WOMEN'S HEALTH ACTION

Creating health strategies for older women

by Women's Health Action

Women's Health Action is a women's health promotion, information and consumer advisory service.

WE ARE A NON-GOVERNMENT ORGANISATION THAT WORKS WITH health professionals, policy makers and other not for profit organisations to inform health policy and service delivery for women. Women's Health Action, which grew out of Fertility Action, founded by women's health activists Phillida Bunkle and Sandra Coney is in its 31st year of operation and remains at the forefront of women's health in Aotearoa New Zealand.

We are highly regarded as leaders in the provision of quality, evidence-based consumer-focused information and advice to ensure health policy and service delivery meet the needs of diverse women, and has intended and equitable outcomes.

We have a special focus on breastfeeding promotion and support, body image, as well as women's sexual and reproductive health and rights.

WE PROVIDE:

- Expertise in the development of high-quality health consumer information resources.
- Consumer representation and women's health perspectives in a range of consultations, working parties and health service reviews.
- Extensive networks in the public health and not-for-profit sector. We coordinate regional networks in breastfeeding and eating disorder services.
- Discussion forums, seminars and presentations on women's health, public health and gender issues
- Evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women's health (including screening), public health, gender and consumer issues including a focus on reducing inequalities.
- A range of breastfeeding promotion activities which connects us with women, their families, and communities.

Issues paper: *Creating health strategies for older women*
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"The aged [sic] are our future selves. If we continue to have discriminatory attitudes towards the aged, we ourselves are likely to become the victims of those prejudices."[1]

Introduction

FROM THE LATE 20TH CENTURY ONWARDS THERE WERE significant demographic changes in Aotearoa New Zealand. Fertility rates decreased while life expectancy continued to increase. As a result, it is expected that the proportion of older people to the rest of the population will significantly increase[2] and by 2051 older New Zealanders will make up 26 out of every 100 people, the majority of whom will be women.[3]

This pattern of increasing longevity of people throughout the industrialised world has generated a substantial body of new policy and theory.[4] Alongside calls for a renewed vision of the roles and functions of people in what is referred to as the Third Age,[5] the health care demands of this growing group are often discussed by problematising ageing. The focus is primarily on perceived economic and other burdens and is characterised by both gender and age discrimination.[6]

A reductive focus on costs does not recognise the valuable contribution older people make to society or the factors that improve experiences of ageing. The New Zealand Positive Ageing Strategy identifies ten important goals that will contribute to the health and wellbeing of older people. These include income, health services, housing, transportation, security, culturally appropriate services, accessible services, ageism, work, and opportunities for personal growth and community participation.[7] However, older women in Aotearoa New Zealand face significant and unique challenges to their health which risk being obscured without a specific gender focus.

This paper provides a review of the issues around women's ageing and identifies the following six key strategies for improving older women's health;

1. Gender and age equality
2. Recognising diversity and the social determinants of health
3. Gender and age sensitive health care practice and research
4. Addressing high risk illnesses and chronic disability among women
5. Enhancing quality of life and supporting independence
6. Taking a human rights based approach

Ageing in Aotearoa New Zealand

IN AOTEAROA NEW ZEALAND THE FIRST OF THE 'BABY BOOM' generation has reached 65 years of age, marking the beginning of a dramatic increase in the proportion of older people here. However, it is important to recognise diversity between women aged 65 and over and the implications of diversity on health and wellbeing.

The latest Ministry of Health briefing paper notes female life expectancy at birth is 83.0 years which is four years longer than male. However, female life expectancy has increased by 0.8 years for females compared with 1.3 years for males since 2007. The gap between Māori and non-Māori life expectancy at birth is narrowing, but is still 7.2 years for females and the number of Māori over 65 is growing at a faster rate, but Māori rates of disability are increasing.[8]

While life expectancy has continued to increase for all New Zealanders[9] the increase in health expectancy has not kept pace and girls can expect to live 14 percent of their lives in poor health.[10] Some reports suggest that long term disabilities will have an increasing impact on health expenditure. While cancers and ischemic heart disease are the leading causes of female mortality, older women also have higher rates of arthritis, osteoporosis, asthma and chronic obstructive respiratory disease than men.[11] Approximately one in five older females have a disability and falls are a common cause of female hospitalisations for injury in the older age groups. Mental health is also an issue for older women who are more likely to outlive male partners, face social isolation and anxiety about lack of financial security and safety. In addition there is anecdotal evidence that distress caused by these issues may be medicalised rather than addressed at a social or economic level.

