

# CANADIAN ASSOCIATION ON GERONTOLOGY

## OLDER WOMEN'S HEALTH ISSUES PAPER

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In 1995, the United Nations Human Development Report rated Canada as the best place to live for men. For women, however, Canada's relative status fell to ninth place (United Nations, 1995). According to this report, "in no society do women enjoy the same opportunities as men". Although attention to women's issues, and women's health in particular, has increased in recent years, information is still relatively scarce in terms of the distribution, causes, and consequences of health practices and problems among older community-based and institutionalized women in Canada. This point is particularly salient when considering the rapidly increasing proportion of senior women in Canada. For example, in 1991, 13% of Canadian women (1.9 million) were aged 65 years and over and it is estimated that this proportion will increase to 18% by 2016, and to 25% by 2041. More importantly, these figures illustrate that the most rapid increase will occur to the oldest old, namely, women aged 85 years and older (Statistics Canada, 1995).

Given the longer life expectancy of women, it is not surprising that many of the health issues of aging, such as an increased risk for multiple drug use (polypharmacy), multiple concurrent chronic illnesses (e.g. heart disease, arthritis, rheumatism, osteoporosis, cancer) and disabilities, and falls, have been referred to as women's issues (Gee & Kimball, 1987). Older women are also at increased risk for institutionalization, and appear to experience relatively higher rates of depression and other mental health problems associated with increased age and changes to physical health (e.g., loneliness due to loss of a spouse, memory problems associated with medication use) compared with older men (Health Canada, 1993). Unfortunately, our understanding of older women's health risks and potential areas for intervention has been limited by a lack of appropriate research and insufficient knowledge about the role of health care, cognitive, psychological and sociocultural factors in facilitating positive health behaviors among older women. Each of these is discussed in turn.

### **1. Multiple Drug Use (Polypharmacy):**

Several epidemiological studies conducted in Canada and other countries (Campbell et al., 1990; Chrischilles et al., 1992; Graham et al., 1995; Hogan et al., 1994; McKim and Mishara, 1987) have consistently demonstrated high prevalence rates of drug use and polypharmacy among older individuals and senior women in particular. The prevalence estimated for prescription and over the counter medications related to pain management and sleep or anxiety problems are considerably higher among older women than men at all age groups. The higher rate of psychotropic medication use among women may reflect either an increased willingness of women to take these medications or an increased willingness of doctors to prescribe them to women. In the study by Campbell et al. (1990), 32 percent of elderly women were commonly started on psychotropic drugs at a time of bereavement and they were more likely than men to have lost a spouse.

An important concern regarding the relatively higher utilization rates for certain drug classes among older women relates to their increased risk for adverse drug reactions. Elderly women may be more likely than men to experience adverse drug effects (e.g., sedation, disorientation, falls, peptic ulcers and gastrointestinal bleeding) for several reasons that have not been well studied:

- an increased risk for multiple drug use and comorbidity
- and increased risk for altered drug pharmacokinetics (absorption, distribution and elimination) and pharmacodynamics (response) because of smaller body size, exposure to hormone therapy, altered composition (higher body fat content, lower body water volume), altered body metabolism, multiple drug use, and comorbidity.
- an increased likelihood of diminished physiological reserve necessary to compensate for drug-induced perturbations in normal homeostasis.

There is also increasing evidence that drug response for certain medications (e.g., beta blockers, psychotropic, and neuroleptic drugs) may differ among ethnic groups (Merkatz et al., 1993; Morioka-Douglas and Yeo, 1990), thus illustrating the importance of considering the older woman's ethnic background in prescribing practices.

## **2. Chronic Illnesses and Disabilities**

Although cancer, particularly breast cancer, has gained prominence as a health issue among women, it is cardiovascular disease (CVD) and blood vessel disorders that constitute the most significant health burden for older women. The significance of heart disease among older women becomes apparent when considering the total numbers affected and the associated morbidity and mortality rates. It is estimated that 1 in every 2 women in the United States can expect to experience serious heart trouble in her lifetime compared to 1 in every 9 for breast cancer (Healy, 1995). Moreover, 245,000 women in the United States die each year of heart disease whereas 46,000 do so from breast cancer. Canadian figures similarly reflect that overall, disproportionately more older women die from heart disease than breast cancer. Nonetheless, no extensive studies have been undertaken to specifically examine sex-related differences in heart disease risk and prevention among the elderly, despite the recognition that heart disease is preventable.

