and France, girls born at the end of the 1980s also could expect to live to at least age 80. Thus, while American women tend to live longer than American men, a comparison with women in other countries suggests that there is room for improvement in life expectancy for women in the United States.

Leading Causes of Mortality

As in all of the highly industrialized countries, the most common causes of death in the United States are heart disease, cancer, and stroke (World Health Organization 1992). These diseases account for 67 percent of American women's deaths. The percentage is somewhat higher for men (NCHS 1992).

Heart disease, historically the leading cause of death in America among females of all races, has been overtaken by cancer as the leading cause of death among white women. In 1990, among white women, the cancer mortality rate[1] was 111, compared to 103 for heart disease as seen in Table 2.

Table 2 • LEADING CAUSES OF DEATH FOR WHITES AND BLACKS BY SEX, 1990 (number of deaths per 100,000 persons in population)

	Females		*Males*	
	White	*Black*	*White*	*Black*
Malignant neoplasms (cancers)	111.1	137.2	160.3	248.1
Heart diseases	103.1	168.1	202.0	275.9
Cerebrovascular diseases	23.8	42.7	27.7	56.1
Accidents and adverse effects	17.6	20.4	46.4	62.4
Chronic obstructive pulmonary diseases	15.2	10.7	27.4	26.5
Pneumonia and influenza	10.6	13.7	17.5	28.7
Diabetes mellitus	9.5	25.4	11.3	23.6
Chronic liver disease and cirrhosis	4.8	11.5	11.5	20.0
Suicide	4.8	2.4	20.1	12.4
Septicemia	3.1	8.0	4.2	11.6

Source: National Center for Health Statistics 1993.

[1]A mortality rate is the ratio of deaths—overall, or from a specified cause—to the population, or a particular segment of the population, in a given year. Unless otherwise specified, the population unit on which mortality rates are calculated is 100,000. Mortality rates by race, sex, and/or age group are calculated on the basis of the appropriate segment of the population.

Among black women, however, heart disease remains the leading cause of death. Men of both races are more likely to die from heart disease than from cancer.

Proportionally more black women than white women die from all the leading causes of death, except for suicide and chronic obstructive pulmonary disease (a lung condition usually resulting from emphysema, asthma, or chronic bronchitis). Mortality rates among black women are nearly twice as high for stroke and over twice as high for diabetes and septicemia (blood poisoning) as they are among white women.

HEALTH STATUS ACROSS THE LIFE SPAN

In general, the primary health concerns of women who are of reproductive age are different from those of postmenopausal women. This section begins with a discussion of conditions found largely among younger women, and goes on to a review of conditions found mostly in postmenopausal women—that is, women over 50 years old. It should be recognized, however, that most of the conditions discussed in this section can occur at any age.

Health Concerns of Younger Women

Some diseases, while not life threatening, cause impairment and disability and limit one's ability to perform daily functions, including working and caring for family members. Such illnesses often necessitate frequent contact with health care providers. For younger women, conditions in this category include gynecological infections, emotional disorders, and autoimmune diseases. In discussing the health of younger women, it is also essential to consider the impact of illnesses on reproductive health and pregnancy.

Sexually Transmitted Diseases

This country has been experiencing a resurgence of sexually transmitted diseases (STDs), due in part to penicillin-resistant strains of gonorrhea and an epidemic of venereal viruses for which there are currently no cures (Althaus 1991). Rates of infection can only be estimated because not all STDs are required to be reported to health authorities and many cases are asymptomatic (i.e., have no outward symptoms) particularly in women.

In the United States, the most common of these infections are chlamydia, gonorrhea, syphilis, herpes simplex 2 virus, and the human papilloma virus

(HPV) (Horton 1992). Cases of gonorrhea and syphilis are reported by every state. In 1991, the rates (per 100,000) of reported gonorrhea were nearly 263 for men and 202 for women; the rates of reported syphilis were nearly 20 for men, and 15 for women (Centers for Disease Control [CDC] 1992a). Infection rates were higher among adolescent girls than boys, most likely reflecting girls' exposure to infected older men. Among black women, the incidences of gonorrhea and syphilis were four to five times the national rates (CDC 1992a).

STDs are more easily transmitted from males to females than from females to males. Moreover, infection in women is more likely to be asymptomatic and therefore less likely to be identified and treated early. As a result, women are at greater risk than men of suffering long-term consequences from these diseases. This is important because an untreated STD can severely impair a woman's reproductive health, and infection during pregnancy carries a risk for both the mother and the fetus. For example, exposure to chlamydia during birth can result in conjunctivitis (an eye disease) or pneumonia in the newborn, and transmission of herpes simplex 2 virus can lead to newborn infection or death (Althaus 1991).

The STD epidemic is in part driven by increased sexual activity among young people, often in combination with drug and alcohol use. The risk of infection increases when multiple partners and unprotected sex are involved. An individual with a history of STD infection is considered at greater risk of contracting AIDS (Acquired Immune Deficiency Syndrome) because the AIDS virus is more easily transmitted through skin irritated by infection.

Pelvic Inflammatory Disease

Pelvic inflammatory disease (PID) is an acute infection of a woman's upper reproductive tract (uterus, ovaries, and fallopian tubes). The infection may be sexually transmitted (particularly through contact with individuals who have gonorrhea or chlamydia) or may result from an overgrowth of normal bacteria. The risk of having PID is highest for young women. An estimated 10 to 15 percent of American females between the ages of 15 and 44 have had at least one episode of PID. Annually, approximately one million women experience symptomatic PID, resulting in about 210,000 hospitalizations (Althaus 1991).

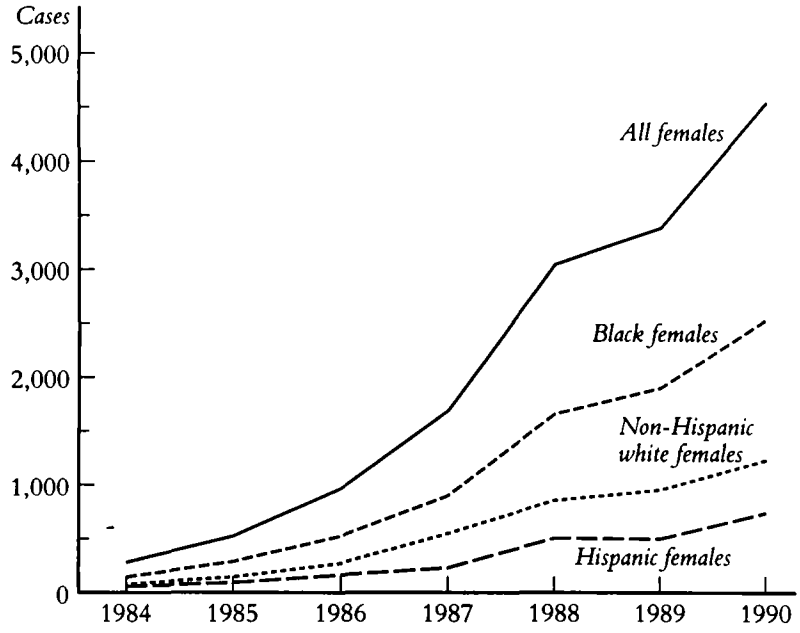
Moreover, the incidence of PID is believed to be significantly underestimated due to the extent of "silent"—asymptomatic—PID. In such cases, the first evidence of infection may be an ectopic pregnancy (pregnancy occurring outside of the uterus), infertility, or chronic pelvic pain (Althaus 1991; Cates and Wasserheit 1991). At this point, extensive medical atten-

tion and treatment are required. Further research on PID must include an evaluation of the efficacy of hospital versus outpatient treatment, a determination of what factors lead to long-term complications, and an effort to detect and assess the prevalence of silent PID (Padian 1992).

Acquired Immune Deficiency Syndrome

AIDS is a disease of the immune system—the body's system for fighting infection. The cause of AIDS is thought to be a virus called HTLV-3, which is believed to be spread through the exchange of body fluids such as semen and blood. Although the initial impact of AIDS in the United States was on men, it is now becoming a leading cause of death among young women. As Figure 2 shows, the number of new cases among females in this country increased by 34 percent from 1989 to 1990, to an estimated 4,544 cases of women with AIDS in 1990.

Figure 2 • AIDS CASES IN FEMALES AGE 13 AND OVER BY RACE AND HISPANIC ORIGIN, 1984–1990

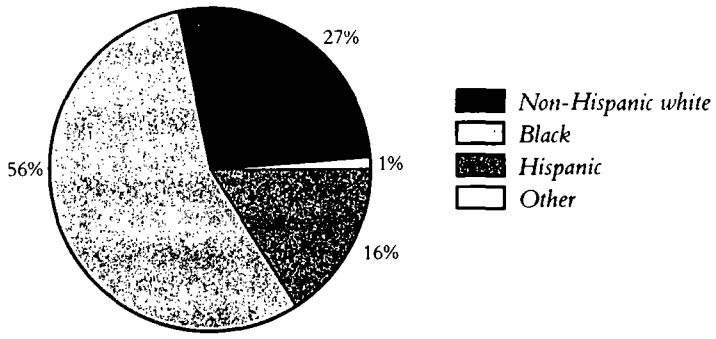


Source: National Center for Health Statistics 1992.

Many more women, while not showing symptoms of the disease, carry the AIDS Human Immunodeficiency Virus (HIV). As AIDS moves from being a disease principally associated with gay men and those who use intravenous drugs to one that threatens the general population, it is dispro-

portionately affecting black and other minority women (see Figure 3). In New York City, for example, AIDS is now the leading cause of death among black women age 25 to 44 (CDC 1992f).

Figure 3 • NEW AIDS CASES IN FEMALES AGE 13 AND OVER BY RACE AND HISPANIC ORIGIN, 1990



Total Cases: 4,544 females

Source: National Center for Health Statistics 1992.

When AIDS first appeared in the United States, it was perceived to be a gay men's disease. The public was not generally aware that AIDS could be transmitted to women through intravenous drug use or sexual contact with infected men. Many women still do not know enough about protecting themselves from AIDS. Others who have the knowledge—those who know about the importance of using condoms, for example—may have difficulty translating knowledge into practice within their sexual relationships.

Until very recently, females were included in the AIDS medical literature only in reference to the transmission of the disease to newborn infants; the effect of AIDS on women themselves was not researched or discussed (Minkoff and DeHovitz 1991). Recent literature suggests, however, that AIDS may progress faster in women than in men. In addition, it is now known that women usually begin to receive medical care for AIDS later in the course of the disease. The Centers for Disease Control recently broadened the definition of AIDS from one that defined symptoms as they were manifested in men to include symptoms that more commonly appear in women with AIDS, such as persistent vaginal yeast infections, severe pelvic inflammatory disease, and cervical cancer (Donovan 1993).

In women, the hallmark symptom of depressed immune function is typically a persistent vaginal yeast infection. Yeast infections of the mouth and

esophagus are common as the immune function deteriorates (Minkoff and DeHovitz 1991; Pfeiffer 1991). HIV-positive females are more likely than uninfected women to have severe pelvic inflammatory disease, and are much more likely to have abnormal Pap smears, indicating some stage of cervical cancer (Minkoff and DeHovitz 1991). Since very little is known about how pregnancy affects the course of the disease, an HIV-positive woman must make careful decisions about current or future pregnancies. An infected woman must also weigh the risk of transmitting the infection to an unborn child, a risk now estimated at 25 percent (down from much higher estimates a few years ago but still clearly a concern). In addition, the risk to both the mother and fetus of continuing AIDS therapy during pregnancy is still uncertain (Pfeiffer 1991).

Much work needs to be done to improve the quality of life and medical care of women with AIDS. To date no studies have been conducted to determine whether women respond differently than men to currently available AIDS treatments. It is clear, however, that AIDS has a different effect on women not only with respect to physical symptoms, but socially as well. Women are often the caretakers of others with AIDS, and as a result tend to postpone their own care when they become infected. Those most affected by AIDS are poor and minority women who must rely for care on government programs or the limited health care resources in their communities. Since the consequences of treating pregnant women with AIDS are still unknown, many treatment programs are reluctant to take on patients who are, or may be, pregnant, leaving this group of women without the care they desperately need (Minkoff and DeHovitz 1991).

Major Depression

Nearly five percent of women, compared to two percent of men, suffer from major depression. Studies repeatedly find depression to be two to three times more prevalent among women than men (Weissman et al. 1984; Coryell, Endicott, and Martin 1992). However, although women in every racial, ethnic, and socioeconomic group have a higher rate of depression than their male counterparts, overall rates of depression are lower among black and Hispanic women than among non-Hispanic white women (U.S. Department of Health and Human Services [DHHS] 1991b). Age is a factor as well since depression is most common among women between 25 and 44 years old (Coryell, Endicott, and Martin 1992; Halbreich et al. 1984; Horton 1992). Increasing rates of depressive behaviors among teenage girls and other young women indicate that the age of onset may be declining (Horton 1992).

The clinical symptoms of major depression include sleeplessness, difficulty in concentrating, eating disorders, physical illness, and suicide. Al-

though women are more likely to attempt suicide, more men than women actually commit suicide.

In addition to sex and age, another risk factor for depression is marital separation or divorce (Anthony and Petronis 1991). The risk of depression for women may be increased by a combination of biological factors, as well as by psychosocial factors such as low self-esteem, marital difficulty, and a sense of limited life options (Public Health Service Task Force 1985).

Although many forms of depression are treatable, only about 30 percent of people with depression receive treatment (DHHS 1991a). One reason may be that primary care physicians often do not recognize early symptoms of depression and do not refer their patients for treatment. Another major factor is that coverage for mental health care is very limited under most insurance plans, making comprehensive mental health therapy a luxury that most women cannot afford.

Eating Disorders

The eating disorders anorexia nervosa and bulimia nervosa, both far more likely to affect females than males, have become increasingly prevalent among teenage girls and young women. It has been estimated that five in every 1,000 adolescent and young adult females are anorexic. Females are at 10 times greater risk for anorexia nervosa than males. Young, white adolescents are at greatest risk (U.S. Congress, Office of Technology Assessment [OTA] 1991).

A distorted body image causes anorexics to believe that they are seriously overweight when they are not, and they refuse to eat. In addition to a weight loss of at least 25 percent of original body weight, clinical manifestations of anorexia include dehydration, amenorrhea (cessation of menstruation), cold intolerance, and dry skin and hair (Smith 1984). An estimated nine percent of anorexics die prematurely, either from suicide or starvation, and fewer than half of anorexics are able to recover fully (Horton 1992). Anorexia is difficult to cure because anorexics tend to deny their disorder and often refuse help from medical professionals.

Bulimia nervosa (binge eating followed by vomiting) is more common than anorexia and usually occurs in girls in late adolescence. It is estimated that between one and four percent of young women have bulimia. A national survey of students indicates that at least 4 percent of eighth and tenth graders are bulimic (Horton 1992). Clinical manifestations of bulimia include irregular menstruation as well as a constant sore throat and problems with the stomach and teeth caused by vomiting (Smith 1984). Bulimics are more likely than anorexics to admit that their behavior is abnormal, and are thus more amenable to treatment.

Autoimmune Diseases

Autoimmune diseases, which are far more common among women than among men, are conditions in which the body makes antibodies against some of its own parts, leading to their destruction. Two of the more common autoimmune diseases are systemic lupus erythematosus (SLE) and rheumatoid arthritis. Females are nine times more likely than males to develop lupus (Horton 1992), and three times more likely to develop rheumatoid arthritis (Pritchard 1992). The onset of SLE may occur anywhere between the ages of 20 and 64. In this disease, several parts of the body may become inflamed, including the skin, joints, kidneys, and nervous system. The prevalence of rheumatoid arthritis peaks between the ages of 35 and 45. Also a chronic inflammatory condition, rheumatoid arthritis affects many joints, particularly those of the hands (Condemi 1992). SLE and rheumatoid arthritis are both characterized by progressive physical deterioration, loss of functional abilities, chronic pain, and shortened life span.

