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Issue Brief

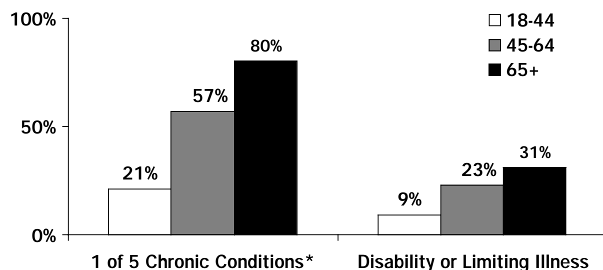
Living Longer, Staying Well: Promoting Good Health for Older Women

Karen Scott Collins and Erin Strumpf

Women are living longer than ever. A woman who is 65 today can, on average, expect to live another 19 years to age 84.[1] Despite recognition of the essential role preventive care and healthy habits play in these later years, older women and their physicians often miss opportunities to promote good health.

Medicare, which provides basic health insurance coverage for those 65 and older, does include coverage of many preventive services. But cost-sharing for many covered services—as well as uncovered services such as prescription drugs—creates financial hardship for many older women, particularly those living on low incomes. This issue brief, based on a new analysis of *The Commonwealth Fund 1998 Survey of Women's Health,* provides insight into the gaps in preventive care that currently exist and the disparities in access to care found between lower- and higher-income older women. It also suggests steps that can be taken to improve older women's health and quality of life.

Figure 1
Health Status by Age, 1998
All women



*Based on physician diagnosis of hypertension, diabetes, arthritis, heart disease, or cancer in the last five years.
Source: The Commonwealth Fund 1998 Survey of Women's Health.

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For more information, please contact:

Mary Mahon
Public Information Officer
The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Tel 212.606.3800
Fax 212.606.3500

E-mail cmwf@cmwf.org

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Four of five women age 65 and older suffer from at least one chronic condition.

Preventive Care

Older women face an increased risk of health and economic difficulties. In addition to the loss of income upon retirement, health problems often create physical and financial hardships for older women. Four of five women age 65 and older suffer from at least one chronic condition, while nearly a third have a disability or illness that limits their participation in daily activities (Figure 1). The risk of serious illness rises with age: women over age 85, for example, are twice as likely to die from cancer as women ages 65 to 74.[2]

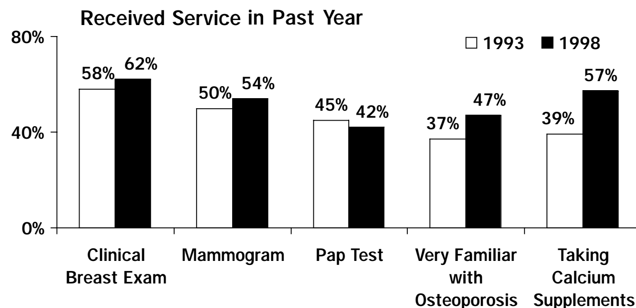
Heart disease remains the leading cause of mortality for older women. Among women in the Commonwealth Fund survey, 21 percent of women age 65 and older reported they had suffered a heart attack or had been diagnosed with heart disease in the past five years, compared with only 6 percent of women ages 45 to 64. These numbers make a clear case that screening and other preventive care must continue after age 65.

A comparison of findings from the Fund's 1993 and 1998 women's health surveys show a general lack of improvement in receipt of preventive services during the intervening five years (Figure 2).[3] Although there was a small improvement in the percentage of women age 65 and older who received clinical breast exams and

Figure 2

Preventive Health Trends, 1993–1998

Women Age 65 and Older

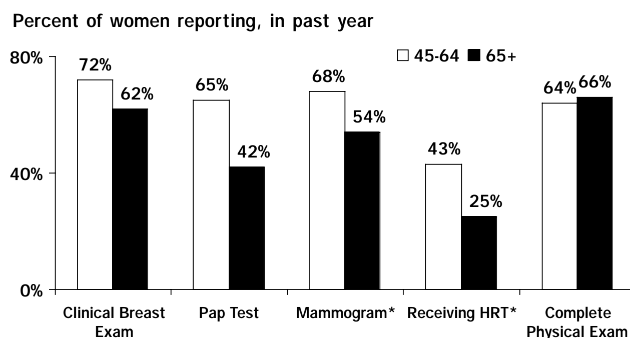


Source: The Commonwealth Fund 1993 and 1998 Surveys of Women's Health.

Figure 3

Preventive Care by Age, 1998

Women Ages 45-64, 65 and Older



*These responses include women age 50 and over.

Source: The Commonwealth Fund 1998 Survey of Women's Health.

mammograms, the percentage of women receiving a Pap test declined. The proportion of older women who said they were very familiar with osteoporosis, however, increased from 37 percent to 47 percent, as did the percentage of women taking calcium supplements (39% to 57%). The success achieved in osteoporosis prevention illustrates the central importance of public education and physician counseling.

