The Australian Longitudinal Study on Women's Health

Women in an Ageing Australian Population

1 AGEING IS AN ISSUE FOR WOMEN AT ALL LIFE STAGES

The ageing of the population has substantial implications for women of all generations. **Older women** are affected because they experience old age-related health effects, and they provide a substantial proportion of formal and informal care for other older people.

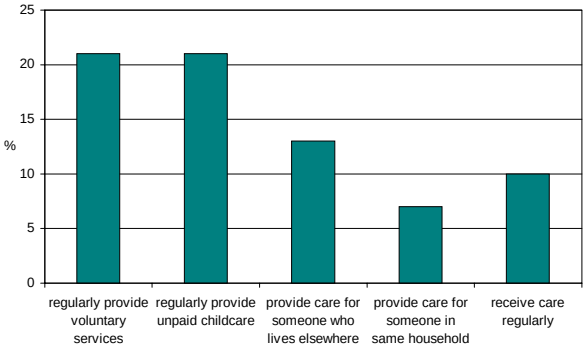
The Older women at ALSWH Survey 1 were more likely to be caring for someone else than being cared for themselves: 17% of women reported they currently care for another person because of that person's long-term illness and disability, and only 8% needed such care for themselves (see Figure 1). Many cared for husbands who were in poor health and described this as their "main occupation"; a small number cared for their elderly mothers. They also care for sick or disabled adult children, and are important carers of grandchildren.

Middle aged women are affected because of their increasing levels of participation in the labour force, and changing retirement patterns, as well as their roles in caring for parents, husbands, children and grandchildren.

ALSWH data indicate that labour force participation is associated with better physical and mental health.

"We all dread the day when you can only sit in a chair... we feel the longer you use everything, the longer it will keep going."

Figure 1. Older women: Receipt and provision of practical care (Survey 2)



However, women commonly have less full-time employment and less superannuation than men,and are affected by increasing reliance on private financing of retirement and aged care.

At Survey 3, over 75% of Mid-age women in the study were in the paid workforce. It is important to understand the factors that influence these women's continued participation in the workforce, the impact on their health, and the availability of informal caregiving over the next 20 years.

Younger women are affected because they are the focus of policy aimed at increasing fertility rates. ALSWH data show that although Younger women see a combination of paid work and motherhood as the norm, many Younger women are delaying childbearing. They have more qualifications than women of their mothers' generation, and most Younger women without children are in paid employment, but they may have fewer children as a result of this delay. In contrast, in other countries, where a combination of work and parenthood is promoted, fertility rates have been maintained at higher levels.

Further information is available in the technical report *Women in an Ageing Australian Population*

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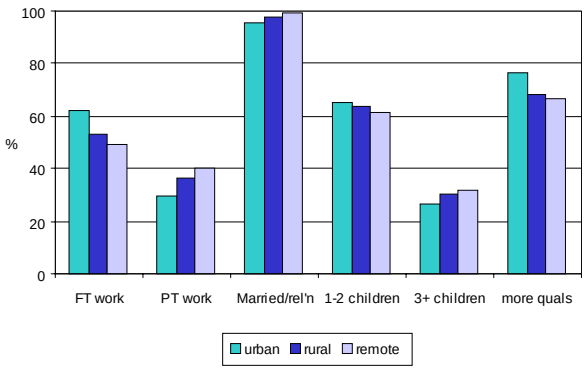
2 ARE WOMEN TORN BETWEEN ROLES? *Or compressed between them?*

