BOlder Women's Health Coalition: A call to action

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Two of the most significant demographic trends changing the landscape in the United States are the aging of the baby boomers—persons born between 1946 and 1964—and the increasing longevity of this cohort of the US population. Although these trends affect all individuals, providing women with the health and wellness support they need and deserve as they age presents a unique challenge for which this country may not be fully prepared.

Many female baby boomers envision healthy aging in a way that differs from that of previous generations. They see themselves as independent, self-sufficient, and resilient, with an expectation of continuing to have fulfilling lives well into their older years. By contrast, other boomers may face obstacles to healthy aging—specifically health inequities and health disparities, some of which are much more common for women than for men. As a nation, we need to embrace a comprehensive, integrated approach that provides the opportunity for all women to be as healthy as possible as they age. Therefore, gaps in access to healthcare, effective health policy, clinical education for healthcare providers (HCPs), public education, and research must be addressed.

The BOlder Women's Health Coalition, led by the National Association of Nurse Practitioners in Women's Health (NPWH), is an alliance of innovative leaders in women's health and in the aging community. These leaders come to us from the nonprofit, public, and private sectors and are committed to defining, creating, and promoting a cohesive health agenda for older US women. The Coalition's aim is to answer the two key questions "What are the health needs of older women?" and "What are the best strategies to meet these needs?" Its work focuses on four established pillars: policy, clinical education, public education, and research. In this article, we provide a background on the current status of aging women in the United States and we identify health issues, social and structural determinants of health, health disparities, and health inequities that are particularly pertinent to aging women. We also describe the four pillars and outline the steps that the Coalition will take to facilitate the collaborative work across sectors needed to address the

For a list of organizations that have participated in coalition planning go to **Bolder Womens Health Coalition.**[A]

challenges and close the gaps to improve the health of all older women.

This call to action is intended to reach legislators, government agencies, research funding entities, HCPs and their representative organizations, academic leaders in the healthcare professions and their representative organizations/institutions, and organizations and agencies that advocate for public awareness and education regarding aging, women's health, specific health conditions, caregiving, and underrepresented/marginalized groups.

Background demographic information

In 2020, the number of US women age 50 years and older was approximately 64 million, a number that is expected to climb to 77 million by 2040.[1] Women who survive to age 50 years are expected to live an average of 33.3 more years, more than one-third of their life, with an average life expectancy of 81 years.[2] Although men slightly outnumber women in the general population, the statistics shift with aging. Women tend to outlive men and represent an increasingly higher proportion of older adults as they age. For example, women represent almost 60% of persons age 75 years and older and 70% of those age 90 years and older.[1] The increasing longevity of women, coupled with the increase in the absolute number surviving beyond midlife, highlights the need for a comprehensive plan to fully address gender-appropriate, health-related services for older women.

Older women's perception of healthy aging

Many older women today view healthy aging as enjoying a sense of well-being, knowing that they have met many of their life goals but still seeking opportunities to grow. They describe healthy aging as being independent, self-sufficient, and socially engaged. A holistic approach to caring for older women that includes health promotion, disease prevention, and management of chronic health conditions is most likely to address their unique needs. Even when living with chronic diseases, older women do not feel defined by them. They desire to live a purposeful life, both mentally and spiritually, no matter where they are on the health spectrum.[3] Beyond one's health status, however, healthy aging can happen only when inequities in social and structural determinants of health are addressed, giving all older women the resources and resilience to maintain independence and optimize their sense of well-being and quality of life (QOL). Concerted efforts to educate HCPs, inform the public about healthy aging, develop and implement legislative and regulatory policies that support social and structural equity and prevent health disparities, and increase medical and social research regarding aging are crucial to ensure optimal health for women throughout the lifespan.

Key health issues for aging women

Providing appropriate healthcare services for aging women relies on an understanding of the interplay between gender and aging with respect to chronic health conditions and their management, sexual and pelvic healthcare management, and the best approaches to disease prevention.

Chronic health conditions

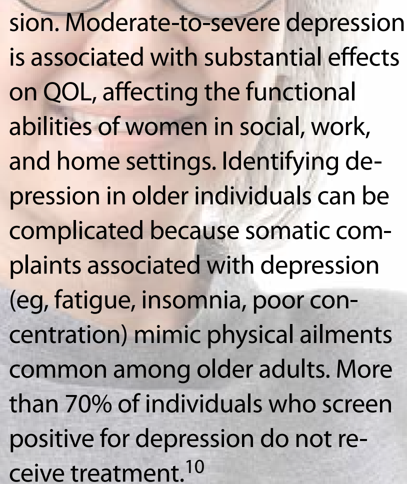
Approximately 88% of women age 65 years and older have at least one chronic condition, and 60% of older women have two or more chronic conditions.[4] These conditions include, but are not limited to, cardiovascular disease (CVD), cancer, osteoporosis, cognitive impairment, depression, pulmonary disease, and diabetes. Some HCPs, including those who specialize in certain areas, may not appreciate the role that gender differences play with respect to the prevention, detection, progression, and treatment of these chronic conditions.

