Australian Longitudinal Study on Women's Health

Submission to the 2021 Consultation for a new Queensland Women's Strategy

October 2021

women's health AUSTRALIA | Australian Longitudinal Study on Women's Health

Introduction

The Australian Longitudinal Study on Women's Health (ALSWH) is a long-running survey that has tracked the health and health service use of women living across the country since 1996.

The Study is a national research resource funded by the Australian Government Department of Health and managed by the University of Queensland and the University of Newcastle. ALSWH surveys women in four cohorts which encompass the adult lifespan: women born in 1989-95, 1973-78, 1946-51, and 1921-26. The Study's purpose is to provide scientifically valid information – based on current, accurate data – that is relevant to the development of health policy and practice in women's health.

Our submission to the consultation on the new Queensland Women's Strategy uses data from the 1989-95, 1973-78 and 1946-51 cohorts of ALSWH who were **residing in Queensland** when they completed the most recent surveys. This included:

- 1630 women from the 1989-95 cohort surveyed in 2019 (aged 24-29)
- 1540 women from the 1973-78 cohort surveyed in 2018 (aged 40-45); and
- 1814 women from the 1946-51 cohort surveyed in 2019 (aged 68-73).

We support the intent of the new Queensland Women's Strategy and welcome the opportunity to provide input to the consultation of the Strategy. Our submission aims to strengthen the policy links between social and economic factors and overall health.

ALSWH submission

We strongly support gender equality as the strategic focus of the new Queensland Women's Strategy. The Queensland Women's Strategy Discussion Paper identifies key areas of gender inequality that need to be addressed including economic security, under-representation of women in leadership roles and high rates of domestic and sexual violence experienced by women. In this submission we use data from the **Queensland participants of ALSWH** to demonstrate the relationships between several social and economic factors and women's overall health. We recommend that strategies to address gender inequality recognise these links and implement cross-portfolio policies and programs to address all factors that influence women's health.

1. Cohort characteristics

Select economic and social characteristics for each cohort are included in **Table 1**. Women in the two older cohorts were more likely to live outside metropolitan areas – this is because in the original cohorts, women living in rural and remote areas were sampled at twice the rate of those living in urban areas to allow statistical comparisons between these groups. Women in the two younger cohorts were more likely to report that they had difficulties managing on their income, and the percent of women living in rental housing was highest in the 1989-95 cohort. The percent of women reporting that they had ever been in a violent relationship was similar across the three cohorts, while the percent of women reporting that they had any exposure to abuse or household dysfunction in childhood (psychological, physical or sexual abuse; exposure to substance abuse, mental illness, criminal behaviour or parental violence in the home) was highest in the 1989-95 and 1973-78 cohorts.

Table 1 Frequencies and percents of select characteristics of the 1989-95, 1973-78 and 1946-51 cohorts of ALSWH

	1989-95 cohort (24-29 years) N=1630	**1973-78 cohort (40-45 years) N=1540**	**1946-51 cohort (68-73 years) N=1814**
Area of residence			
Metropolitan area	1189 (72.9%)	847 (55.2%)	760 (41.9%)
Regional centre	283 (17.4%)	386 (25.1%)	541 (29.8%)
Rural town/remote community	159 (9.7%)	302 (19.7%)	513 (28.3%)
Perception of ability to manage on income			
Not too bad/easy	925 (59.0%)	872 (58.3%)	1268 (70.9%)
Difficult all or some of the time	643 (41.0%)	624 (41.7%)	521 (29.1%)
Precarious employment			
Never/rarely worried about losing job	-	943 (76.5%)	-
Always/sometimes worried about losing job		290 (23.5%)	
Housing status			
Own home/living with parents/rent-free	646 (41.9%)	1198 (79.9%)	1569 (90.5%)
Rental housing/pay board or lodging	894 (58.1%)	301 (20.1%)	164 (9.5%)
Partner violence			
Never had violent partner	1104 (75.4%)	1012 (70.2%)	1309 (73.2%)
Ever had violent partner	360 (24.6%)	429 (29.8%)	480 (26.8%)
Number of adverse childhood experiences			
None	638 (40.0%)	662 (54.1%)	1004 (61.4%)
One to three	786 (49.3%)	482 (39.4%)	516 (31.6%)
Four or more	170 (10.7%)	80 (6.5%)	115 (7.0%)

To demonstrate the relationships between social and economic factors and health, in the following sections we report on the economic and social indicators included in **Table 1** by the self-rated general health of women in each of the cohorts.