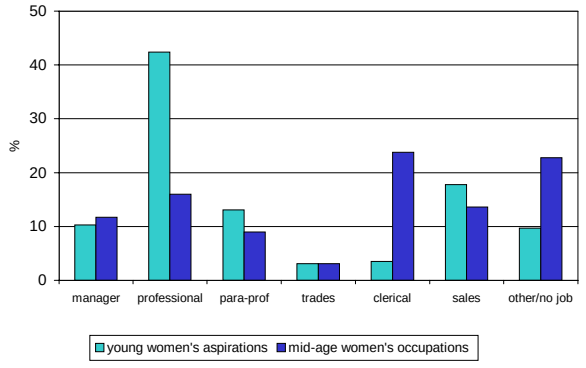
When asked about their aspirations, Younger women at both Survey 1 and Survey 2 said they wanted to have children and relationships; they also wanted education and paid work. However, there are some differences between the aspirations of Younger women in the cities and those in rural areas, who have more traditional expectations (see Figure 2).

Figure 2. Younger women's aspirations for age 35 by area of residence (Survey 1)



When Younger women's aspirations at Survey 1 were compared with the actual occupations of Mid-age women at that time, it seems that Younger women not only expect to combine motherhood and employment, they want jobs with higher occupational status than those their mothers' generation have had (see Figure 3).

Figure 3. Younger women's aspirations and Mid-age women's actual occupations (Survey 1)



However, between Survey 1 and Survey 2, the aspirations of the Younger women in the study changed, reflecting the realities of balancing motherhood and employment. They wanted fewer children, and more hoped to be in part-time rather than full-time work at age 35.

" I do the work of an occupational and physiotherapist, nurse, housewife, psychologist, chief cook and bottle-wash, gardener and finance manager and for that I receive $57 a fortnight, $28 a week. It's cruel that "carers" have so little value …
My job as carer is 24 hours a day every day with no respite, no holidays…. We've been in situations where
there's not been enough money to buy food and we've had to live on what meagre items were in the cupboard."

Far from "retiring" in their fifties, many Mid-age women have a high level of workforce participation and many are increasing their hours of paid work. Between Survey 2 and Survey 3, about 35% of Mid-age women took on more hours of paid work.

Mid-age women who were caring for someone who was frail, elderly or ill were more likely not to be in paid work (Survey 2). However, about 15% of all employed Mid-age women in the study, irrespective of their hours of work, were providing care for an elderly person or someone in poor health at the time of the third Survey.

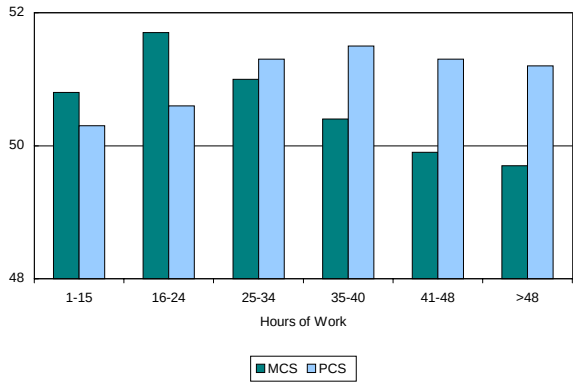
At Survey 3, about 40% of Mid-age women were also providing childcare, either for their own grandchildren or for someone else's children. Rural women were more likely than urban Mid-age women to be providing this type of care. By Survey 2, about 30% of Younger rural women had become mothers, compared with less than 15% of Younger urban women, indicating a greater need for childcare in rural areas.

3 IS THERE AN IDEAL BALANCE BETWEEN WORK AND HEALTH?

Employed Mid-age women have better self-rated health than those who are not employed. At Survey 1, 55% of employed women said their health was excellent or very good, compared to 40% of unemployed women. Cause and effect are difficult to determine: work maintains good health, but illness or disability makes it difficult to work.