A pregnant woman with an autoimmune disorder has reason for additional concern. The condition may be transmitted to the fetus, although long-term effects are rare (Giacoia 1992). There also is an increased risk of miscarriage. Symptoms may subside during pregnancy, but an exacerbation of the condition typically occurs in late pregnancy or right after childbirth. Another concern is whether and how to treat these diseases during pregnancy. Given the prevalence of autoimmune diseases among women, and changes in the illnesses during pregnancy, hormonal factors may play a role in autoimmune diseases although more research is needed to determine exactly what that role might be.

Violence

As violence against women is more widely publicized, reported, and studied, the horrifying dimensions of this epidemic are beginning to be appreciated. There were over 92,000 reported rapes in 1988. An estimated four million women are severely assaulted by their male partners every year. More than half of the women murdered in the United States are killed by current or former male partners (American Medical Association [AMA] 1992). Most rapes, as well as most other types of assault against women, are committed by persons known to the victims.

The psychological impact of sexual and physical abuse may be manifested in feelings of dependency, vulnerability, and betrayal—and by depression and suicide attempts. In addition to psychological damage, women who have been sexually assaulted usually suffer lacerations, bruises, and an increased risk of AIDS and other sexually transmitted diseases, as well as of unwanted pregnancy.

Women who have been battered usually have injuries to parts of their bodies that would not normally be injured in an accident. Among abused pregnant women, for example, bruises to their abdomens are typical. National data from a 1985 survey found that 154 out of every 1,000 pregnant women were assaulted by their partners during the first four months of pregnancy, and an even greater number (170 out of every 1,000) were assaulted during the fifth to ninth months. This abuse is not only very painful for the pregnant women involved but it also increases the risk of placental separation, uterine rupture, fetal fractures, hemorrhage, and preterm labor (AMA 1992).

The American Medical Association recently issued recommendations to help train physicians

- to identify evidence of violence;
- to discuss it with their patients;
- to refer patients for proper treatment; and
- in general to help health professionals become more comfortable in dealing with this complex medical and social issue (AMA 1992; Sugg and Inui 1992).

Health Concerns of Older Women

The health concerns of women during and after menopause become primarily the chronic conditions associated with aging and changes in hormones. In some respects, the conditions of concern become more similar to the concerns of their male counterparts. Yet hormonal changes and longevity result in conditions of unique concern to women.

Heart Disease

Coronary heart disease, which includes angina (intermittent chest pain) and heart failure, accounts for about 31 percent of female deaths. Symptoms of heart disease typically develop in women about 10 years later in life than is the case for men. In other words, for females heart disease is largely a postmenopausal disorder. Illness and death resulting from heart disease rise dramatically in women after age 55 (Lerner and Kannel 1986).

Risk factors for heart disease have been found to be similar for men and women, but smoking, diabetes, and systolic hypertension (high blood pressure) appear to be more important risk factors for women than for men. On the other hand, the type of cholesterol known as high density lipoprotein

(HDL) appears to be more protective in women than in men (Lerner and Kannel 1986).

Whereas the first sign that a man has heart disease is likely to be a heart attack, the first sign in a woman is more likely to be angina (Lerner and Kannel 1986). Nevertheless, heart attacks occur in about 30 percent of female heart patients (Hendel 1990). The risk of having a heart attack increases with age. A woman is more likely than a man to die after a heart attack, or to have a second attack (Hendel 1990; Becker 1990).

One reason for these differences may be that the therapies used, which have been tested mainly on males, may not be directly applicable to the care of women. Recent studies find that women respond differently than men to both medical and surgical treatments for heart disease (Clyne 1990; O'Conner 1992). More research is needed to determine why such discrepancies exist and how the treatment of heart disease in women can be improved.

Cancer

Breast cancer and lung cancer are not only the most commonly occurring cancers in women, but together they are also responsible for nearly half of all cancer deaths in women. The gynecological cancers (cancer of the cervix, ovaries, and uterus) are less common (see Table 3) but are of concern to women throughout their lives. Mortality rates for white women are higher than for black women for lung and ovarian cancer, but lower for breast, endometrial, and cervical cancer. These differences by race may be related to the availability of preventive care and access to treatment.

Table 3 • INCIDENCE AND DEATH RATES FOR SELECTED CANCERS AMONG WOMEN BY CANCER SITE, 1989 (per 100,000 women)[1]

	Incidence		*Deaths*		
Cancer Site	*White*	*Black*	*All Races*	*White*	*Black*
Breast	108.2	87.6	23.1	23.1	26.5
Lung and bronchus	40.1	45.2	24.9	25.3	25.0
Endometrial	21.9	16.7	2.6	2.4	4.5
Ovary	15.8	10.6	6.4	6.6	5.0
Cervix	8.2	12.8	2.7	2.3	6.2

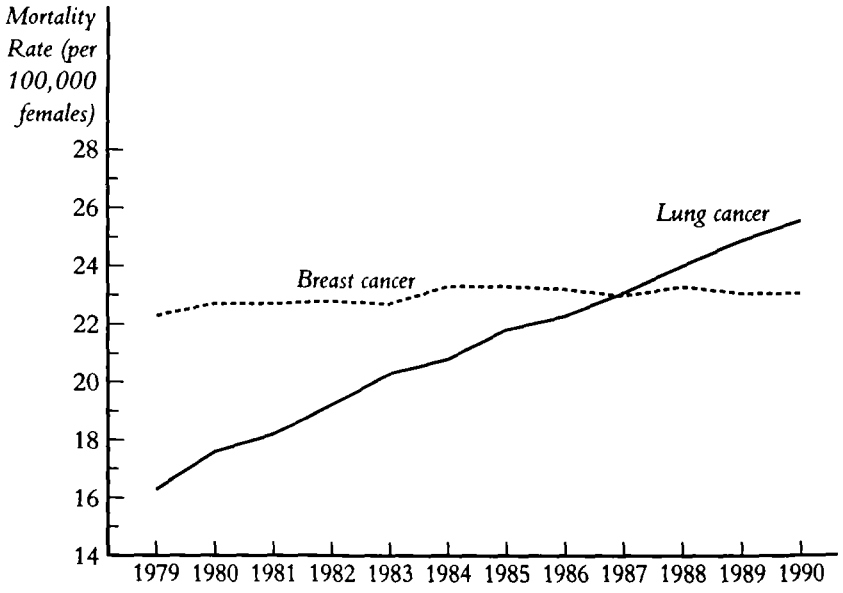
[1]Rates are age-adjusted.

Source: National Center for Health Statistics (NCHS) 1992 (incidence rates) and NCHS, unpublished cancer statistics, January 1993 (mortality rates).

Lung Cancer. Twice as many males as females die of lung cancer, but while the death rate for men is leveling off, the death rate for women continues to rise. The lung cancer death rate among women has quintupled in the past 30 years, from a (per 100,000) mortality rate of 5.4 in 1958 to 28.2 in 1988 (American Cancer Society [ACS] 1992). In 1987, for the first time, more women died from lung cancer than from breast cancer as Figure 4 illustrates. Most female lung cancer deaths occur among women who are between the ages of 55 and 74 (NCHS 1989).

In proportion to their numbers in the population, more black women than white women get lung cancer; in 1989 the (per 100,000) incidence rate was 45.2 among black females and 40.1 among white females (see Table 3 above). The incidence rates for breast cancer among females of both races are much higher than for lung cancer; however, lung cancer is the leading killer cancer among white women. Among black women, it lags slightly behind breast cancer.

Figure 4 • FEMALE MORTALITY FROM LUNG CANCER AND BREAST CANCER, 1979–1990 (age-adjusted mortality rates)[1]

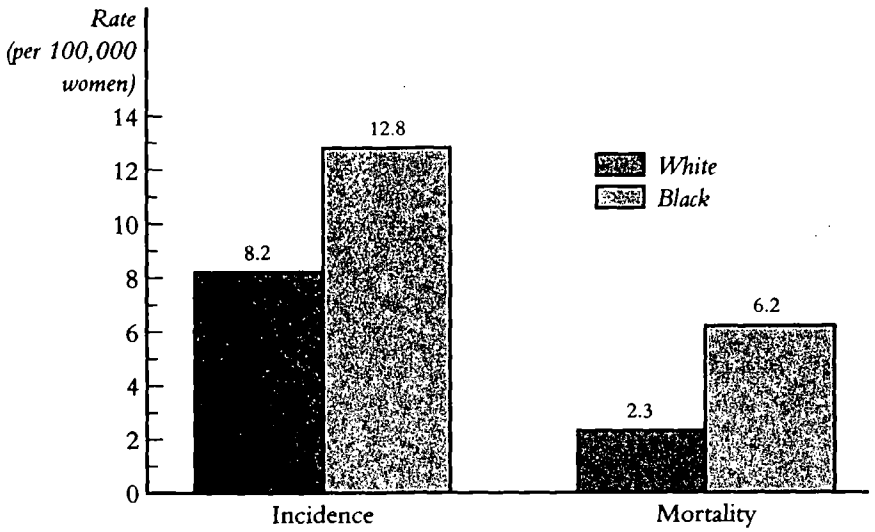


[1]A mortality rate is the number of deaths in a given year per 100,000 persons in the population. An age-adjusted rate is a weighted average of the age-specific rates, where the weights are the proportions of persons in the corresponding age groups of a standard population. This is done to reduce the potential confounding effect of age.
Source: National Center for Health Statistics, unpublished cancer statistics, January 1993.

Approximately 85 percent of lung cancers are attributable to smoking, and the number of years that women smoke during their lives is now approaching that of men. The increase in female lung cancer deaths is not expected to begin to level off until the year 2013 (CDC December 1990).

Cervical Cancer. Cervical cancer is one of the most detectable and treatable cancers. The five-year survival rate for women whose cancer is detected early is 90 to 100 percent (ACS 1992). Mortality rates for cervical cancer have steadily declined in the past 40 years, due almost entirely to the Pap smear, which can detect the cancer before it has begun to spread—thereby allowing for curative treatment. Annually there are an estimated 13,500 cases and 4,400 deaths from cervical cancer. However, as Figure 5 shows, the incidence of cervical cancer among black women is about one-third higher than the incidence among white women. The mortality rate among black women is three times as high as the mortality rate among white women (ACS 1992). Mortality from cervical cancer is also higher among Native American women and low-income elderly women. Lack of

Figure 5 • CERVICAL CANCER: INCIDENCE AND MORTALITY RATES FOR WHITE AND BLACK WOMEN, 1989[1]



[1]A mortality rate is the number of deaths in a given year per 100,000 persons in the population. An incidence rate is the number of new cases in a given year per 100,000 persons in the population. Rates are age-adjusted.
Source: National Center for Health Statistics (NCHS) 1992 (incidence rates) and NCHS, unpublished cancer statistics, January 1993 (mortality rates).

regular Pap smears, intercourse at an early age, smoking, the presence of the human papilloma virus, and a history of multiple sexual partners are all risk factors for cervical cancer.

Ovarian Cancer. One in 70 women will be diagnosed in her lifetime with ovarian cancer (ACS 1992). Both incidence rates and mortality rates for ovarian cancer are higher among white women than among black women. Because ovarian tumors are typically diagnosed at advanced stages, survival rates for ovarian cancer are the poorest of all the gynecologic cancers; only 39 percent of white women and 36 percent of black women survive for five years after being diagnosed with ovarian cancer. (Although a higher percentage of white women with ovarian cancer survive for five years when compared to black women, white women's overall mortality from ovarian cancer is higher than black women's.)

The risk factors for ovarian cancer are not well understood, and there is currently no effective screening procedure that can be widely applied to identify ovarian cancer at an early, highly treatable stage when the tumor is asymptomatic. Very recent evidence indicates that the use of oral contraceptives that suppress ovulation may help protect against ovarian cancer (Hankinson et al. 1992).

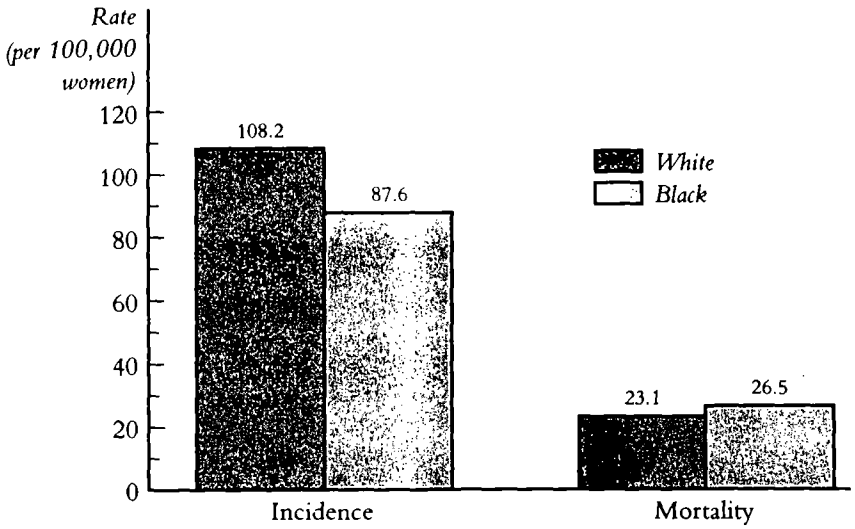
Breast Cancer. One out of every nine women can expect to be diagnosed with breast cancer in her lifetime. According to the American Cancer Society (1992), there were 46,000 deaths from breast cancer and 180,000 new cases of the disease in 1992.

Breast cancer is associated with a history of cancer in a mother or a sister, never having been pregnant, early menstruation, late menopause, and benign breast disease. White women, and women of high socioeconomic status, are also at higher than average risk. Excessive consumption of food with a high fat and caloric content as well as excessive consumption of alcohol appear to increase the risk of breast cancer (Mettlin 1992).

Various combinations of surgery, chemotherapy, and radiation therapy have been used to treat breast cancer; however, survival is closely linked to the stage of the cancer at the time of discovery, as well as to treatment decisions made by the patient and her physician. Screening by clinical exam and mammography has proven very effective in detecting early breast cancer in women over age 50. (Mammography is discussed in greater detail later in this chapter.)

Although the incidence of breast cancer is higher among white women than among black women, the latter are more likely to die from this disease

Figure 6 • BREAST CANCER: INCIDENCE AND MORTALITY RATES FOR WHITE AND BLACK WOMEN, 1989[1]

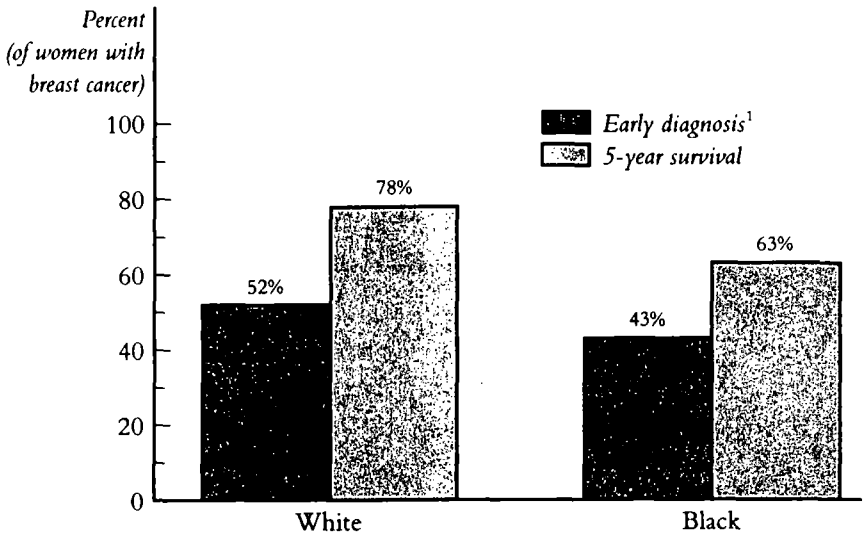


[1]A mortality rate is the number of deaths in a given year per 100,000 persons in the population. An incidence rate is the number of new cases in a given year per 100,000 persons in the population.
Source: National Center for Health Statistics (NCHS) 1992 (incidence rates) and NCHS, unpublished cancer statistics, January 1993 (mortality rates).

(see Figure 6). Part of the problem is that the disease is typically more advanced in black women when they are diagnosed: only 43 percent of black women, compared to 52 percent of white women, are diagnosed at a stage when the disease is still localized (Boring, Squires, and Tong 1992). However, as Figure 7 illustrates, even among black and white women diagnosed at the same stage, five-year survival rates are lower for black women.