2. Self-rated general health

At each survey ALSWH participants are asked to rate whether their general health is: excellent; very good; good; fair; or poor. This is a commonly used measure of health and has been shown to be a good predictor of morbidity, service use and mortality.

Among the Queensland participants of ALSWH the following percentages of women in each cohort rated their general health as excellent/very good/good or fair/poor:

1989-95 cohort (24-29 years) N=1630		1973-78 cohort (40-45 years) N=1540		1946-51 cohort (68-73 years) N=1814	
Excellent/very good/good	**Fair/poor**	**Excellent/very good/good**	**Fair/poor**	**Excellent/very good/good**	**Fair/poor**
83.2	**16.8**	**84.5**	**15.5**	**85.1**	**14.9**

3. Economic factors and self-rated general health

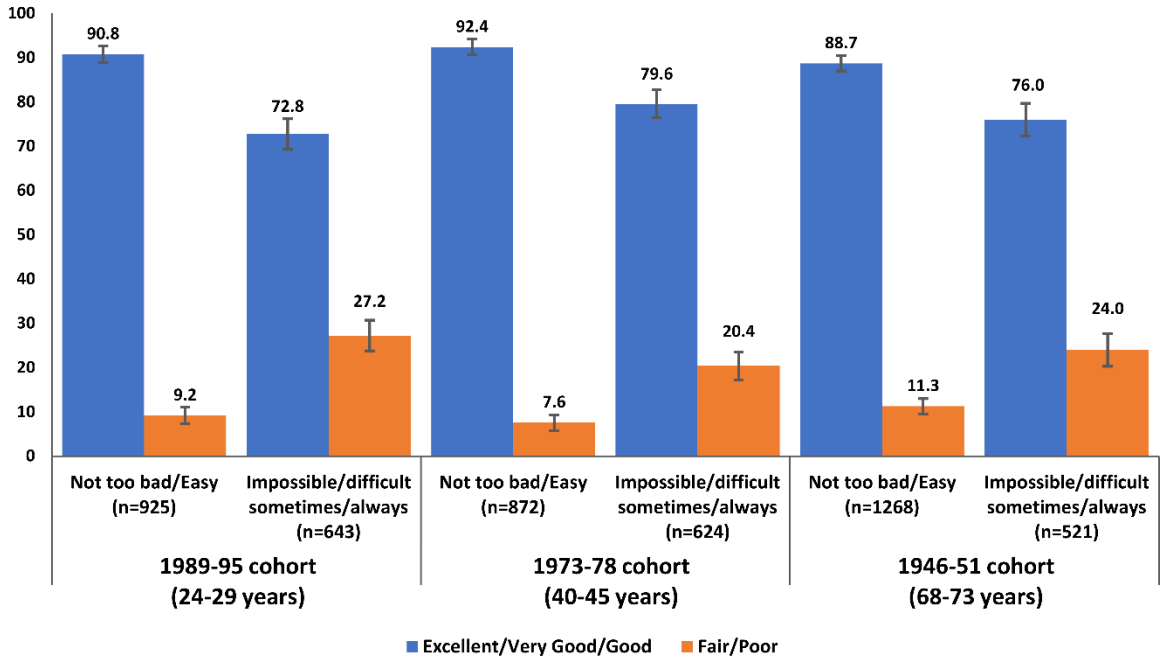
Women are more likely to report **poorer self-rated health** if they:

- report **difficulties managing on their income**;
- are in **precarious employment**; or
- live in **rental housing**.

