

**Gender Impact Assessment  
No. 10**



**Women's Health  
Victoria**

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**Women and Ageing**

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## **Women and Ageing**

(Gender Impact Assessment No. 10)

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## 1. Introduction

The experience of ageing and old age is different for women and men. Women's physical and mental health, housing and care arrangements, social connectedness and financial security change as they age. The way in which older women are viewed by wider society, and how this is different for men, also impacts upon women's experience of the ageing process. For most women, maintaining their independence through good health, economic security and housing choice is paramount<sup>1</sup>. Women more than men report being concerned about their dependence on others and inability to care for themselves in old age<sup>2</sup>. Old age can be a time of change and loss, and women confront these challenges with resilience, however ageing is not a homogenous process for all women. Diverse groups such as Indigenous women, women with disabilities, women from culturally and linguistically diverse (CALD) backgrounds, women living in rural and remote areas, and same sex attracted women, experience ageing differently and not all women within these groups experience it in the same way.

This Gender Impact Assessment considers the health and wellbeing of older women in Victoria, and the factors that affect it. Older women are defined as being over 65 years of age, using the Australian Bureau of Statistics (ABS) definition, unless otherwise specified. An overview of the various determinants of the health and wellbeing of older women is provided in this paper. The policy context for issues relating to women and ageing in Victoria and Australia is also evaluated.

## 2. The Issues

Australia's ageing population means that ensuring the health and wellbeing of older Australians is likely to become a dominant policy issue in the future<sup>3</sup>. How this will be resourced is a key concern for policy makers and it is important that the social context of this demographic shift, in which women and men are affected in different ways, is recognised<sup>4</sup>.

Ageing is a biological and social construct that is influenced by a broad range of determinants<sup>5</sup>. The social, economic and environmental conditions under which women live and age affects their health and their experience of old age. Gender is a key determinant of this and results in a different old age experience for women and men. The experience of ageing also varies for diverse groups of women.

Old age is generally associated with increased levels of illness and disability, however poor health depends on a range of factors, not only age. Australian women can expect to live around four years longer than men<sup>6,7</sup>, but they are more likely than men to be widowed, live alone or in residential care<sup>8</sup>, experience financial insecurity<sup>9</sup>, more chronic illness, multiple disabilities<sup>10</sup> and greater health service use<sup>11</sup>. Furthermore, older women are often marginalised or regarded as 'socially invisible' in Australian society<sup>12</sup>. All of these factors impact on the physical and mental health and wellbeing of women in Australia.

For Aboriginal and Torres Strait Islander women, this ageing trajectory is quite different as the size of the Indigenous population falls sharply after 45 years of age<sup>6</sup>. Life expectancy for Indigenous women is 64.8 years of age and 59.4 years of age for men. This is almost 20 years less than that of non Indigenous Australians<sup>13</sup>. Thus, the 'older' Indigenous population

is generally considered to be 50 years of age and over. Across all the determinants explored below, Indigenous women experience poorer health because of factors such as discrimination, inadequate housing and education, exposure to violence, substance abuse and poor nutrition<sup>6</sup>.

## 2.1 Health and wellbeing

The majority of older Australians are in good health and lead full lives, although ill-health increases in the last few years of life<sup>1</sup>. Health has been cited as the major predictor of life satisfaction and a dominant concern for older people<sup>12</sup>. Although the physical health of older women is generally poorer than that of younger women, their mental health is often better<sup>14</sup> (although Aboriginal and Torres Strait Islander women are more likely to report fair to poor health than other Australians<sup>6</sup>).

Hypertension and arthritis are the most common chronic conditions for older women and the prevalence of osteoporosis also increases as women age<sup>14,15</sup>. These conditions mean that women may need help with daily tasks and are more likely to access health services, including general practitioners (GPs), specialists and hospitals<sup>14</sup>. For rural women, however, this may be more difficult. The lack of GPs and specialists in rural areas mean that older rural women are more likely to be hospitalised for care than older women living in urban areas<sup>16</sup>.

One American study of 2,500 older women found that the top five health priorities for women in this age group included memory loss, muscle weakness, urinary incontinence, depression and falls<sup>17</sup>. The likelihood of falls is increased in this age group by greater frailty and poor vision. Old age and frailty can also heighten the risk of serious injury from falls and a longer recovery time<sup>18</sup>. Osteoporosis also affects the seriousness of falls for women as even minor incidents can result in bone fractures<sup>5, 19</sup>. Not only that, falls also impact on confidence and independence, with many older women restricting their movement and travel as a result.