Breast cancer also appears to strike black women at an earlier age than their white counterparts, raising questions about variations in the nature of the disease, and about the adequacy of current screening guidelines with respect to minority women. Another concern is that because breast cancer education typically has targeted higher-income white women, the population at greatest risk of breast cancer, many minority women believe they are not at significant risk.

Figure 7 • WHITE AND BLACK WOMEN WITH BREAST CANCER: PERCENTAGE EARLY DIAGNOSIS AND FIVE-YEAR SURVIVAL, 1981–1987



[1]Cancer diagnosed in local stage.
Source: Boring, Squires, and Tong 1992.

Endometrial Cancer. The incidence and mortality rates for endometrial cancer (cancer of the uterus) have remained constant over the past decade (the 1989 rates are shown in Table 3 above). This disease, which typically afflicts women over age 50, generally has a good prognosis. Age, a history of infertility, failure to ovulate, estrogen therapy, and obesity are all considered risk factors for endometrial cancer (ACS 1992). Five-year survival rates are about 85 percent overall, higher if the disease is diagnosed and treated early. Preventive screening for endometrial cancer involves regular checkups, prompt medical attention for abnormal bleeding, and sampling of the endometrial tissue by biopsy at menopause for women who are at high risk for the disease (ACS 1992).

Cerebrovascular Disease

Cerebrovascular disease, the third leading cause of death among females, is the inclusive name for the diseases relating to the blood supply to the brain, including stroke and multi-infarct dementia (a form of brain disease causing a rapid failure of mental functioning). Nine percent of deaths among white women and eight percent of deaths among black women are caused by cerebrovascular disease.

Among women overall, mortality from cerebrovascular disease is less common than it is among men overall. However, mortality rates for blacks of both sexes are much higher than for their white counterparts. As Table 2 shows (see above), in 1990 the rate for black women was 42.7 per 100,000 persons—nearly 80 percent higher than the rate for white women.

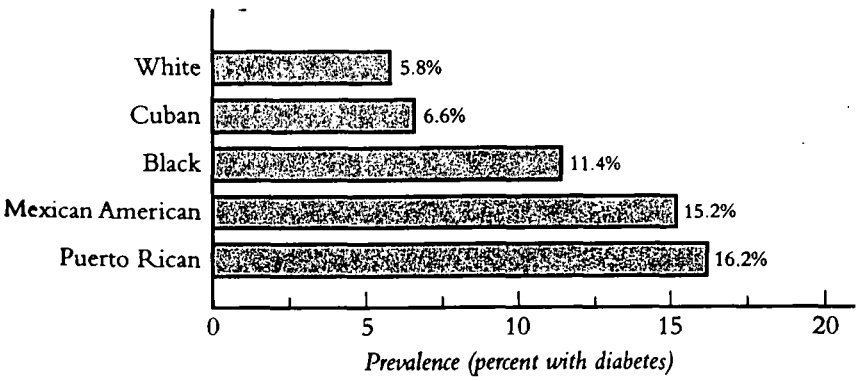
Not only is cerebrovascular disease a major killer, it is also a major cause of physical and mental disability. It is largely a disease of the old: 87 percent of deaths from the disease, and 74 percent of hospitalizations due to it, involve people age 65 and over (CDC 1992c).

Diabetes

Diabetes is both a disabling condition and one that can lead to death if untreated or poorly managed. It ranks fourth among the leading causes of death for black women, and seventh for white women (see Table 2). Diabetes is also a condition that disproportionately affects the older age groups, with death nearly four times more likely to occur among women age 65 to 74 than among those age 45 to 64 (NCHS August 1991).

Diabetes is more prevalent among females than males, almost entirely because its incidence is very high among black, Hispanic, and other minority women (CDC November 1990). In the 45 to 74 age group, for example, 11 percent of black women and over 15 percent of Mexican American and Puerto Rican women have diabetes, compared to only six percent of white women (see Figure 8).

Figure 8 • PREVALENCE OF DIABETES AMONG WOMEN AGE 45 TO 74, SELECTED RACES AND HISPANIC ORIGINS[1]



[1]Data for whites and blacks are from the National Health and Nutrition Examination Survey II, 1982–1984. Data for Hispanics are from the Hispanic Health and Nutrition Examination Survey, 1976–1980.
Source: Flegal et al. 1991.

As a chronic disease, diabetes can give rise to many disabling conditions including:

- kidney disease, which can lead to kidney failure;
- eye disease, which can lead to blindness;
- peripheral vascular disease, which affects blood circulation in the extremities and can ultimately lead to amputation of the legs or feet; and
- increased risk of death from coronary heart disease or stroke (Lerner and Kannel 1986).

Risk factors for diabetes include a family history of the disease, obesity, and a history of diabetes during pregnancy. Early control of blood sugar through diet and exercise can retard the development of complications, or the need for medications.

Osteoporosis

Osteoporosis is a condition in which bone density has been reduced, in some cases to the point where fractures can result from minor accidents or even normal physical activity. Women are more likely than men to be affected by osteoporosis because they have less bone mass to begin with, and bone loss is accelerated as estrogen levels decline during and after menopause. While data are not available on the prevalence of this disease nationally, it is estimated that 50 percent of women over age 45, and 90 percent of women over age 70, have some degree of osteoporosis (U.S. DHHS 1991a).

The most common clinical manifestations of osteoporosis are fractures of the vertebrae, hip, and wrist. A total of 1.3 million fractures per year are attributed to osteoporosis. Hip fractures are of great concern because of the attendant high rates of illness and death. Most hip fractures cause some degree of permanent impairment; 25 percent require institutionalization and 20 percent result in death (Resnick and Greenspan 1989). Seventy-five to 80 percent of the approximately 250,000 hip fractures that occur annually are to women (Horton 1992). The consequences of vertebral fractures are not as severe, but vertebral fractures can lead to spinal deformity, chronic back pain, and loss of height.

Because at every age white women typically have less bone mass than either their black counterparts or men, they are at greatest risk for having osteoporotic fractures (Farmer et al. 1984). Other risk factors for osteoporosis include being thin, smoking, having a family history of the disease, and having experienced amenorrhea.

Alzheimer's Disease

Alzheimer's disease is an illness characterized by a gradual loss of memory and cognitive abilities. People in the advanced stages of the disease typically do not recognize even their closest relatives, have lost the ability to manage the simplest tasks involving personal hygiene, and are often fearful about their surroundings. At this point, the cause of the disease is not known.

The incidence of Alzheimer's disease increases dramatically after age 70 (Treves 1991). Some studies have found a higher prevalence of Alzheimer's among women, even after taking into account the higher proportion of females among the aged (Schoenberg, Anderson, and Haerer 1985; Schoenberg, Kokmen, and Okazaki 1987).

Whether women are truly at greater risk than men is one of the many questions about Alzheimer's disease that need to be answered. Other items on the current research agenda include an examination of head trauma and family history as risk factors, the reported association between heart attacks and Alzheimer's in women (Aronson et al. 1990), and the development of early diagnosis methods and new forms of treatment. Alzheimer's disease will increase in prevalence as the population ages.

IMPROVING WOMEN'S HEALTH

Preventing Disease

Several preventive measures can make a significant difference in the health outlook for women overall. First, women themselves can avoid risky behaviors that are known to cause health problems. Second, early detection and treatment can often arrest a potentially serious disease that is not yet symptomatic. And third, even a disease that is already symptomatic can often be arrested, or its progress retarded, by the right treatment and good management.

Many risk factors, such as age and family history, cannot be altered—but some others can be. Altering these risk factors depends primarily on an individual's willingness to make behavioral changes. The evidence is clear that smoking, dietary habits, and physical activity significantly affect the risk of cardiovascular disease, lung cancer, respiratory disease, and diabetes. Dietary habits also are likely to affect risks for other cancers and for osteoporosis. The health consequences of alcohol and drug abuse are well documented. Nevertheless, it must be recognized that behavioral changes can be very difficult to achieve, often because cultural influences as well as personal decisions are involved.

Certain medical interventions can, however, significantly affect and improve a woman's health. The most notable of these are the Pap smear, mammography, hormone replacement therapy, and blood pressure measurement (see Table 4).

Table 4 • EARLY DETECTION AND PREVENTIVE SERVICES FOR WOMEN: GUIDELINES AND USAGE, 1990

Service	*For Early Detection or Prevention of*	*Screening Guidelines*	*Percentage of Women Who Had Service in Past Year*
Mammography	Breast cancer	From age 40 to 49, every one to two years; annually after age 50	—[1]
Clinical breast exam	Breast cancer	From age 20 to 40, every three years; annually after age 40	53
Pap smear	Cervical cancer	Annually[2]	50
Hormone replacement therapy	Osteoporosis; cardiovascular disease	Physician counseling on risks and benefits to menopausal women	—
Blood pressure check	Hypertension	Every one to two years[3]	91

[1]Data are not available on the percentage of women having mammography in the past year. However, 31 percent of women reported following the American Cancer Society guidelines for frequency.
[2]Frequency may be reduced after three normal tests.
[3]If normotensive, at least once every two years; if borderline (diastolic 85–89 mmHg), every year.
Source: American Cancer Society 1992a; U.S. Preventive Services Task Force 1989; Piani and Schoenborn 1993; and Centers for Disease Control September 14, 1990.

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Source: National C

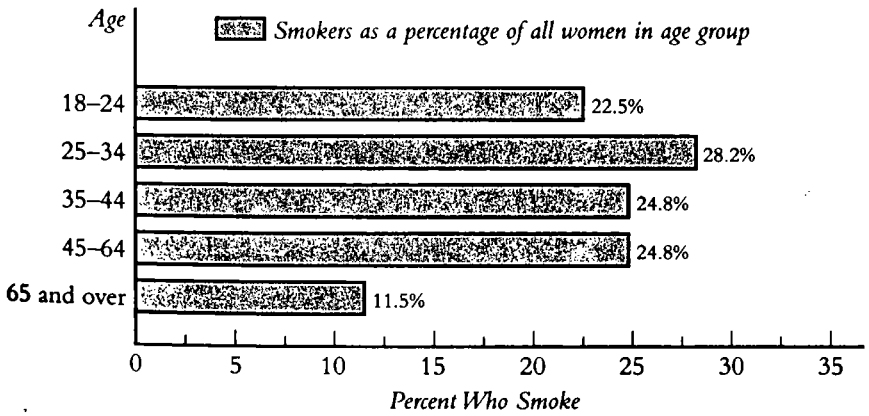
Use of these preventive interventions has increased over the past two decades, but analyses show persistent differences by age and race (Makuc, Freid, and Kleinman 1989) as well as by socioeconomic status (CDC September 1990; Piani and Schoenborn 1993). The following sections discuss some preventive measures and their effectiveness in improving women's health.

Smoking Cessation

Smoking is associated with the major killers of women—heart disease, lung cancer, and cerebrovascular disease. In 1988, the deaths of almost 150,000 women were attributed directly to the effects of smoking (CDC February 1991). Smoking is also linked to osteoporosis, cervical cancer, and poor pregnancy outcomes, including low birth weight and miscarriage (CDC October 1991). Smoking cessation is one of the most important behavioral changes a woman can make to improve her prospects for good health. Quitting can make a difference—after 10 years of smoking cessation, the risk of lung cancer decreases by 30 to 50 percent as compared to the risk among smokers (CDC December 1990).

Smoking rates have been declining for both women and men, although they have been diminishing at a faster rate for women since 1985. Currently about 23 percent of women smoke, compared to 28 percent of men. Smoking rates are about the same for white and black adult women, but they are higher for Native American and Puerto Rican women, at 28 and 30 percent, respectively (Lefkowitz and Underwood 1991; Amaro 1992). White teenage girls are more likely to smoke than their male counterparts, but they are less likely to become long-term smokers. As Figure 9 shows, among

Figure 9 • WOMEN SMOKERS BY AGE, 1990



Source: National Center for Health Statistics 1992.

women overall, those between the ages of 25 and 34 are the most likely to smoke.

Passive smoking—exposure to smoke from others' smoking—is another serious concern. Women are exposed to the toxic effects of smoke by being around men who smoke. Although the scientific evidence about the negative effects of passive smoke is building, general public awareness is limited.

Helping women to stop smoking requires an understanding of smoking habits and attitudes. Although younger women are more likely to smoke than older women, the latter tend to be heavier smokers and are less likely to try to quit (CDC October 1991). Poor and less educated women are not as likely as their male counterparts to be informed about the health effects of smoking (Brownson et al. 1992). Many women believe that quitting smoking will cause them to gain weight, although recent studies dispute the hypothesis that there is a connection between the two. Another problem is that women may suffer more severe withdrawal symptoms than men when attempting to quit (Waldron 1991).

Programs need to be developed to inform women about the dangers of smoking. Tobacco ads that portray women who smoke as slim, youthful, and liberated need to be countered with the hard facts about the ill-effects of the habit. Educational programs should focus both on preventing girls and women from starting to smoke and on encouraging smokers to quit. Methods to help smokers stop often include a combination of behavioral and physician counseling, and, more recently, pharmaceutical interventions such as the nicotine patch. These methods are often not fully covered by insurance.

Cancer Screening

Pap Smear. The spread of cervical cancer can be prevented, and the cancer cured, if it is detected during its relatively long preinvasive stage. It can be detected early by the Papanicolaou (Pap) smear. Having a regular Pap smear is considered the most important measure a woman can take to guard against invasive cervical cancer. In 1990, 50 percent of women had received a Pap test in the year past, though rates varied by demographic characteristics (see Table 5 and Figure 10). The women least likely to get regular Pap smears are poor, elderly, and uninsured women (Makuc, Freid, and Kleinman 1989; Haywood et al. 1988; Piani and Schoenborn 1993).

The U.S. Preventive Services Task Force (USPSTF) recommends that all sexually active women be screened every one to three years at their physicians' discretion, based on risk factors. Women at higher risk benefit significantly from having a Pap smear every year. On the other hand, Pap smear screening may be discontinued at age 65 if the patient has a history of

Table 5 • WO
THE PAST YE

Characteristics

Total, age 18 an

Family income
Less than $10
$10,000–$19,
$20,000–$34,
$35,000–$49,
$50,000 or m

Age
18–29
30–44
45–64
65 and over

Race
White
Black

Hispanic origin
Hispanic
Non-Hispanic

Education
Less than 12 ye
12 years
More than 12 y

[1]Data for mammog
Health Statistics.
Source: Piani and S

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Table 5 • WOMEN WHO HAD SELECTED PREVENTIVE SERVICES IN THE PAST YEAR BY SELECTED CHARACTERISTICS,[1] 1990

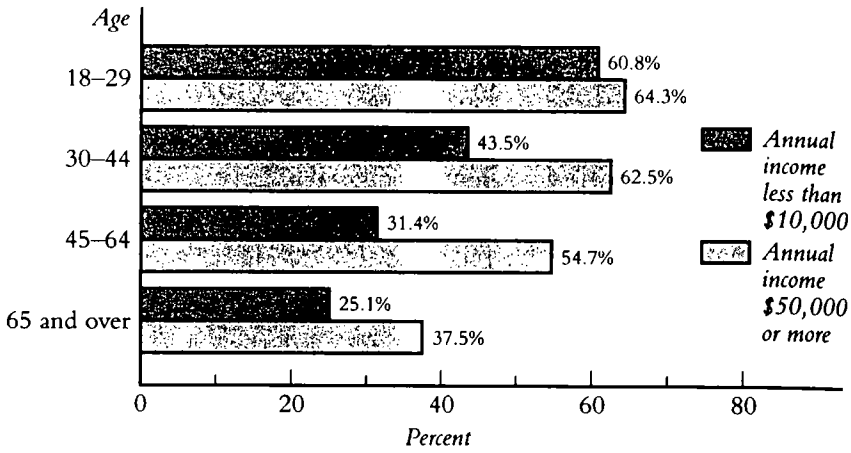
	Percentage Who Had		
Characteristics	*Pap Smear*	*Clinical Breast Exam*	*Blood Pressure Check*
Total, age 18 and over	50.1	53.1	90.8
Family income			
Less than $10,000	41.0	45.5	89.5
$10,000–$19,999	44.0	47.0	89.2
$20,000–$34,999	50.1	53.0	90.4
$35,000–$49,999	55.2	58.3	91.0
$50,000 or more	58.9	61.4	92.6
Age			
18–29	63.9	62.2	92.1
30–44	55.2	55.6	89.9
45–64	43.6	49.1	90.0
65 and over	30.4	42.0	91.7
Race			
White	49.7	53.1	90.6
Black	54.3	55.3	92.6
Hispanic origin			
Hispanic	49.1	50.4	88.3
Non-Hispanic	50.1	53.4	90.9
Education			
Less than 12 years	37.9	43.0	88.9
12 years	49.6	52.2	89.9
More than 12 years	57.2	59.7	92.7

[1]Data for mammograms in the past year are not available from the National Center for Health Statistics.