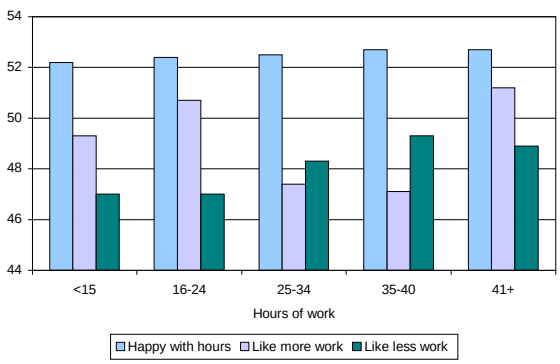
As Figure 4 shows, better mental health for Mid-age women appears to be associated with part-time work of around 18-24 hours per week. However, women working full-time have better physical health. Taken together, these results suggest that having about 25-34 hours of paid work per week is best for Mid-age women's health.

Figure 4. Mental health score (MCS) and Physical Health Score (PCS) by hours of paid work (Survey 1).



Generally it seems that Mid-age women want to be in paid work, but are not happy when they are working long hours. The health of Mid-age women who are satisfied with the hours they are working is better than those who are unhappy about the amount of their paid work (see Figure 5) regardless of the actual number of hours worked..

Figure 5. Mental Health by satisfaction with hours of paid work (Survey 2).



An analysis of Mid-age women's movements into and out of paid work between Surveys 2 and 3 was carried out. It showed that the physical health of Mid-age women who are continuously in employment is better than those who are not in the labour force or who have a period out of paid work.

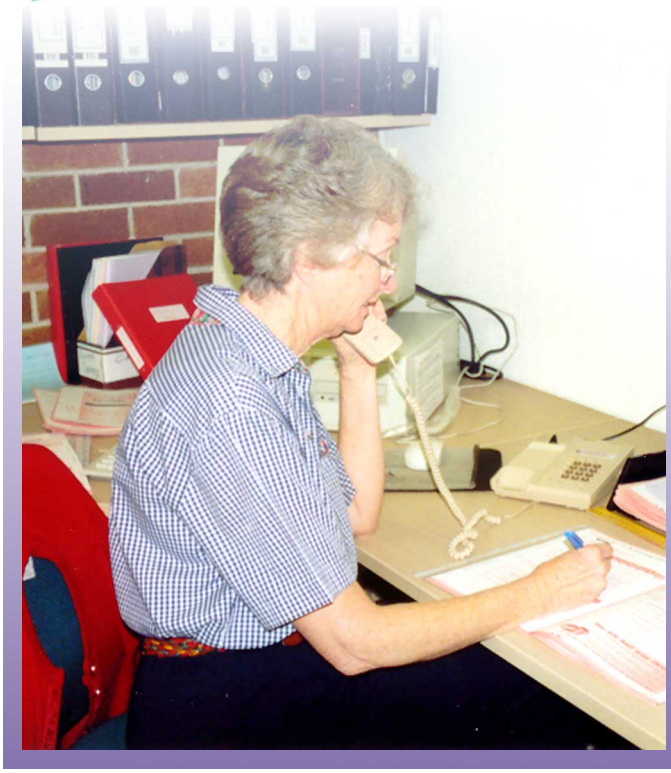
Employed Mid-age women who provide care for someone else are more likely to move out of the labour force subsequently (Surveys 2 and 3).

Caregivers have to deal with stress and restrictions on employment, social and leisure choices. Among Mid-age women, carers are more likely to smoke, but less likely to drink alcohol.

Mid-age caregivers seem to be in poor health, while Older carers are in relatively good health (Survey 1). This may be because older women in poor health are more likely to be provided with professional health care for their family members.

Carers often feel that their caregiving role interferes with their ability to perform well at work.

"I often find the stress/lack of sleep interferes with my diabetes and this in turn occasionally affects the level of my work as an RN and I feel that I am not functioning to my full capacity, and could maybe at some time lose my job."



4 OLDER WOMEN: A PICTURE OF HEALTHY AGEING?

The Older women in ALSWH represent a generation of women who have lived through experiences of the Depression, global war, and overwhelming technological and social change.

Most (90%) have participated in paid work at some time during their lives. Over 90% have had at least one child, and almost one quarter have had four or more children. At the time of Survey 1 these women were aged between 70 and 75 years. Many (41%) lived alone, and most of these women were widows.

