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Global Aspects of Older Women's Lives

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▶ Abstract

This paper is based on a public lecture presented at the Brookdale Institute in June 1987. It reviews the global health implications of longer life expectancy for women. In 1985, the average life expectancy in developed countries was 77 for women and 70 for men. Female life expectancy in developing countries is improving and mean life expectancy globally for women increased by 13 years from 1950 to 1985.

The health implications of differential life expectancy are that women will be the longest survivors into old age, the ones most likely to be left alone as mates die, and the ones most vulnerable to the health problems of the "old-old".

Older women face a unique threat of poverty: although they live longer, they have less income in old age. In the United States, 15% of elderly live below the poverty line, but among older women in the US the poverty rate is double at 30%. Older women have a strong likelihood of "cycling into poverty" as the result of high health care costs.

Aging women face greater mental health risks due to the higher probability of widowhood and financial and environmental stress. Depression, the most common of emotional disorders in old age, is reported to be twice as common in older women than in men.

The vulnerability of older women to health problems results not simply from longevity *per se* but from the fact that longevity can cause a woman to outlast her personal resources and to overwhelm current prevention, treatment and rehabilitation capacities in the community. The author concludes with a series of suggestions for improving health prospects for older women.

▶ A Global Look at Older Women

Women represent a striking majority of the old in every developed country, with a five year difference in life expectancy in 1950, and seven years in 1985. Average life expectancy in developed countries was 77 for women and 70 for men. Two factors seem to account for this:

- Genetics—2 to 4 years longer life expectancy for females than males.
- Environmental factors—especially the heavier use of alcohol and smoking among older men.

There is stronger correlation in women than in men between female life expectancy and per capita GNP in developed countries. Women seem to benefit more from medical and other advantages than men, but have not yet been as affected by unhealthy practices associated with more affluence, such as smoking, excess food and alcohol, fast driving (accidents) and high stress.

As one vivid example, Japan will have gone from 8.8% of its population over 65 in 1989 to 14.0% over 65 by 2000. And Japanese women are the longest living women in the world.

Turning to the developing countries, female advantages in life expectancy over males are not as apparent—but promise to emerge as countries develop. We see currently a two-year difference in male-female life expectancy in the developing countries (62 for women and 60 for men). In India, Nepal and Pakistan, men actually live about a year longer than women. This is due to the fact that between ages 1–5, female mortality rates may be 30%–50% higher than for boys because of less medical care, and less food and care in general. Boys are simply valued more highly and are given more resources.

Fourteen Third World countries, mostly in sub-Saharan Africa and South Asia, have not yet reached a life expectancy of 50 years for women (or men). But the good news is that all countries have been improving since 1950 and the gap between

rich and poor nations has narrowed to some extent. The mean life expectancy globally for females increased by 13 years from 1950 to 1985.

I want to emphasize that as each country develops, it appears likely that we will see the pattern of greater female life expectancy emerging—as it now has in every developed country.

We do find some variations on this theme. For example, Israel appears to have less of a difference between the sexes' life expectancy than other developed nations. The figures are a 3.5 year difference at birth between Israeli men and women and 1.3 year difference at age 65. In speculating why such a relatively small difference exists, we have heard at least one major hypothesis: namely, that the religious-cultural restrictions among Jews and Muslims against alcohol may mean that alcoholism does not play the role in earlier deaths for men that it does in many other developed countries. Nonetheless, Israeli women are still living longer and fit many of the patterns we see emerging worldwide.

The global health implications of differential life expectancy are that women will be the longest survivors into old age, the ones most likely to be left alone as mates die, and the ones most vulnerable to the health problems of the "old-old".

Along with length of life, another major factor for older women generally is poverty—the inability to buy sufficient goods and services to deal with old age, especially with long-term health problems. The paradoxical issue here is that although women live longer than men, they have less income in old age to start with, rather than more to compensate for that longer life—this is true universally. Even Canada, with one of the soundest medical and social insurance programs for old age, describes its older women as living in "genteel poverty", compared to the more "abject poverty" of many older US women.