Although the Framingham study provided critical data on major risk factors for cardiovascular disease (e.g., smoking, hypertension, obesity, diabetes) which were viewed as applicable to both women and men, regrettably the study perpetuated the belief that women do not get coronary disease and that their complaints of chest pain are needless (Healy, 1995). Further, age-based exclusions in clinical trials of drug and other therapies for heart disease (Gurwitz et al., 1992) have resulted in an under-representation of older women in research and thus, a lack of evidence regarding the benefits and

risks of such therapies among senior women. Such erroneous beliefs and research limitations have directly affected how women with cardiovascular problems are treated within the health care system (Beery, 1995).

For example,

- Women with chest pain and abnormalities in their diagnostic tests are less likely to be referred for more intensive clinical evaluations than men.
- Women with chest pain are less likely to receive various therapies (e.g., beta blockers, anticoagulants) and invasive interventions than men.
- Women have typically been excluded from research examining the role of risk factors in the development and prevention of heart disease (e.g., LDL and HDL cholesterol).
- Age rationing of cardiovascular care also leads to sex rationing of care since heart disease in women occurs 10 to 20 years later than in men.

Data from both Canada and the United States reveal an exponential increase with age in the proportion of the population with reported disabilities. More importantly, these data illustrate that the prevalence rates of various disabilities are consistently higher among older women than men at all ages (Kovar et al., 1995; Statistics Canada, 1995). The consequences of the greater life expectancy among older women compared with men is that the former are more likely to live in a disabled state for a longer period of time without a spouse (and possibly without other social resources) to help them live independently in the community. Although under debate, some researchers suggests that gender differences in disabilities may be the result of methodological artifacts rather than true health differences between women and men (Gee and Kimball, 1987). This issue requires clarification.

### **3. Falls:**

Falls account for a substantial proportion of injury-related morbidity and mortality among all age groups, and particularly among seniors. Recent statistics from Canada and the United States illustrated that falls are the leading cause of injury related hospitalization and accidental death among persons aged 65 years and older (Kiel, 1993; Riley, 1992). Several studies have reported an increased risk for falls among senior women compared with men (Campbell et al., 1990). Possible reasons include a reluctance of men to report falls and an increased likelihood for women to be socially isolated, to have reduced muscle strength and to use multiple medications, especially psychotropic drugs. Older women not only appear to experience higher fall rates than men, but they are also more likely to suffer serious soft-tissue injuries and fractures, the latter reflecting their increased risk for osteoporosis (Sattin et al., 1990).

Among fall-related injuries, hip fractures are the most common and are associated with the highest hospitalization and mortality risk. In addition to injury and hospitalization, falls and associated fractures also result in serious short and long term physical and psychological effects that are further complicated in senior women when coupled with increased comorbidity and differential treatment by the health care system. Some of the effects reported are:

- fear, anxiety, and depression
- increased susceptibility to future falls
- social isolation
- declining health and functional status
- loss of independence and confidence
- reduced quality of life
- death

#### **4. Institutionalization Among Women:**

The higher likelihood of entering an institution among women has been documented in numerous studies in Canada and elsewhere (Kemper and Murtaugh, 1991; Young et al., 1994). There are a number of factors that contribute to the increased risk for women, but the main explanations involve the inter-relationships between changes in health and changes in social relationships over the life course. The longer life expectancy among women of various ages is also accompanied by a greater probability of and relatively longer periods with a disability (Parker et al., 1996).

The excess mortality among older men of comparable age is also an important determinant of institutionalization among women. Older men with functional impairments typically have a living spouse available to provide social support for activities of daily living (ADL) and instrumental activities of daily living (IADL). However, the tendency of women to marry older men and the higher mortality rate of men make women much more likely to experience widowhood (Martin Matthews, 1991). Consequently, older women are more likely to live in a disabled state without a spouse to help them live independently in the community. Although children are a valuable source of social support to elderly widows, they may not have sufficient resources to cope with the onset of severe disabling conditions. Similarly, access to formal community services which may reduce the odds of institutionalization is not available in sufficient amounts to have a widespread effect on institutionalization rates.

Surprisingly little contemporary research has been done on the social and psychological aspects of institutional life, and much less is known about how these aspects relate to gender. The increased likelihood for older women to be without a spouse may have important consequences for quality of life, access to health resources, as well as health outcomes. Residents in institutional settings with no or poor social networks have been reported to be at higher risk for:

- lower levels of autonomy
- lower psychological well-being
- poorer rehabilitation outcomes
- reduced access to volunteers
- recipients of fewer services
- mortality

As women far outnumber men in institutional settings for the elderly (typically 3:1), older women may be at greater risk for poorer outcomes than older men within these settings because they are more likely to live long enough to experience greatly reduced social networks, and to experience deterioration's in health associated with increased age. Little is known about the positive effects on institutionalization, particularly for those senior women who lived alone without support in the community.