At Survey 1, over one-third of the women rated their health as excellent or very good and only 4% rated their health as poor. Older women's physical health is poorer than that of the Younger women, but their mental health is better (see Figures 6 and 7).

Figure 6. Physical health subscales by age cohort (Survey 1)

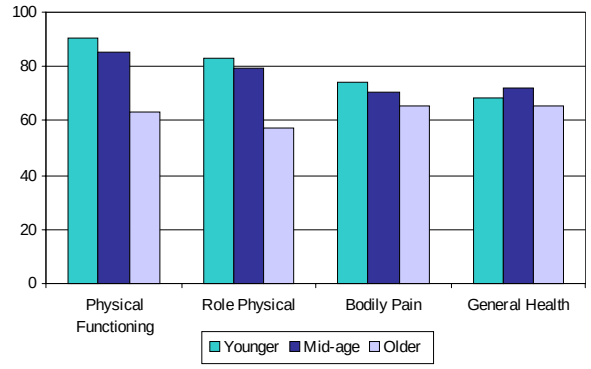
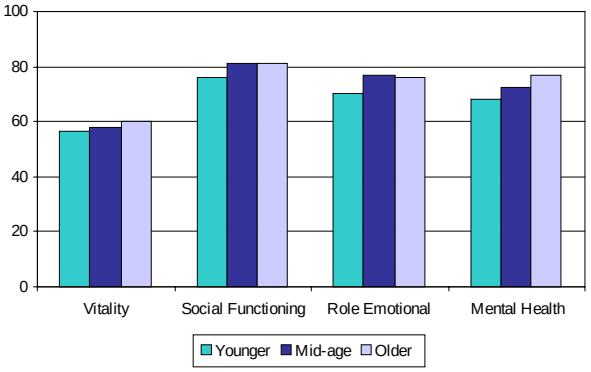
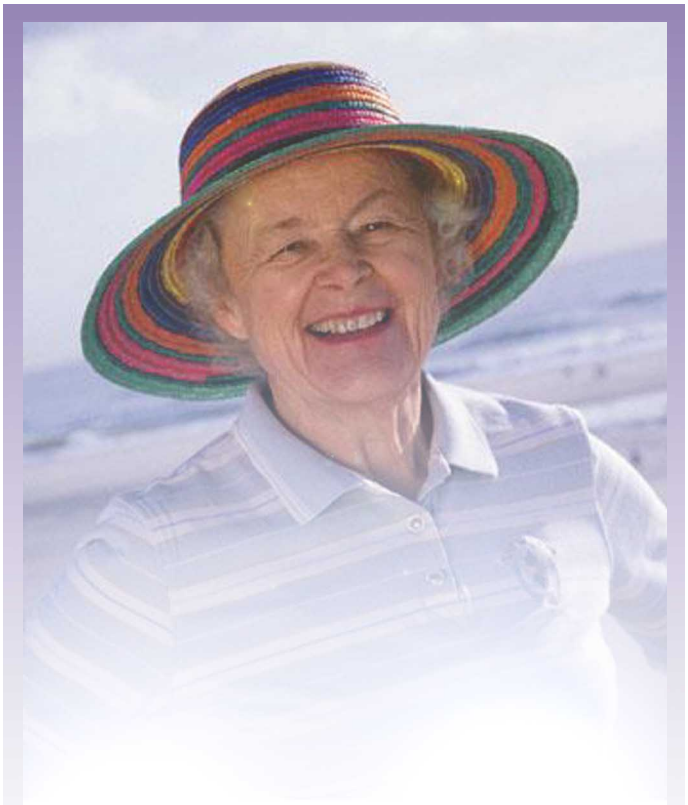


Figure 7. Mental health subscales by age cohort (Survey 1)



Many women described themselves as being "in really good health for my age", despite their health conditions.