However, physiological changes such as a reduction in bone density and eyesight are a normal part of the ageing process and these do not necessarily lead to changes in independence or overall wellbeing. At the same time, social factors such as living standards, income and access to health care are variable and greatly affect how individuals experience ageing. There are considerable differences in health outcomes and challenges between men and women and between women. In cultures where both sexism and ageism are present older women face the "double jeopardy of exclusion related to both".[12]

The social, political, cultural, and physical conditions under which people live and grow older are also important influences on health "*and have cumulative effects over a lifetime*".[13] In Aotearoa New Zealand there are significant disparities in the health of different groups of women. For example,[14] Māori have poorer health outcomes and a higher burden of chronic illness than older non-Māori. Rates of mobility and agility disability were also higher for older Māori compared with older non-Māori. Diabetes featured in the top five causes of death for Māori males and females but did not feature in the top five for non-Māori of either gender.[15] Differences can also be found in the health of Pacific women and other groups such refugees, and lesbian, bisexual, queer and transgendered women reflecting the effects of a range of intersecting factors including racism, homophobia and the transgenerational effects of colonisation as well as structural barriers and socio economic differences.[16,17,18,19]

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Furthermore, there are considerable cultural differences and attitudinal differences between women over the age of 65, due to different experiences based on age, ethnicity, class and other factors. For example, women now in their eighties may have lived through the 1930s depression and World War II, and may have become a parent in the 1950s or 1960s.[20] The life experiences of this age group is different from that of women who are just turning 65 who were "the first generation to have access to the oral contraceptive pill" growing up in a period of rapid technological and societal upheaval and change.[21] It is important to remember the diversity of this population.

Key issues affecting the health of older women in Aotearoa New Zealand

Locating older people as a burden

Concepts of ageing and attitudes towards older people and being older are variable and culture based.[22] By the twentieth century western popular culture began to present an increasingly negative view of older people and for the first time in history, long life had become a problem.[23] Such a reductive, negative view of ageing could have harmful effects on the population, and should be critically examined.

In Aotearoa New Zealand, recent economic policies have led to a constriction of the involvement of the state in supporting the most vulnerable New Zealanders.[24] This has coincided with an emerging discourse about the 'burden' of the ageing population when many countries are looking at ways to reduce health care costs. The increasing focus on the health care 'burden' of the ageing populations means a reduction in state funded benefits is a real risk. In this context, older women, particularly those from groups who already experience health disparities, may face significant challenges accessing health care and other services and in maintaining good health.

At the same time, the inevitability of health care for older people becoming an unsustainable economic burden, is questionable. Nor should age be equated with an inability to contribute to society. There is evidence that many older adults are successful at remaining functional in the community and in relatively good health despite frequently reporting the presence of chronic conditions and physical symptoms.[25] In addition older adults tend to report being more satisfied with their lives than younger people and research findings on activity and bodily limitations further underscore that many older adults, even with increased levels of disability, function well in the community and look positively on their own health.[26]

Locating the idea of good health with a particular age group or gender does not necessarily reflect the reality of health care costs. Youth, for example, is not necessarily always associated with happiness or good health. It is important that access to health care as a basic human right be reflected across age groups and genders. In their efforts to improve the quality of life for older people, policy-makers, government agencies and health care services need to envisage older women not just as recipients of assistance, but also as agents of change and development who can help identify solutions for the problems affecting them.[27]

The effects of ageism and sexism

"*Western ideals, often geared to marketing concerns, penetrate cultures around the globe, glorifying youth and distorting age. Stereotypes of all ages are reflected back to audiences as reality, spreading the idea of older women, especially rural women, as a burden on a younger generation.*"[28]

Many studies suggest that viewing ageing as a pathological process gives rise to negative beliefs about getting older including inevitable mental and physical deterioration, loss of sexuality, and social withdrawal and disengagement.[29] Other societal norms, particularly those relating to appearance often make getting older more of a challenge for women than for men.[30] Other recent studies also argue that cultural representations of ageing and sexuality have combined to paint an unnecessarily negative and inaccurate picture of female sexuality in mid and later life for women where menopause is constructed as a time when women either lose their interest in sex and later life a time when sexual activity is no longer important.[31,32,33]

Information about older women's health is obscured by ageism and sexism in medical research and care. Women also face unique challenges including domestic violence and poverty which affect experiences of health and wellbeing throughout their lives. Furthermore, women's double burden of ageism and sexism and the pathologising of ageing more broadly, results in the devaluing of older women's contributions to their families and communities, and makes valuable information about how to improve women's experiences of ageing more difficult to recognise.