Older women in the US are in a unique threat of poverty because the United States is the only major industrialized nation that does not have a national health insurance plan or a national health care service. Medicare covers only 40% of health care

bills. The remainder must be covered by private insurance or out of the patient's pocket.

Let me explain how this leads directly to poverty or the threat of poverty, particularly for women living alone, mostly widowed. This poverty usually lies "hidden in the averages". The average poverty rate for older people in the United States is 15%. But among older women living alone the rate is nearly double, approaching 30%. Many more live in near-poverty, a result of a peculiarity that can be called the "cycling in" factor. Middle-class women have a strong likelihood of cycling into poverty, as a result of high health care costs for their aging spouses and themselves joining the lifelong poor female population. Only then are they eligible for state-sponsored welfare, known as Medicaid, to help in paying long-term care bills.

Turning again to the global view, more women than men are poor and the proportions are growing with "development":

- The hourly wages of women worldwide are 3/4 of those of men.
- Things are worse in many developed countries—e.g., Japan's women earn 53% of what men earn. The United States is only slightly better, and recent figures show some improvement.

Malnutrition is an index of poverty in developing countries. The United Nations estimates that 1/4 of the population of the Third World is undernourished, with the following conditions generally applicable:

- Malnutrition is disproportionately higher among women and girls.
- Food taboos are more commonly imposed on women.
- In many Third World countries, the custom is for men to eat first, boys next, girls and women last—with older women at the tail end of the food distribution chain.

Some of the reasons for universal female poverty in old age include:

- Women typically work in lower paid jobs in the outside work force.
- Many must work more sporadically than men because of family responsibilities, so they do not accumulate private or social insurance pensions as easily.
- Homemakers are seldom compensated for work in the home or for unpaid work such as caregiving to the elderly.

The unpaid labor of women, according to one UN report, if given economic value, would add an estimated 1/3 to world's annual Gross National Product. For example, rural women account for more than half of the food produced in the Third World and as much as 80% of food production in Africa. A modern and telling example of failing to understand the value of women's work is the current struggle of every developed nation to provide the home care to the elderly that was formerly given by female family members. Many are making the mistake of paying home care workers minimal pay with no fringe benefits—with a resultant poor quality of worker or an absence altogether of applicants for the jobs.

I'd like now to become a bit more specific to the US experience in terms of the pattern of health issues of older women.

In terms of physical health, since older women live longer, they accumulate more chronic diseases as a result of their longevity. Some researchers also believe women actually have greater incidence of disease and disability compared to men of the same age. *But* when men *do* become ill, they tend to become more acutely ill than women, require more intensive care, and are more likely to die from their illnesses at an earlier age.

A clear pattern of service use evolves from these trends:

- Older men are more likely to be hospitalized in acute

hospitals.

- Older women tend to make more use of outpatient services and home care. They are 75–80% of US nursing home residents. Many have outlived not only their husbands, but also their male and occasionally their female children. One-fourth of all women over age 75 in US nursing homes have no living children.

Disease states found to be particularly disabling for US older women are osteoporosis, arthritis, Alzheimer's disease, breast and other cancers and incontinence. To describe just one of these disorders, until perhaps five years ago, most American women did not know what osteoporosis was. An intensive program of public education has brought greater awareness among women and movement toward prevention through diet, exercise and estrogen use. But the exact preventive techniques remain controversial, as research evidence is just now significantly accumulating on this disease.

For example, one of the recommended treatments itself is under scrutiny, namely estrogen. This has led to a powerful new anxiety among older women – "estrogen anxiety". Estrogen has long been used for symptoms surrounding the menopausal period of a woman's life and it has been expecially effective in controlling hot flashes along with vaginal dryness. In the late 1970's, evidence associated estrogen with a higher rate of endometrial cancer. There is also a widespread, but so far, unsubstantiated fear of a connection with breast cancer. Many women stopped taking estrogen altogether, at their own or their physician's instigation. In the past several years, medical opinion has once again moved in the direction of use of estrogen, this time in combination with progestin and in much smaller doses for the relief of menopausal symptoms. But many older women remain skeptical about estrogen's safety. Happily, accumulating research on long-term experience with estrogen is beginning to look more reassuring and even therapeutic—as a protection not only against menopausal problem, but also against heart diseases

and osteoporosis. Unhappily, the long-term effects of progestin are not known. For example, its use in combination with estrogen may negate estrogen's positive effects against heart disease even while progestin is protective against uterine cancer.