"Reading back through my own answers I appear to be doing very well for my age and so will many others in my age group 70-74. We are mostly a tough, resilient group, having lived through the depression years in our childhood, World War II (with its worries and limitations) and our battles to make homes, work hard and raise families over the years. Many of us married ex-servicemen whose health was not always good. "

Arthritis was one of the most common chronic conditions among Older women (42% at Survey 2). Women with arthritis were more likely to need help with daily tasks, and were higher users of health services, including GPs, specialists and hospital doctors. Older women with arthritis rated their access to GPs and medical specialists as less satisfactory than did other women. Approximately half of all Older women with arthritis also reported having visited an alternative practitioner in the past twelve months.

The prevalence of osteoporosis increased markedly amongst Older women over time. For example, it was reported by 22% of women at Survey 1 and a further 13% at Survey 2. Having osteoporosis was associated with needing help with daily tasks, and higher use of health services, including GPs, specialists and hospital doctors.

5 OPPORTUNITIES FOR HEALTH PROMOTION FOR OLDER WOMEN

ALSWH data show that continued well-being for women into older age is related to nutrition, physical activity, patterns of medication use, and support from family and community. While over 40% of Older women were overweight, nearly all met basic nutrition criteria (see Figure 8).

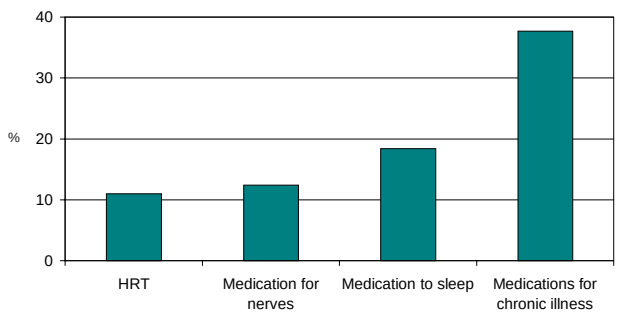
Figure 8. Older Women and Nutrition

Physical activity among Older women is associated with emotional well-being over and above its effects on physical health. Between Survey 1 and Survey 2, Older women who maintained or adopted some physical activity had better mental health scores than those who didn't.

ALSWH qualitative data on Older people's attitudes to physical activity found that perceived barriers included poor health, no-one to exercise with, inappropriate or unsafe environments and facilities, and lack of interest. Media messages were seen as confusing, but focus group participants supported the idea of campaigns encouraging older people to be active.

Medication use was common amongst Older women (see Figure 9). Longitudinal ALSWH data show that the use of prescription medications for "nerves" and "to help you sleep" is often long-term among women in this age group. The use of sleeping medication (17% at Survey 1 and 15% at Survey 2) was associated with poorer health-related quality of life, with increased risk of falls and accidents, and with more GP visits.

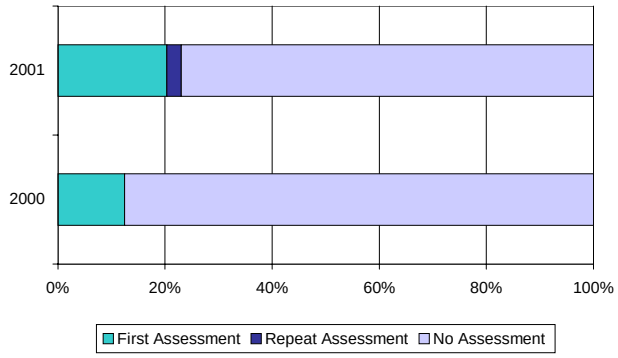
Figure 9. Older Women and Medication (Survey 1)



Hormone Replacement Therapy (HRT) was used by 11% of Older women at Survey 1, and a further 11% had used HRT at some time in the past. HRT use was associated with osteoporosis, vaginal discharge and leaking urine.