A lack of gender-related health information

The diversity of women aged 65 and over coupled with the lack of gender based research in many areas of health means information about the health of older women in Aotearoa New Zealand is limited. Obtaining objective health information and health care advice becomes even more challenging in an environment influenced by cultural ideals and business interests. Aotearoa New Zealand remains one of only two countries in the world that allow direct to consumer advertising (DTCA) of pharmaceuticals (for example cholesterol-lowering statins and bisphosphonates for osteoporosis). The promotion of pharmaceuticals within a culture obsessed with youth and women's appearances makes unbiased information about health and medicine difficult to obtain and analyse. As health care has become more complex, health literacy and obtaining independent, evidenced based information can be difficult. In addition, both online and offline health care advice is often delivered by those manufacturers standing to profit from delivering medical information.

Reliable health information is further undermined by challenges around care for older people, ageism, and insufficient attention to gender differences, creating compounding health issues for older women. In all older people, multiple medications and fragmentation of care may result in serious side effects being unreported. Similarly, age based stereotyping may mean symptoms are wrongly identified as age related.[34] Other health challenges include prescribing of drugs that have not been adequately tested on elderly women and a failure to recognise that women are more likely to experience drug reactions than men. In addition, the medicalisation of ageing, including over diagnosis and overtreatment with multiple drugs can steal away healthy old age. Adverse reactions, multiple drug interactions, a lack of evidence for safety in the elderly and in women, has resulted in some physicians calling for managed deprescribing programs to be instituted and there is now good evidence for discontinuing anti-psychotics and anti-depressants, sleeping pills, diuretics, and hypertension and cholesterol drugs.[35]

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Lack of robust informed consent procedures, media based misinformation, medication or treatment-induced illness, unsubstantiated statistics (for example mortality rates following hip fracture), along with patient disempowerment, all add to health challenges for older women. An important barrier in constructing health policies for older women is gender bias of health research that guides policy development and it can be argued that much of what is known in medical research is characterised by gender blindness. This includes both the under representation of women in medical trials and a lack of analysis of research based on gender or sex[36] despite the fact that men and women may present with different symptoms and may react to treatment differently. This illustrates the importance of focusing on both age and gender and bringing the specific needs of older women to the forefront of the research agenda.

The literature also identifies two other key issues, which are more likely to affect women than men: elder abuse and poverty.

Elder abuse

Each year, New Zealand's Age Concern's Elder Abuse and Neglect Prevention (EANP) services receive over 1000 referrals about people who may be facing elder abuse or neglect. Two thirds of abused older people are women. EANP notes that older people who are dependent on others are particularly vulnerable to abuse and that for many both their physical and mental health was significantly affected by the abuse they experienced. Many experience long-term consequences including physical injury leading to complications and financial losses[37]. Two out of every five abused people experienced a significant reduction in their independence, loss of confidence and self-esteem, and reported feeling very frightened or anxious and emotionally distressed. Abuse of elderly people by care services is not uncommon[38] but abuse by family members is most common.[39]

Age Concern New Zealand (ACNZ) data shows that referrals have been increasing steadily for some time, and that services are not always able to respond to demand.[40]

Poverty

Poverty is associated with poorer health outcomes across all age groups and has significant impacts on older people. Denton and Boos argue that much of the gender differences in wealth can be explained by the gendering of work and family roles that restricts women's ability to build up assets over the life course. But beyond this, there are significant gender interaction effects indicating that women are further penalized by their participation in family life, employment and where they live.[41] There are few New Zealand studies about the impact of poverty on women over 65 but there is evidence in the international literature that there are gender differences in levels of poverty amongst older people. In Aotearoa New Zealand there is predominance of female workers on low pay in the aged care workforce.[42]