Source: Piani and Schoenborn 1993.

normal tests (USPSTF 1989). The American College of Obstetricians and Gynecologists and the American Cancer Society have made similar recommendations. Pap testing is highly effective, its importance is widely accepted by physicians, it can be done conveniently as part of a regular exam, and its cost is relatively low.

Figure 10 • WOMEN WHO HAD A PAP SMEAR IN THE PAST YEAR BY AGE AND INCOME, 1990

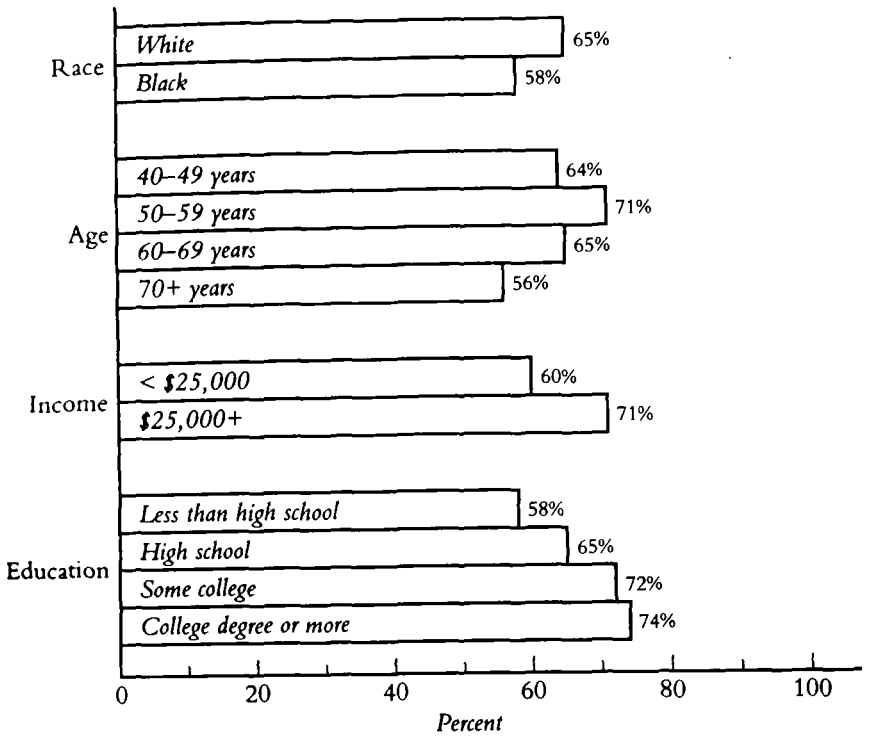


Source: Piani and Schoenborn 1993.

Mammography. Mammography, along with the clinical breast exam, significantly improves survival from breast cancer by detecting tumors at an early stage. For women age 50 and over, the value of mammography is uncontested; but its effectiveness with respect to younger women, particularly those between the ages of 40 and 49, is less certain. Guidelines current in 1993 call for mammograms every year for women age 50 and over, and every other year for women age 40 to 49, depending upon risk factors (ACS 1992). However, the guidelines for women under 50 are being challenged by recent studies that do not show a benefit from mammography in this age group (Miller et al. 1992). These findings may result in revised screening guidelines in the near future.

In 1990, 58 percent of women age 40 and older reported having had a mammogram in the past two years (CDC 1992b), and 64 percent reported having had a mammogram at some time during their adult lives (CDC September 1990). The number of women who had mammograms nearly doubled over a five-year period. Nevertheless, over one-third of women (36 percent) had never received this important, effective screening. Moreover, although in 1990 twice as many women reported ever having had a mammogram than in 1987, only 31 percent of women were following the recommended schedule of screening. In addition, as shown in Figure 11, demographic differences in mammography use persist. Women who were black, over age 70, or of low-income and educational levels were less likely to receive mammograms in 1990.

Figure 11 • WOMEN REPORTING EVER HAVING HAD A MAMMOGRAM BY SELECTED CHARACTERISTICS, 1990



Source: Centers for Disease Control September 14, 1990.

Women report that physicians' advice, cost of mammography, and knowledge of the importance of the screening are leading influences for obtaining regular mammograms. Women are also more likely to have mammograms if they believe that they are at risk for the disease. Some targeted programs have increased the use of mammography by developing coordination between family practitioners, gynecologists, and radiologists—and by making screening available at women's places of employment. Questions that still need to be resolved include the effectiveness of mammography for women under age 50, and whether screening guidelines should be adjusted for black women (who appear to get breast cancer at younger ages than white women). Better data collection to monitor who is getting screened and who remains at risk is also needed.

Hormone Replacement Therapy

Hormone replacement therapy (HRT) is the use of estrogen or an estrogen/progesterone combination to alleviate symptoms of menopause and to prevent conditions that accelerate after menopause. The strongest preventive effect of hormone replacement therapy is to slow the rate of osteoporosis. There is also good evidence that HRT protects against heart disease (Stampfer and Colditz 1991).

There are, however, risks associated with hormone use. Taking estrogen without progesterone increases the risk of endometrial (uterine) cancer, and long-term (15 to 20 years) combination therapy may increase the risk of breast cancer (Kelsey 1992). When counseling women about hormone therapy, therefore, physicians must assess individual factors and explain the benefits and risks to patients, recognizing that there is a greater lifetime risk of osteoporosis or heart disease than of cancer (Pettiti 1992).

There are currently no national data on the use of hormone replacement therapy or on the extent to which physicians counsel patients and recommend it. The role of HRT as a preventive measure is being critically reviewed by the U.S. Preventive Services Task Force, and clinical trials are under way to expand and clarify knowledge about the risks and benefits of therapy.

Prevention of Heart Disease

The potential is great for preventing deaths from heart disease among women as well as men. Programs that encourage people to eat low fat diets, to exercise, and to stop smoking have already contributed to a decline in deaths from heart disease among all groups. Given the increased risk of heart attacks in postmenopausal women, further research is needed on the role of menopause and estrogen. As noted above, one area currently being explored is the role of hormone therapy in preventing heart disease. A low dose of aspirin as a preventive measure against heart attacks has been studied in men but, although observational studies suggest that aspirin may have a similar effect in females, clinical trials are required to establish the appropriateness of this treatment for women (Manson 1991).

Hypertension (high blood pressure) adds significantly to the risk of stroke and coronary heart disease in people of both sexes after age 55 (NCHS 1992). Through regular blood pressure measurement, hypertension can be detected early and treated so that the risks of heart disease and stroke are reduced. The U.S. Preventive Services Task Force recommends that blood pressure be checked every one to two years (USPSTF 1989).

In 1990, about 80 percent of women and 69 percent of men had their blood pressure measured (Piani and Schoenborn 1993). Older women and black women, who are at greatest risk of hypertension, are more likely than

younger and white women to have their blood pressure checked (Makuc, Freid, and Kleinman 1989). Since this procedure is a routine part of any contact with a physician or a nurse, it is not surprising that most women have their blood pressure measured at least once a year. And the likelihood that she will have her blood pressure checked can be expected to increase as a woman ages, since physician contact becomes more frequent with age. It is important that people who have high blood pressure maintain treatment and have regular checkups throughout the year.

Prevention of Osteoporosis

Teenagers and young women as well as older women are the targets of efforts to prevent osteoporosis, and women should be counseled on the preventive measures appropriate for their age. Adolescents and young women should be encouraged to make sure their diets include plenty of calcium, and should be informed about the importance of exercise in increasing bone density. Middle-aged women should be counseled about the value of hormone replacement therapy, diet, and weight-bearing exercise in slowing the loss of bone mass after menopause. For elderly women, the focus shifts to helping them prevent falls that can result in hip fracture. Screening for osteoporosis has received considerable attention, and several radiographic methods are available to measure bone density. However, while these may be helpful for high-risk women, some of the tests are expensive and the value of the information they provide is questionable (Cummings and Black 1986; Melton 1990).

Access to Preventive Services

There are three key factors that determine whether, and to what extent, people take advantage of preventive services:

- having a regular source of care;
- having the knowledge—or a physician with the knowledge—of the services that are available; and
- having either the personal means to pay for the services or insurance that will cover the costs.

Limited insurance coverage is a major deterrent to the use of preventive services.

Private indemnity insurance, more commonly known as fee-for-service insurance, generally covers diagnostic services but not screening, counseling, or preventive services. Health maintenance organizations (HMOs)—group health care practices that provide a set of services to members for a flat

fee—typically offer preventive care at minimal or no cost. Medicaid coverage for breast and cervical cancer screening differs from state to state, with wide variations in reimbursement rates and eligibility criteria (American College of Obstetricians and Gynecologists 1991). Medicare has recently been expanded to cover Pap smears and mammography to a limited extent; however, Pap smears are covered only once every three years and mammography is covered only once every two years (U.S. Congress, House Committee on Ways and Means 1992). Standardizing preventive service coverage among all types of health insurance plans, based upon individual age and risk factors, would increase the chance of all women receiving needed services.

IMPROVING ACCESS TO CARE

Women typically differ from men both in their use of health care services and in the financial and structural barriers to services they confront.

Utilization of Health Care Services

As women grow older, concerns related to reproductive health, sexually transmitted diseases, and depression are likely to be gradually replaced by concerns about the risks of cardiovascular disease, cancer, and diabetes that increase with age, especially after menopause. To some extent, women's health needs at various points in their lives are reflected in national statistics on health care utilization. Other needs, such as counseling on AIDS or domestic violence, are not so readily quantified. A look at how much contact women have with the health care system throughout their lifetimes, however, validates concerns about whether the system is really meeting women's needs.

Women use more health services than men at all ages. In 1987, for example, 76 percent of women—compared to 59 percent of men—reported having visited a physician at least once in the preceding 12 months (see Table 6). The contrast is greatest during the ages corresponding to a woman's reproductive years: almost three-quarters of women age 25 to 44, compared to only one-half of men in that age group, reported at least one visit to a physician in the year past.

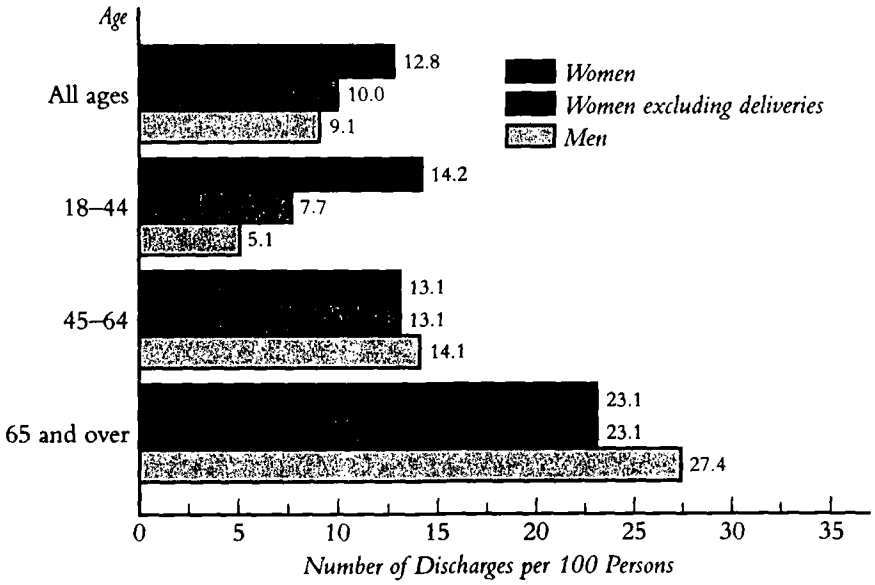
In addition, women were more likely than men (83 percent as opposed to 73 percent) to report having a regular source of care. Much of the difference between women and men in the use of health care services is undoubtedly related to women's needs for gynecological and obstetrical

Table 6 • PHYSICIAN VISITS AND USUAL SOURCE OF CARE BY SEX AND AGE, 1987

	Percentage Reporting			
	At Least One Physician Visit in Past Year		*Having Usual Source of Care*	
	Women	*Men*	*Women*	*Men*
Total, age 18 and over	76	59	83	73
Age				
18–24	68	45	76	64
25–44	74	53	79	67
45–64	77	67	85	82
65 and over	86	80	91	89

Source: Estimates are based on the Agency for Health Care Policy and Research 1987 National Medical Expenditures Survey.

Figure 12 • HOSPITAL DISCHARGE RATES BY SEX AND AGE, 1990[1]



[1]Number of short-stay discharges per 100 persons in the population.
Source: Adams and Benson 1991.

care. In 1990, for example, a much higher proportion of reproductive-age women than of men in the same age group had hospital stays, but as Figure 12 illustrates, the difference narrowed considerably when hospital stays for childbirth were excluded.

This pattern is consistent with medical recommendations that women of reproductive age receive regular gynecological exams and early prenatal care. The need to seek care for pregnancy and gynecological disorders, and for most forms of birth control, also brings women into regular contact with the health care system. Visits to obstetricians/gynecologists account for nearly one-third of all office visits to specialists by women age 18 to 44 (Adams and Benson 1991). Women are more likely than men to have diagnostic procedures performed during visits to physicians, and for women, one-third of these procedures are related to reproductive health (DeLozier and Gagnon 1991).

Among older women, the patterns of health service use are somewhat different, reflecting the ebbing of the reproductive functions and the onset of chronic diseases. By age 45, women are typically already beginning to pay more visits to internists and fewer visits to gynecologists (DeLozier and Gagnon 1991). While older women visit physicians and report a regular source of care more often than men, the gap narrows with age. Among elderly women and men, contact with the health care system is almost comparable.

Hospitalization rates are lower for women after age 45 than for their male counterparts. This may reflect the fact that males are at greater risk of developing acute conditions that require hospital care, while for females the greater risk is of developing chronic conditions that can be managed on an outpatient basis. Women are consistently more likely than men to use outpatient care.

Financial and Structural Barriers to Care

In some respects, the U.S. health care system is one of the finest in the world. Nevertheless, millions of Americans do not benefit from it because they lack financial resources, they lack health insurance altogether or have inadequate coverage, or the health care services they need are not available.

Low Income

The poor and near-poor populations are less likely than better-off Americans to be insured and they are less able to afford out-of-pocket expenses for health care. Poverty has repeatedly been found to be associated with poor

Table 7 • POVERTY STATUS OF WOMEN AND MEN BY AGE, RACE, AND HISPANIC ORIGIN, 1990

	Women		*Men*	
	Total Number (in millions)	*Percent Poor*	*Total Number (in millions)*	*Percent Poor*
Total, age 18 and over	95.8	13.3%	87.8	8.4%
Age				
18–24	12.6	19.5%	12.3	12.2%
25–44	41.2	12.6%	40.4	8.1%
45–64	24.4	9.9%	22.6	7.3%
65 and over	17.6	15.4%	12.6	7.6%
Race				
White	81.2	10.8%	75.5	7.0%
Black	11.4	31.0%	9.3	19.0%
Native American[1]	.5	29.1%	.5	16.6%
Asian	2.6	10.9%	2.3	8.8%
Other	.2	18.2%	.2	11.5%
Hispanic origin				
Hispanic	7.0	26.2%	6.9	18.8%
Non-Hispanic	88.8	12.3%	80.8	7.5%

[1]Includes American Indians and Alaskan Natives.
Source: Estimates are based on the Bureau of the Census March 1991 Current Population Survey.

health status and reduced access to care. The authors' analysis of the National Medical Expenditure Survey for 1987 found that one-third of all poor women who were between the ages of 18 and 64, and nearly two-thirds of those who were over age 65, reported either fair or poor health status (Agency for Health Care Policy and Research 1987).