In 1999, the Health Assessments Initiative was introduced by the Australian government, aimed at providing annual health care checks for older people. Less than a quater of ALSWH Older women had had an assessment. There were very few differences between women who had health assessments and those who did not, either in regard to social factors, such as where they lived, or in regard to their health.

Figure 10. Uptake of health assesments by ALSWH Older women: Medicare data



"I am a very independent 74 year old with lots of interests including a part-time job, a voluntary job, play lots of bridge, on the board of the Bowls club - and I think this is the answer to keeping fit and well."

Socioeconomic status

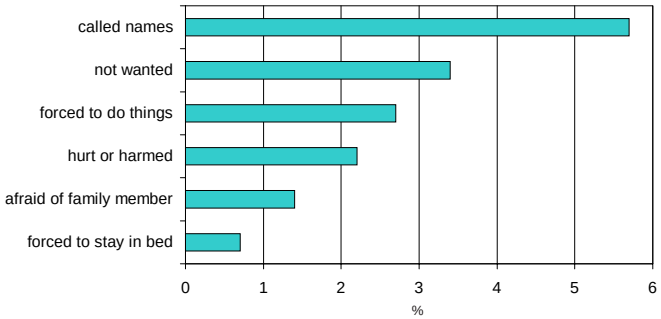
The relationship between health and ageing is affected by social factors such as gender, ethnicity and income. ALSWH data suggest that while the impact of socioeconomic status (SES) on physical health may diminish as women grow older, the impact of the SES differential on emotional health, health service use and mortality persists into older age.

An analysis of the SES of ALSWH women suggests that SES must be considered differently in different age groups and that income, education, type of family situation, and ethnic background are the most meaningful components of SES for Older women.

Elder abuse

While the abuse of older people by a family member or someone close to them is an important social issue, there is very little information about the extent of this problem in the community or the characteristics of those individuals and families who are most at risk of abuse. The data shown in Figure 11 give some sense of situations which make Older women more vulnerable to violence or abuse from a family member.

Figure 11. Older women's experiences of violence or abuse



Being widowed is a normal life stage for women because they live longer than men and tend to be slightly younger than their husbands. At Survey 1, 35% of Older women were widowed, and a further 7% had become widows by the time of Survey 2.

Widowed women in the ALSWH were more likely to use medications to help them sleep (30%) than other women (less than 20%). However, despite poorer self-rated health, widows did not make greater use of health services. Hospital admissions, number of visits to GPs, use of multiple medications, and use of medications "for nerves" did not differ from married women.

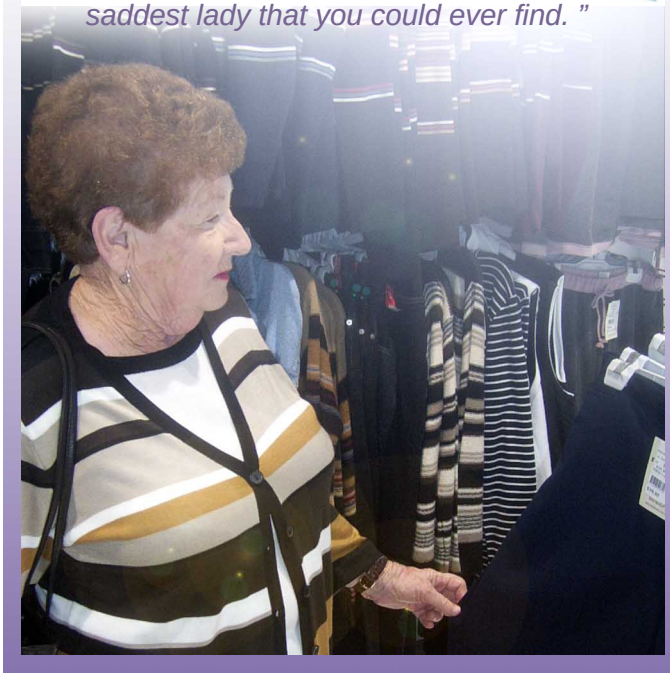
The health differentials associated with being widowed are transient, with "recovery" for most women occurring within 12-24 months. Women who had been widowed less than 12 months rated their own health significantly lower than either married women or women who had been widowed longer than 12 months (see Figure 12).