For example, 45% of women develop CVD, the leading cause of death in women age 65 years and older.[5] Nevertheless, some HCPs may fail to recognize and diagnose CVD in women who present with cardiac symptoms unique to their gender.[6]

About 50% of women suffer a bone fracture related to osteoporosis in their lifetime, with aging and being female major risk factors.[7] Approximately 25% of women older than age 50 years who sustain a hip fracture die within a year.[7] Although Medicare covers the cost of bone mineral density screening for women age 65 years and older, studies show that few women undergo this screening.[7]

Women experience dementia—primarily Alzheimer's disease (AD)—disproportionately. Two-thirds of the 5.8 million seniors with AD in the United States are women.[8] Although the excess number of women with AD may be attributable in part to their longevity, evidence is emerging that women's physiology and a range of social factors account for the higher prevalence of AD relative to that in men.[8] Of interest is that about 39% of primary HCPs report they are never or only sometimes comfortable making the diagnosis of dementia.[9]

Women of any age are more likely than men to be affected by depres-



sion. Moderate-to-severe depression is associated with substantial effects on QOL, affecting the functional abilities of women in social, work, and home settings. Identifying depression in older individuals can be complicated because somatic complaints associated with depression (eg, fatigue, insomnia, poor concentration) mimic physical ailments common among older adults. More than 70% of individuals who screen positive for depression do not receive treatment.[10]

Sexual and pelvic health

Attitudes and stereotypes about women and aging can have a major impact on the care they receive, especially in regard to sexual and pelvic health. Many HCPs are not prepared to initiate important conversations about these topics. Sexism and ageism can result in stigmatization and biases that influence whether these health issues are addressed or ignored. Sexual activity may be viewed as reserved only for the young and healthy, yet 40% of women age 65 years and older report that they are sexually active with a partner and that sex is an important part of their QOL.[11] These women are diverse with respect to marital status, sexual orientation, sexual practices, and health conditions.

Pelvic health includes urinary continence. Urinary incontinence (UI), which often has an adverse effect on QOL, affects 44% to 57% of women age 40 to 60 years and 75% of women older than 75 years.[12] Although appropriate management can result in substantial improvement, fewer than half of individuals with UI consult with their HCP about the problem because of embarrassment, lack of information about the availability of treatment, and the misperception that UI is a natural condition of aging.[13]

Preventive services

Older adults who obtain clinical preventive services and practice health-promoting behaviors increase their likelihood of remaining healthy and functionally independent. Preventive services can help lower health risks and costs of treating chronic disease, as well as prevent or delay the onset of disease. The cost of several preventive services for older women is covered by Medicare as part of well-woman care for those age 65 years and older and by most health insurance companies for women age 50 to 64 years.[14] With prevention strategies, HCPs can encourage healthful lifestyle changes, enhance risk reduction and safety, increase early detection of conditions resulting in more expeditious treatment, and provide disease-preventing immunizations. Many women are not aware of these recommendations and available insurance coverage, and many HCPs do not include all of these components as part of the well-woman visit for older patients.