The Age Gap

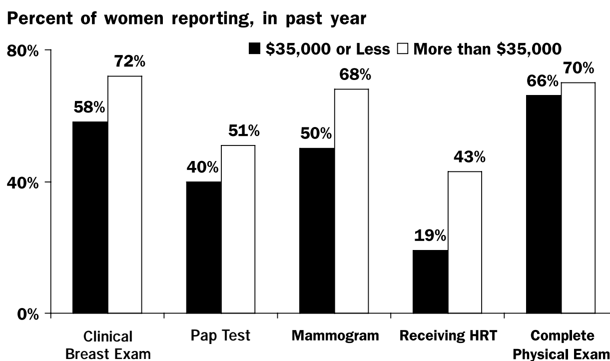
The 1998 survey also found that women over age 65 receive less preventive care than women ages 45 to 64. Large gaps between the two age groups are evident in four key areas: clinical breast exams, Pap tests, mammograms, and hormone replacement therapy (Figure 3). Despite the rising incidence and mortality from breast cancer with age, women 65 and older are less likely to receive a mammogram. Even over a three-year period, these older women are less likely to get a mammogram or Pap test than women ages 45 to 64 (72% vs. 84%, and 62% vs. 83%, respectively). Annual physicals are another important component of preventive care, especially as a means of identifying early signs of heart disease and other chronic conditions in older women. Yet only two-thirds (66%) of women age 65 and over had a complete physical exam in the past year—a rate just slightly higher than that for women ages 45 to 64.

Effects of Cost-Sharing

Because of changes made to Medicare in the Balanced Budget Act of 1997, the program now covers annual mammograms without cost to beneficiaries. However, physician services and preventive services, including Pap tests, remain subject to patient cost-sharing. The financial barriers that cost-sharing creates may contribute to the lower rate of preventive care among lower-income older women (Figure 4). Moreover, the exclusion of prescription drugs from Medicare coverage can also affect use of medications that lower the risk of osteoporosis: only one of five older women with incomes below $35,000 receives hormone replacement therapy, compared with two of five with incomes above $35,000.

Women over 65 receive less preventive care than women ages 45 to 64, including breast exams, Pap tests, and mammograms.

Figure 4
Preventive Care by Income, 1998
Women Age 65 and Older



Source: The Commonwealth Fund 1998 Survey of Women's Health.

Lower-income, older women have higher rates of illness and greater problems getting needed care.

Role of the Ob/Gyn

Several preventive care services important to a woman's health are usually performed by an obstetrician/gynecologist (ob/gyn). Women with both an ob/gyn and an internist or family practitioner are more likely to receive a full set of preventive services than those not seeing an ob/gyn.[4] Even so, of those women who have a regular doctor, only one-fourth age 65 and older also see an ob/gyn, compared with more than half of younger women (Figure 5). This disparity likely contributes to the lower rate of preventive care found among older women. Women age 65 and over who have seen an ob/gyn in addition to their primary physician were more likely to receive any preventive service in the past year than those who saw only an internist or family practitioner for primary care (95% vs. 87%).[5]

Education and Counseling

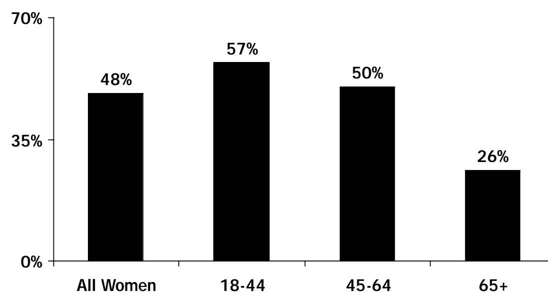
In addition to clinical screening services, counseling and education are also vital components of preventive care. The 1998 survey found considerable room for improvement on these measures (Figure 6). Just half of older women reported that their doctor discussed with them diet and weight, exercise, or the importance of calcium intake. Furthermore, only 13 percent of older women had discussed alcohol or drug use with their physicians. These rates are comparable to those reported by younger women, indicating that improvement in this area is needed among women of all ages.

Figure 5

Sees an Ob/Gyn in Addition to Primary Provider

All Women*

Percent of women who receive care from an ob/gyn in addition to their regular doctor



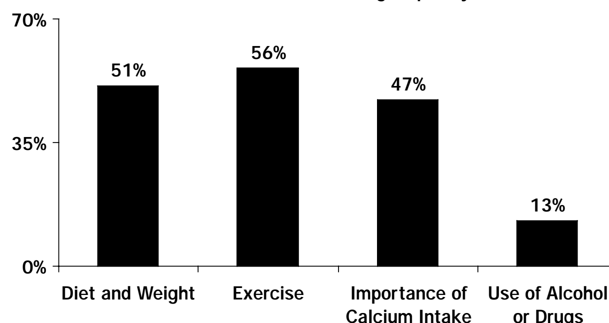
*Base: This question was asked only of women who said they have a regular doctor, 81 percent of the total sample.
Source: The Commonwealth Fund 1998 Survey of Women's Health.