The state of research on diseases specific to older women's health is rapidly improving in many areas—but major questions also remain. For example, the basic physiology of the menopausal hot flash is still unclear. The death rates from breast cancer have not improved in 20 years. Lung cancer has just recently passed breast cancer as the leading cancer of women.

Major questions also remain in the area of mental health for older women. To begin with, the criteria for measuring emotional health in women are under scrutiny. Major theories of psychology, especially in the Western world, have been built on the notion that psychic separation from others and a focus on developing the individual personality represent a major goal of maturity. Women researchers, particularly, are challenging this assumption by claiming that current measurements of maturity place far too much emphasis on autonomy, competitiveness and power over others rather than emphasizing cooperation, nurturance and responsibility for others—traits historically identified with the female sense of self.

In fact, blending the development of self with development of care and concern for others is emerging as an ideal in maturity for both men and women. For those who come to this late in life, there is still the opportunity and apparently even an inclination to move in this direction. Karl Jung, observed that man "discovers his tender feelings and woman her sharpness of mind in the middle years". David Gutman, in studies here in Israel and elsewhere has found what appears to be a universal tendency for men to become more nurturing in old age, while women become less dependent and more self-actualizing.

Personality becomes more complex the older one gets. This is the accumulation factor. Some of this is due to personality characteristics developed over one's lifetime. Other

characteristics develop for the first time in mid– or late life. Some are universal responses to the natural course of growing older. Some are individual responses to aging. Some have physical components, connected with changes in the body. All point to the need not to approach the old with fixed notions about personality in old age. There are more surprises and variations to be found in this age than in any other.

Moving back again to older women, the reporting of rates of mental disorders has a bias, particularly where women have been the primary victims. The incidence of rape, battering and other sexual and violent abuse and their psychological consequences have been much underreported. Alcoholism in the US is widely believed to be underreported as well, especially among older women who drink in the privacy of their homes. Depression, on the other hand, may be overreported because it fits cultural stereotypes about the passive nature of females. Depression is frequently overlooked in men, hidden under reports of alcoholism and violence.

Reports that American women make greater use of mental health facilities than men have been interpreted as evidence that women have more emotional problems. But the behavior of women in the face of symptoms may simply be different. It is socially more acceptable for women to ask for help. Women may also be more knowledgeable than men about the meaning and significance of symptoms, particularly since many have had experience in attending to the emotional needs of other family members. An even simpler explanation is that a greater number of women than men still work primarily at home or have part-time jobs and therefore have more opportunity to visit health facilities open during the day.

Let's now take a look at the so-called "classic" mental disorders of older women:

Depression is the most common of all emotional disorders in old age. Although the rate of depression increases with age, it is often said to be twice as common in older women than men. Is

this really true? And if true, are women more psychologically more prone to depression or is there some other explanation? Suicide, the final act of depression, is much more common in older white men in the US than in any other gender or race group. Other more general evidence of depression by gender in old age is less clear, but tends toward higher rates for women. Even if it is possible to demonstrate more depression among women than men, factors other than psychological vulnerability may well be involved. Women are more likely to be widowed, live alone, and experience greater financial and environmental stress. All of this means that depression in old age requires a new look to make certain that what might be an expected depressive reaction to difficult or intolerable surroundings is not misconstrued as evidence of frailty in the older female character structure.

Depression can also be genetically based, as in manic depression, or it can be a symptom of a wide array of physical diseases, medical treatments and mental conditions such as organic brain syndromes. To add to the confusion, older women often have a number of diseases or disorders all at once, each with its own emotional components. So the diagnosis of depression in older women (and I might add in older men) is an intellectual puzzle worthy of Agatha Christie, as one looks for the most accurate combination of clues to the disorder. Diagnosis and treatment must be sensitively calibrated to each individual with ongoing observation of outcome and an alert capacity to change both the diagnosis and the treatment if conditions warrant.

