Introduction: Health Expectations for Older Women: International Perspectives

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Dramatic life expectancy gains are among the greatest achievements of the twentieth century. For women, longer lives have brought important changes in work and retirement patterns, family life, and caregiving. Early in the century, most of the gains came from controlling infectious diseases and improving public health (Fuchs, 1974; Olshansky, Carnes, Rogers, & Smith, 1997). These gains brought additional years of good health. Beginning about three decades ago, death rates for fatal diseases often associated with older age fell considerably. This decline was particularly notable for cardiovascular diseases, such as stroke and heart disease (Davis et al., 1985; McGovern, Burke, Spafka, Folsom, & Blackburn, 1992). Reduced mortality from major fatal diseases brought even more years of life for the average individual. However, many researchers found that these longevity gains also brought additional years spent in worse health (Colvez & Blanchet, 1981; Crimmins, Saito, & Ingegneri, 1989). Thus, the demography of longevity and health has important implications for women of all ages: those who are old, a group that can, on average, antici-
pate many more years of life than most women of previous generations; those who are approaching old age and must plan for many years of continued work or lengthy retirement; younger women who care for aging parents informally; and the large corps of women who serve older persons in the formal health care system.

Another momentous epidemiological shift appears to have been underway during the past two decades, again with important implications for the lives of women. In the United States and a number of other developed countries, there is growing evidence that the proportion of the older population with severe disability has declined (Doblhammer & Kyrit, 2001; Freedman & Martin, 1998; Manton, Corder, & Stallard, 1993). This decline in the prevalence of disability has been attributed to many factors, including better knowledge of healthy lifestyle choices, advances in medical treatment and technology, and prescription drugs (Rowe & Kahn, 1998; Vita, Terry, Hubert, & Fries, 1998). These dramatic changes in longevity and health at older ages have redefined how we conceive of old age. In response to a recent national poll of older people conducted for the National Institute on Aging, for example, almost 50% of people between ages 65 and 69, and nearly a third of those in their seventies, said they consider themselves middle-aged (Clendinen, 2000).

Policymakers, practitioners, and researchers agree that the demand for health care resources and expenditures for health care and other services for older people depends on both the number of older people and their health status (Jacobzone, 2000; Lubitz, Beebe, & Baker, 1995). But the relationship between changing disability levels and use of formal and informal services is complex. Use and cost outcomes will depend on many factors. Will current trends reducing the prevalence of disability continue? Will high costs of health care at older ages be avoided—or merely postponed to later life? At what rate will health care costs rise (Freudenheim, 2001; Hogan, Lunney, Gabel, & Lynn, 2001)? Only time will provide certain answers for these questions. But the extraordinary increase in life expectancy, and growth in the number of older people throughout the world, has made disability a pivotal factor for understanding health care resource needs and social system planning.

Increasingly, policymakers are using disability indicators as a measure of population health. One useful indicator of population health is “health expectancy.” This indicator was first proposed by the U.S. Department of Health, Education, and Welfare (1969) about three decades ago, and has been adopted for use by the World Health Organization. To estimate health expectancy, researchers partition total life expectancy into two component parts. One part is healthy life expectancy, also often referred to
as active life expectancy or disability free life expectancy. This component is a measure of the years an individual can expect to live free of disability. The second part measures the years a person can expect to live with disability, also commonly referred to as inactive life expectancy or disabled life expectancy.

Researchers are actively studying both healthy and disabled life expectancy. For example, an international group of research scientists, known as the International Network on Health Expectancy or REVES (Réseau Espérance de Vie en Santé), has developed and compared various measures of health expectancy across countries and time spans to evaluate changes in health expectancies among populations. Olshansky and Wilkins (1998) review the development of the REVES network. A comprehensive review and synthesis of research conducted by REVES network scientists during the past decade is provided in Determining Health Expectancies (in press).

VOLUME OVERVIEW

Studies included in this volume examine recent trends in health expectancies with a special focus on older women. Women comprise the majority of most older populations, and both the number of older women and their percentage of populations throughout the world will grow rapidly in the coming decades (Kinsella, 2000). Thus, health expectancy trends for women are particularly important. Authors for this volume were selected to represent a variety of developed countries, as well several perspectives about developing countries. These studies provide information that can be used by practitioners, policymakers, and researchers alike to help plan for a wide range of long-term care services and policies. These include services and policies that would assist older women and men, as well as their caregivers.