Sexuality is an intrinsic part of health and wellbeing, yet the sexuality of older women is systematically overlooked. Age is 'not a deterrent to a happy and healthy sex life' yet myths are perpetuated in our society in which older people are regarded as asexual<sup>20-22</sup>. Sexuality continues to be a part of women's wellbeing and identity and should not be sidelined or ignored. The loss of a partner at this time often represents the loss of a lifetime of physical and emotional intimacy however this often goes unacknowledged by the wider community. Improving attitudes towards ageing, increasing respect for older women and acknowledging sexual expression in older people is needed to reverse these stereotypes<sup>23</sup>.

Although the mental health of older women is generally good<sup>14</sup>, anxiety and depression are the most prevalent mental health conditions for older women<sup>24</sup>. These conditions can be intensified by the loss of a partner and friends. Risk factors for depression include female gender (more women than men suffer anxiety in this age group<sup>24</sup>), economic deprivation, the onset of poor health and reduced functioning, bereavement and other life crises<sup>25</sup>.

Dementia is also a key health issue for older Australians. Almost two-thirds of older people with dementia in Australia are women, although a higher proportion of men under 75 years of age have dementia (29 percent compared with 13 percent of women)<sup>26</sup>. This has implications

for women's role as carers of their partners, as well as their own access to informal care. Women with disabilities are also disproportionately impacted – the prevalence of dementia and Alzheimer's disease was 17 percent among older people with a profound or severe core activity limitation compared with four percent of the older population in general<sup>6</sup>.

Across this age group, there is a higher prevalence of disability in women compared to men. This is attributable to both the higher incidence and longer duration of disability in older women<sup>27</sup>. The severity of disability increases with age and a higher proportion of women 60 years of age and over have a severe or profound core activity limitation (27 percent compared with 17 percent of men)<sup>6</sup>. The need for more intensive personal care and assistance for women with disabilities also increases with age<sup>6</sup>. However it is important to note that the broader health context is different for women with early-onset disabilities rather than disabilities that developed in old age<sup>28</sup>. Some older women with early onset disabilities have experienced a lifetime of discrimination and social isolation that is then exacerbated by their age. They may also not have family members or children to care for them<sup>28</sup>. These experiences are compounded for Indigenous Australians, who have higher rates of disability across all age groups than non-Indigenous Australians<sup>6</sup>.

Health literacy also affects the health and wellbeing of older women in Australia. Health literacy describes the 'cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health'<sup>29</sup>. One American study reported that adults over 65 years of age are the largest population group to have limited health literacy levels. This impacts on their ability to use health information and make informed decisions about their health<sup>30</sup>. It also affects success of health promotion campaigns that do not adequately target this population group. For older women in CALD communities, this is compounded by language and cultural barriers as well as old age. Older women born overseas in non-English-speaking countries are generally healthier than the Australian-born older population, but face considerable barriers to accessing health services in part due to poorer health literacy<sup>6</sup>.

## **2.2 Housing and the built environment**

According to the 2006 Australian Census, 48 percent of people over 65 were living as a couple without children. Living alone was increasingly likely in this age group although the proportion of people living alone declined in the very old age groups from a peak of 39 percent at the age of 85. This is associated with increased frailty which makes independent living difficult<sup>26</sup>. Almost half of all Australian women and one third of men will enter permanent residential care at some point<sup>31</sup>. However it has been shown that most older people prefer to 'age in place', that is, in their home and community<sup>6</sup>.

Due to a greater life expectancy and the experience of widowhood and divorce, older women are more likely to live alone than older men<sup>8</sup>. How women respond to and experience living alone varies. One study of older women living alone found that most women viewed living alone as neither all positive nor all negative<sup>8</sup>. Living alone may be linked to the development of depression, as well as increased isolation and reduced participation in community life<sup>8</sup>. Research also suggests that older people who live alone are at a greater risk of infections, falls, injuries and dehydration<sup>8</sup>. However living alone does not equate to loneliness or poor

health and for many women it is an important signifier of independence and freedom<sup>8</sup>. Many women feel a sense of attachment to their home, may value the privacy that it brings or may not want to live with their adult children.