Income insecurity: In the 1989-95 cohort 41% (n=643) of women reported that it was impossible or difficult to manage on their income. In the 1973-78 and 1946-51 cohorts 42% (n=624) and 29% (n=521) of women respectively reported income difficulties (**Table 1**). In all cohorts there was a strong relationship between **income insecurity** and **poorer self-rated health**. Women who reported that it was impossible or difficult to manage on their income were much more likely to report poorer self-rated health than women who reported that managing on their income was not too bad or easy (**Figure 1**).

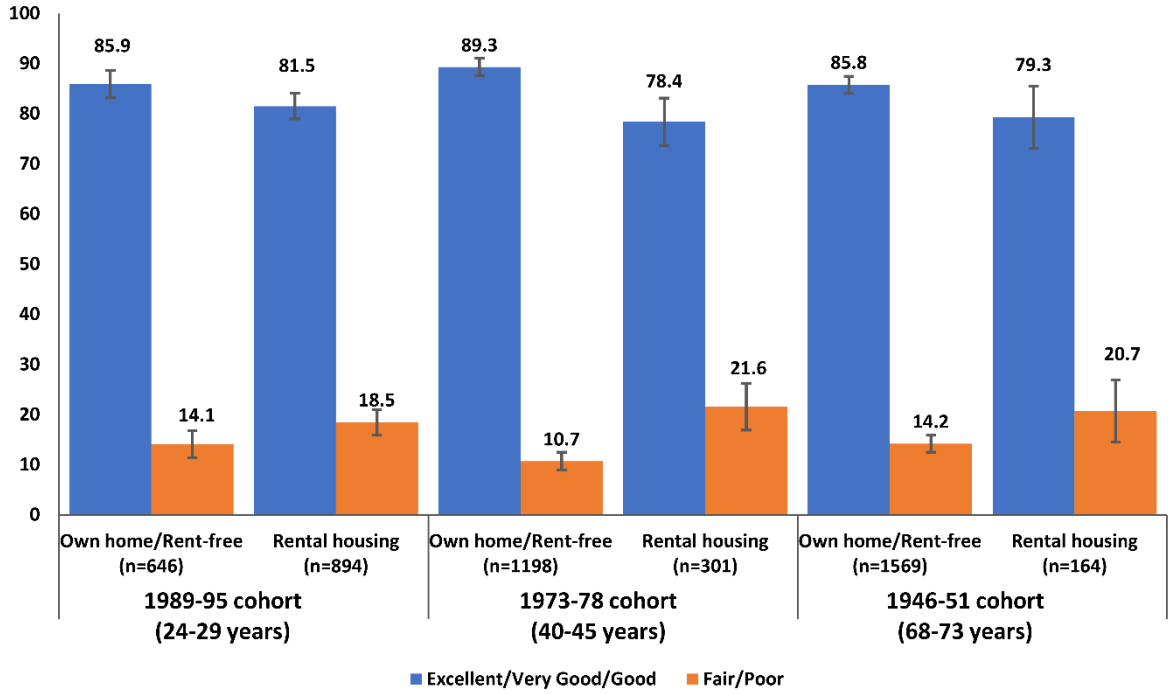
Precarious employment: In the 1973-78 cohort, women were also asked about **precarious employment** and 23% (n=290) reported they were worried about losing their job (**Table 1**). A higher percentage of women who were **worried about losing their job** rated their **general health as fair/poor** (18%, n=51) than women who were never or only rarely worried about losing their job (8%, n=79).

Figure 1: Percent of women in each self-rated health category by how well they report managing on their income



Housing status: In the 1989-95 cohort 58% (n=894) of women reported they lived in rental housing and 42% (n=646) reported they lived in their own home (with/without a mortgage) or lived with their parents. In the 1973-78 cohort these percentages were 20% living in a rental property (n=301) and 80% living in own home or with parents (n=1198). In the 1946-51 cohort 9% of women (n=164) reported they lived in rental housing or paid board or lodging, while 90% (n=1569) reported they lived in their own home or in rent-free accommodation (**Table 1**).