Influence of inequities and disparities on the health of aging women

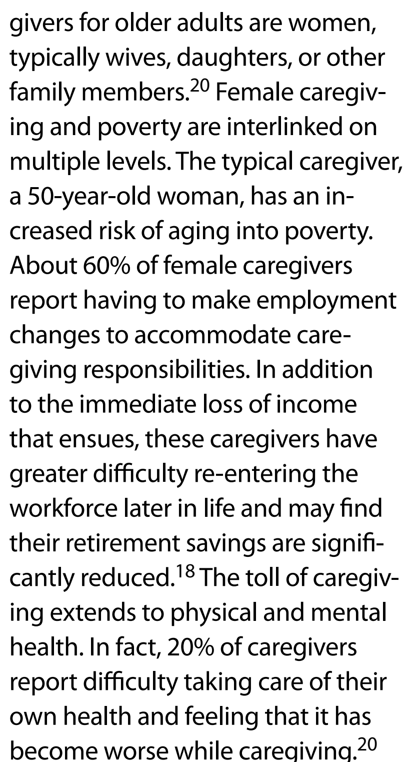
The context of the lives of aging women is intricately connected to a lifetime of social determinants, which include areas such as education, work, socioeconomic status, race and racism, ethnicity, sexual orientation, gender identity, immigration status, religion, and disability status. Structural determinants are closely linked to social determinants and include, but are not limited to, discrimination, geographic location, housing, safety, and transportation. These structural determinants can limit access to nutrient-rich foods, a usual source of healthcare, community-based resources for managing chronic conditions, and services to support aging in place. Health inequities and health disparities are the consequence when social and structural determinants result in bias, discrimination, or exclusion.[15,16] The intersectionality of aging and being female, along with other determinants, presents uniquely distinct issues that are often ignored during discussions about aging policy, economic policy, and health policy.[3] The powerful effect of these social and structural factors on health status is enormous in light of the power of healthcare to counteract them.[17]

Poverty

The gap in poverty rates between women and men widens as they grow older: 13.2% of women age 75 years and older live in poverty, as compared with 8.8% of their male peers.[18] Beyond gender, disproportionate poverty rates exist for older women based on race and ethnicity, marital status, disability status, and lesbian, gay, bisexual, transgender, questioning (LGBTQ) status. The highest rates of poverty are experienced by American Indian or Alaska Native women, Black women, and Latinas. Among women age 65 years and older, poverty rates are highest for those who are divorced or never married.[18] Compared with men with disabilities and women without disabilities, older women with disabilities are more likely to live in poverty. LGBTQ women experience higher rates of poverty than do cisgender straight women and men.[18] Compared with their male counterparts, women in rural areas, especially older women, experience higher rates of poverty, with resulting limited local healthcare, transportation, community-based services, and social supports.[19]

Caregiving

Approximately 61% of unpaid care-



givers for older adults are women, typically wives, daughters, or other family members.[20] Female caregiving and poverty are interlinked on multiple levels. The typical caregiver, a 50-year-old woman, has an increased risk of aging into poverty. About 60% of female caregivers report having to make employment changes to accommodate caregiving responsibilities. In addition to the immediate loss of income that ensues, these caregivers have greater difficulty re-entering the workforce later in life and may find their retirement savings are significantly reduced.[18] The toll of caregiving extends to physical and mental health. In fact, 20% of caregivers report difficulty taking care of their own health and feeling that it has become worse while caregiving.[20]

Insurance and payment

The capacity for individuals to afford healthcare depends on several payment mechanisms, including self-pay fee for service, private insurance, and government-funded programs. Regardless of insurance and government-funded programs, out-of-pocket spending continues to rise with age and is higher for women than for men.[21]

The structure of government-funded payment systems has historically equated women's health with reproductive health, leaving a gap in insurance coverage and appropriate healthcare for many women between their reproductive years and Medicare eligibility. The Affordable Care Act (ACA), enacted in March 2010, significantly increased the number of US citizens and legal US residents with health insurance and has helped bridge this gap for many women not yet eligible for Medicare. By 2017, with Medicaid expansion and increased private insurance coverage through the ACA, the uninsured rate for women younger than age 65 years decreased but was still 10%.[22] Uninsured rates remain highest among low-income women and Latinas.[22]

Medicare helps pay for many medical services for those who are age 65 years and older, as well as for some individuals younger than 65 years who have a long-term disability. Traditional Medicare without supplemental insurance has relatively high deductibles, cost-sharing requirements, and no limit placed on what beneficiaries may need to pay out of pocket. Of these Medicare beneficiaries, 20% have no supplemental coverage.[21] Traditional Medicare also does not pay for long-term-care (LTC) services, dental services, eyeglasses, hearing aids, or outpatient prescriptions, all of which may be particularly important for older individuals. Medicare recipients must enroll in a supplemental insurance program with monthly premiums to cover outpatient prescription medications and still may have a co-pay. Women are disproportionately burdened with the cost of LTC services. About two-thirds of all residents of nursing homes and residential care communities are women.[23] Out-of-pocket costs for LTC can be prohibitive, and many women must rely on supplemental Medicaid.[23]

Strategies to address challenges/gaps and improve the health of older women

Older women's interconnected challenges for improving health and wellness demand a comprehensive, integrated approach to prepare public policymakers, HCPs and educators, researchers, corporations, and nonprofit service providers and advocates to better serve this growing population. Collaboration across sectors can bring about the greatest success in addressing challenges/gaps, eliminating health disparities, and achieving health equity for older women.

