.9	1.5
West	47,227	2.7	45.4	1.5

^aIncludes persons with other or unknown ethnic/racial background and unknown marital status.

^bExcludes persons under 18.

^cDifficulties in activities of daily living (ADLs) resulting from a physical or mental health problem and including bathing, dressing, toileting, feeding, and transferring from bed or chair; and in instrumental activities of daily living (IADLs) including use of the telephone, shopping for personal items, transportation, managing money, light housework, and preparing meals.

^dCell size too small for reliable estimates.

Source: Agency for Health Care Policy and Research, National Medical Expenditure Survey—Household Survey, 1993.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

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COMMENTS:

First set of changes/edits!

Older Women Are Far More Likely Than Men to Live Alone. Forty-two percent of women aged 65 and over lived alone in 1992, compared with just 16% of older men. The proportion of women living alone increases dramatically with age. About one third (34%) of women aged 65 to 74 lived alone, compared to over half of women aged 85 and over.⁵ Because women have longer life expectancies and many women marry men who are older, the life expectancy for widowed women in the United States is about 17 years beyond the death of their spouses — years in which increased frailty or disability are generally endured alone.⁶

FINANCIAL STATUS

Older women are typically poorer than older men, and women over 85 and minority women are even more likely to be poor. The most vulnerable group is elderly women living alone.

Older Women Are Poorer Than Older Men. The median income for women 65 or older is \$8,600 a year. The median income for men is about \$15,000, 76% higher than the median for women.⁷

~~RESEARCH~~ Fifteen percent of older women live in poverty, compared with 8% of older men. Twenty-one percent of women over age 85 have incomes below the federal poverty level.⁸ Forty percent of women aged 65 to 74 and 56% of women over 75 live on incomes below twice the poverty line (\$14,000).⁹ 57%

41% **Minority Women Are Poorer Still.** Minority women have substantially lower incomes. In 1992, the median income of elderly white women (\$8,600) was 38% higher than the median income of black women (\$6,200), and 44% higher than the median income of Hispanic women (\$6,000).¹⁰

⁵National Institute on Aging, Profiles of America's Elderly, November 1993.

⁶C. Costello and A.J. Stone eds. *The American Woman 1994-1995*, Women's Research and Education Institute, 1994.

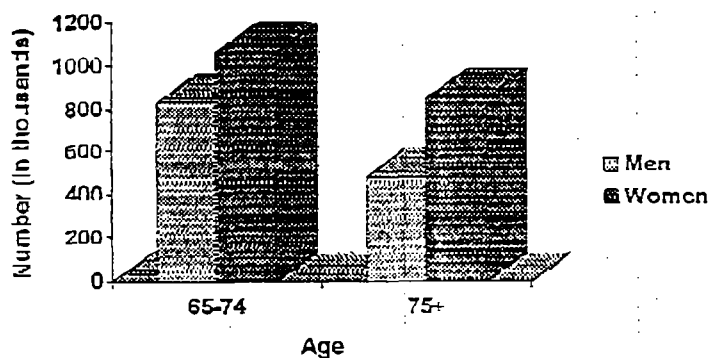
⁷U.S. Bureau of the Census, Current Population Reports, Series P-60-188, Income, Poverty and Valuation of Noncash Benefits: 1993.

~~RESEARCH~~ Ibid.

~~RESEARCH~~ Ibid.

¹⁰U.S. Bureau of the Census, Current Population Reports, Series P-60-184, Money Income of Households, Families and Persons in the United States: 1992.

Number of Persons with Diagnosed Diabetes, 1993



Diabetes is the fourth leading cause of death by disease in the U.S. and a leading contributor to heart disease, stroke, blindness, nerve and kidney damage and amputation. Complications of diabetes are a major reason why diabetes consumes one of every seven health dollars — almost \$100 billion annually.

There has been a steady increase in both the number of people with diabetes and the prevalence rate during the past 35 years. The steep increase in prevalence over time is partly due to aging of the U.S. population and the higher rates of diabetes in older adults. Increases in prevalence may also be due to a reduction in mortality of persons with diabetes, and changes in the criteria used to diagnose the disease. The net effect of improving the sensitivity of the biochemical measures used for detection of diabetes and the accelerated effort of screening may be an increase in the reported prevalence of diabetes since 1960.

SLIDE: Data from the National Health Interview Survey. In 1993, there were 7.8 million diagnosed diabetic patients, 40% of whom were age 65 or older.

In the 65-74 age group, 44% are men (855,000), 56% are women (1,064,000). In the 75+ age group, the disparity is greater: 36% men (487,000) and 64% women (854,000). Many researchers equate diabetes in adults in population surveys with NIDDM. The national surveys are interpreted as reflecting the trends in the prevalence and incidence of NIDDM for persons 25 years or older.

Note: 62% of women over 75 and 43% of men in this age group suffer from arthritis.