Figure 2: Percent of women in each self-rated health category by housing status



Women who lived in **rental housing** were more likely to report **poorer self-rated health**. This was particularly evident in the 1973-78 cohort (aged 40-45 years) where 22% of women who lived in rental housing rated their general health as fair/poor compared to only 11% of women who lived in their own home (**Figure 2**).

4. Adverse experiences and self-rated general health

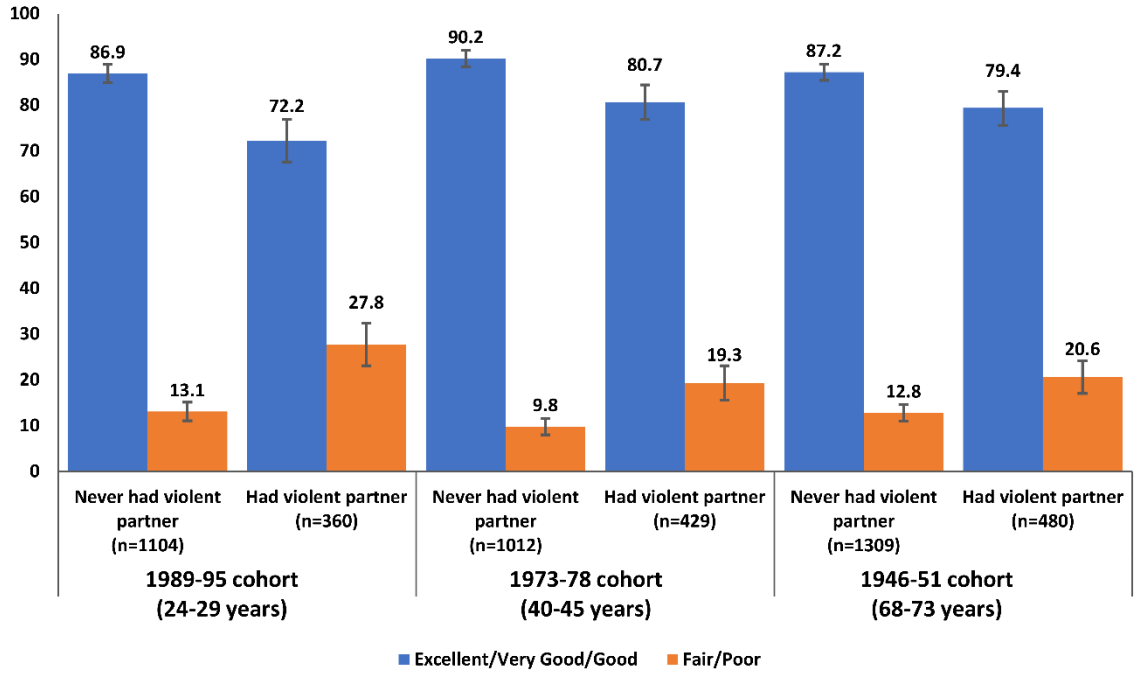
Women are more likely to report **poorer self-rated health** if they:

- have ever been in a **violent relationship**;
- have experienced **adversity in childhood**.

Intimate partner violence: In the 1989-95 cohort 25% of women (n=360) reported they had ever been in a violent relationship. In the 1973-78 and 1946-51 cohorts 30% (n=429) and 27% (n=480) of women respectively reported ever having a violent partner (**Table 1**).