Security of housing tenure is an ongoing concern as women age and this can have a significant influence on overall wellbeing. An increasing number of older Australians are unable to sustain home ownership as costs rise<sup>6</sup>. Six percent of older households are public renters (compared with 3.6 percent of younger households) and 5.1 percent are in private rental accommodation<sup>6</sup>. Private rental is the most insecure form of housing tenure yet this represents a growing segment of older Australians<sup>6</sup>.

Transport is a significant concern for older women and a lack of appropriate transport can considerably impinge on independence and access to services including health services<sup>5, 11</sup>. In the *Australian Longitudinal Study of Women's Health*, 51 percent of women aged between 76 and 81 drive, 29 percent are driven by others and 23 percent of women in urban areas rely on public transport (or five to ten percent in rural areas)<sup>15</sup>. No longer being able to drive and unsafe, expensive or inconvenient alternatives, such as public transport or taxi services, all impact on older women's sense of independence and autonomy.

The neighbourhood and wider community are also important for older women. Older women in the *Australian Longitudinal Study of Women's Health* report that they are generally happy with where they lived. They feel that they are treated with respect and can trust their neighbours<sup>14</sup>. The social dimension of their neighbourhood is important, as is living close to services, however their experience of vulnerability is significant<sup>32</sup>. Research has indicated that older women, and particularly older women on low incomes, have a disproportionate fear of crime in relation to their actual likelihood of being a victim of crime<sup>33</sup>. This is heightened by media representations and can contribute to increasing isolation. Widowhood and the loss of car transport and safe mobility have been found to contribute to a sense of fear<sup>33</sup>. These factors inevitably affect the levels of social connectedness felt by older women in Australia.

Because women live longer and have less access to informal care than men, women are more likely to enter into residential aged care facilities<sup>34</sup>. Approximately 70 percent of people in permanent residential care are women (across both low care and high care settings)<sup>35</sup>. The decision to move into residential care can be complex for older women and their families as most older people prefer to 'age in place'<sup>6</sup>. For many women, entry into residential care is associated with an end to autonomy and independence<sup>36</sup>. For others, it represents a positive and secure setting<sup>12</sup>. Finding affordable facilities that are acceptable to both the individual and their family, and that meet the needs of diverse groups of women, can be difficult.

One area that illustrates this is in relation to sexuality. Sexual expression within residential aged care facilities is often problematic. The values and attitudes of staff can influence the way in which the sexuality of older people in their care is viewed and responded to<sup>20</sup>. Clear policies around sexual behaviour are needed that respect privacy, sexuality and accommodate the needs of residents (such as double beds for couples)<sup>22, 37</sup>. This should incorporate awareness raising and training for staff<sup>37</sup>. For same sex attracted women, these issues can be more complex. Most aged care services are heteronormative and many are provided by religious groups<sup>22</sup>. Same sex attracted older women have identified a number of

issues that stem from this including the impact (and reinforcement) of previous experiences of discrimination, the effect of invisibility and identity concealment, a lack of gay, lesbian, bisexual, transgender or intersex (GLBTI) friendly facilities, and the need for an environment that enables sexual expression<sup>38</sup>. One study of aged care service providers in Victoria found that a common perception among staff was that 'being GLTBI was about "who you had sex with"', and, as older people are stereotyped as being 'asexual', the needs of GLTBI residents become even more marginalised<sup>38</sup>. This inevitably impacts on social inclusion and connectedness for this group of women.

### **2.3 Social connectedness**

Social connectedness refers to the level of engagement and trust an individual has with others in their community. People can feel part of and valued by their community through the roles they take on, their friendships and participation in different activities<sup>39</sup>. Older women in Australia with high social support rate their general health more highly, have fewer chronic conditions, take fewer medications, are less likely to need assistance with daily tasks and have fewer visits to the GP<sup>14</sup>. In the *Australian Longitudinal Study of Women's Health*, 93 percent of older women report that they have spent time with people outside their households in the week prior to the survey which highlights the social nature of this group of women and their connection to their community<sup>15</sup>. However these connections can be more precarious for women in this age group as many major life events at this time involve loss. They include illness, the deaths of partners and close friends, and the impact of caring for partners as they die.