Organic brain diseases, or dementias, can be as complicated as depression for purposes of diagnosis and treatment. *Alzheimer's disease* is the best known. Women have Alzheimer's disease much more frequently than men, possibly because it is sex-linked, and certainly because incidence increases with longevity. It is irreversible and eventually leads to death.

Multi-infarct dementia, the other major irreversible brain syndrome, used to be known as "hardening of the arteries." It is now understood that multiple small strokes over a period of time cause damage to the brain. This dementia occurs more frequently in men.

An estimated 10% of all dementias are caused by medical states of one kind or another and may be treatable or even reversible. The most treatable are those due to chronic infection, heart failure, hyper– and hypothyroidism, nutritional deficiencies including anemia (common among older women), traumas resulting from falls and other injuries and, most important, drug reactions.

Older women are particularly susceptible to *drug-induced dementias* because many must take a combination of drugs for a variety of conditions. Problems can arise for many reasons: a lack of coordination among various doctors, an inability to take drugs as prescribed, a habit of sharing prescription drugs with friends to reduce costs and a lack of information from doctors about side effects. Doctors may be guilty of overprescribing and of not knowing the effects of various combinations of drugs. Individual women may metabolize drugs differently from one another and from younger people, a factor requiring careful medical monitoring of individual response.

Caregiving responsibilities for their husbands' aging, and perhaps for older parents and other relatives, can be a major mental health stress for women, beginning in their fifties. Not only do women live longer than men, but most women marry men older than themselves. In addition, many families now have four and even five generations still living, so that middle-aged and older women carry much of the responsibility for the caregiving at a time when people live longer.

It is clear that the care of just one sick older person can frequently become overwhelming. But many women are responsible for more than one person at any one time, both in and out of their homes, and at different and changing levels of

care. High-quality service designed to make such care easier, such as day care, home nursing, homemakers and respite care are both difficult to find and expensive in nearly every nation.

There is also a lack of genuine help and support around other major life cycle issues for women. For example, little is known about female retirement patterns and needs. Why do women retire earlier than men? 1) Is it to be available for care of aging males? 2) Is it pressure from men because they don't want to be home alone while wives work? 3) Is it that women's jobs are so unchallenging and uninteresting that women have little psychological investment in work? 4) Or is it simply because nearly every government offers early retirement to women and women fall into an expected pattern of early retirement without evaluating it for themselves?

Other aspects of the special psychology of aging for women have received meager attention. Services for the newly-widowed are developing, but primarily for the middle class in the US. The same might be said for the process of dying, with the exception of programs that tend to emphasize certain diseases like cancer. Perhaps the most neglected late life issue is the simple loneliness that stems from many of the oldest and frailest women outliving their mates, friends, older family members and even their own children, particularly male children.

Health professionals with a positive attitude toward older women and a solid understanding of their typical mental health and physical health problems are still relatively rare. It is common for older women to report that their symptoms are not taken seriously and that they are either treated inappropriately or sent home without treatment. Studies have established that women are more likely than men to be given tranquilizers and antidepressant drugs.

Less well-documented but often noted, older women's symptoms are frequently diagnosed as "postmenopausal syndrome", senility, or hypochondriosis. All are considered difficult or impossible to treat. It is still unusual, for example, for

an older woman (or an older man, for that matter) to be given an active course of psychotherapy, particularly on an ongoing basis.

▶ Improving Health Prospects for Older Women

The vulnerability of older women to health problems results not simply from longevity *per se*, but from the fact that longevity can cause a woman to outlast her personal resources and to overwhelm current prevention, treatment and rehabilitation capabilities in the community. The following are examples of directions that would provide important supports for older women:

1. Reducing the physical disabilities that now frequently accompany the longevity of older women, or "squaring the disability curve"—finding further cures and preventions for the many diseases and disabilities of the old that bring with them so much emotional anxiety, depression and pain. Health promotion and disease prevention must be major parts of this effort. Promotion of exercise, prudent nutrition and anti-smoking campaigns show much promise towards reducing illness and health care costs.
2. Finding a prevention or cure for Alzheimer's disease. Already there are promising leads in this direction. The effects of eliminating Alzheimer's disease would be revolutionary, especially for women. Perhaps half the nursing home beds in the US would no longer be necessary. Since there are currently 1.4 million older persons in American nursing homes and about 75% of these are older women, more than half a million older women might be spared institutional care at any one time.