## **5. Mental Health:**

The tendency by health professionals and the public to disregard the significance of mental health problems (such as depression and anxiety) to the health and quality of life of older persons has been particularly detrimental to older women. This is because such problems are more prevalent among women and increase with several age-associated factors, including reduced income, inadequate social support, recent stressful life events and bereavement, physical disability and drug use (Koenig and Blazer, 1992; Weissman et al., 1996). Not only may depressive illness contribute to adverse emotional, social and economic effects, it may exacerbate, prolong and precipitate physical illness among older women by affecting various physiological systems, self-care and treatment compliance (Lyness et al., 1996).

Although depression is generally considered to be treatable among older persons, the recognition and appropriate treatment of depressive disorders by health care professionals has consistently been found to be relatively poor, particularly for older and more disabled patients (Jackson and Baldwin, 1993; Lyness et al., 1996; Small et al., 1996). Further, data for community-based elderly indicate that very few older persons seek out mental health professionals or services for help (Koenig and Blazer, 1992). Although relatively unexplored among the elderly, it is also likely that the social stigma associated with mental illness may result in greater reluctance among certain cultural sub-groups of older women to recognize or report symptoms. Further research is needed to explore the risks and adverse effects of mental problems and their under-treatment among older women.

Although current findings regarding sex-differences in the prevalence and incidence of Alzheimer's disease and related disorders (ADRD) are inconsistent, the exponential increase in dementia with age suggests that women aged 80+ years will be at greater risk of experiencing dementing disorders (Health Canada, 1993). Also, it is possible that future research efforts may illustrate the relevance of sex-related factors (e.g., hormones) in the development of ADRD. Further, given their predominance as caregivers, it is women, including senior women, rather than men who tend to experience the significant caregiver burden and the associated emotional and physical health consequences of caring for persons with dementing disorders.

## **6. Preventive Health Behaviours:**

Despite considerable effort to examine the contribution of preventive health behaviours to the health of younger and middle aged women (e.g., exercise, nutrition, smoking, cancer screening), the relevance of these behaviours to the health and well-being of senior women is less clear and subject to much debate. Major research efforts on risk factors and the effectiveness of health promotion and disease prevention activities have generally excluded elderly persons, and, in particular, senior women. Consequently, a substantial proportion of women at greatest risk for adverse health outcomes, namely, those in the older age groups, have not been identified within current guidelines for appropriate preventive health interventions. The relative lack of information concerning the risks associated with poor health practices in old age and the potential benefits of preventive initiatives after age 65, is largely because of the traditional emphasis on younger populations for primary preventive measures. This point is illustrated by the present controversy regarding the appropriateness of breast cancer screening for older women. It has been noted that most of the landmark studies on the benefits of mammography screening did not include older women (Costanza, 1994), despite evidence that the burden of this disease falls

disproportionately on the older age groups (National Cancer Institute of Canada, 1996)

The failure to acknowledge the potential benefits of various preventive strategies among older women is unfortunate in light of increasing evidence which suggests that older women may experience significant improvements in their health and quality of life by altering their lifestyle and improving their preventive health practices, including increasing their level of exercise, improving their nutrition and quitting smoking (Bravo et al., 1996; Maxwell & Hirdes, 1993; Rosenberg et al., 1990; Siu et al., 1993; U.S. Department of Health and Human Services (DHHS), 1990).

In addition to a lack of research, there are other barriers which have contributed to insufficient or inappropriate clinical and research efforts regarding preventive health practices for older women:

- failure to acknowledge that older women represent an extremely heterogeneous group in terms of their psychosocial, cultural, and physical characteristics.
- tendency for health care professionals and the public to classify health issues of older adults, particularly older women, as “health problems which are not illness”
- the belief that the implementation of certain preventive health activities among older women (e.g., exercise, smoking cessation) would profoundly reduce the older woman’s quality of life and that the costs of the reduction in risk would far exceed the benefits
- failure to acknowledge that older women may use different strategies for health prevention.

The possibility that the attitudes and behaviours of health practitioners toward older women (e.g., their attributions regarding symptoms/illness and diagnostic, therapeutic and referral practices) may be negatively influenced by the socioeconomic status, age and ethnic background of the older female patient, further magnifies concerns about potential health care inequities among older women. A question of particular interest for further research relates to whether older women and ethnic elders in particular, are more likely than other groups to receive less extensive investigation, fewer treatment options and preventive health interventions, including advice about screening and lifestyle changes.

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