Figure 6

Physician Counseling, 1998

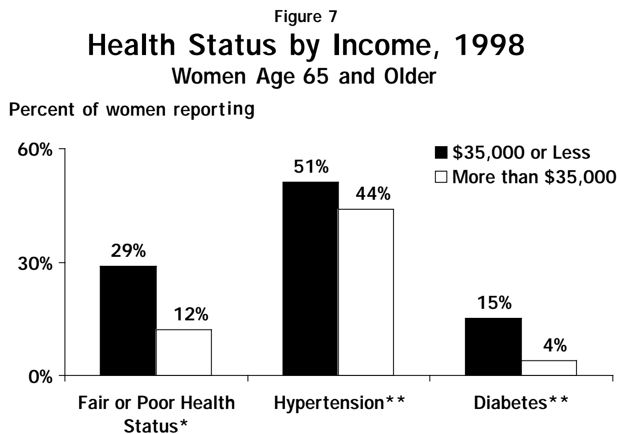
Women Age 65 and Older

Percent of women who received counseling in past year



Source: The Commonwealth Fund 1998 Survey of Women's Health.

Figure 7
Health Status by Income, 1998
Women Age 65 and Older



* Self-rated.
** Diagnosis of condition made by physician within past five years.
Source: The Commonwealth Fund 1998 Survey of Women's Health.

Lower-Income Older Women and Access to Care

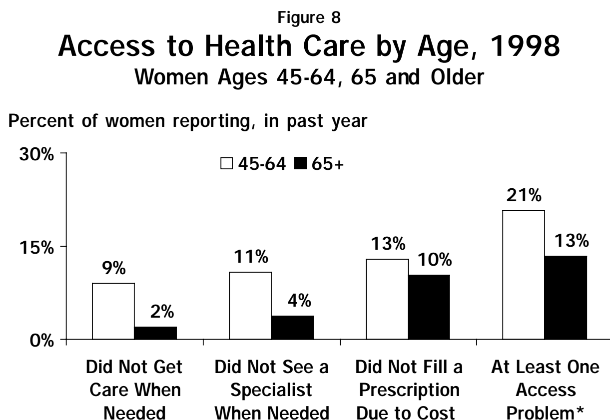
Elderly women with lower incomes are at greater risk for poor health and disability than those with higher incomes—and nearly 70 percent of women over age 65 have yearly incomes of $35,000 or less. While chronic conditions are already quite high for women in the 65-and-older age group, lower-income older women have significantly higher rates of hypertension and diabetes. These women are also more than twice as likely to rate their own health as fair or poor (Figure 7).

Medicare's Limitations

Medicare is important in providing a floor of health insurance coverage for all older women. Compared with women under age 65, older women are much less likely than women ages 45 to 64 to report problems getting care. Younger women are more likely to report difficulty seeing a physician or specialist, or filling a prescription due to cost (Figure 8). However, a significant proportion of older women with lower incomes have a hard time getting needed prescription medications or additional health insurance to supplement their Medicare benefits. In fact, one of eight (13%) with incomes of $35,000 or less reported a time in the past year when they could not fill a prescription due to the cost. In contrast, only 6 percent of women with incomes above $35,000 reported a similar experience (Figure 9).

Lower-income women are much more dependent on the adequacy of Medicare benefits.

Figure 8
Access to Health Care by Age, 1998
Women Ages 45-64, 65 and Older



*Did not get care when needed, did not see a specialist when needed, or did not fill a prescription due to cost.
Source: The Commonwealth Fund 1998 Survey of Women's Health.

Removing financial barriers to preventive and primary care is an important first step in promoting better health for older women.

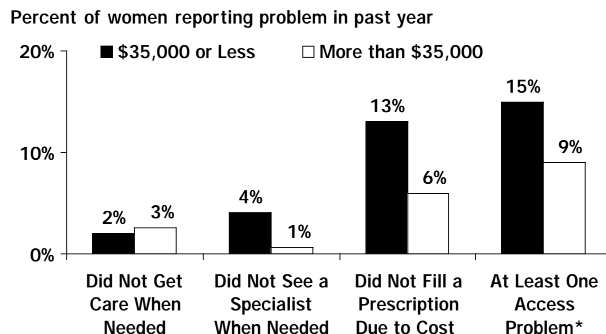
Lower-income older women are much more dependent on the adequacy of Medicare benefits. More than one of five (22%) have no supplemental coverage to pick up their share of Medicare premiums or to help pay for services that Medicare does not cover. Only half, meanwhile, have private supplemental coverage through a retiree health plan, MediGap policy, or managed care plan (Figure 10).