Figure12. SF-36 subscales for married and widowed women (Survey 1)

Women who move house

Moving house was a major life event for Older women in the ALSWH. Women who moved (6% at Survey 1, 10% at Survey 2) had more symptoms than women who remained in their original homes. Also, they did not show the significant improvements in mental health reported by other Older women between Survey 1 and Survey 2.

"... stay inside all day, they lose their ability to converse. They are not involved in anything... I have a sister-in-law like that, and she is the saddest lady that you could ever find. "

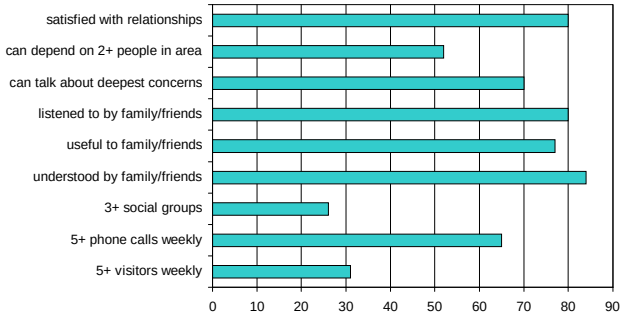


7 A PLACE FOR OLDER WOMEN...IN FAMILIES AND COMMUNITIES

Many Older women in the ALSWH emphasised the importance of maintaining active lives and participating in their families and communities.

At Survey 1, 78% of Older women had high or very high levels of social support (see Figure 13). About 14% had a fair amount of support, and 8% had low levels of support. Older women with high levels of support from their family and community were more likely to be well educated, to be currently married or widowed rather than single, to find it easier to manage on available income, and to be born in Australia.

Figure 13. Older Women and social support (Survey 2)



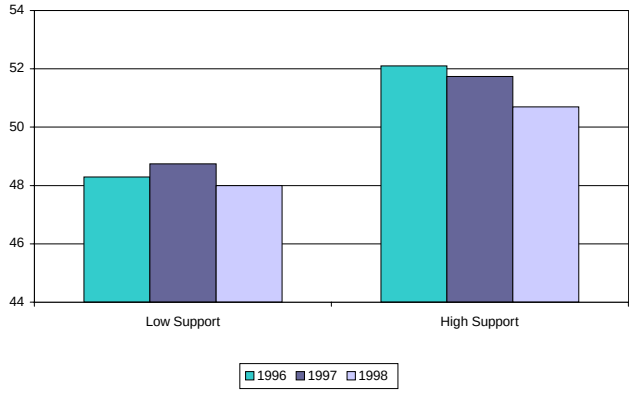
Women with high social support tended to rate their general health more highly, had fewer chronic conditions and symptoms, took fewer medicines, were less likely to need help with daily tasks, and had fewer GP visits. Women who were satisfied with their most recent visit to a general practitioner were also likely to have higher social support.

An ALSWH sub-study examined the relationship between social support and change in physical health over a three year time period (see Figure 14). Women in the group with high social support started with health scores that were well above average whereas women in the low support group had scores well below average. These differences persisted over the three years. Even though the high support group's scores did fall during this period they were still above the average for the cohort.

The link between social support and health outcomes was also shown through an ALSWH analysis of Older women's sense of neighbourhood and feelings of safety. A higher sense of neighbourhood was associated with better physical and mental health, lower stress, better social support and being physically active.

Older women generally are happy with where they live, feel they are treated with respect, and trust their neighbours.

Figure 14. Social support and the physical health of Older women



"Although I am not a well person, it is possible to have a diversity of interests to keep your brain active, even if you are unable to participate in the more physical activities."