In the first study, Douglas A. Wolf, James N. Laditka, and I examine life expectancy and active life expectancy among older women distinguished by race, education, and marital status, from two perspectives. We examine the variability inherent in estimates of active and inactive life, and differences in active life expectancy among population subgroups. The results highlight the uncertainty associated with forecasting demand for long-term care services. The results also underscore the heterogeneity of disability in older populations, reinforcing the usefulness of separately estimating health expectancies among well-defined groups of older women.
This volume also includes two perspectives about gender differences in life expectancy associated with specific diseases. These perspectives are useful when evaluating research and policy options addressing various diseases, and also for projecting demand for health care services. Dorly J. H. Deeg, France Portrait, and Maarten Lindeboom use “health profiles,” which group individuals based on the type and extent of health problems, to identify differences in disease types for older women and men in The Netherlands. Among the differences in the health profiles, older women are more likely to be cognitively disabled than older men, and also live longer with this disability. Using data from the United States, Eileen M. Crimmins, Jung Ki Kim, and Aaron Hagedorn examine health expectancy differences for six major diseases and two important health risk factors for older women and men. They find that women live longer than men with all major diseases studied, including heart disease, despite notably later disease onset. However, men are more likely to experience risk factors (being overweight and not seeing a physician on a regular basis) than women.

Gender differences for risk factors such as smoking and obesity and for several diseases are examined by Alain Bélanger, Laurent Martel, Jean-Marie Berthelot, and Russell Wilkins using data from Canada. They find individuals with diabetes or cancer live more disabled lives than those without these diseases. Using data from the United Kingdom, Carol Jagger and Fiona Matthews examine gender differences in functional, cognitive, and physical impairment, and the influence of missing data on impairment estimates. Their results show that women are substantially more likely than men to suffer from cognitive, physical, and functional impairments, particularly at older ages. Importantly, they find that excluding missing data, which is often present in large surveys of older people, is likely to result in underestimates of impairment for women and men.

Colin D. Mathers, Christopher J. L. Murray, Alan D. Lopez, Ritu Sadana, and Joshua A. Salomon present estimates of total, active, and disabled life expectancy for older women and men in many developing and developed countries. Dr. Mathers and his colleagues find women live notably longer in developed countries than in developing countries; for most countries studied, they also find there are substantial gender differences in healthy life expectancy and in the prevalence of specific diseases that cause disability. Jean-Marie Robine, Carol Jagger, and Emmanuelle Cambois use data from the European Community Household Panel to examine gender differences in life expectancy and healthy life expectancy in twelve European countries. Although women live notably longer than men in all twelve countries, this research finds that the proportion of healthy life expectancy and unhealthy life expectancy differs substantially
between women and men among the countries studied. This result highlights differences in health expectancy among relatively homogeneous populations.

Ichiro Tsuji, Catherine Sauvaget, and Shigeru Hisamichi review the results of two recent studies of active life expectancy for older women and men in Japan, finding striking gender differences in the disability process and healthy life expectancy. Drs. Tsuji, Sauvaget, and Hisamichi discuss evolving patterns of education, marriage, and caregiving in Japan, focusing on women, and report on a national long-term care insurance program introduced in Japan in 2000. The policy implications of the active life expectancy results they describe are considered in the context of caregiving and formal long-term care service use and costs.

Sela V. Panapasa’s study of Fiji highlights the complexities of defining disability in the context of Fiji and Pacific culture, and prompts us to reconsider the relative ease and simplicity with which the literature often defines disability. Using census and survey data, Dr. Panapasa finds notable gender and socioeconomic differences in healthy life expectancy, and considers the implications of the findings for Fiji and other developing countries. Finally, James N. Laditka and I provide a critical synthesis of the recent active life expectancy literature. Policy implications include a greater understanding of the role of education and racial and ethnic diversity in active life trends, and an increased public policy emphasis on prevention and treatment of chronic disease, together with adoption of more healthy lifestyles.

In sum, the studies in this volume shed new light on variations in healthy life expectancy across groups of older women, as well as differences in life expectancy and active life expectancy between older women and men. Studies examining health expectancies among various groups of older women illustrate the heterogeneity of active life expectancy, and indicate, among other implications, the life cycle effects of poorer health for at-risk populations, defined by income, race, and ethnicity. Results of studies focusing on gender differences highlight differences in diseases and disability onset and progression among older women and men, generally showing that older women live longer both with and without diseases and disability than men. This finding offers challenges and opportunities for practitioners, policymakers, and older women and men and their families. The studies presented in this volume illustrate the broad inquiry addressing health expectancy, and reveal fruitful areas for future research.

REFERENCES


Introduction