For women, being alone is inevitably part of their experience of old age. Women live longer than men and are therefore more likely to experience bereavement and widowhood<sup>40</sup>. They are also more likely to live alone which can make them more vulnerable to isolation<sup>1</sup>. Married women are less likely to report feelings of isolation<sup>41</sup>. However 25 percent of women aged between 60 and 69 years are widows and this increased to 75 percent of women aged over 80 years<sup>1</sup>. Married women who have spent time caring for husbands during their final years will then be without the care and support of a spouse when they are ill<sup>42</sup>. Upon widowhood, many women also report feeling 'left out' of the social networks that they were a part of when they were married, as our society is structured around heterosexual couples<sup>12, 41</sup>. Same sex attracted women may have experienced this marginalisation throughout their lives. Many same sex attracted women also lack the intergenerational support of children that other women rely on as they age<sup>43</sup>. This can contribute to a sense of social isolation and a lack of informal care, which can be alleviated by strong friendship networks.

The friendships that women make in old age have been shown to make women more resilient to isolation and loneliness<sup>44</sup>. Activities and conditions in which social connectedness is enhanced are therefore very important in this age group and spiritual and religious affiliation can also be a source of support for many older women<sup>45</sup>. However old age is a period in which friendships may be more difficult to maintain due to relocation, lack of mobility and increasing health problems, chronic illness and disability<sup>41</sup>. For women from CALD backgrounds who may have recently migrated to be closer to children, feelings of loneliness and isolation may be intensified by their relocation away from their connections

and networks. Tensions between cultures and attitudes towards ageing may compound these experiences<sup>41</sup>.

Older women require more help and assistance as they age yet they are more likely to be caring for someone else, rather than being cared for themselves<sup>14</sup>. Much of the research on informal caregiving shows older people as recipients of care by middle-aged daughters but this overlooks the invaluable contribution made by older people to caregiving and challenges the notion of older people as a 'dependent and unproductive group'<sup>12</sup>. Forty three percent of older women in Australia aged between 76 and 81 undertake volunteer work and 39 percent care for children<sup>15</sup>. Sixty percent of children receiving informal child care are being looked after by grandparents<sup>6</sup>. Gender differences in informal childcare were most pronounced in the 50 to 74 years age group, with women being twice as likely as men to have cared for another child (19 percent compared with 9 percent)<sup>46</sup>.

The consequences of caregiving for women can be considerable and include financial costs, disruption of employment and social activities and poor health<sup>12</sup>. For most, however, the caregiving relationship is complex. Older women caring for their partners or elderly siblings report a sense of intimacy, companionship and satisfaction at being able to care for their loved ones at home. Some also report increasing isolation from friends and social networks<sup>12</sup>. Caring for grandchildren is regarded by many older women as a positive and satisfying task and one that contributes to their social connectedness and wellbeing<sup>47</sup>.

## **2.4 Financial security**

Old age is characterised by a considerable gap in financial security and retirement income between women and men<sup>9</sup>. In Australia, retirement income is made up of three elements – the Age Pension, compulsory employer superannuation and voluntary savings<sup>6</sup>. Superannuation payouts for women are approximately half that for men. Women are more likely to be solely reliant on the Age Pension<sup>9</sup>, and are also more likely to be recipients of the single rather than partnered rate<sup>6</sup>.

Women's working lives are marked by gender inequality which undervalues their role in both paid and unpaid work. Throughout their lives, not only are women more likely to earn less than men and in part-time or casual work, they also move in and out of the workforce in response to caring responsibilities as they have children or care for their own ageing parents<sup>12</sup>. In this way, women 'accumulate poverty' over the lifecourse<sup>9</sup>.

Single older women experience the highest levels of poverty compared to all other household types and are at the greatest risk of persistent poverty<sup>48</sup>. There is some evidence to suggest that socioeconomic disadvantage in earlier life, such as lower paid work or educational attainment, is associated with poorer health in later life. Gender inequality in the paid workforce, as described above, is also a factor. These socioeconomic differences persist into old age and are a key determinant of health inequalities in older women<sup>49</sup>. A lack of economic security is a significant concern for many older people, who report wanting to retain their independence for as long as possible<sup>12</sup>. This has a considerable impact on the economic security of Australian women as they move through old age and affects their quality of life, health and independence.