By coordinating advocacy and policy efforts, sharing resources, supporting appropriate research, and creating a universal BOlder Women's Health Agenda, we can more effectively serve aging women and the HCPs, family members, caregivers, advocates, and organizations caring for them. This is the mission of the BOlder Women's Health Coalition. More than 35 organizations and agencies have participated in Coalition meetings to date, representing a broad and diverse range of talents and resources supporting collaboration around the four key interconnected pillars of policy, clinical education, public education, and research.

Policy

A policy agenda that advocates for changes to improve health and healthcare for older women is critical. Health disparities should not determine health outcomes. It needs to be acknowledged that certain groups of women experience marginalization that results in inequitable healthcare as they age.

Clinical education

Preparing HCPs to care for older women requires broadening their understanding of gender differences within the aging population and of issues specific to preventive health and disease management of aging women. Knowledge about the effects of social and structural determinants such as gender, race, and poverty, and the intersectionality of these factors on aging women's health can enhance the ability to serve this population. Opportunities to address implicit bias in ageism, sexism, and racism are critical to enhance patient–clinician communica-

tion, asking the right questions, and providing information that women need. Collaborative skills must be acquired to promote continuity of care and address multiple issues beyond healthcare. Although aging women receive care from a variety of medical specialists, they would greatly benefit from an increase in geriatric specialists in the clinical community.

Public education

Promoting healthy aging and removing stigmas and stereotypes of aging go beyond clinic walls. Public education campaigns and networks can be used to reach women, families, and communities with evidence-based, culturally aware information about physical and mental health and resources they can use in decision making, managing their own self-care, and taking action to improve their health. Compared with the abilities of single organizations, the united efforts of nonprofit, public, and private organizations that promote women's health can provide a greater number of resources and reach a greater number and variety of audiences.

Research

The Office of Women's Health Research within the National Institutes of Health serves as a catalyst for research across the entire spectrum of women's health, advocating for inclusion of women in all studies, including clinical trials, and providing women-specific research results. The National Institute on Aging has given high priority to research on AD and other dementias disproportionately experienced by women. The Study of Women's Health Across the Nation, the Baltimore Longitudinal Study of Aging, and the Women's Health Initiative study each provide ongoing research results about women's health as they age. Continued funding for these initiatives enables our knowledge to progress and expand.

Research is limited, however, with regard to the health, well-being, and QOL of certain vulnerable populations of aging women. Studies of aging lesbian, bisexual, transgender, and nonbinary populations have been extremely limited, yet these populations have both unique and similar challenges as they age. Further research addressing the health challenges of women of color is needed to provide health services that address gender, racism, and race/ethnic-specific health risks and to inform policy on the inequities in morbidity and mortality and access to healthcare. Research into the physical and mental health effects of caregiving on women is also needed. Interdisciplinary research can further our understanding of the roles of social and structural determinants of health and can help reduce health disparities for all women as they age.

BOlder Women's Health Coalition – Next steps

"BOlder Women's Health Coalition: A call to action" will be disseminated to a variety of stakeholders in the policy, clinical education, public education, and research arenas to create leverage in a shared goal of promoting older women's health. Specific action steps for 2020–2021 include:

- Coalition members who sign on to BOlder Women's Health Coalition: A call to action will disseminate the information through websites, social media, meetings, written publications, and conference presentations.
- A BOlder Women's Health resource hub website will be launched and maintained by NPWH to share older women's health resources, research findings, public health campaigns, and educational activities provided by Coalition members.
- Coalition members will explore avenues to engage with congressional members to spotlight issues and encourage a more holistic approach to aging, health, and economic policies that promote healthy aging for women.
- The Coalition will meet as a group in 2021 to:
  - finalize the Coalition principles that will guide the creation of a BOlder Women's Health Agenda;
  - define that agenda with specific action steps and goals for each of the four pillars: policy, clinical education, public education, and research; and
  - generate funding for future initiatives.

Call to action

For the baby boomer generation of women, the approach to aging differs from that of their mothers and grandmothers. Organizations and systems that serve older women today must come together and rethink how we support women's healthy aging and take action to break down the social and structural barriers that stand in the way. This generation deserves a coordinated strategy to anticipate needs, identify gaps, and integrate responses across disciplines. The BOlder Women's Health Coalition aims to unify and guide that response and help the country transform the way we support aging women. ■

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Web resource

A. bolderwomenshealth.org