39% of

suffer from arthritis, compared with ~~[HHS - NEED NUMBER]~~ men.¹⁵ For 61% of older women, and 44% of poor elderly women, have arthritis, compared with 46% of older men ~~1987 data~~.¹⁶ These conditions may contribute to a loss of functioning, particularly as women age.

Women 85 And Older Are Even More Vulnerable. These problems become more serious with increasing age. Women over the age of 85 are extremely vulnerable. More than half of all women over age 85 have problems managing basic daily activities like bathing and eating, as compared to only 34% of men in the same age group.¹⁶ In addition, because women generally live longer than men, they are more likely to get diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis.

The following table illustrates the prevalence and risks of particular diseases faced by older women.

[JASON - INSERT TABLE HERE]

Revised table attached.

✓ ~~NEED NUMBER~~ NCHS, "Trends in the Health of Older Americans: United States, 1994," Vital and Health Statistics, Series 3, ¹⁶Health Care Financing Administration (HCFA), Medicare: A Profile, February 1995. No. 30, April 1995.

Disease	Prevalence/Number of Women Affected	Additional Information
Heart Attack and Stroke	The rate of illness and death from heart disease rises rapidly for women over 55. One in three women over 65—3.6 million women—suffers from heart disease (1990 figure). Women are more likely than men to die after a heart attack, or to have a second attack. Mortality from heart disease, at all ages, is highest among black women. Cerebrovascular disease (including stroke) is the third leading cause of death among women. People over 65 account for nine out of ten deaths from the disease. In 1990, 1.1 million older women had a stroke.	The higher mortality among female heart attack victims may be attributable to the fact that the heart disease therapies used have been tested primarily on men, and may not be as effective for women.
Cancer	Lung cancer and breast cancer are the leading causes of cancer deaths among older women. Overall, these two diseases account for over half of all female cancer deaths. One out of every nine women will be diagnosed with breast cancer in her lifetime. Although the incidence of breast cancer is higher among white women, black women are more likely to die of the disease. Part of the problem is that breast cancer is usually more advanced in black women by the time it is diagnosed. About 70 percent of all deaths from cervical cancer occur among women over 50. Mortality from the disease is especially high among low-income elderly women. While the incidence of cervical cancer is about one-third higher for black than for white women, the mortality rate for black women is almost three times as high. Older Hispanic and Native American women are also more likely than older white women to be diagnosed with and die of cervical cancer.	Although pap smears and mammograms can greatly reduce the risk of invasive cervical and breast cancer, many women do not receive these tests on a regular basis. Older women are less likely than younger women to have regular mammograms, despite the fact that the risk of breast cancer increases with age. Many older women without private insurance or supplemental Medigap coverage do not see physicians or receive preventive tests because they cannot afford the out-of-pocket costs (e.g., copayments, deductibles).

Disease	Prevalence/Number of Women Affected	Additional Information
Osteoporosis	Osteoporosis affects half of all women over 45 and 90 percent of women over 70. All told, 20 million women (and 5 million men) have osteoporosis. The disease causes 250,000 hip fractures a year. Women account for 75-80 percent of these hip fractures—about 200,000 a year. One out of every two women will have an osteoporosis-related fracture in her lifetime.	Hip fractures are a leading cause of hospitalization and nursing home placements among older women. One out of every four older women who were living independently prior to the hip fracture required institutional care for at least a year after the injury.
Falls	About 40 percent of all falls by women over 75 result in a fracture. More deaths of women in this age group are caused by falls than by pneumonia, diabetes or all other accidents combined.	
Diabetes	Diabetes, a leading cause of death by disease and also a leading contributor to heart disease, stroke, blindness and amputation, is more prevalent among women than men. This is largely due to the high incidence of the disease among black, Hispanic and other minority women. Black women are twice as likely as their white counterparts to die of diabetes. In 1993 there were over 3 million people age 65 or older with diabetes, of whom 60 percent—almost 2 million—were women. Diabetes is particularly dangerous for older women; women age 65 to 74 are four times as likely to die of the disease as women age 45 to 64.	
Arthritis	Arthritis is much more common in women than in men. While half of all persons over 65 report problems with arthritis, four out of every five women over 65 suffer from the disease.	

Disease	Prevalence/Number of Women Affected	Additional Information
Alzheimer's Disease	About 4 million people suffer from Alzheimer's. Women are, again, more likely than men to be stricken by the disease, even taking into account the larger number of older women.	Care for Alzheimer's patients, which can be exceptionally demanding, is disproportionately provided by older women.
Depression	Older women are twice as likely to experience depression as their male counterparts. Symptoms of "pseudo dementia," depression that often follows major life losses (e.g., death of a spouse) can include withdrawal, confusion and memory loss.	Although treatment can assist most people who suffer from depression, many do not seek treatment.