Because women are living longer and because of their traditional lack of financial retirement planning, they are prime candidates for poverty.[43] Older women who lack financial security such as superannuation, or owning their own home, may try to live very frugally – cutting costs on heating, quality food, activities that promote social connectedness, or health care. These women might not experience poverty per se but are 'living poor'. In addition, the health care reforms of the last decade have also had a negative effect on poorer people, including the closing of acute-care beds, and early release from hospital without a corresponding increase in support in the community which has left many ageing women with an increased and unrecognised burden of caring for partners and other family members who are ill or frail.[44]

The positive economic and social contributions of older women

THE HEALTH OF OLDER WOMEN DOES NOT NECESSARILY HAVE to be placed in a context of problematising discourses about economic burden[45] or negative views of ageing and recent research has challenged these approaches and beliefs.[46] Older people make valuable economic contributions to society through the time they spend in voluntary work and in unpaid caring of family members and in services to the wider community. However, there is evidence that the benefits, both personal and societal, of women's unpaid work is undervalued and ignored by policy makers.[47] For example, a 2003 Australian study found that Australians aged over 65 years contribute almost $39 billion per year in unpaid caring and voluntary work and, if the unpaid contribution of those aged 55 to 64 years is included, this rises to $74.5 billion per annum.[48] Other Australian studies suggest this undervaluing of the contribution of older people has direct parallels to the undervaluing of the unpaid contributions of women who leave the workforce to raise children, or who raise children while continuing to work.[49,50]

Social capital has been well demonstrated to have an effect on health and there is evidence that psychological capacities greatly influence the way in which people age. Coping styles, self-efficacy, optimism, and a sense of coherence are linked to mental and social well-being as one ages and appear to influence a person's ability to maintain meaning in life despite personal losses, physical decline and ageism.[51] In a study in which the health in older women was considered from four perspectives of fitness,[52] researchers found that it was not health, per se, which is so crucial in women's later lives, but rather the attitudes and coping strategies to meet new situations, losses and crises. Preliminary findings in another study also suggest that while widowhood has an initial negative impact on the health and wellbeing of older women, in the long term it may be accompanied by a positive shift. Other studies have detailed the value of activism and social and political involvement in later life.[53] The responses of others, including health professionals, are also noted as important in enabling older women to live productive lives in spite of adversity.[54]

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For some spirituality and/or religion provides much of this meaning and may also provide a source of social support and of self-esteem as well as pastoral care. Studies have found that faith institutions and religious groups can be an important source of social support, validation, hope and reassurance that her life and death have meaning. In a study which interviewed women over the age of eighty about their experiences of purpose in life, very old women were found to experience purpose in life both in their daily activities and in their contact with a spiritual world facilitated by a positive view of life.[55]

Strategies for improving older women's health

By 2051, the population of women over 65 in Aotearoa New Zealand is expected to increase to 718,000, including an estimated 93,000 females aged 90 years and over. Women's Health Action believes strategies should be put in place now to improve older women's health. Following our review of the literature, including recommendations put forth by the United Nations and a review of approaches taken in similar countries to Aotearoa New Zealand, Women's Health Action has identified six key principles on which health strategies for older women should be based.

Gender and age equality

Promoting good health for older women involves eliminating both age and gender based inequalities. This includes addressing the inequitable access to work and lower incomes experienced by women throughout their lives, restricting access to work and pensions, and addressing domestic violence and elder abuse. Enabling full and equal participation in society and encouraging intergenerational solidarity and respect while acknowledging diversity amongst older women is important and means challenging misconceptions, negative attitudes and stereotypes about women and ageing, and valuing the unpaid work that older women do. Social inclusion of ageing women can be supported by involving older women in decision-making related to political, social, spiritual and economic issues and reducing the isolation of older people by creating environments that enable their continued physical and social involvement in community life.

Recognising diversity and the social determinants of health

Aotearoa New Zealand has an increasingly diverse population of women over 65. While a disease based approach can highlight the major health challenges faced by this group in general, it does not take into account issues such as poverty, ethnicity, migration or the effects of colonisation or discrimination. These issues have an impact on individuals' health and their ability to access appropriate and timely care, for example low socioeconomic position in particular is associated with poor health.[56] Greater recognition of diversity among the population of older women and understanding of how these social determinants intersect and affect health is necessary to improving the health and wellbeing of diverse groups of women.