3. Improving home care services and financing for those estimated 10–15% of older persons, mostly older women living alone, who, with assistance, could remain in their own homes even though in need of care.

4. Providing national systems for financing long-term care, so older women know that they can obtain care for their spouses or themselves without becoming paupers subject to the whims of the poverty programs of the system under which they happen to live.

5. Learning more about optimal aging of women by conducting studies of those women who manage to thrive in old age.

6. Confronting those conditions at every stage of life that result in an unequal distribution of resources for women versus men in old age. Equal access to employment, child care services, equal pay and better pension vesting are critical, especially during the child-rearing years when employment tends to be more sporadic for women.

7. Better training and pay, including fringe benefits for home health care workers and nursing home aides so such care becomes more professionalized, and not an after-thought.

8. Careful screening of health care workers to weed out those with strong biases against or little interest in older women.

9. Intensive training of such workers to understand and to empathize with older women—and more specifically, to look beyond the physical aspects of "oldness" in women, to an exploration and understanding of character, culture, personality and life history.

10. Developing a more accurate and sophisticated psychology of aging for women.

11. Constructing more ways in which older women can feel in control of their lives, from education in self-care and the prevention of illness to active participation in planning and implementing health and mental health programs designed to serve them.

If I could focus now on essential challenges ahead for the health care of older women, I would select three for the moment:

1. The difficulty we seem to be having in moving beyond the concept of caregiving to the elderly, whether in the home or in institutions, as low-paid work for untrained women—no fringe benefits, no status, no potential for personal and professional growth. Essentially we seem to be waiting for those elusive middle-aged daughters to return and provide free care as they always have in the past. But many of these women now need to work outside the home, and even if in the home, they need help in managing the increasing numbers and generations of elderly in each family. Furthermore, not all older women even have daughters. To be effective, home and institutional care requires trained and decently paid personnel.

2. Another difficulty is the emergence of the female, because of her life expectancy, as the model for aging. In 1958 we received rather startling news. Biologists confirmed that the human embryo is structurally female for the first 5 or 6 weeks in the womb. At that point the male hormones activate, and the male differentiates out from the female structure and develops male sexual organs. In essence we have Adam out of Eve, biologically if not theologically.

   Now in old age in the last quarter of the century, we have another startling piece of news, namely the genetic advantage of the female in longevity. This has been found to be true in most of the animal world as

well. Female longevity began to be apparent already at the turn of the century with improvements in general public health—and accelerated with the discovery of antibiotics in the 1930's and 40's and the consequent drastic reduction in maternal mortality in midlife.

What are we to do with this predicament? If we are to address the health issues of old age, we must look essentially to the female, usually widowed, at the age of 75 and beyond. But we have been acculturated to think of women as the support system, the backup team, the helpmeets of their husbands, rather than as individual pioneers in this new landscape of old age. We will need to learn from them about how they live so long, as well as learning with them how to meet their needs. To be on target we must adjust our thinking to a much more female-oriented view of old age, certainly for the immediate future.

3. Finally, how will we pay for all of this? How can we support these older women, and eventually many more older men as well, in a lengthening old age? It will require a drastic reorienting of national and personal priorities, including changes in the way we look at productivity and aging itself, and at health maintenance and prevention of illness. It will challenge us to think of these new years of life in ways that humans have never thought before. One way is nihilism and thoughts of eliminating the old as burdens. Another is passive neglect. But those with imagination will seize the chance to make this what it really can become—a long-awaited gift of added years.

The possibility of a healthy, active and productive old age is not illusory. For the first time in human history we may have, nearly within our grasp, the chance for a long enough life to truly have the time to grow up and mature as human personalities. But in the meantime, we have an old age that is

too often an endurance test. For many women this means a sheer struggle for survival as nations are struggling to catch up with the worldwide revolution in life expectancy. For many men it means a less than equal share of that life expectancy. Clearly this is work for visionaries as well as practical thinkers.

היבטים ייחודיים בחיי נשים קשישות

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