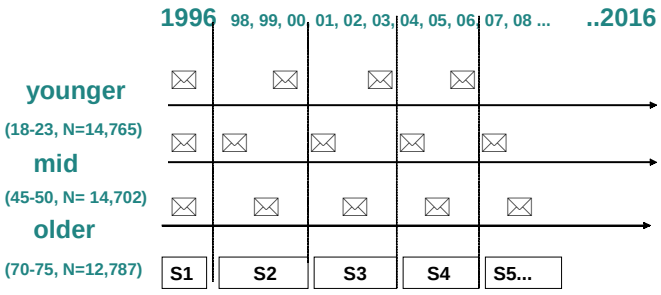
"Generally I am satisfied but one has to work hard to look after oneself and maintain a reasonable lifestyle and not be swamped by increasing age and less money and alone, and less importance in the community."

8 Background: What is the Australian Longitudinal Study on Women's Health?

The Australian Longitudinal Study on Women's Health (ALSWH) – widely known as Women's Health Australia - is a longitudinal population-based survey which examines the health of over 40,000 Australian women. It provides information to assist the Commonwealth Department of Health and Ageing – and other Commonwealth and State Departments - to develop policies which are appropriate to Australian women of all ages.

Women in three age groups (aged 18-23 years, 45-50 years and 70-75 years in 1996) were selected from the Medicare database. Sampling was random within each age group, with women from rural and remote areas sampled at twice the rate of women in urban areas. The study is designed to run for 20 years, with each age cohort surveyed every three years.

Figure 15. Timeline for ALSWH Surveys



The groups were selected in order to follow women through life stages which are critical to their health and well-being. When the study began, the Younger age group was in transition from adolescence to adulthood. They can be tracked as they move into the work force, enter adult relationships, and become mothers. At Survey 1, most were living with their families of origin (51%) or in shared housing (24%). Almost half (48%) were students; 79% were single; and 92% had no children. By Survey 2, 48% were married or in de facto relationships, although only 17% were mothers. Two-thirds (67%) had post-secondary educational qualifications and 59% were in full-time paid employment.

The Mid-age group was selected to examine the social and personal changes of that life stage as well as menopause. At Survey 1, 75% were married; 37% had full-time employment and 31% part-time. While 91% were mothers, only 58% had children under 16 living with them. Middle age is a time of relative stability, so the picture was similar at Survey 3, with 78% married, 37% in full-time work and 23% in part-time work, although the number with children living at home had fallen to 37%.

The Older group were in their early 70s when selected, to recruit older women who are still healthy and active. The focus is on predictors of continuing well-being and independence in older adult life. At Survey 1, the majority of older women (58%) were married, but widows increased from 36% to 41% of the sample by Survey 2. Over 80% are pensioners, though 35% have superannuation or other income.

The study goes beyond a narrow perspective that equates women's health with reproductive and sexual health, and takes a comprehensive view of all aspects of health throughout life. It assesses:

- Physical and emotional health (including health-related quality of life, diseases and conditions, symptoms)
- Use of health services (GP, specialist and other visits, access, satisfaction)
- Health behaviours and risk factors (diet, exercise, smoking, alcohol, other drugs)
- Time use (including paid and unpaid work, family roles, and leisure),
- Socio-demographic factors (education, employment, family composition)
- Life stages and key events (such as childbirth, divorce, widowhood).

Participants are also invited to consent to linkage of survey responses with unit records from the Medicare database, which provides information about type of service, characteristics of the provider, and out-of-pocket costs for Medicare-eligible services.

The information in this report was compiled by Julie Byles, Penny Warner Smith and the ALSWH team

If citing this report: Summary report from the Australian Longitudinal Study on Women's Health, conducted by researchers at the Universities of Newcastle and Queensland and funded by the Commonwealth Department of Health and Ageing

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