Gender and age sensitive health care practice and research

Age and gender based perspectives must be integrated into all health policy and research. Such integration would allow sex, gender and age differences to be taken into account in the provision of all health care including the prescribing of medications, treating mental health problems such as depression, and dealing with health problems related to violence and abuse. Government statistical data must be disaggregated by sex and age to provide gender specific information about health.

Gender sensitive research is also required. For example, investigation into the specific issues faced by women including safety and mobility, effective options and legal guidelines for providing long-term and end-of-life care, the differential use of medications by older women and men and the impact of health care reform on gender equity.

Addressing high risk illnesses and chronic disability amongst women

Following on from the previous strategy, the particular illnesses and circumstances that contribute to chronic disability and poor health in older women must be addressed, using gender and age sensitive health care research, policy and practice as detailed above. Women are more likely to experience illnesses such as migraine and osteoarthritis and experience other issues such as domestic violence that impact on their health. Interventions that target chronic disability or health must be gender sensitive. For example, research shows development of services specifically suitable to the needs of older women who experience domestic violence is vital. It is also important that health care professionals in all service segments understand the help-seeking barriers that older victims face and replace myths and stereotypes about the nature and prevalence of domestic violence, particularly by families among older people. Mental and primary health services, for example, must *"pay special attention to women who have experienced elder abuse or other forms of violence."*[57]

Enhancing quality of life and supporting independence

One of the challenges of getting older is the fear of becoming a burden on others and losing independence.[58] Strategies to support independence could include changes in work practice that enable older women to remain in both the formal and informal labour markets and facilitate gradual retirement. Studies indicate help with housework was the most common identified need and family and friends were the most likely to help older people with everyday tasks. However, lower fertility rates and an increase in the number of people who do not have children means increasingly older people do not have families to share the caring role[59] and more could be done to support the work of unpaid carers. The transfer of formal care to unremunerated care provided by ageing women without providing compensation for lost wages and community support services is discriminatory. Priority setting in health care services should be free from systematic gender and age biases and based on evidence from research that is undertaken with older women and in consultation with them.

Additional strategies such as creating housing designs that enable multigenerational living and assistance with home modifications and repairs; accessible housing; hazard-free streets and buildings; safe, accessible public transportation; creating public spaces that encourage active leisure and socialisation along with age-friendly cities and communities; and education about new technologies can address many of the factors in the physical environment that help determine the state of older women's health. They will also improve the health of the rest of the population.[60]

Taking a human rights approach

The dominant discourse which views ageing as a social burden needs to be replaced with a human rights approach. A human rights framework for discussing ageing would promote health, wellbeing, security, and dignity as basic human rights throughout individuals' life courses, including old age. Human rights are obscured in current discussions by negative influences such as the increasingly held view that older people are a burden, the medicalisation of ageing and the influence of the pharmaceutical industry on the public's view of health.

However, the promotion and protection of older women's human rights are particularly important as they are more likely to face multi-sectored challenges, *"As they age, women and men share the basic needs and concerns related to the enjoyment of human rights such as shelter, food, access to health services, dignity, independence and freedom from abuse. The evidence shows however, that when judged in terms of the likelihood of being poor, vulnerable and lacking in access to affordable health care, older women merit special attention."*[61]

Summary

THIS PAPER HAS PRESENTED A REVIEW OF RECENT LITERATURE in regards to the health of women over the age of 65 and identified some of the key health policy issues for older women in Aotearoa New Zealand including the effects of gender and age discrimination. The studies we have reviewed suggest similar strategies to those proposed by the United Nations. We need to take more than a disease based approach if we are to ensure all older women in Aotearoa New Zealand enjoy good health and appropriate health care when they face illness or disability.

The achievement of improved and equitable health care for older women will require taking a life course approach to women's health and removing age and gender bias from health research and service provision. Included in this approach must be strategies which address the underlying determinants of health, differences in population and age groups and socioeconomic factors. This issues paper has detailed key recommendations to inform discussion of older women's health strategies.