## 2.5 Discrimination

Ageism has been defined as the 'process of systematic stereotyping of and discrimination against people because they are old'<sup>12</sup>. Stereotypes about ageing and old age often centre on dependence, frailty, slowness, uselessness, asexuality and financial reliance<sup>12</sup>. These stereotypes inform the way that older people are viewed and treated and 'at the centre of this process is the body and its betrayals: the greying, wrinkling, sagging, weakening, and their gendered meanings'<sup>50</sup>.

Gendered ageism is a term that is used to express this intersection between sexism and ageism and reflects the fact that age discrimination is experienced differently for women<sup>51</sup>. Australia's youth-oriented culture impacts on attitudes towards ageing which is then compounded by gender<sup>1</sup>. Women's value is sexualised in our society, giving primacy to women's physical appearance and sexual and reproductive role. These roles diminish as women age and older women are, very often, 'socially invisible' in Australian society<sup>12</sup>. This impacts on income, employment and health and wellbeing of older women.

Gendered stereotypes are entrenched in a number of ways. For example, ageist barriers to employment can be particularly damaging as they can limit women's participation in the paid workforce and in the public sphere<sup>12,35</sup>. The primacy of the formal economy contributes to the devaluing of older people as they move out of the paid workforce. It also devalues the role of women in unpaid work such as caregiving and volunteer work. Although many people over the age of 65 are no longer part of the paid workforce, they continue to make a valuable contribution<sup>4</sup>. In fact, Australians over 55 years of age contribute an estimated \$75 billion per year in unpaid care and volunteer work<sup>35</sup>. This counters the assumption that Australia's ageing population represents a financial burden<sup>1</sup>. The contribution that older women make to the health and wellbeing of their families and communities must be valued more highly:

By rejecting the patriarchal ideal of femininity, by challenging the sexual division of labour, by asserting themselves as competent, strong and resourceful, women can begin to reclaim their right to age without stigma<sup>12</sup>.

Indigenous women, women with disabilities, women from CALD backgrounds and same sex attracted women experience discrimination in multiple forms in addition to gendered ageism. For example, one Australian study investigated access to services for older same sex attracted people<sup>43</sup>. Participants expressed a concern that residential care may restrict their ability to express their identity and said that they would like to receive services from openly same sex attracted staff or organisations. For many, previous experiences of discrimination in accessing health care services affected expectations of future care<sup>43</sup>. This highlights the invisibility of non-heterosexual service users in the aged care sector and echoes the experiences of older women in other marginalised groups in Victoria<sup>52</sup>.

## 2.6 Elder abuse and violence against women

Elder abuse has been defined by the Victorian Government as 'any act occurring within a relationship where there is an implication of trust, which results in harm to an older person'<sup>53</sup>.

This encompasses financial abuse; physical abuse; sexual abuse; psychological or emotional abuse; social abuse; and neglect<sup>46</sup>. It is a non-gendered term that describes violence against women<sup>54</sup>. Violence against women does not stop as women age, however research in this area is relatively new<sup>55</sup>. Most women who experience violence as older women have experienced it throughout their lives<sup>56</sup>. There may, however, be a change in perpetrator with women reporting children, grandchildren, other relatives and carers, as abusers<sup>55</sup>. Some findings indicate that physical and sexual abuse may decrease with age, whereas other types of abuse remain or escalate, such as psychological or emotional abuse and financial abuse<sup>55</sup>. It is likely, however, that women experiencing one type of abuse will also be experiencing other types<sup>55</sup>.

New vulnerabilities have been identified as emerging with age, including increasing frailty, shrinking social and friendship networks, reduced access to information and loss of economic power<sup>46</sup>. These may be compounded by a lifelong history of abuse however research in this area is limited<sup>57</sup>. Studies estimate that the prevalence of elder abuse is between one and five percent and that elder abuse increases dramatically over the age of 80<sup>46,58</sup>. One study demonstrating the link between abuse and poor health found that nearly half of older women in the study have experienced psychological or emotional abuse, physical abuse, sexual abuse and controlling or threatening behaviour since the age of 55<sup>55</sup>. Australian women in their early 70s have also reported a range of indicators of violence such as physical abuse (two to three percent) and psychological abuse (three to eight percent)<sup>58</sup>.

