

# Housing and Care for Older Women Policy Brief

*Author: Julie Byles. Prepared: February 2019.*

## Scope

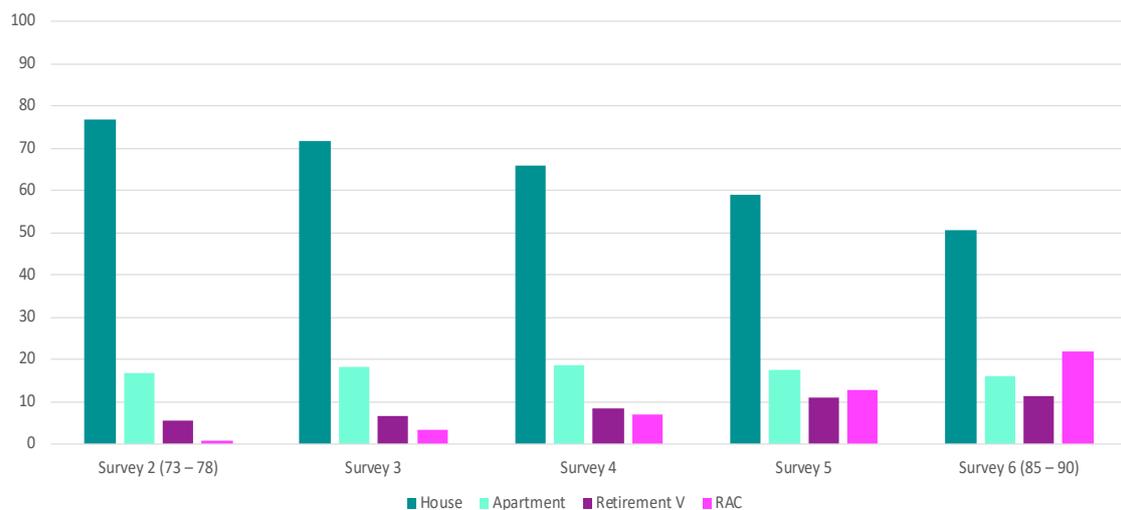
Aged care policy emphasises “staying at home” with support services designed to help people remain in the community for longer. There are also expectations that older people will change their housing as they adapt to their changing needs, enabling better access to aged care and support. By moving, older people are also expected to realise the capital in their home, and free up housing stock for younger people. However, the majority of older women want to remain within their own homes, and don't wish to move from their familiar neighbourhoods.

This brief looks at older women's housing, their changing needs, and the intersections between housing and aged care.

## Research Findings

### Changes to older women's housing

- As women in the 1921-26 cohort aged from their mid-70s (age 73-78) to their late 80s (age 85-90) proportionally fewer women were living in a house and more women moved into aged care (see Figure 1).



**Figure 1. Changes in housing for women in the 1921-26 cohort from age 73-78 to age 85-90.**

At Survey 2, 94% of women lived in a house or an apartment, with few women in retirement villages or aged care. By Survey 6, when the women were 85-90, 67% were still in a house or an apartment, 11% were in a retirement village, and 22% were in residential aged care.

A more detailed analysis looked at the transitions in housing over the course of the women's later lives, based on the type of housing women were living in at each survey, and whether they had survived to that survey point. Over time women showed seven patterns of change in housing.

- Four patterns represented 80% of women who remained most of their later life: in a **house** (61%), an **apartment** (13%), or a **retirement village** (6%).
- Three patterns represented transition in housing type, whereby: 7% **downsized** from a house to an apartment or a retirement village, 8% **transitioned** from an apartment

to a retirement village to aged care, 6% of women moved from a house into **residential aged care** before age 85.

Women who remained in a house or an apartment until their 90s, and those who downsized, tended to be healthier than women in the other groups. Living in an apartment, or moving to one, was more likely in major cities than in rural and regional areas, and for women who lived alone. Those in retirement villages were also more likely to be in major cities, and living alone. However, these women had lower scores for physical function, reflecting more difficulties with daily activities<sup>1</sup>. Living in a retirement village had highest risk of transition to residential aged care compared with women living in the general community<sup>2</sup>.

### Housing in the 1946-51 cohort (Survey 8, aged 65-70 years)

- 80% lived in a house; 15% lived in an apartment; 4% lived in retirement village/caravan; 1% in other accommodation.
- The dwellings had a mean of 3.3 bedrooms, and 75% were single storey.
- Women had lived in their home for a mean of 18.0 years.
- 78% owned the home outright, 10% owned the home with a mortgage, and 12% lived under some form of rental or other arrangement.

Expectations over the next ten years were to: remain in the same home (54%); downsize (18%), live in a retirement village (6%), live in a caravan (0.5%); live in residential aged care (0.6%). 21% had no idea what their housing arrangements would be.