"Ageing women represent an important and growing political constituency in both developed and developing countries. Recognising and supporting their full participation – regardless of socioeconomic status and ethnicity – will benefit the health and well-being of individuals, families, communities and nations."[62]

Notes

1. Mizner, G.L. and D. Strauss. 1981. "Later Adulthood and Old Age" in R.C. Simons and H. Pardes *Understanding Human Behavior in Health and illness*, Williams and Wilkins, Baltimore.
2. United Nations, Global Issues: Ageing http://www.un.org/en/globalissues/ageing/
3. In 1956, women accounted for 53.8 percent of those aged 65 years and over, with 116 older women for every 100 older men. This was even more extreme for those aged over 85 years: there were 142 women for every 100 men in this age group at this time. But by 2051, it is expected that in the 85-plus age group there will be 162 women for every 100 men. Statistics New Zealand. Population projections. http://www.stats.govt.nz/browse_for_stats
4. Markwick, C. (1995) "Longevity Requires Policy Revolution" *Journal of the American Medical Association*, 273(17): 1319-1321. Banks, D.A., and M. Fossel (1997) "Telomeres, Cancer and Aging: Altering the Human Lifespan" *Journal of the American Medical Association*, 278(16):1345 –1348. Wetle, T. (1997) "Living Longer, Aging Better: Aging Research Comes of Age" *Journal of the American Medical Association*, 278(16):1376 –1377.
5. Cornman, J.M. (1997) "Questions for Societies with 'Third Age' Populations: The Extension-of-Life Working Group, The Gerontological Society of America." *Academic Medicine*, 72(10):856 –862 "Referring to a "time in the life course when the basic work of parenting is done, when individuals leave paid, full-time employment, and when few positive roles are recognised".
6. In this paper *Age discrimination* specifically refers to deeds completed with the intention to reject and restrict opportunities to certain people solely based on their age. This is often associated with ageism, which has significant effects in many areas, including employment, financial services and health care. *Age and gender based discrimination* refers to the restricting of older women from full inclusion and participation in social, economic, cultural and political affairs because they are women and because they are old.
7. Ministry of Social Development, 'The New Zealand Positive Ageing Strategy' http://www.msd.govt.nz/what-we-can-do/seniorcitizens/positive-ageing/strategy/index.html
8. Ministry of Health NZ. Briefing paper for incoming Minister.2014. http://www.health.govt.nz/publication/briefing-incoming-minister-health-2014
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11. Ministry of Health NZ. 2013. Health and Independence Report. Wellington.
12. United Nations. 2012. 'Between gender and aging': the status of the world's older women.' http://www.who.int/gender/documents/ageing/9789241563529/en/index.html
13. Ministry of Social Development. 2010 'The Social Report' http://socialreport.msd.govt.nz/health/life-expectancy.html
14. Tatau Kura Tangata: The Health of Older Māori Chart Book 2011 presents a snapshot of the health of Māori aged 50 years and over.
15. Ministry of Health. 2011. 'Tatau Kura Tangata: Health of Older Māori Chart Book 2011' http://www.health.govt.nz/publication/tatau-kura-tangata-health-older-maori-chart-book-2011
16. This study "looks at those aged 50 years and above because Māori continue to have a lower life expectancy than non-Māori. Additionally, due to small numbers of Māori aged 65 years and above, analysis from age 50 has allowed for a further age and gender breakdown while ensuring the estimates are reliable". All indicators compare Māori with non-Māori. In general, prioritised ethnicity was used when people identified with more than one ethnic group. A person was classified as Māori if any one of their recorded ethnicities was Māori; all other people were recorded as non-Māori. For example, a person recorded as both Māori and NZ European was counted as Māori. 'Unknown' or missing ethnicity was counted as non-Māori.
17. MOH. http://www.health.govt.nz/publication/tatau-kura-tangata-health-older-Māori-chart-book-2011
18. Ministry of Social Development (2010) 'The Social Report' http://socialreport.msd.govt.nz/health/life-expectancy.html
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25. Ministry of Health NZ figures note less than 1 in 12 of the older disabled population is cared for in rest homes.

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"Ageing women represent an important and growing political constituency in both developed and developing countries. **Recognising and supporting their full participation** – regardless of socioeconomic status and ethnicity – **will benefit the health and well-being of individuals, families, communities and nations**."

"As they age, women and men share the basic needs and concerns related to the enjoyment of human rights such as shelter, food, access to health services, dignity, independence and freedom from abuse. The evidence shows however, that **when judged in terms of the likelihood of being poor, vulnerable and lacking in access to affordable health care, older women merit special attention**."