Poverty is a particular problem for women. The authors' analysis of the Current Population Survey of March 1991 found that one-third of all women are either poor or low income compared to 26 percent of men. As seen in Table 7, women are more likely than men to live in poverty at all ages past childhood. By the time a woman is 65 years old, she is almost twice as likely as her male counterpart to be living in poverty (Bureau of the

Census 1991). For minority women, the statistics are even more devastating. Nearly one-third of all black women, 29 percent of Native American women, and 26 percent of Hispanic women live below the poverty level.

Health Insurance Coverage

For most Americans, it is health insurance coverage that provides the means to overcome financial barriers to care. People who lack insurance are far less likely than those who have it to get adequate care. Indeed, the uninsured are up to three times more likely than privately insured individuals to experience low health care utilization, inadequate care, and poor health outcomes (U.S. Congress, OTA 1992). Because the inability to pay frequently delays care, the result is too often emergency hospitalization or hospitalization for conditions that, if diagnosed and treated earlier, could be handled on an outpatient basis.

The fragmented health care system in this country makes any discussion of insurance coverage complex. The majority of Americans are covered by either private or public insurance (including Medicaid and Medicare); however, more than 35 million people—14 percent of Americans—are entirely uninsured, with no coverage of any kind at any time during the year (Bureau of the Census 1992). Another 60 million people are underinsured—that is, their insurance is inadequate; or they risk losing coverage if they become ill; or their policies require them to pay very high out-of-pocket expenses before the insurance coverage begins.

The most significant contrast with respect to insurance coverage is between the elderly (age 65 and over) and the non-elderly. Almost all elderly people (99 percent) are insured, most of them under the Medicare program. As Table 8 shows, among men and women under age 65, equivalent proportions (75 percent) were covered by private insurance in 1990. However, a larger proportion of women than of men (eight percent versus three percent) had coverage under Medicaid. As a result, women were somewhat less likely than men to lack insurance altogether (15 percent compared to 19 percent). Nevertheless, because of the system's patchwork structure, gaps, and inconsistencies, it often fails to meet women's health care needs.

Private Insurance. The majority of Americans have financial access to health care through private health insurance. For most people, coverage is linked to their own full-time employment or that of a family member, with employers providing group health insurance as a benefit to workers and their dependents. In general, large firms are more likely than small firms to have health insurance plans for their employees, and firms in the manufac-

Table 8 • HEALTH INSURANCE COVERAGE STATUS OF WOMEN AND MEN AGE 18 TO 64 BY AGE AND INCOME, 1990

	Total Number (in millions)	*Total Percent*	*Percent Distribution*			
			Private	*Medi-caid*	*Other Public*[1]	*None*
WOMEN						
Total, age 18–64	78.3	100	75	8	2	15
Age						
18–24	12.6	100	64	11	3	22
25–44	41.2	100	77	8	2	14
45–64	24.4	100	79	6	3	13
Income[2]						
Poor	10.1	100	23	42	3	33
Low-income	12.9	100	57	10	4	28
Middle-income	26.5	100	84	2	3	11
High-income	28.8	100	94	[3]	1	5
MEN						
Total, age 18–64	75.2	100	75	3	3	19
Age						
18–24	12.3	100	64	4	3	29
25–44	40.4	100	75	3	2	19
45–64	22.6	100	80	3	4	12
Income						
Poor	6.4	100	25	21	5	49
Low-income	11.6	100	51	6	6	37
Middle-income	26.2	100	78	1	3	17
High-income	31.0	100	91	[3]	1	7

[1]Includes Medicare, CHAMPUS, and CHAMPUS-VA.

[2]Income levels: Poor is less than 100 percent of federal poverty level; low-income is 100 to 199 percent of federal poverty level; middle-income is 200 to 399 percent of federal poverty level; high-income is 400 percent or more of federal poverty level.

[3]Indicates sample size too small to make national estimates.

Note: Details may not total to 100 percent due to rounding.

Source: Estimates are based on the Bureau of the Census March 1991 Current Population Survey.

turing industry are more likely to offer coverage than those in the service, agricultural, and retail industries.

The connection between health insurance and full-time employment has important implications for women. Because women often have caregiving responsibilities for children or elderly parents, they are more likely than men to work part time (Piacentini and Foley 1992), and consequently are less likely than men to have health insurance coverage through their own jobs.

The authors' analysis of the March 1991 Current Population Survey found that employed women who are insured through an employer-provided plan are twice as likely as men to have their coverage through a family member—usually a spouse—rather than through their own job. This is true even of women who work year round, full time: 18 percent of those who were insured under an employer-provided plan in 1991 had their coverage through a family member's job. The comparable percentage for men was 9.4 percent (Bureau of the Census 1991).

Even when they participate in the workforce, women are more likely than men to rely on dependent coverage (Older Women's League 1992). Dependence on a spouse's coverage places women at risk of becoming uninsured in the event of divorce or widowhood (Berk and Taylor 1984). When coverage through an employer or spouse is not available, women must choose either to bear the prohibitive cost of purchasing individual policies or become uninsured. Nearly one-quarter of women over age 45 buy individual health insurance, compared with 17 percent of men (Bureau of the Census 1991). In many cases, these costly health insurance policies offer only limited benefits.

Medicaid. Medicaid, the nation's public health insurance program for the poor, plays a critical role in assuring access to health care for many poor women, as well as some near-poor women, but it falls far short of providing comprehensive, uniform coverage across the country. Eligibility for Medicaid, which is jointly financed by the federal and state government, is largely determined by the states under broad federal guidelines. By federal law, Medicaid coverage is automatic for women who meet their states' eligibility criteria for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI), a public assistance program for the poor, elderly, and disabled. Federal law also now requires Medicaid to cover prenatal and neonatal care for pregnant women with incomes below 133 percent of the poverty threshold. Some states are more generous, covering pregnant women with incomes of up to 185 percent of poverty, but in general, eligibility is highly restricted.

Medicaid's emphasis is on low-income families with children, and, in

particular, on poor families that are headed by women. As a result, Medicaid provides coverage for more young adult females than for any other adult age group (see Table 8 above).

Medicaid eligibility is predicated upon passing both an income and a categorical test. Because of this, many poor women do not meet the criteria for coverage. For example, a childless woman who is poor but not pregnant, elderly, or disabled is ineligible for Medicaid. Of the 10.1 million women between the ages of 18 and 65 who were poor in 1990, one-third (33 percent) had no health insurance coverage of any kind during that year (Bureau of the Census 1991).

Although Medicaid can provide coverage for a broad array of services, persons who are publicly insured receive fewer health services than their privately insured counterparts (U.S. Congress, OTA 1992). Some states limit coverage for important preventive services. For example, Medicaid coverage for pregnant women is limited to treatment for pregnancy-related conditions, and benefits end 60 days after the woman gives birth unless she is, or becomes, eligible for cash assistance or AFDC. Moreover, women who have Medicaid coverage often have problems finding physicians who will accept Medicaid payment for services. Because reimbursement rates are low and administrative requirements burdensome, many physicians—particularly obstetricians—refuse to take Medicaid patients. Obstetricians have the lowest Medicaid participation rate of all specialists (Mitchell 1991).

Medicare. Medicare is the federally financed and administered health insurance program for the elderly and persons with permanent disability or end-stage renal (kidney) disease. Unlike Medicaid, it is not means-tested. To qualify for Medicare, persons must be either age 65 or older and eligible for Social Security or railroad retirement insurance, or have been permanently and totally disabled for two years or more.

Medicare Part A provides coverage for inpatient hospital expenses (for up to approximately 90 days) and limited coverage for skilled nursing care at home. Coverage for outpatient expenses (Medicare Part B) may be purchased for an additional premium ($36.60 per month in 1993).

Although Medicare insures the vast majority of the elderly population, there are significant gaps in the coverage it provides. Prescription drugs and long-term care services are not covered. These are critical services for elderly women, who are more likely than elderly men to have limited incomes and to require prescription drugs and long-term care because of chronic health conditions and longer life expectancy.

Most elderly people buy additional private insurance (often known as "Medigap" insurance) to supplement Medicare, primarily to pay for copay-

ments and drugs. Without this additional coverage, Medicare beneficiaries are vulnerable to high out-of-pocket costs. As shown in Table 9, 68 percent of elderly women and 73 percent of elderly men supplement Medicare with private health insurance. Because of their typically lower socioeconomic status and more limited retirement benefit coverage, elderly women are slightly more likely than elderly men to be either solely dependent on

Table 9 • HEALTH INSURANCE COVERAGE STATUS OF THE ELDERLY POPULATION BY SEX AND INCOME, 1990

			Percent Distribution			
	Total Number (in millions)	*Total Percent*	*Medicare and/or Private*[1]	*Medicare and Medicaid*	*Medicare Only*	*None*
WOMEN						
Total, age 65 and over	17.6	100	68	8	23	1
Income[2]						
Poor	2.7	100	37	27	34	2
Low-income	5.2	100	61	9	30	1
Middle-income	5.8	100	77	3	19	1
High-income	3.9	100	85	2	13	[3]
MEN						
Total, age 65 and over	12.6	100	73	5	21	1
Income						
Poor	1.0	100	28	30	38	4
Low-income	3.0	100	57	9	33	1
Middle-income	4.8	100	78	2	19	1
High-income	3.8	100	90	[3]	9	[3]

[1]Medicare and/or private includes those persons with either Medicare and private coverage or private coverage only.
[2]Income levels: Poor is less than 100 percent of federal poverty level; low-income is 100 to 199 percent of federal poverty level; middle-income is 200 to 399 percent of federal poverty level; high-income is 400 percent or more of federal poverty level.
[3]The sample size is too small to make national estimates.
Note: Details may not total to 100 percent due to rounding.
Source: Estimates are based on the Bureau of the Census March 1991 Current Population Survey.

Medicare or to have coverage under Medicaid, which serves as supplemental insurance to Medicare for the low-income elderly persons who are eligible (Piacentini and Foley 1992).

The Uninsured

In 1991 more than 35 million Americans, 14 percent of the population, had no health insurance coverage of any kind at any time during the year. About 11.8 million of the uninsured were adult women between the ages of 18 and 65, and of these, nearly one-fourth (2.8 million) were under 25. Among both women and men, it is this 18 to 24 age group that is most likely to be uninsured. Twenty-two percent of the women and 29 percent of the men in this age group lacked insurance throughout the year. The authors' analysis of the March 1991 Current Population Survey found that of poor nonelderly adult women, 33 percent were uninsured (see Table 8 above) (Bureau of the Census 1991).

Approximately 65 percent of uninsured women of working age had some work experience in 1991, and about a quarter of them were year-round, full-time workers. Poor women who worked were much more likely than poor women who did not work to be uninsured (41 percent versus 29 percent in 1991) (Bureau of the Census 1992). Minority women—especially Hispanics—are heavily overrepresented among uninsured women workers. Indeed, Hispanics of both sexes are the most likely of all Americans to be uninsured (Bureau of the Census 1991). Many more women are at risk of becoming uninsured or underinsured as a result of employer changes in insurance coverage, preexisting condition rules of insurance companies, changing jobs, or serious illnesses.

Moreover, many states have recently been forced to reduce their supplemental state-funded Medicaid coverage because of fiscal crises. For example, in 1992 the precedent was set when a state that had offered coverage to pregnant women at 185 percent of the poverty level dropped back down to the federally mandated level of 133 percent. In general, the current system leaves access to health care for women unstable.

Delivery of Services

Having health insurance does not by itself guarantee access to quality health care. In Chapter Two of this volume, Wilhelmina Leigh discusses the barriers to care that arise from cultural differences. Geographical distances can also be a barrier. The shortage of primary care providers in rural areas and inner cities is well documented. For example, a recent report found that, in

1988, there were 111 nonmetropolitan counties in the United States without a physician, and nearly 1,500 counties without an obstetrician (Summer 1991).

An issue key to improving the delivery of care, especially to women, is better coordination between providers. It is recognized throughout the health care field that a renewed emphasis on comprehensive care, including preventive services, is needed. Coordination of care is a particular problem for women because for them even routine care typically involves both a gynecologist and an internist. This type of fragmentation increases the chances that women will not receive needed services or that other services will be unnecessarily repeated (Clancy and Massion 1992). Most likely to be left out are services like counseling on violence or depression that are outside the strict clinical realm of gynecologists and internists.

National Health Care Reform

The current national health care reform debate has focused on controlling skyrocketing costs and increasing access to care for the millions of Americans who are uninsured and underinsured. The issue of universal coverage primarily applies to those under age 65, since Medicare covers nearly all elderly persons. The reform debate has focused on three approaches: the single-payer plan; the so-called "play or pay" plan that requires employers to provide coverage; and managed competition. These options are summarized below, along with their possible implications for women.

The Single-Payer Plan

The single-payer approach would provide universal health insurance coverage and replace the current patchwork of multiple public and private insurers with a system in which all health services would be financed through federal government tax revenues. The Canadian health care system is an example of this approach. Under the plan, individuals could go to any provider they chose, with all bills sent to a central "insurer" for payment. Costs would be contained by setting an annual national health care budget. (In Canada, it is up to each province to stay within its allocated budget.) The single-payer plan would standardize benefits for the entire population, and stress primary and preventive care.

Proponents of the single-payer approach believe it is the best way to assure universal coverage, to control costs, and to reduce administrative burdens. Opponents fear that it would lead to rationing of care and discourage continued advances in medical technology. For women, however, a

single-payer system could eliminate many of the current barriers to adequate care, since insurance would not be linked to employment or welfare status.

The Employer-Mandate Approach

Widely known as "play or pay," this plan would build on the existing system under which a majority of Americans are covered by health insurance provided through employers. The difference would be that the government would require all employers to participate. Proposals under consideration generally would require all employers to either provide insurance for their employees and, in some cases, their dependents, or pay a tax to a public health insurance fund. The taxes paid would help finance a public plan to cover uninsured workers and those not connected to the workforce, thus achieving universal coverage. Proposals based on this approach have featured basic benefits packages. Some include specific preventive health care services; others neglect preventive services for adults—such services as, for example, mammography and Pap smears.

Managed Competition

Managed competition is an approach to controlling health care spending that is based on the creation of a consumer-driven health care market. Under managed competition, consumers would be given a choice of competing health plans and would be provided with incentives to select the most cost-effective one. A quasi-public intermediary organization would be created to help consumers compare the costs and quality of different health plans. This intermediary would select and offer several different health benefit plans to consumers. Under some proposals, a federal health board would establish standards and certify the health plans selected by the intermediary. All insurance companies would be required to offer a basic benefits package.

Developers of managed competition believe that given sufficient information and incentives, health care consumers would select cost-effective plans. Insurance plans would have to respond to consumer demands for quality and value in order to survive. The plans most likely to be competitive are managed care arrangements such as health maintenance organizations or similar programs. The basic administration of managed competition would be through the quasi-public intermediaries, which would collect information on health plans, distribute information to consumers in their regions, and facilitate the enrollment of beneficiaries.

Concerns with managed competition include the ability to restructure the present health care system, feasibility in areas of the country in which

there are too few people or providers to support competition among several plans, and the ability to adequately adjust capitated payments based on risk (Merlis 1993). Risk adjustment (the modification of payment based on the probability of use of health care services) is an important issue because there are also concerns that the poor and low-income would be viewed by managed care plans as "too sick," more likely to use health care services, and therefore too costly. As a result, negative incentives may be created that continue to limit access to care for the poor.

It will be hard to assess how well a managed competition proposal would meet the needs of women and others with special needs until the composition of the basic benefits package is determined. Also critical would be the proposal's ability to monitor and regulate plans and to risk-adjust payment rates to eliminate any negative incentives for underservice. In addition, it would be of great importance, particularly for women who have long-standing ties to physicians and other providers, to be assured that provider choice and continuity would be maintained.

CONCLUSION

In the past, concern about women's health problems as distinct from men's has focused largely on reproductive health. However, it is now understood that there are many other health conditions that, even if not unique to females, are much more likely to affect women than men, or are likely to affect them in quite different ways.