Victims of elder abuse may face a range of barriers to accessing support. Older women may be more dependent on their partners as they age or alternatively, may be caring for a partner in declining health. Both situations may make a woman reluctant to leave an abusive relationship<sup>57</sup>. Participants in one study expressed concern for their abuser's advanced age and increasing need for care<sup>56</sup>. Other women have reported fearing that they would be placed in residential care, or, for women from CALD backgrounds, being cut off from their cultural communities<sup>54, 59</sup>. Elder abuse also often goes undetected by service providers<sup>58</sup>. It is important that health professionals recognise the prevalence of abuse for older women and how this links to poor health. Health professionals should be alert, in particular, to conditions such as depression, anxiety, digestive problems and chronic pain as older women who are being abused report these conditions more than older women who are not<sup>55,58</sup>. Other studies have found that many older women believe that domestic violence services, including women's refuges, are targeted towards younger women and are confusing or unsuitable for their needs<sup>56, 59</sup>.

The invisibility of this group is exacerbated by the fact that there is little collaboration between aged, health and domestic violence services<sup>59</sup>. Older women fall through the gap between the sectors responsible for 'elder abuse' and 'domestic violence'<sup>54</sup>. Connections and learnings may not be made or transferred between these sectors, leading to, for example, a lack of recognition of the gendered nature of elder abuse, or the predominance of domestic violence services that target younger women and their children. This represents a considerable barrier for older women experiencing violence and abuse.

### 3. Policy Context/Challenges

Federal and state governments share responsibility for ageing policy. A number of measures have been introduced to address the lives of older Australians and the anticipated needs of Australia's ageing population. These measures respond to different aspects of the lives of older Australians and relate to the themes described above. However the majority, if not all, of these policies are gender blind and do not reflect the way in which ageing is experienced differently by women and men in Australia.

Evidence has shown clearly that ageing is a gendered process yet this is not systematically addressed in policy or practice. Nor is there interdepartmental commitment at a federal level to address the ways in which the different determinants of the health and wellbeing of older women intersect. In Victoria, however, overarching strategies address the social context in which older people live. These strategies recognise the need to create an 'age-inclusive' society and refer to the way old age is experienced differently by different groups, including women. Although they do not comprehensively engage with the multiple ways that ageing and old age is gendered, they are important in considering the social determinants of health and how they connect. Both the Australian and Victorian government policies will be explored in more depth below.

#### 3.1 Federal Government

The Australian Government's response to population ageing has a number of elements. These include Australia's retirement income system, which incorporates the Age Pension, superannuation and private savings. Recent changes to, for example, superannuation have been designed to increase retirement incomes<sup>35</sup>. However the inequities in men's and women's superannuation savings are yet to be addressed.

One important funding and policy arrangement for older Australians is the Home and Community Care program (HACC)<sup>60</sup>. This is a joint program across Commonwealth, state and territory governments. It broadly reflects an 'age in place' philosophy as it aims to support frail older people (and younger people with disabilities) to remain in their community. It does this by providing domestic assistance, personal care, allied health care and nursing services and respite care. The Assistance with Care and Housing Program specifically targets low income older people who are in insecure housing or who are homeless<sup>35</sup>. All aged care services are expected to provide culturally appropriate care through two key initiatives – Partners in Culturally Appropriate Care and the Community Partners Program<sup>35</sup>.

Many government measures encourage active, independent ageing and are informed by the Government's broader social inclusion agenda<sup>35</sup>. An Ambassador for Ageing was appointed by the Federal Government in 2008 to 'promote healthy, positive and active ageing messages within the community; lead promotional activities to ensure our communities value and respect older people; and explain Government programs and initiatives to the public including assisting older people to be aware of programs and how to access them'<sup>53</sup>.

'Ageing well ageing productively' has been listed as a National Research Goal with funding provided by the National Health and Medical Research Council and the Australian Research Council<sup>35</sup>. This reflects the current policy focus on preventative health which is evidenced by

the publication of *A Healthier Future for All Australians*, the report by the National Health and Hospitals Reform Commission<sup>61</sup>, the release of the *National Preventative Health Strategy*<sup>62</sup>, and the publication of the *Draft Primary Health Care Strategy*<sup>63</sup>. Older women are indirectly incorporated into these proposals.

