Keynote Address

Taking Charge: A Personal Responsibility

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Synopsis

Women can adopt health practices that will help them to maintain good health throughout their various life stages. Women can take charge of their health by maintaining a nutritionally balanced diet, exercising, and using common sense. Women can also employ known preventive measures against osteoporosis, stroke, lung and breast cancer, and accidents. Because women experience increased longevity and may require long-term care with age, the need for restructuring the nation's care system for the elderly becomes an important women's health concern. Adult day care centers, home health aides, and preventive education will be necessary, along with sufficient insurance to maintain quality care and self-esteem without depleting a person's resources.

I WANT TO DISCUSS SOME good news: taking charge, a personal responsibility. This is not only about your life, but about the lives of other women who are important to you: your mothers, daughters, sisters, aunts, clients, patients, neighbors, and friends. You care about these people, and so do I.

During these times of rapid change for women, people who make public policies and those who shape the course of major institutions must pay close attention to the impact that change has on women's lives. Tracking that change in my view is why a national conference on women's health is so important, and I am pleased to help you focus the spotlight on the health issues facing women and facing our health care institutions today.

I would like to discuss three matters: some of the health practices that women can adopt at any stage in their lives which will help them stay healthy; some specific things that women in the middle of their lives can do to make sure that they remain healthy and independent as they become older; and the future of long-term care, so critical for elderly women, and the pressing need we have in finding alternative ways of providing and paying for long-term care.

Women today live an average of 8 years longer than men, but this additional longevity may be a mixed blessing. Although women do not have as much acute illness as men, they suffer more chronic illness, and when very old, women often require intensive long-term health care. Most of this care is provided by families, typically by daughters, with some assistance from private groups, health agencies, and other community agencies. For most of the ill and independent elderly, care is provided in nursing homes.

Whatever the source of care, the costs are very high, including the emotional and social costs to family members and friends as well as the financial costs to the elderly themselves, their families, and the taxpayer. The devastating costs of long-term nursing care are everyone's problem. All of us, families, the health care system, government financing programs, and the private sector financing institutions must respond to the challenge of finding solutions. A staff member once told me what she thought was a basic difference between how men regard the concept of responsibility and how women do. She said, "By and large, a man fixes responsibility on who should be blamed when something goes wrong. A woman thinks of responsibility in terms of who should respond when something goes wrong."

Well, one thing this administration is saying is that more of us, besides the public sector and nonprofit charities, should respond to people in need. Our responsibilities are mutual, and the private sector should be involved, asking questions about social change and public policies and how it can be involved.

We need to encourage a sense of mutual responsibility between the public and private sectors, espe-

cially for catastrophic and long-term care, so that in 25 years, when the babyboomers are approaching 65, there will be long-term care choices that they and their families and the nation can afford.

What, after all, should be our national health policy toward the elderly? I believe we should provide the supports that the elderly need to stay functional and independent for as long as possible. Here is a fact that may startle you: Seventy-five percent of the patients in nursing homes are women. A portrait of that statistic shows us that the average nursing home patient is a woman, approximately 84 years old, who has at least six chronic conditions and two acute conditions, and has no one close to her who can continue to care for her. She was probably admitted to a nursing home because she suffered a stroke or a fall, perhaps a hip fracture from which she did not recover well enough to manage daily tasks for herself and take care of her personal needs. Or she may have become seriously disabled by Alzheimer's disease or urinary incontinence, leading causes of admission to nursing homes. The latter condition is treatable and preventable.

Even if the health and personal care services she needed to remain independent were available in her community, she probably would not be able to pay for them, and there is, in this country, virtually no health insurance coverage for long-term care.

Medicare does not pay for extended care, and Medicaid coverage begins for nursing home patients only after a person has become impoverished by the cost. An average stay in a nursing home of about 3 months will impoverish the average patient and allow her to become eligible for Medicaid.

Two-thirds of those who enter nursing homes spend all of their assets within 3 months. Approximately half of all persons in nursing homes are on Medicaid. What are the costs of nursing home care? Many of you with elderly relatives in nursing homes know that the cost can be more than $25,000 a year.

In 1984, the nation spent $32 billion on nursing home care. Expenditures have more than quadrupled since 1972. Four years from now, the cost is expected to increase to $82 billion. These costs are about evenly divided between public and private sources. Private sources of payment are overwhelmingly the funds of the elderly and their families. Private insurance accounted for only 1.8 percent of the private outlay, and Medicaid is the largest public payer for institutional care. It paid out almost $14 billion in 1984. Medicaid was intended to pay for the medical bills of the poor of all ages, not to pay for institutional care of the elderly.