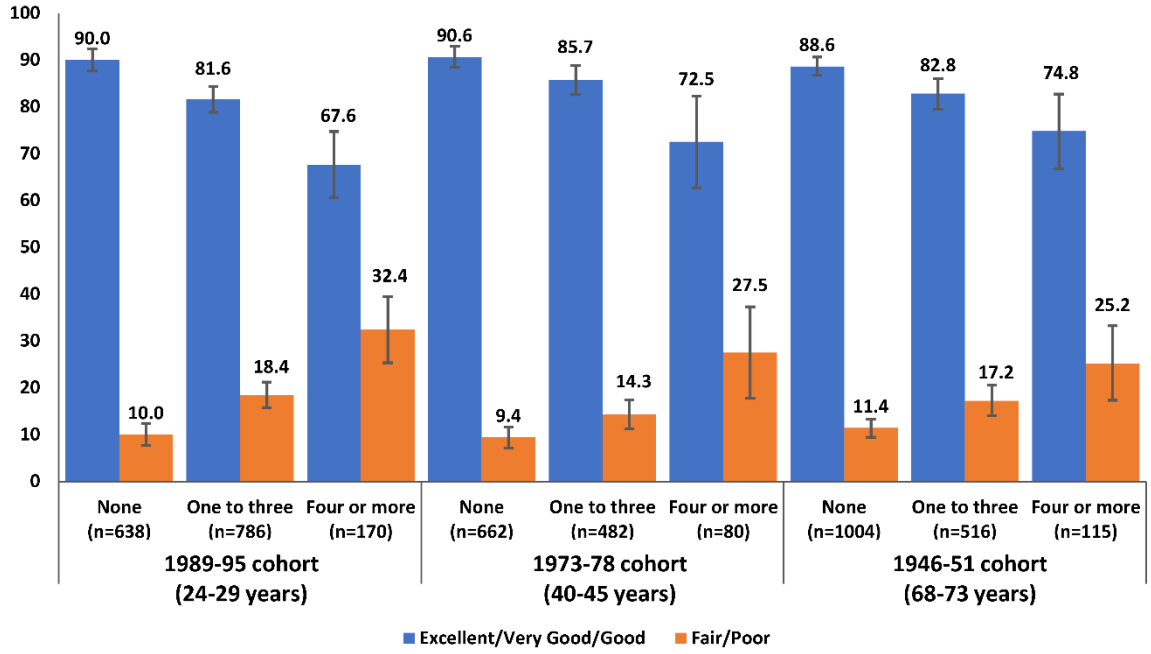
In all three cohorts there was a strong association between **domestic violence** and **poorer self-rated health**. In the 1989-95 cohort, nearly one in three women who had ever been in a violent relationship rated their general health as fair or poor (**Figure 3**).

Figure 3: Percent of women in each self-rated health category by violent partner status



Adverse childhood experiences: Sixty percent of women in the 1989-95 cohort reported experiencing at least one adverse childhood experience (psychological, physical or sexual abuse; exposure to substance abuse, mental illness, criminal behaviour or parental violence in the home) – 49% reported 1-3 experiences (n=786) and 11% reported four or more experiences (n=170). In the 1973-78 cohort, 46% of women reported at least one adverse experience (39% 1-3 experiences, n=482 and 7% ≥ 4 experiences, n=80). The percentages were lower for the 1946-51 cohort with 39% reporting at least one experience (32% 1-3 experiences, n=516; 7% ≥ 4 experiences, n=115)(**Table 1)**.

Figure 4: Percent of women in each self-rated health category by number of adverse childhood experiences



Adverse childhood experiences were also strongly related to **poorer self-rated health**. In all cohorts, the percentages of women who reported poorer self-rated health increased with an increasing number of reported adverse childhood experiences (**Figure 4**).

5. Conclusion

Women are more likely to report **poorer self-rated health** if they:

- report **difficulties managing on their income**;
- are in **precarious employment**;
- live in **rental housing**.
- have ever been in a **violent relationship**;
- have experienced **adversity in childhood**.

ALSWH supports the priority areas of participation and leadership; economic security; safety; and health and wellbeing to continue to address gender inequality in Queensland. However, data from ALSWH reinforces the need for cross-portfolio collaboration and strategies to address the social and economic determinants that have an impact on women's health.

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A detailed description of the background, aims, themes, methods, and representativeness of the sample and progress of the study is given on the project website. Copies of surveys are also available on the website, along with contact details for the research team, abstracts of all papers published, papers accepted for publication, and conference presentations.