A range of other strategies have been put in place to deal with different aspects of ageing. These include the *National Aged Care Workforce Strategy*<sup>64</sup> which endeavours to build and strengthen the aged care sector with a view to addressing the needs of an ageing population. The *National Framework for Action on Dementia 2006-2010*<sup>65</sup> aims to improve the quality of life of people living with dementia, their carers and their families. Five priority areas are identified: care and support; access and equity; information and education; research; and workforce and training. Dementia is acknowledged as a growing health and social issue and the Strategy's recommendations attempt to address this. The *National Continence Management Strategy*<sup>66</sup> works to improve the quality of life of older Australians who experience incontinence. It was established in 1998 and, at present, has received funding until 2010. Its priorities are public awareness; education and information; prevention and health promotion; quality of service; and research.

Other initiatives include the *National Eye Health Initiative*, which focuses on eye health in particular population groups, including Australians over 40 years of age<sup>67</sup>. The *National Falls Prevention for Older People Initiative: 2004 Onwards* targets falls prevention in different settings, including residential care, acute and community settings<sup>68</sup>. Other support strategies are in place – the *National Respite for Carers Program*, for example, addresses the needs of family and friends caring for people unable to care for themselves due to disability or frailty. It is made up of a number of components including respite services, a network of carer associations and the *National Carer Counselling Program*<sup>69</sup>.

For Indigenous Australians, aged care policy begins at 50 years of age to accommodate differences in life expectancy<sup>35</sup>. In 1994, the *Aboriginal and Torres Strait Islander Aged Care Strategy* was released. The Strategy covers training and education; the provision of individual needs based financial assistance; and the introduction of flexibility into service delivery modes and funding models that allowed for variation of the mix of care in response to the needs of the community<sup>70</sup>. This Strategy, now fifteen years old, remains the only policy reference point for older Indigenous Australians, although Indigenous services are also provided through HACC funding.

Most federal aged care services are funded through the Department of Health and Ageing, however the Department of Veterans' Affairs provides a range of practical and financial assistance programs to veterans and war widows<sup>35</sup>.

### **3.2 Victorian Government**

The Victorian Government also has in place a range of policy initiatives that address ageing. These include:

- *Positive Ageing: A strategy for current and future senior Victorians*<sup>71</sup>

This four year Strategy, which began in 2004/05, aims to address the 'quality of life and social recognition of senior Victorians'. A discourse of human rights is evident in the strategy together with an acknowledgement of the past, present and future contributions that older people make in Victoria. Initiatives aim to promote a more 'age-inclusive society' through measures such as awareness raising, intergenerational forums and research into the labour market experience of older women.

- *Making this the age to be in Victoria: A forward agenda for senior Victorians*<sup>72</sup>  
This broad agenda, published in 2002, aims to create opportunities for older Victorians to live active and fulfilling lives, within the context of an ageing population. The diversity of older Victorians is noted and the way in which women are affected differently by the ageing process is acknowledged. The 'directions' that make up the Agenda focus on support to live healthy, active lives, participation in economic, social and community life, consultation and the provision of information about rights, choices and opportunities. Improved health status is identified as a measure of progress on the key directions.
- *Rights Respect Trust: Victorian Government Elder Abuse Prevention Strategy*<sup>73</sup>  
This Strategy, published in 2009, addresses the various forms of elder abuse that occurs. It is supported by *With respect to age – 2009: Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse*<sup>46</sup> which is a comprehensive document that provides information on types of abuse and risk factors, gender and diversity considerations and strategies for service providers.
- *Pathways to the Future, 2006 and Beyond Dementia Framework for Victoria*<sup>74</sup>  
This document sets out a number of strategies to address the different stages in the 'pathway of dementia'. This approach directs policy and practice towards 'healthy and active living, which may assist risk reduction and prevention of some dementias, and the early, middle and late stages on the pathway of dementia'. Support for carers is central.
- *Recognising & supporting care relationships for older Victorians*<sup>75</sup>  
This is an Action Plan for 2006-2009 based around three principles – recognition and respect; supporting care relationships; and participation. It specifically addresses the role of unpaid carers and sets out actions to support those care relationships. The expertise and knowledge of carers is acknowledged.
- *Residential aged care policy*<sup>76</sup>  
This policy aims to support older Victorians to live in their homes and communities for as long as possible. It recommends that facilities compliment other community services and be closely connected with the community. Public sector policy directions in this respect include the facilitation of access to residential aged care services in rural and regional areas and the improvement of care and access for client groups with specialised care needs.