Remember, though, that most elderly women do not live in nursing homes. Today, only 29 percent of the long-term care population resides in an institutional setting. Seventy-one percent reside in the community. Most of the elderly live in their own homes. Of the 8 million elderly Americans who live alone, 80 percent are women. Their average age is 75. And most of them report that their health is good. With proper attention to diet, exercise, preventive health measures, and a generally healthy lifestyle, women will probably continue to live healthier, longer lives than men.

The graying of America is upon us. Between 1950 and 1980, the population over 65 doubled to 24.9 million. By the year 2030, it will double again, accounting for one-fifth of the total U.S. population, and the fastest growing group are those over 85. Their number is expected to double by the end of the century. Most of the very old will be women. They will face the highest risks of severe physical and mental disabilities that can rob women of their independence and well-being.

While it is true that some preventive health measures can be taken by the elderly, we must start educating women about what they can do before they get too old to avoid the severe disabilities we see among the elderly today: becoming immobilized through stroke, hip fracture, heart disease, or any other acute condition, immobilized to the point that we can no longer get around by ourselves, feed ourselves, or dress without help is a terrible thing to consider.

One of the sessions at the Conference deals with osteoporosis, a condition often found in elderly women in which the bones become brittle and lose their density. When a fracture occurs, these bones do not heal properly, and the patient experiences serious disability, pain, even death. About 210,000 hip fractures occur each year in the United States, most of them among women. They account for a very large number of women's admissions to nursing homes and, for many, can initiate a severe decline. Twenty percent of those who do not recover normal function after a hip fracture die within 1 year.

In 1983, the total cost of osteoporosis and fractures of the hip, spine, wrist, and other bones was estimated at $6.1 billion. This terrible disability among elderly women can be prevented. One strategy to prevent fractures is through estrogen replacement therapy, calcium supplements, and regular exercise. Studies have shown that up until menopause, a woman's natural estrogen will protect her from bone loss, but during and after menopause, when estrogen levels drop, women experience a significant loss of bone density. Estrogen replacement therapy, using

low doses, is highly effective in preventing osteoporosis in postmenopausal women, and when estrogen is used with progestin, the increased risk of endometrial cancer associated with estrogen administration may be eliminated.

There is still some controversy about the risks associated with estrogen replacement therapy, particularly with regard to heart disease. Certainly, women will want to discuss this with their physicians.

In 1984, a National Institutes of Health consensus panel on osteoporosis recommended that, in addition to estrogen replacement, midlife women ingest between 1,000 and 1,500 mg of elemental calcium every day and undertake a program of modest weight-bearing exercise, such as walking.

Those of you who are involved in women's preventive care will want to look carefully at the new research on osteoporosis prevention to see how your patients and clients may benefit more by becoming more aware. Another strategy is preventing falls that cause breaks. The Centers for Disease Control are identifying causes and pinpointing prevention steps the elderly can take to avoid falls and other injuries. Our hope is to develop a public education program national in scope, and I hope that this program will become a nationwide effort.

Next to hip fracture, stroke is a frequent catastrophic event that necessitates long-term care for women. Strokes cost the nation an estimated $8 billion a year. Again, as with osteoporosis, a woman's natural hormones may protect her from stroke, but as with osteoporosis, the drop in natural hormones with aging removes her protection. After menopause, women have as many strokes as men, and the rate for older women is higher than that for older men. The good news is that there has been a steady decline in deaths from strokes for both sexes over the last decade.

In 1975, there were 91 fatal strokes per 100,000 people. In 1984, that number had dropped to 65 per 100,000. Much of the decline is due to improvement in the diagnosis and treatment of what are called little strokes or transient ischemic attacks, whose symptoms, tingling or weakness in a limb or on one side of the face, may disappear within minutes but also can be the warning of a major stroke. People know how important blood pressure control and proper diet are to prevent strokes, and since women are more likely than men to practice good health and nutrition measures, the rewards in stroke prevention are there for women who avoid cholesterol-rich foods, keep their blood pressure at normal levels, stop smoking, exercise regularly, decrease their salt intake, watch their weight, and avoid stress.

The women's health movement has been telling women from the very beginning to take charge of their health. Get the information you need to make good decisions. Work in partnership with your doctor, and ask the right questions. We still feel somewhat intimidated in that environment and are reluctant to query the expert whom we are paying for information. You have some exciting opportunities here to promote solid, reliable health practices and in doing so to make some real inroads against two of the most terrible threats to the self-sufficiency of older women: osteoporosis and stroke.

There is one area where prevention and health promotion have gone awry, where women's good sense about their health has taken a dive. I am sure you have all heard the saying, "If women are going to live like men, then they are going to die like men," and granted, men and women have a lot of good things to learn from each other, but cigarette smoking is not one of them. Deaths of women from lung cancer have overtaken deaths from breast cancer.