It is now known, for example, that young adult women are much more likely than men to suffer from emotional disorders, autoimmune conditions, and long-term consequences from sexually transmitted infections. As they grow older, women's health concerns change. Chronic conditions that increase with age and hormonal changes after menopause leave women at risk for disability.

The good news is that there are effective preventive services that can have a significant impact on women's health. Unfortunately, not all women who would benefit from these services receive them. The barriers that limit access to preventive services include cost, lack of knowledge about the services, and inconveniently located health care providers.

Limits on access to care, of course, mean more than limits on access to preventive services. Affording care is a major problem for the millions of women who are uninsured, or at risk of losing their insurance in the event of a job change or serious illness. Women with Medicaid coverage may find

themselves at risk of receiving reduced benefits when states are faced with difficult budget decisions. A majority of the public, health care providers, and legislators now agree on the overwhelming need for national health care reform to provide everyone with access to quality services and to reduce the astronomical cost of health care in America.

If it is to address the particular needs of women adequately, health care reform will

- provide universal access to care;
- eliminate the problems associated with employment-based insurance and Medicaid;
- cover prescription drugs and long-term care services for the elderly;
- include preventive services (counseling as well as procedures);
- ensure that quality health care is available to women in convenient settings;
- include initiatives to increase the supply of primary care physicians;
- develop a more even distribution of health care providers and hospitals; and
- address cultural barriers to care at the community level.

And finally, a more personal level of reform will be required to empower women with knowledge of their health status and risks, and to train physicians to use greater sensitivity in communicating with women on such topics as sexual behaviors and violence.

There are several factors that emerge as influences on the health status of American women. Those factors that reflect gaps in knowledge about how to prevent and treat illnesses in women and in access to quality health care must be addressed in order to improve the health outcomes and quality of life for women. Further research and a reformed health care system can close these gaps, if the concerns and needs of women are considered.

Chapter Seven

RACE, POVERTY, AND WOMEN'S AGING

Julianne Malveaux

The woman is almost sixty and it shows. She wears the starched white uniform of a nurse or home health aide, and carries herself with the stiff dignity of someone used to working hard for a living. Her cracked knuckles and rough skin suggest that she is not afraid of using elbow grease or of getting down on her knees and scrubbing floors to survive. Her cushioned white shoes suggest that many of her years have been spent standing on her feet. Today, she accompanies a wheelchair-bound woman down a city street, a woman not 15 years older than herself. Women like this pair are often separated by race. They are tenuously connected by their age (one is "old-old," the other "young-old"), bound by their gender, separated by their economic status, connected by their predicament of being old and alone, and separated by the way they survive this predicament.

It takes little to establish that the woman navigating the wheelchair has always worked in low-wage jobs like this one, as a home health worker, cleaning service worker, private household worker, or nurse's aide, earning an hourly wage that puts her at the bottom of the pay distribution. At the same time, it is obvious that her charge is protected by her economic past. Perhaps her spouse died recently, leaving her a pension. Perhaps she was a single career woman who put 40 years into the labor market and left having built up a pension history for herself. Even though she is being cared for, though, her position is far from secure. If the insurance company that invested her pension funds chose junk bonds, her ability to afford the help she gets may be jeopardized. If her certificates of deposit exceed $100,000 and they are held by a bank that faltered, her income is also at risk. For that matter, if her disability persists or worsens so that she requires full-time care, even a generous pension income will not be adequate. She will then be forced to "spend down" her savings to qualify for public assistance with which to pay nursing home fees.

In what year are we observing these women? It could be 1950, when more than half of all black women worked as private household work-

ers, when the typical black woman could be found in some caretaking role. It could also be 1990, when, despite changed occupational status, black and brown women were far more likely to be home health aides and other service workers. Will racial differences in economic status persist until 2030? Will the woman in the wheelchair still be white, her caregiver a woman of color? Will both continue to face an uncertain economic future? The answers depend on policy decisions we make today.

We avert our eyes from the women on the sidewalk because we hope that their fate is one we will be spared—working into old age with no pension to come, or being in faltering health, dependent on a stranger, worrying that the money will run out and poverty will follow. Although most older women have not met this fate—more than two-thirds have incomes of at least 150 percent of poverty level—the possibility of poverty is ever-present for many women who have not contemplated it before.

The economic status of older women is a map or mirror of their past lives, reflecting their education, employment history, and marital status. The economic problems that older women face are extensions of the problems and choices they faced earlier in their lives. Those who were underemployed as adults have this status reflected by continued underemployment and low retirement incomes in their older years. Those who spent years out of the work force providing family care may be devastated by the loss of pension income when a spouse dies. Half of all women aged 65 and over who live alone have incomes below 150 percent of the poverty line ($6,268 a year for an elderly person living alone in 1990), compared with 39 percent of similarly situated men. Of these poor and near-poor older women, more than one in four (27 percent) are African-American or Latina.

Because economic status reflects past experiences, it is difficult to address elder poverty through social policy targeted strictly to the elderly. Poverty is reflective of low pay and occupational segregation during women's working lives, as well as the key assumption society makes about the focus of women's lives—that they will bear responsibility for caregiving in families, whether they are mothers, daughters, sisters, nieces, or wives, without social support for child care or eldercare.

Is this situation likely to change in the future? Today's young and middle-aged women have an advantage that older women do not. They have higher education levels and time before old age to improve their economic histories and, thus, the likelihood that their later years will offer more economic options. Some will not have children, and so will take less time from the paid labor force for caregiving. Others

will work at firms whose parental leave policies will not force them to choose between work and family. Does this differ for women of color? In general, the labor market profile of women of color has changed along with that of white women. As is the case with white women, an increasing number of African-American women and Latinas are likely to have continuous work histories. But because many minority women still lack opportunities for higher education and fewer will work in high-paying professions and management (Sokoloff 1992), fewer women of color than white women will escape poverty.

If changes in workplace demographics are not accompanied by changes in labor market and family policy, younger women's greater work-force attachment may not be enough to protect them from the plight of today's older women. In some cases, structural changes in the labor market may put some women of color at increasing risk of poverty. In particular, the economic status of African-American men, and their lower rates of labor-force participation (than those of white men) suggest differences in family economics between this group and others.

Even the best prepared older women, regardless of race, are often unable to protect themselves from poverty. The high cost of nursing homes, or of continuous home health care, and the requirement of depleting assets before public (Medicaid) assistance is available for long-term care, mean that women whose spouses have had lengthy illnesses face widowhood with few financial resources. Other widows may not inherit their spouse's pensions. Still others have annuities jeopardized by the uncertain financial status (if not outright failure) of some life insurance companies. Despite the best intentions and preparations, for many older women poverty is an accident waiting to happen, a function of the death or disability of a spouse or adult child, or of life's other uncertainties.

Furthermore, the current fiscal and regulatory climate provides older people with less, not more, government protection, and as governments grapple with issues of limited resources, this is likely to get worse. Because the elderly are not the only ones facing economic uncertainty, legislators have begun to question how much health and social insurance should be provided exclusively for older people. But social spending has clearly made a difference in the economic status of this group. Eighty-six percent of those seniors who would be poor without federal programs are lifted out of poverty by government tax and transfer programs (Taylor 1991).

In 1990, there were some 2.7 million women aged 65 and over who lived in poverty. Some of them accompanied wheelchairs; others rode in them because government subsidies provided them with home

health care. A disproportionate number of them were women of color. This chapter discusses the economic status and poverty levels of minority women in the present and future.

Issues of race and gender equity have dominated political discourse in the latter part of this century and have been pivotal in the life experience of the baby-boom generation. These issues will continue to play themselves out as our population ages and as the members of the baby boom enter retirement in the first decades of the next century. Although women of color have experienced some labor market progress in the past two decades that is likely to pay off in the future, this progress must be balanced by the current, stagnant economy and the social indifference to racial economic gaps. It is entirely possible that the debates about equity and distribution that shaped the adolescence and adulthood of baby-boom women will also affect them in old age.

POVERTY, INCOME, AND THE FAMILY STATUS OF OLDER WOMEN

The elderly poor are not a large group today—in 1990 at about 3.7 million, they were 12 percent of the total elderly population. But poverty is not evenly distributed among the elderly. It hits women harder than men, and people of color harder than whites. In 1990 women were 58 percent of the population aged 65 and over, but almost 74 percent of the poor population for that age group (see table 7.1).

Table 7.1 ELDERLY (AGED 65 AND OVER) POPULATION AND PERCENTAGE IN POVERTY IN THE UNITED STATES, 1990

	Elderly		Poor Elderly	
	# (thousands)	Percentage of Total Elderly	# (thousands)	Percentage of Poor Elderly
Total	30,093	—	3,658	
Men	12,547	41.69	959	26.22
Women	17,546	58.31	2,699	73.78
White men	11,235	37.33	634	17.33
White women	15,663	52.05	2,073	56.67
Black men	1,031	3.43	286	7.82
Black women	1,516	5.04	574	15.69
Hispanic men	461	1.53	86	2.35
Hispanic women	631	2.10	159	4.35

Source: U.S. Bureau of the Census (1991a).

Among older women, poverty is disproportionately concentrated among women who live alone and women of color. In 1990, black women constituted 8.6 percent of women aged 65 and over, but 21 percent of the female poor in that age group. (In contrast, white women made up 89 percent of all elderly women, and 77 percent of the female elderly poor; Hispanic women[1] constituted about 4 percent of the elderly female population and about 6 percent of poor elderly women) (U.S. Bureau of the Census 1991a.)

Although the majority of older women are not poor, the average older woman is within poverty's reach. In 1990, there were more than 17.5 million women aged 65 and over. These women had a median annual income of $8,044, an amount that was a scant 28 percent above the poverty line of $6,268 for an individual aged 65 and over living alone in that year (U.S. Bureau of Census 1991b). Women of color had lower median incomes than white women—elderly black women had a median annual income of $5,617, which was 66.4 percent of white women's income; Hispanic women had a median annual income of $5,373, or 63.5 percent of white women's income. These income gaps are consistent with income gaps that women of color experience during their working lives, as well as with differences in the labor market status of minority men that affect the pensions women of color receive as widows and survivors.

More than 15 percent of all older women (aged 65 and over), or 2.7 million women, had incomes below the 1990 poverty line (table 7.1). In general, older women have a lower incidence of poverty than do young women (aged 18–24) and girls (under age 18), but a higher incidence of poverty than women of other ages (table 7.2). Poverty

Table 7.2 POVERTY RATES FOR WOMEN IN THE UNITED STATES, BY AGE, RACE, AND HISPANIC ORIGIN 1989

Age	Total (%)	Black (%)	Hispanic (%)	White (%)
Total	14.4	34.0	28.3	11.3
Under 18	19.8	44.8	35.6	14.7
18–24	18.2	34.5	29.1	15.2
25–34	13.9	31.5	26.0	11.0
35–44	9.6	22.8	23.0	7.6
45–54	8.9	19.0	20.9	7.4
55–59	11.4	33.3	18.9	8.8
60–64	10.5	29.2	21.6	8.4
65 and over	13.9	36.5	22.4	11.8
65–74	10.6	32.7	19.1	8.3
75 and over	18.5	42.0	29.2	16.4

Source: U.S. Bureau of the Census (1991b).

rates rise sharply after age 75: the incidence of poverty among women aged 75 and over is 75 percent higher than that for women aged 65 to 74. The rise is sharpest among white women, but rates in this oldest group are about 10 percentage points higher for both black and Hispanic women, as well. This sharp increase in poverty among the oldest, most vulnerable women reflects, perhaps, the dwindling resources on which many women rely as they age.

How is this likely to change in the future? The occupational profile of African-American and Hispanic women has improved, and more work in jobs that qualify for pensions. Based on current data, it is likely that poverty will continue to be unequally distributed among older women by race; still some women of color, especially those with continuous work histories, will escape poverty.

The Prevalence of Near Poverty

Poverty data understate the economic predicament of many older women. Although older women's poverty incidence in 1990 was 15.4 percent, nearly a third of all women had incomes within 150 percent of the poverty line (see table 7.3). This was the condition for the majority (57.7 percent) of black older women, for nearly half (47.1 percent) of all elderly Latinas, and nearly 3 in 10 (29 percent) white older women. In contrast, just over half (55.2 percent) of all women could be considered "out of the woods" economically, with incomes higher than twice the poverty line. Fewer than a third of all black women could be so described. Indeed, 6 percent of all older black women had incomes only half as high as the poverty line or less.

In contrast, few women conform to the image of the wealthy elderly. Fewer than 1 in 12 women aged 65 and older had incomes of $25,000 or more in 1990. Fewer than 2 percent of black and Hispanic women had incomes at that level (U.S. Bureau of the Census, 1991b). To be

Table 7.3 POVERTY AND NEAR POVERTY FOR OLDER WOMEN (AGED 65 AND OVER) IN THE UNITED STATES, BY RACE AND HISPANIC ORIGIN, 1990

Income[a]	Total (%)	Black (%)	Hispanic (%)	White (%)
Half poverty line	**2.4**	**6.0**	**2.4**	**2.0**
At the poverty line	**15.4**	**37.9**	**25.3**	**13.2**
125 percent of poverty	23.4	49.6	38.2	20.9
150 percent of poverty	31.5	57.7	47.1	29.0
175 percent of poverty	38.7	64.2	54.5	36.3
Twice the poverty line	44.8	68.4	61.7	42.6

Source: U.S. Bureau of the Census (1991a).

a. Each entry represents those who earn that income level or less.

sure, some 1.4 million women did have incomes in that range, but depending on their marital status, health, and age, these income levels may not be secure. Far more older women live in poverty (2.7 million), at poverty's periphery as "near poor" (2.8 million), and at risk because their incomes are between 150 percent and 200 percent of the poverty line (2.3 million). Nearly half of all older women fit into one of these three categories.

Annual poverty data are most commonly released by the U.S. Department of Commerce, and provide information for blacks, whites, and Hispanics. Data on Asian poverty are only released with decennial census data. Although Asians have often been portrayed as the "model minority," with median income higher than that of whites, experts indicate that there is a significant incidence of poverty among Asians. In particular, poverty among Vietnamese-Americans is estimated at 36 percent, and at 25 percent among Filipino-Americans (Bergman 1991). Many Asian working-class men have little education, are concentrated in agricultural employment, and have life expectancies similar to those of black men. As a result, their widows are at higher risk for poverty. These women, many of whom are not facile with English, sometimes face discrimination in applying for federal income supplements like Supplemental Security Income (SSI) (see the section following for further discussion of this income source). Only a portion of those eligible receive this assistance, partly because they have difficulty dealing with the bureaucracy (Bergman 1991). Some of this is likely to change in the future. The assimilation of immigrant populations makes it easier for them to deal with the bureaucracy, as does the rise of advocacy groups (like San Francisco's Chinese-American group, Self Help for the Elderly) that target their efforts to minority elders.

The Significance of Family Status

When poverty incidence is viewed by family status and living arrangement, the highest concentration of poverty is among older women living alone (i.e., those widowed, separated, divorced, or never married who are not living with other family members). Nearly 1 in 4 elderly women living alone is poor, compared with 1 in 8 older women heading households, and 1 in 20 older women living in married-couple families (right-hand column of table 7.4). When the composition of poverty by living arrangement is examined, one finds that those living alone represent the vast majority—nearly three quarters—of older poor women (middle column of table 7.4).

Table 7.4 POVERTY AMONG WOMEN AGED 65 AND OVER IN THE UNITED STATES BY SELECTED FAMILY/LIVING STATUS, 1989

Race/Ethnicity Family/Living Status	Poor Women Aged 65 and over		Poor Women as Percentage of all Women Aged 65 and Over in Family/Living Status Category
	Number (thousands)	Percent Distribution	
All Races			
In all family/living status categories[a]	2,398	100.0	13.9
In married couples	367	15.3	5.4
Household heads	180	7.5	12.2
Living alone	1,698	70.8	23.2
Black			
In all family/living status categories[a]	541	100.0	36.5
In married couples	56	10.4	15.0
Household heads	93	17.2	30.9
Living alone	350	64.7	60.6
Latina			
In all family/living status categories[a]	124	100.0	22.3
In married couples	29	23.4	13.8
Household heads	16	12.9	17.6
Living alone	62	50.0	41.9

Source: U.S. Bureau of the Census (1991b).

a. Includes women living in household relationships other than those listed separately below.