Other government initiatives include the *Seniors 'Go for your life' Initiative* which has been in place since 2003. This aims to promote physical activity and social participation for older people and provide information and support on how to be active<sup>77</sup>.

### **3.3 Gender analysis framework**

One way of ensuring that policies and programs reflect the multiple ways that ageing is gendered is through a gender analysis framework. A gender analysis framework is a tool that encourages the development of policy to take account of and be responsive to gender. It is predicated upon the following:

- All policies have an impact on women and men;
- Policies and programs affect women and men differently; and
- Diversity exists between individual women and men and within groups of women and men.

The framework can help identify, understand and address the various and overlapping factors that influence the ageing experience for women. The framework consists of three elements:

1. *Gendered data:*  
Use gender-disaggregated statistics proactively in planning to gauge the extent to which women and men benefit or are affected by policy.
2. *Gender impact assessment:*  
Monitor new and existing policies for their gender impact and use knowledge to adapt existing or proposed policies to promote gender equity in both planning and implementation.
3. *Gender awareness raising:*  
Take opportunities to build capacity and understanding of how policies and programs can cause or lead to discriminatory effects.

These stages will help to ensure that policies and programs reflect the lived experiences of older women in Australia.

## **4. Recommendations**

1. *Gender sensitive policy*  
Policy that takes into account and is responsive to gender in a comprehensive and systematic way is needed. This should occur across all the determinants of older women's health and wellbeing and can be achieved through the use of a gender analysis framework.
2. *Enhancing economic security for older women*  
This could be achieved through the removal of barriers to women's participation in the paid workforce; closing the gender pay gap; investment in measures to redress women's disadvantage in the superannuation scheme; and recognition and reward for unpaid care in the retirement income system<sup>9</sup>.

3. *Improving access to health services for same sex attracted older women*

This group of women are often overlooked in policy and program design. Inclusive services should be promoted through signage indicating inclusive services for same sex attracted clients, training for staff and the updating of policies and procedures to encompass same sex attracted relationships<sup>52</sup>.

4. *Support for a National Older Persons Housing Strategy*

This strategy has been devised by the Council on the Ageing (COTA) and Aged and Community Services Australia and would ensure security and affordable housing for older people so that they can 'age in place'<sup>78</sup>. It considers the maintenance and development of existing housing stock to support ageing in place and increasing the supply of affordable and appropriate housing for older people.

5. *Support for a range of specific health measures*

COTA recommend a number of specific measures that address the social determinants of health for older people in Australia. These include the development of a national mental health strategy for seniors; dental review implementation; and mental health planning which should be guided by the following principles<sup>79</sup>:

- Maximise the economic, social and political participation of older Australians and challenge ageism.
- Promote positive views of ageing, reject ageism and challenge negative stereotypes.
- Promote interdependence and consciousness across generations.
- Redress disadvantage and discrimination.
- Protect and extend services and programs that are used and valued by older people living in Australia.

6. *Intersectoral programs and policies regarding violence against women*

Learnings from the aged care sector, the domestic violence sector and the health sector should be shared through the implementation of intersectoral policies and programs.

7. *Adoption of policies on sexuality in aged care settings*

Residential aged care facilities should adopt clear, inclusive policies on sexuality and sexual expression that are underpinned by a human rights approach<sup>37</sup>.

8. *Challenging stereotypes of ageing and older women*

Programs and policies that challenge myths and stereotypes about ageing and older women are needed across all the determinants of health and wellbeing to ensure older women are valued and respected in our communities.

## 5. Conclusion

Older women experience the ageing process very differently to men. In the face of an ageing population, it is vital that policy planning and design takes into account the broader social context for women. This context is shaped by housing options, financial security, social

connectedness, discrimination and elder abuse. Women's role as caregivers, and the fact that being alone is part of the experience of ageing for most women, are also important considerations. All of these factors affect the health and wellbeing of older women in Australia.

Many policies are already in place that address these different aspects of the lives of older women, at both a federal and a state level. However these measures can be strengthened to specifically address how women experience these life changes. Strategies must actively acknowledge how the experience of the ageing process differs between women and men, and between different groups of women. Policies and programs need to address the complexity of women's lives as they age, and recognise the contribution that women have made and continue to make to the lives of their families and communities.

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