Breast cancer has been the nemesis of women for years, but it is starting to dim with the onrush of lung cancer caused by smoking. There is a real increase in deaths from lung cancer. Mortality from breast cancer has stayed the same for 15 years at 26 per 100,000 women. Deaths from lung cancer have risen 600 percent in the last 30 years, most of them due to smoking.

The National Cancer Institute and the Public Health Service Office on Smoking and Health are directing educational efforts to women informing them in particular of the dangers of smoking during pregnancy. They are now identifying and developing strategies to discourage teenage girls from smoking. There have been advances in the diagnosis and treatment of breast cancer, and we all know the prevention value of the regular Pap test for cervical cancer.

Death rates for coronary heart disease in women have declined as much as 30 percent over the last 20 years, but women who smoke still have two to four times the risk of heart attack than nonsmoking women. Are women going to throw away their leading edge in longevity by dying like men from lung cancer and heart disease? If this happens, women have not come such a long way after all.

I have discussed the kinds of things women can do in their younger years which will help them to avoid the debilitating conditions we see today among elderly women, conditions which can spell financial ruin and much suffering. There is one condition I have not mentioned in this connection. We do not know enough about it yet to say what people can do

to prevent it, and that condition is Alzheimer's disease.

Approximately 2.5 to 3 million Americans suffer from Alzheimer's disease. Most, because they live to age 80 and beyond, are women. In fact, Alzheimer's disease may be the leading cause of admission to nursing homes. One in three women over age 80 is at risk, and the cost of the disease to the nation, including nursing home care, will approach $40 billion a year.

Some research progress has been made. We know that Alzheimer's disease is not a natural consequence of aging. We are learning more about how to manage the disease and about what it might cost to determine the cause; however, still more research is needed before we can find answers to give us clues as to how to address this issue.

I want to turn now to a little forecasting about long-term care. I think American women are not going to be backsliding into an old age that is dependent and ill. Women have too much work to do in this world to let that happen, and I think our health care system will be responsive to women, to help them as they age to achieve the well-being and sense of dignity that all elderly people deserve. The nation's long-term care system must be restructured. Even now, States are developing and implementing innovative home and community-based long-term care programs for which they are receiving waivers under Medicaid. Care is provided through adult day care centers, homemaker and home health services, and self-care programs in wellness and accident prevention.

These experiments in providing care in the home and community are crucial to assessing the cost effectiveness of various long-term care cost alternatives, and cost effectiveness is a major issue in long-term care. I think the private and public sectors together will develop ways to pay for long-term care, ways that will not deplete an individual's or a family's economic resources or force taxpayers to pay exorbitantly for the care that the elderly need.

Early in 1986, President Reagan asked Secretary Bowen to develop some ideas on how to get the private sector involved in solving this problem and another problem, how to pay for catastrophic health care and long-term care. Dr. Bowen named a public-private advisory committee to gather facts and explore ideas in these areas, and one of these issues that the committee is looking at very closely is how to put the insurance principle to work in long-term care. It is assessing the current method of financing long-term care and identifying problems and gaps. It is evaluating emerging methods for private financing.

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It is identifying barriers that are preventing widespread adoption of private financing mechanisms, and it will make some recommendations to promote private financing.

The committee will look very closely at how private financing mechanisms improve the quality of life and dignity of the individual, how they strengthen and not deplete the resources of the family, and how they contain Federal expenditures and assure system-wide cost-effectiveness.

As important as it is to have a responsive health care system, I firmly believe in taking personal responsibility for one's own health. It may be a condition of our being able to respond compassionately and competently to the needs of others. Some of the more gifted leaders of this nation's social reform movement in the 1890s were the women who founded and directed the settlement houses in our cities. Lillian Wald Henry Street settlement in New York City and Jane Addam's Hull House in Chicago undertook whatever they had to do to better the lives of the city poor. They responded to disease, overcrowding, and ignorance, as well as to hunger, poor working conditions, and many problems of the then huge, immigrant population. The settlement leaders, mostly educated middle-class women, all shared the conviction that no emergency or crisis of the destitute was alien to the settlement house.

Mary Anderson, a shoe worker, who became director of the U.S. Women's Bureau, worked with Jane Addams at Hull House and recalled its basic sympathy and hospitality when she said, "Hull House and Jane Addams open a door to a larger life." Similarly, today's network of women's health organizations and you who are their leaders are helping to keep the door open to a larger life for American women. Women can and must take charge of their health. Our social institutions can and must support them, and there must be a free flow of ideas into the public policy arena. We welcome all of your contributions to meeting the challenge before us.