The pattern of high concentration of poverty among women living alone cuts across racial lines, though it is less strong among elderly black and Hispanic women than among all elderly women. The slogan often used by women organizers, "a woman is only a husband away from poverty," is less true for women of color than for white women. Fifteen percent of older black women in married-couple families are poor; 31 percent of all older black women who head households live in poverty (right-hand column of table 7.4). But consistent with the overall pattern, the majority of black poor women, 64.7 percent, live alone (middle column of table 7.4).

Hispanics have different family patterns than the other groups studied here. Hispanic poor women aged 65 and over are more likely than their black or white counterparts to live in families, especially married-couple families (table 7.4). Even so, the overall pattern of single women's poverty prevails among Hispanics, too. The incidence of poverty among Hispanic women living alone is much higher than among those who live in families (right-hand column of table 7.4). And women living alone are the largest group of the elderly Hispanic poor (left-hand column of table 7.4).

The information in table 7.4 suggests that policy directed toward relieving poverty among older women must focus on women who live alone. This may be as true in the future as in the present, especially for women of color. Demographers project that the proportion of married women aged 65 and older will rise only slightly, from 31 percent to 33 percent, between 1990 and 2030 (Zedlewski et al. 1990), and current life expectancies for black and Hispanic men are lower than those of white men. Further, the projected rise in the proportion of never-married women (from 4.5 percent in 1990 to 8.2 percent in 2030) is likely to be greater among women of color. If current data, which show an increase in the number of black never-married women under age 35, hold, there will be more, not fewer, black women living alone in the future. In chapter 2 of this volume, Taeuber and Allen estimate that there will be 4.4 million black women aged 65 and over by 2030. If present trends hold, 1.7 million of them would be poor and another .9 million would have incomes between 100 percent and 150 percent of the poverty level.

SOURCES OF INCOME AND POLICY

The race/gender income gap (which compares the earnings of black, Latina, and white women to those of white men) is more pronounced

for women over age 45 than for their younger counterparts. If current income is a proxy for future economic well-being, extrapolating this information might suggest that the disproportionate incidence of minority women in poverty would decline in 20 years.

But the data still do not suggest future parity between men and women. Further, although black and Latina baby boomers (i.e., the 35–44-year-old cohort) earn more than both older and younger minority women, there are continuing gaps between minority women and their white women counterparts at younger ages. The earnings gap is smallest between black and white women aged 35–54. Indeed, black women aged 35–44 have slightly higher earnings (about 3 percent more) than white women of their age group. Much of this difference relates to the greater work effort required of African-American women, given differences in family status (Malveaux 1990).

Current income data are likely to tell only part of the story. Another way to understand the poverty that many elderly minority women face today, and the chance of elderly women of color facing such poverty in the future, is to examine the sources of income available to them and the ways that their life circumstances may have influenced their access to these income sources. Then we can address the relationships between the sources of minority women's income and their disproportionate poverty.

Social Security

Social Security benefits are the major source of income for the elderly. More than 90 percent of all seniors, including 19.4 million women aged 62 and over, receive Social Security income (Sidel 1986). Social Security contributes about 42.5 percent of the income that individuals aged 65 and over receive, as well as 28.5 percent of the income that families with householders in that age group receive. The contrast between the jobs that the poor and nonpoor hold in their working years results in a different set of opportunities to accumulate wealth and to invest in other income-producing assets. Chapter 6 in this volume, by Rayman, Allshouse, and Allen, addresses issues of women's employment income and Social Security benefits. Poor and near-poor individuals and families are far more reliant on Social Security income than are the nonpoor, with the average elderly poor individual receiving nearly 80 percent of her or his total income from Social Security, and the average poor family receiving nearly three-quarters of total income from Social Security. For about a third of older unmarried women, Social Security provides about 90 percent of income

(Muller 1983: 23–31), and 60 percent of all older women depend on Social Security as their only source of income (Older Women's League 1991a).

There is no direct race bias in the Social Security program. Retirees' benefits are based on the number of quarters they work, earned income, and spousal income. However, differences in work patterns yield differences in Social Security benefits by race, as do differences in life expectancy and family status. These differences have an impact on the poverty status of older women of color today and will continue to do so in the future.

Some of the differences include:

- ☐ A higher incidence of female-headed households among blacks.
- ☐ A lower male life expectancy among minorities (66 years for black men, compared with white men's 73).
- ☐ Differences in pension-earning income. Women of color are still more likely to be employed "off the books" where benefits do not accrue.

In general, although there have been many reforms to the Social Security system in the past decade, women fare less well than men, and black and Hispanic women fare less well than white women. These differences both reflect lifetime differences in earnings and are a function of ignoring differences in the family responsibilities shouldered by women—differences that are likely to persist in the future.

How could the Social Security system be changed to minimize the amount of older women's poverty? One way would be to allow women credit for caregiving responsibilities. At a minimum, a woman should not be penalized for the time she spends out of the labor force doing family care. Perhaps women's earnings should be calculated on the basis of 25, not 35, years of paid work to allow for the greater number of years a woman spends out of the labor force on her family responsibilities. Indeed, the estimated value of women's unpaid work ranges from $700 billion to $1.4 trillion (Prescod 1991). Crediting that unremunerated work would certainly close the gap between men's and women's Social Security, and thus reduce the prevalence of older women's poverty. Congresswoman Barbara-Rose Collins, of Michigan, plans to develop legislation on crediting unpaid work. However, such legislation is not likely to be passed in the near future, mostly because the belief that unremunerated work should be rewarded is far from universal. Still, it represents a basis for the development of a more equitable Social Security system, and a pivot from which to look at women's poverty issues.

Whatever the flaws in the Social Security system, it is important to note the progressive income redistribution inherent in this program, and its effectiveness in moving elderly Americans out of poverty. "If Social Security benefits payments were excluded from after-tax income, the poverty rate in 1986 among the elderly would have been about 45.9% rather than 12.4%" (Hurd 1990: 581). The challenge in changing this progressive income redistribution system is to structure it to allow for differences in family type, so that all benefits are not calculated as though the norm is working husband and stay-at-home wife, a badly outmoded family stereotype that now describes just one-tenth of all American families.

Means-Tested Cash Assistance

The needy elderly qualify for the Supplemental Security Income program, a joint federal-state program that guarantees a minimum level of income to financially hard-pressed individuals who are aged 65 and over or blind or disabled. About 2 million elderly individuals and families received SSI in 1989, with slightly more individuals than families receiving the benefit. Seventy-five percent of those receiving SSI aged benefits were women (U.S. Department of Health and Human Services 1990: 33). Although about 10 percent of the elderly received SSI, only 30 percent of all poor elderly individuals and a third of all poor elderly families received this benefit. Why do so few poor seniors qualify for SSI? This low participation is not fully understood, but one factor is the assets test. Seniors must be extremely poor and own few assets to qualify for SSI. Except for the value of a home and car, some personal property, and a small life insurance policy, assets must be worth no more than $3,000 per couple. In addition, monthly income must be less than a minimum, which varies by state, although some types of income (e.g., part of earned income, food stamps, and some gifts) are not counted.

The base SSI benefit amount was $422 a month for an individual in 1992, with a larger amount available for couples. States supplemented the base amount by a variable sum, depending on other income and need—$28 in Washington State and $223 in California in 1991. Many older persons and families receive only a fraction of the SSI amount, because they have income from other sources.

The Politics of Future SSI Policy

The fact that states may supplement SSI payments by variable amounts raises questions about the future size and stability of these payments.

Although at the federal level the political strength of older Americans has made it almost impossible to cut senior programs, most states are unable to run budget deficits from year to year. Issues of competing need among age groups that are only hinted at on the federal level are the source of heated discussion at the state level, and few programs have been left intact in the recent round of state budget cuts.

The black and Hispanic aged, with a history of low-paying jobs and intermittent work histories, bear a heavier burden when SSI is cut than do others (Torres-Gil 1990). SSI programs are not a political sacred cow like Social Security, and pressure to keep Social Security intact or to minimize cuts to that program does not protect the SSI program, which clearly addresses the needier elderly. Future support for SSI programs will depend on both the politics and economics of the future. Should elderly individuals and families have an income floor? How can we pay for this, given state budget shortfalls? The answers that legislators provide to these questions will determine the fate of the SSI-dependent elderly, a disproportionate number of whom are black and brown women.

Wages and Salaries

It is tempting to think that though older women's past labor market experiences affect their present economic circumstances, current labor market problems have little impact on them. However, this is not the case. More than 1 in 6 older (aged 65 and over) Americans continue to work. Older white men are most likely to work, followed by black men, black women, and white women (data in this category were not available for Hispanics), and participation rates fall off with age (U.S. Department of Labor 1992). The poor and near poor are much less likely to work, and earnings account for a lower percentage of total income for them. There is a similar pattern for families with householders aged 65 and over (although the higher percentage receiving wage income may be a function of the number of under-65-year-olds in the household) (U.S. Bureau of the Census 1991a).

Where do older women work? Private household workers are among the most likely to stay in the labor market, reflecting both their low income and the fact that such jobs do not provide pensions (Shaw 1988). In addition, private household workers can work "off the books" and receive small amounts of SSI or Social Security income. Note that this income would not be reflected in data showing older people's income sources. It may be that poor and near-poor women

work for pay more often than is reported. Unlike many of the white men who stay in the labor market because they enjoy their work, or because their prestigious managerial and professional jobs have no mandatory retirement provisions (in constrast to most manufacturing and clerical jobs), the private household workers in the labor market are there because they need the income. According to Shaw (1988), elderly women with only Social Security or SSI income had poverty rates, in 1984, of 25 percent. But those who were either employed or had a pension in addition to Social Security had poverty rates of 5 percent.

Shaw (1988) also noted that women who work often do so without jeopardizing their Social Security benefits. Social Security recipients face an earnings test; those aged 65–69 must forfeit $1 of every $3 of their earnings above the exempt amount of $9,720 (in 1991). However, that amount is more than half the average earnings ($13,500) of a female clerical worker. In other words, a woman working half time as a secretary would not jeopardize her Social Security income. Thus, although some economists suggest that the structure of the Social Security system dampens the work incentive for those subject to a means test, especially over age 65 (Herz and Rones 1989), women's wages may be so low that the question of work incentive is irrelevant.

Pensions

In 1940, pension coverage was rare, and only 15 percent of all private wage and salary workers were covered by pension plans (Turner and Beller 1989). But private pension coverage grew rapidly in the 20 years that followed 1950, so that by 1970, 46 percent of all workers were covered by pension plans. Until very recently, these numbers have remained steady—in 1988, 46 percent of all private-sector workers were covered by pension plans, as were 83 percent of all public-sector workers (Hurd 1990).

In chapter 2 of this volume, Taeuber and Allen describe the increasing likelihood that a young minority woman will work in a job covered by a pension. However, pensions have been structured to reflect male employment patterns, and to reward continuous employment. Despite some reforms, biases against women in pension policy persist. Women have greater childcare and eldercare responsibilities, which mean that they work fewer years and less continuously than do men. And women's pay is lower than men's pay. When women switch jobs or move because of family responsibilities, it affects their access to

pensions (most pensions vest at 5 or 10 years, and the median job tenure for women is 3.7 years, compared with 5.1 years for men) (Older Women's League 1990). Further, women's concentration in part-time work, and as employees of small businesses, means that fewer women than men will, in the future, have access to pensions. Finally, as women have moved into self-employment and business ownership, often to avoid work-family conflicts, they have removed themselves from the very jobs that provide pension coverage.

Pensions in a Shifting Economy

The role of government in regulating and insuring pension funds is important, especially as workers have been encouraged not to rely fully on Social Security for their retirement income. Even though pensions are safeguarded by government regulation, the 1980s were an unstable financial period, in which the words "junk" and "bonds" were ironically used in the same sentence. For those pension funds whose viability depended on the type of investment, the 1980s were a period where some defined contribution plans yielded low, if any returns.

The case of Executive Life, in California, although extreme, illustrates the danger. Retirees bought annuities in an insurance company that went on to invest in junk bonds, speculative real estate, and other shaky investments. As a result, thousands of individuals who had purchased annuities received less than they were promised as a return (Willis 1990: 137). More significantly, large corporate pension funds that put money into annuities at Executive Life have jeopardized the incomes of their retirees. Under the provisions of the Employee Retirement Income Security Act of 1974, the U.S. Department of Labor sued the Pacific Lumber company for violating its fiduciary responsibility by buying annuities from Executive Life (Lucas 1991).

There has also been concern about the effects of mergers and acquisitions on pension payments, especially as overfunded pension plans have been described as a lure for corporate raiders (Mitchell and Mulherin 1989). The Pension Protection Act of 1987 was passed to protect pensions from the acquisition process, and although economists see this law as perhaps inhibiting the corporate acquisition process, its passage indicates legislators' concern about the viability and integrity of pension plans. On the other hand, during the 1990–91 recession, at least 18 states considered delaying or reducing their contributions to their pension funds. Further, growing numbers of state and local governments began to see funds accumulated in pension funds as possible loan sources (Stevenson 1991). Public employee

pension coverage is far more comprehensive than private employee coverage, with 83 percent of all public-sector workers having coverage (Andrews 1985). Although public-sector occupational distributions reflect the race and gender bias of private-sector occupational status, it is interesting to note that women and minorities are disproportionately represented in the public sector (Malveaux and Wallace 1987). Experts in pension accounting disagree about whether or not withdrawals and deferred contributions imperil pension funds in the long run—in most states, no short-term consequences are predicted for one-time borrowing. But public employee unions say that borrowing on a one-time basis sets a bad precedent, and it is ironic that government is protecting private-sector pension funds on the one hand and using public-sector pension funds to bridge budget gaps on the other.

Pension Coverage and Older Women's Poverty

The pension issue is important to older women, because those receiving pensions, or some income source other than Social Security, are less likely than others to live in poverty, and because the transition to widowhood seems to induce poverty for some older women, simply because of the assets lost upon the death of a spouse. Hurd (1990: 583) has stated that the average increase in poverty following widowhood is 30 percent, due to permanent changes in economic resources.

There was a slight decline in pension coverage during the 1980s, and those not covered were more likely to be women than men. With 46 percent of all full-time workers participating in employer-funded pension programs, 49 percent of men and 43 percent of women were covered. Low rates of coverage were found among those working less than five years and among those employed in very small companies (less than 10 employees), where only 11 percent of employees were covered (*Social Security Bulletin* 1990).

Will these trends continue into the future? And will there be a special impact on women of color? To the extent that women of color hold the least advantaged positions in the labor market, they will continue to have less access to pension coverage, and erosions in the pension fund structure will affect them. Women of color are disproportionately employed in the public sector, so borrowing on public pension funds has a greater impact on them. On the other hand, to the extent that women of color have employment profiles that begin to resemble those of white men, their pension coverage rates and income should improve.

PRIVATE RESOURCES: INTEREST, DIVIDENDS, AND PERSONAL WEALTH

Although income is a snapshot of monies received during a year, wealth and net worth measure assets accumulated over a lifetime. The way this wealth has been used, in buying a home or in investing in interest-bearing securities, affects the way older people, especially elderly retirees with low incomes, are able to live. Wealth also measures consumption opportunities, flexibility, and mobility. For example, if most net worth is tied up in a home, then the homeowner may have much less choice and flexibility than if wealth is distributed among an array of assets.

Home Equity and "House Poverty"

When the value of home equity is subtracted from the median net worth ($25,088) of the lowest income quintile of households aged 65 and over in 1988, remaining assets are valued at about $3,200, hardly enough to invest in interest-producing assets. Households in the lowest income quintile represented 37 percent of all families with householders aged 65 and over in 1988 (U.S. Bureau of the Census 1990). When home equity is subtracted from net worth, it is easy to see why so many elderly women are house-poor, and have little mobility. NBC's situation comedy "The Golden Girls" suggests that this house-poverty can be dealt with by finding a few friendly roommates, but in a weak housing market, when the option is unavailable, too many older people, especially older women, are stuck in homes too large for them and with incomes insufficient to maintain them.