### Transport

- At Survey 3 (age 76–81 years), 55% of women were driving themselves: 86% of these women were still driving themselves at age 79-84 years, and 73% were still driving themselves at age 82–87 years. Women who stopped driving relied on someone else to drive them. Few used public transport or taxis.
- Women were least likely to continue driving if they lived in a major city and most likely to drive if they were in outer regional or remote areas. Driving was less likely if women reported diabetes, stroke, vision problems, and need for help with daily tasks, and if

they had lower SF-36 Physical Function scores. Women who cared for someone who lived with them were 32% more likely to drive, and women who cared for someone who lived elsewhere were 69% more likely to drive, compared to women with no caring responsibility. Likewise, women who were single, divorced, or widowed were more likely to drive than married women<sup>3</sup>.

### Need for help with daily tasks

- Need for help with daily tasks increased steeply with age, from less than 10% at aged 70-75 to over 20% at age 85-90.
- Most of this care was provided by partners, family and friends. Older women were also likely to care for other people. At age 70-75, women were twice as likely to be caring for someone else than needing care for themselves. Later in life this ratio was reversed first as women's own needs for help increased, and then as their role in caring for others diminished.

### Help and support for 1921-26 cohort

- By the time they were aged 85-90, around 70% of women had used Home and Community Care (HACC).
- Factors associated with greater use of HACC were older age, living in an apartment (rather than a house), caring for others, not having a partner, difficulty managing on income, need for help with daily tasks, falls, more chronic conditions, and lower SF-36 physical function scores.
- Approximately 54% of women who used home care used only a few basic services. The remaining service users were grouped as using mostly low volume domestic services (16.5%, median 57 hours), home meals (5%), or higher volume and mix of services (25%) including combinations of domestic services, nursing, transport, and centre-based day care<sup>4</sup>.

### Residential Aged Care (RAC) use in the 1921-26 cohort

- Over 13 years, from age 73-79 to 86-91, around 30% of women were admitted to permanent RAC, 23% died without entering care, and 47% were still living in the

community. After adjusting for health-related needs, age was a major factor for moving into residential aged care, while living in a rural/remote area reduced admission to RAC (in part due to a lack of residential care facilities in rural areas). Women living in a house at the start of the observation period had the lowest rate of residential aged care admissions over the 13 years, and women living in retirement villages had the highest rate. Length of stay in RAC was around 2.2 years, but with some women living as long as 12 years in long term care. Around 28% of women admitted to residential aged care lived there for at least three years<sup>2</sup>.

- Among women with dementia (29% of the 1921-26 cohort): over 80% were in RAC, around 20% used respite care, and 62% had one or more hospital admissions (median 3 admissions, 23 days stay) in the last two years of life. Among women who did not have dementia, 40% of women with stroke, 31% of women with heart disease, and 23% of women with chronic respiratory disease were in RAC at some time in the last two years of life<sup>5</sup>.

### Aged Care use in the 1946-51 cohort

- Around 13% of women in the 1946-51 cohort had already used Home and Community Care prior to age 70, and around 3% had used Residential Aged Care or Transitional Care.

## Recommendations

- Housing policy is important for women's health and wellbeing in later life, with most women remaining in their own homes. Moves may also be limited by few options or incentives to downsize.
- Women in the 1946-51 cohort may be at risk of housing stress (if don't own outright).
- Women living in retirement villages have higher rates of admission to RAC, but no higher use of home care. Strategies to increase use of community services in retirement villages may delay or prevent admission to residential aged care.

- Over a third of women are likely to enter RAC at some time, and to remain in care for around 2-3 years. RAC should be seen as an important stage in the women's life course, with attention to lifestyle, engagement and ongoing wellbeing.
- Dementia and stroke are major drivers of residential aged care, and most women with dementia will enter residential care and/or acute care in the last years/months of life. Full attention needs to be given to developing services to care for the needs of these older women in later life, anticipating their end of life needs and avoiding unnecessary hospital admissions and treatments.
- These findings highlight the importance of providing a range of services to meet the diverse care needs of older women, especially in the community setting.
- Driving remains the main means of transport for women in late life: strategies to enable driver safety and/or to enable women to transition to other transport options are important for women's wellbeing.

## References

1. Byles J, Curryer C, Vo K, Forder P, Loxton D & McLaughlin D. (2018). Changes in housing among older women: Latent class analysis of housing patterns in older Australian women. *Urban Studies*, 55(4):917-34.
2. Forder P, Byles J, Vo K, Curryer C & Loxton D. (2018). Cumulative incidence of admission to permanent residential aged care for Australian women - A competing risk analysis. *Australian and New Zealand Journal of Public Health*, 42(2):166-171.
3. Byles J & Gallienne L. (2012). Driving in older age: A longitudinal study of women in urban, regional and remote areas and the impact of caregiving. *Journal of Women & Aging*, 24(2):113-125.
4. Rahman ME, Efird JT, Kendig H & Byles JE. (2018). Patterns of home and community care use among older participants in the Australian Longitudinal Study on Women's Health. (Under Editorial Review).

5. Dobson A, Waller M, Forder P, Dolja-Gore X, Hockey R, Byles J & Mishra G. (2018). *Health service use at the end of life by older Australian women with chronic conditions*. Report to the Department of Health from the Australian Longitudinal Study on Women's Health.