Summary and Recommendations

Chronic conditions, physical limitations, and the risk of cancer and heart disease all increase as women age, making preventive screening and care a key part of health care for older women. Assuring that older women receive preventive services must be a continuing priority for health care providers, policymakers, and consumer health advocates—as well as for women and their families.

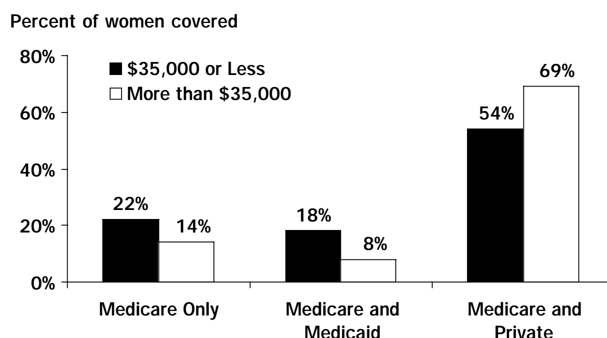
Removing financial barriers to preventive and primary care is an important first step in promoting better health and well-being among older women of all income levels. As the role of pharmaceutical drugs in caring for the elderly continues to expand, helping Medicare beneficiaries afford prescribed medications is crucial as well. The Medicare program could also more actively promote the use of essential preventive care services through its quality standards for managed care plans and its

Figure 9
Access to Health Care by Income, 1998
Women Age 65 and Older



*Did not get care when needed, did not see a specialist when needed, or did not fill a prescription due to cost.
Source: The Commonwealth Fund 1998 Survey of Women's Health.

Figure 10
Health Coverage by Income, 1998
Women Age 65 and Older



Source: The Commonwealth Fund 1998 Survey of Women's Health

beneficiary education efforts. With future gains in longevity a virtual certainty, clinical researchers will need to gauge the effectiveness of preventive services at advanced ages and develop clearer guidelines regarding their delivery.

Physicians caring for older women need to take greater responsibility, too. Doctors should urge women to get regular preventive care. They must also provide counseling to patients about their options for improving health and reducing the risk of chronic illness. Because older women are more likely to rely on one physician for their care rather than two, doctors need to take full advantage of their time spent with patients; a missed opportunity for preventive care will not be "made up" somewhere else. Standard medical practice guidelines and quality-of-care measures, such as those developed for the Health Plan Employer Data and Information Set (HEDIS), should also include measures relevant to preventive care for older women. Finally, more comprehensive insurance coverage and greater awareness of the value of preventive care among doctors and patients will help improve women's health and, ultimately, enjoyment of life in their later years.

Doctors need to take full advantage of time spent with patients, since preventive care will not be "made up" elsewhere.

Methodology

The Commonwealth Fund 1998 Survey of Women's Health, conducted by Louis Harris and Associates, Inc., from May through November 1998, consisted of 20-to-25-minute telephone interviews with a random, national sample of 2,850 women and 1,500 men age 18 and older, with an oversampling of minority women and men. The unweighted sample included 850 women ages 45 to 64, and 459 women age 65 and older. To adjust for sampling design and to represent the adult population, the analysis weights responses to the March 1997 Current Population Survey by sex, race, age, education, and health insurance status.

The Commonwealth Fund 1993 Survey of Women's Health was conducted by Louis Harris and Associates, Inc., from February through March 1993. It consisted of telephone interviews with a random, national sample of 2,525 women and 1,000 men age 18 and older, with an oversampling of minorities. The unweighted sample included 743 women ages 45 to 64, and 448 age 65 and older. To represent the adult population, the analysis weights responses by age, race, education, insurance status, and census region using March 1992 U.S. Census Bureau data.

Notes

1 U. S. Department of Health and Human Services, National Center for Health Statistics, *Health United States 1999*, Figure 5, p. 87.

2 *Health United States 1999*, Table 39, p. 170.

3 Karen Scott Collins, Cathy Schoen, Susan Joseph, Lisa Duchon, Elisabeth Simantov, and Michele Yellowitz, *Health Concerns Across a Woman's Lifespan: The Commonwealth Fund 1998 Survey of Women's Health*, The Commonwealth Fund, May 1999.

4 Marilyn M. Falik and Karen Scott Collins (eds.), *Women's Health: The Commonwealth Fund Survey*. Baltimore: Johns Hopkins University Press, 1996.

5 Preventive services include a complete physical exam, blood cholesterol test, physical breast exam, mammogram, Pap smear, or colon cancer screening.