This lack of mobility may be exacerbated for black and Latino seniors by depressed housing values in inner cities. For many, housing appreciation is a key method of wealth accumulation, but those whose property values have been constrained by redlining may be strangled both by high property taxes and urban decay. Stanford (1990: 47) suggests that housing policy is an area with a special impact on the black aged. Since a greater portion of black wealth is concentrated in home value (67 percent, compared with 42 percent for whites and 58 percent for Hispanics), the housing issues that Stanford raises are especially important to blacks.

Wealth data reflect the same pattern of differences among the elderly by race that appears in data on income, unemployment, and poverty. White families in which the householder was aged 65 or over had a

median net worth of $81,600, compared with $22,210 for black families with elderly householders and $40,371 for Hispanic families in 1988 (U.S. Bureau of the Census 1990). There may be intergenerational consequences to the low net worth of elderly black and Hispanic households. Those with few assets are likely to depend more on their children who, based on their own occupational options, may have less than others to give.

When aging baby boomers boost the elderly portion of the black population from 8.2 percent in 1990 to 17.5 percent in 2030, the ratio of the black retirement age population (aged 65 and over) to the black working-age population (aged 20 to 64) will rise from about 15 per 100 to about 31 per 100 (U.S. Bureau of the Census 1989). If policy changes are not made to prepare the minority members of the baby boom economically for old age, their children may have to take on more responsibility than the baby boomers are assuming for their own parents.

Wealth, Poverty, and Women of Color

Two factors are important in explaining how private income sources affect the poverty status of older women of color. First, what wealth has a woman amassed during her working lifetime? Second, are her children in a position to contribute to her well-being after she retires? Older women of color today, who earned less in their lifetimes, are likely to have less wealth upon retirement. Depending upon the way the private labor market closes racial wage gaps, the children of these women are also likely to have less to spend on supporting their mothers. The stark difference between the status of middle-income minorities and poor minorities may mean that in the future there will be both a larger group of elderly minority women who are financially secure and a continued high incidence of poverty. In 1990, 14 percent of all black families had earnings that exceeded $50,000, while about a third lived below the poverty line (U.S. Bureau of the Census 1991a, b). Twenty years from now, these differences will be reflected among the black elderly.

THE LOW-INCOME ELDERLY IN A STAGNANT ECONOMY

In the 1980s, cities and states followed the federal government in cutting social welfare programs because of budget pressures. In some

cases, a reduction of block grants from the federal government was directly responsible for program cuts at the city and state level. The multiyear economic recovery that followed the 1981–83 recession was accompanied by corporate downsizing, lower wages for workers, and other erosions of the economic status of ordinary people. Indeed, in 1979, a quarter of all workers earned less than $12,000, about the poverty rate for a family of four. By 1988, that proportion had risen to 31.7 percent (Mishel and Frankel 1991). This erosion of worker status was compounded by the recession of 1990–92, when unemployment rates reached 7.5 percent.

The short-term attention accorded cyclical issues of recession and recovery mask long-term structural changes in the economy and society. The labor market currently provides less job security than it has in a decade, with those, like women and minorities, at the periphery especially affected. If current wages affect future economic status, then the displacement of thousands of workers, as well as the increase in part-time jobs and self-employment, have implications for the elderly minority women of the future.

Structural change in our economy has rendered a larger portion of our population more vulnerable and insecure. Some families have struggled to maintain their economic position by moving from a one-earner to a two-earner base. Those families with only one earner, meanwhile, have watched their standard of living erode as the "family wage" has lost value. These are adults who will have fewer resources to share with aged parents and fewer resources to set aside for their own retirement. Workers who have moved from manufacturing to service jobs may have experienced not only a drop in their standard of living; if they faced long periods of unemployment, they may have been forced to cash out any accumulated retirement benefits. In the past, federal employment and training programs might have eased the transition between sectors, but between 1980 and 1990, federal spending on employment and training was cut by 70 percent. In the 1990s, with a large budget deficit, a political climate hostile to public spending for social programs, and no explicit labor policy, workers have little assistance in making the sectoral transition.

Many economists assessing the current situation agree that there must be some coordinated response to current structural shifts. Absent a response, only a few American workers can look forward to the "good jobs" that offer pensions, benefits, and perquisites (Reich 1991). The economic insecurity that workers face today will be reflected in their economic status as seniors in the future. The insecurity workers face may also make them less willing to allocate resources to ease the

plight of the elderly poor, especially a disproportionately minority and female group, with whom they are least willing to identify.

CONCLUSION: PREVENTING OLDER WOMEN'S POVERTY

In the future the over-65 population will be older, and more black and brown than it is today, while continuing to be disproportionately female, especially at the oldest ages. Because elder poverty is concentrated among women and minorities and the very old, these demographic trends suggest that unless corrective policies are instituted, the incidence of poverty will increase in the future. Younger women's educational levels have improved, to be sure, and they are working more continuously. However, the fact that social policy has not been modified to deal with women's dual responsibilities in the workplace and the household, as well as the fact that there is no family policy in the United States, exacerbates the tendency toward older women's poverty. Educational access and occupational shifts may protect some women, but young minority women still lag behind white women in higher education, and many others will be disadvantaged by their need to take time out of the labor force for caregiving. Older women's poverty, then, is not a cohort effect that only affects today's older women, but a necessary outcome of the absence of social, family, and health policies that would support women's dual roles as family caregivers and members of the work force.

Among older women of color, especially black women, poverty seems less a function of marital status than of past work experience. But in 1990, fewer then 1 percent of black women earned more than $50,000 per year (compared with about 2 percent of white women and 11 percent of white men) (U.S. Bureau of the Census 1991b). By 2030, there will be a much greater minority representation among the aged population. From a policy perspective, this fact should draw our attention to labor market policies that currently affect the employment status of minorities, especially minority women, who are more likely to survive into very old age than minority men. The poverty of older women—black and white—can be avoided in the future if labor market policies generate access to good jobs and pensions in the present.

The years that women spend outside the labor market for caregiving responsibilities, the unequal pay women receive even when they are working, the peripheral work that many minority women accept that reduces their access to pensions and Social Security, and the likelihood that women will spend part of their old age alone all contribute

to high poverty rates among elderly women of color. Certain policy initiatives, affecting both older women and those who are preparing for old age, could help young minority women avoid the predicament of older women's poverty. Included among these initiatives are:

- ☐ *Pay equity and other equal pay policies* that would assist women in building pension credit for retirement. Women are still heavily concentrated in low-paying occupations, and the long-term consequence of their low pay is low retirement benefits.
- ☐ *Enforcement of age and race discrimination laws*, which would enable those women who choose to work past age 65 to find employment. It is especially important to note that age discrimination sometimes combines with race discrimination to create a dual hardship for older blacks.
- ☐ *More equitable retirement policies*, which could ensure that higher proportions of older women have retirement income from sources other than Social Security. Such policies include those that would reflect women's unpaid work, that would allow workers to begin vesting retirement benefits sooner, and that would make it easier for workers to invest in vehicles like individual retirement accounts (IRAs). As more women work part-time, it also makes sense to mandate that employers allow part-time workers to accumulate retirement credits on a proportional basis.

Older minority women follow many paths to poverty. Following demographic and social trends, some of those paths will narrow or even disappear, but others may widen in the future. Clearly, some women will be protected because of more continuous work histories and improved labor market profiles; but others who have not had the benefit of higher education and good jobs, or who have worked sporadically because of family responsibilities, poor health, and other factors, will face some of the same risks that women face today. It will take some policy intervention to change this outcome, and the challenge will be to create policies that affect not only minority women who are already over age 65 but the women who are approaching their older years with limited means to protect themselves from future economic hardship and dependency.

Note

1. The U.S. Bureau of the Census uses the term "Hispanic" to refer to a group of people of diverse cultural backgrounds. Mexican Americans make up the largest segment of

this population, followed by Puerto Ricans and Cuban Americans. The Hispanic population also includes people of Central and South American origin or descent.

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FACT SHEET ON OLDER WOMEN AND HEALTH CARE

Income and Financial Status. The average income for women over 65 is about $8,500 a year. Nearly half of elderly women are widowed; 60 percent of older widows have incomes below $14,000 (twice the poverty line for a single individual).

Source of Income. Social Security is the sole income source for many older unmarried women. Half of all women beneficiaries would be poor if they did not receive Social Security benefits. As of 1990, 33% of unmarried women aged 65 or older who received Social Security depended on it for at least 90% of their income; more than 18% had no other income.

Health Status. Female Medicare beneficiaries are often more frail and sick than their male counterparts. More than 50% of women over age 85 have three or more limitations in activities of daily living (such as bathing and eating), as compared with only 34% of men of the same age.

Medicare. Of the 37 million Medicare recipients, over 20 million, or 57% are women.

Medicaid. 60% of all Medicaid beneficiaries are women. Medicaid provides essential services for older women -- like prescription drugs, home and community-based long-term care, and nursing home care -- and covers the costs of Medicare premiums and cost sharing.

- Medicaid will pay over $800 for prescription drugs on average for older women in 1995.

- Approximately 68% of the nation's million nursing home residents rely on Medicaid to pay for some or all of their care. Over 75% of nursing home residents are women. The average annual cost of nursing home care is $38,000.

- In 1995, 5.4 million people had their Medicare premiums, deductibles and copayments covered by Medicaid.

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ON THE WEB

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The George Washington University
WASHINGTON DC

Medicaid Nursing Home Rules: Advocates Warn Against Changes

Congressional Republicans have backed off a plan to repeal outright a 1987 law that protects the rights of America's 1.5 million nursing home residents and the quality of care they receive. Still, advocates for the elderly and disabled warn that language they say "significantly weakens" the landmark act could turn back the clock to a time when some long-term care facilities did little more than warehouse the frail and the infirm.

The House-inspired effort to repeal the Nursing Home Reform Act of 1987 was wrapped up in the general attempt to redesign Medicaid. In their negotiations to end the Medicaid entitlement and substitute a block grant, Republican governors argued that to achieve savings of $170 billion over 7 years, they would need maximum flexibility to run the program, without any of the current strings attached, said Howard Bedlin, legislative representative for the American Association for Retired Persons. "It just so happens one of the strings is the nursing home requirements."

When the Senate softened the approach—partly in response to high-visibility hearings held by Sens. William Cohen (R-**ME**) and David Pryor (D-**AR**), chairman and former chairman respectively of the Aging Committee—advocates breathed a bit easier. But when they saw the omnibus budget reconciliation bill approved in conference, they again sounded the alarm. In a November 17 letter to Pryor, the National Citizens' Coalition for Nursing Home Reform called "weakening the federal standards... unwarranted and unconscionable." Among its concerns are elimination of: 1) individual's rights to quality of care and life (the bill addresses residents collectively); 2) federal standards for resident assessments; 3) protections against discrimination based on source of payments; and 4) enforcement tools, including stepped-up fines for repeated or uncorrected deficiencies and retroactive civil money penalties for past noncompliance.

"They definitely watered it down," Trish Nemore, staff attorney for the National Senior Citizens Law Center, said of the conferees' action. Apart from the reform law, another troubling provision in the bill is a rule deeming the transfer of assets—sheltering money to become eligible for Medicaid—a federal crime. Current law bars offenders from receiving Medicaid but nothing more, Nemore said. "That kind of language will scare people out of their wits." A related concern is the 1989 "spousal impoverishment" rule, which permits at-home spouses of nursing home residents to keep a share of the couple's income and assets when Medicaid coverage begins. The provision has been restored, but the move to end the entitlement to benefits raises serious questions about how it will be enforced, Bedlin said.

With President Clinton's veto of the budget bill—expected as *Notes* went to press—the pendulum could swing back, giving moderates an opportunity to restore some of the stripped provisions. The veto, Bedlin observed, will allow "the real negotiations to begin. We'll have our work cut out for us. We'll have to prioritize."

[Nursing Homes, p.2]

Administration on Aging
Office of the Assistant Secretary for Aging
Initiative on Older Women

The Administration on Aging's Initiative on Older Women

Recognizing that the roles and perceptions of women are evolving, the Administration on Aging (AoA) is launching an *Initiative on Older Women* to develop strategies that optimize the contributions of women to society; educate and inform women about the importance of planning for a long lifespan; and to create an infrastructure that responds to their changing needs. The goal of this important Initiative is to improve the quality of life for America's older women.

To realize this goal, AoA will: 1) build the capacity of the Aging Network to effectively address older women's issues; 2) promote existing, or establish new, intra-departmental and inter-agency partnerships designed to address the needs of older women; 3) educate older women at the grass roots level and the public and private sectors about issues affecting older women, with a primary focus on income security, health, housing, domestic violence, and caregiving (and the importance of addressing these concerns); and 4) reinforce the capacity of women to make significant contributions to society throughout their life cycles.

The strategy for accomplishing the Initiative consists of promoting public and private sector partnerships that will address issues and concerns of older women at the national, state, local and grass roots levels. To support these partnerships, AoA will establish an Older Women's Policy and Resource Center. In conjunction with the activities launched through this Initiative, the Resource Center will assist State and Area Agencies on Aging, as well as other organizations, to be responsive to older women at a grass roots level in a more effective manner.

Older Women Today

- Today, 43 million people in the United States are over age 60.
- 25 million, or approximately three out of five, are women: 3.8 million are minority women, i.e. African American, Hispanic, Native American or Asian American/Pacific Islander.
- Compared to men, elderly women live longer, are three times more likely to be widowed or living alone, spend more years and a larger percentage of their lifetime disabled, are nearly twice as likely to reside in a nursing home, and are more than twice as likely to be living in poverty.
- Almost three-quarters of all elderly persons living below poverty are women, and more than half of elderly widows who are living in poverty were not poor before the death of their husbands.
- Three of five Black women aged 65 and over living alone, and two of five Hispanic women aged 65 and over living alone, have incomes below the poverty level.
- Women often take on competing responsibilities such as full-time careers in the professions and caregiving.
- Women provide 80 percent of the informal care their families receive.

Older Women Tomorrow

- Over the next thirty-five years the population aged 65 and over will more than double; the number of persons aged 85 and over will triple.

- By the year 2030, minority populations will comprise one in four elderly Americans, up from approximately one in eight today.
- Today, average life expectancy at birth is 79 years for women and 72 years for men. Life expectancy is projected to increase into the next century, increasing at a slightly greater rate for women. Seven out of ten "baby boom" women will outlive their husbands. Many can expect to be widows for 15 - 20 years.
- In the year 2020, the median income of single elderly women is projected to be 63 percent that of single elderly men. Two of five women aged 65+ who are living alone will have incomes which are less than 150% of the poverty level.
- Older women of tomorrow will continue to spend a greater percentage of their later years alone than men, represent a higher percentage of the frail and disabled older population, and will be more likely to spend longer periods of time residing in nursing homes.
- Services targeted to women will need to grow simultaneously with their numbers.

The Mission of the Administration on Aging

The Administration on Aging serves as the Federal advocate for the rights of older persons. As such, AoA formulates national policy for issues that impact older persons; serves as liaison with other Federal Departments, as well as the public and private sectors; and oversees a national program of community based supportive services to the aging and a national program of grants and contracts for (applied) research, demonstrations and training.

Through the National Aging Network (57 State, 670 Area Agencies on Aging, and 227 Tribal organizations) AoA provides oversight for the various titles of the *Older Americans Act*. Title III of the Act provides older persons access to over $800 million in supportive services from senior centers, nutrition sites and home delivered meals to isolated seniors, and related services such as transportation and legal assistance. The *Title VI, Grants for Native Americans Program*, provides American Indians, Alaskan Natives and Native Hawaiians access to $15 million in supportive services. The *Title IV Discretionary Program* of grants and contracts supports $29 million in projects designed to improve the delivery of supportive services to older persons. *Title VII, Vulnerable Elder Rights Protection Activities*, provides assistance to states in the prevention of elder abuse, neglect and exploitation.

Priorities of the Assistant Secretary for Aging

In line with priorities set by President William Clinton, Secretary of Health and Human Services, Donna Shalala, and Assistant Secretary for Aging, Fernando Torres-Gil, the Older Women's Initiative is one of several priority areas AoA is launching. Other priority areas include:

- **Long-Term Care**
- **Nutrition/Malnutrition Among the Elderly**
- **Blueprint for An Aging Society**
- **Crime/Violence Prevention**

If you would like further information about the Older Women's Initiative, please contact either of the co-facilitators:

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