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**Submission Health of Older people Strategy.**

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**Submitted by:**

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# Women’s Health Action is a women’s health promotion, information and consumer advisory service. We are a non-government organisation that works with health professionals, policy makers and other not for profit organisations to inform government policy and service delivery for women. Women’s Health Action is in its 31st year of operation and remains on the forefront of women’s health in Aotearoa New Zealand.

# We provide evidence-based analysis and advice to health providers, NGOs and DHBs, the Ministry of Health, and other public agencies on women’s health (including screening), public health and gender and consumer issues with a focus on reducing inequalities. We have a special focus on breastfeeding promotion and support, women’s sexual and reproductive health and rights and body image.

# In 2014-2015 we undertook a stock take and review of recent literature in regards to the health of on women over the age of 65 in Aotearoa New Zealand). Based on this evidence we identified some of the key health policy issues for older women in Aotearoa New Zealand including the effects of gender and age discrimination (*Creating Health Strategies for Older Women* 2014. Attached).

# We welcome the opportunity to give feedback on the Strategy for the Health of Older Persons. Because our area of expertise is the health of women and girls we have focused our comments on strategies for improving the health of older women in Aotearoa New Zealand.

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The Health of Older People strategy currently identifies eight objectives where change is essential to ensure positive aging and promote health and wellbeing of older people. They include older people and their families having the ability to make well informed health choices, integrated, timely and quality health (including both hospital and community services) and disability support programmes. In addition the strategy states older people, including those with high and complex health and disability support needs, will have timely access to proactive primary and community health services and population-based health initiatives and programmes which promote health and wellbeing in older age.

We support these aims but think that there is evidence that a number of other factors must also be considered to promote the health of older New Zealanders. In fact the New Zealand Positive Ageing Strategy notes that as well as equitable, timely, affordable and accessible health services people also need a secure and adequate income, affordable and appropriate housing and transport, culturally appropriate services. Older people must also feel safe and secure and able to age in their communities. This will require people of all ages have positive attitudes to ageing and older people, the elimination of ageism and the promotion of flexible work options and increasing opportunities for personal growth and community participation.

# We submit that while both the goals of the Health of Older People strategy and the Positive aging strategy are laudable, they are far from being achieved. Our research suggests that recognition of the diversity of this population, attention to intersecting causes of health disparities, addressing ageism and a gender specific approach need to be included in order to achieve these goals. The review and our contacts in the sector also indicate that abuse and neglect of the elderly is a frequent occurrence both at home and in aged care services and is a significant health issue that must be given specific attention.

# Background. Getting older in Aotearoa New Zealand

# *“Aging women represent an important and growing political constituency in both developed and developing countries. Recognising and supporting their full participation – regardless of socioeconomic status and ethnicity – will benefit the health and well-being of individuals, families, communities and nations”.*

# In similar countries worldwide, in 2010, the first of the ‘baby boom’ generation reached 65 years of age, marking the beginning of a dramatic increase in the proportion of older people in Aotearoa New Zealand's population. By 2051 older New Zealanders will make up 26 out of every 100 people, and the majority of those older New Zealanders will be women. As this population increases so will its diversity when compared with past generations. There are considerable cultural differences and attitudinal differences between these women, some of which are a reflection of a lifetime experience of health and other inequalities and the increasing disparities in New Zealand.

# There are also considerable differences between the health of men and women. The diversity of older women coupled with the lack of gender based research in many areas of health means information about the health of older women in Aotearoa New Zealand is limited.

# The health of older women

# In Aotearoa New Zealand overall female life expectancy at birth is 81.1 years, nearly five years more than male life expectancy and Mäori female life expectancy is nearly nine years less than for non-Mäori females. While cancers and ischemic heart disease are the leading causes of female mortality, older women have higher rates of arthritis, osteoporosis, asthma and chronic obstructive respiratory disease than men. While life expectancy has continued to increase for all New Zealanders the increase in health expectancy has not kept pace and girls can expect to live 14 percent of their lives in poor health and some reports suggest that long term disabilities will have an increasing impact on health expenditure. Approximately one in five older females have a disability and falls are a common cause of female hospitalisations for injury in the older age groups. Mental health is also an issue for older women who are more likely to outlive male partners, face social isolation and anxiety about lack of financial security and safety. In addition there is evidence that distress caused by these issues may be medicalised rather than addressed at a social or economic level.

# Social, political, cultural, and physical conditions under which people live and grow older are important influences on health “and have cumulative effects over a lifetime”. In Aotearoa New Zealand there are significant disparities in the health of different groups of women. Differences can be found in the health of Māori and Pasifika women and other groups such refugees, and lesbian, bisexual and transgendered women reflecting the effects of a range of intersecting factors including racism, homophobia and the transgenerational effects of colonisation as well as structural barriers and socio economic differences .

# However, physiological changes such as a reduction in bone density and eyesight are a normal part of the ageing process and these do not necessarily lead to changes in independence or overall wellbeing. At the same time, social factors such as living standards, income and access to health care are variable and greatly affect how individuals experience ageing and there are considerable differences in health outcomes and challenges between men and women and between women. In cultures where both sexism and ageism are present older women face the “double jeopardy of exclusion related to both”. Other societal norms, particularly those relating to appearance often make getting older more of a challenge for women than for men.

# The health of older women does not necessarily have to be placed in a context of context of problematising discourses about economic burden or negative views of aging and recent research has challenged these approaches and beliefs. Australian studies have estimated the value of unpaid voluntary work outside the home by older women is estimated to range from AU$670 to AU$975 per woman per year. Social capital has also been well demonstrated to have an effect on health and there is evidence that psychological capacities greatly influence the way in which people age. For some spirituality and/or religion provides much of this meaning and may also provide a source of social support and of self-esteem as well as pastoral care. Coping styles, self-efficacy, optimism, and a sense of coherence are linked to mental and social well-being as one ages and appear to influence a person’s ability to maintain meaning in life despite personal losses, physical decline and ageism. In a study in which the health in older women was considered researchers found that it was not health, per se, which is so crucial in women's later lives, but rather the attitudes and coping strategies to meet new situations, losses and crises. Other studies have detailed the value of activism and social and political involvement in later life. The responses of others, including health professionals, are also noted as important in enabling older women to live productive lives in spite of adversity.

# We therefore submit the Health of Older people Strategy needs to these factors into account and include the following changes:

# The Older person’s health strategy and intersecting strategies such as Positive Aging and Whanau Ora address both age and gender discrimination

# Concepts of aging and attitudes towards older people and being older are variable and culture based. By the twentieth century western popular culture began to present an increasingly negative view of older people and for the first time in history, long life had become a problem. The United Nations has noted the ageing of the world’s population has profound human rights implications which “increases the urgency of addressing the discrimination experienced by older women” and recent studies have concluded that current representations of old age preclude development of cultural attitudes capable of accommodating positive aging

# By 2051 older New Zealanders will make up 26 out of every 100 people, and the majority of those older New Zealanders will be women. This pattern of increasing longevity of people throughout the industrialised world has generated a substantial body of new policy and theory and this growing group are often discussed with by problematising aging and focusing on perceived economic and other burdens and gender and age discrimination. Research also suggests that with many countries looking at ways to reduce health care costs the older adult population can become the target for cost control. The increasing focus on the health care ‘burden’ of the aging populations means a reduction in state funded benefits is a real risk. In this context, older women, particularly those from groups who already experience health disparities, may face significant challenges in accessing healthcare and other services and in maintaining good health.

# The view that older people, and older women in particular are a drain on society is therefore both ageist and sexist. What is often ignored is the contribution ageing women make to the social and economic well-being of their families, communities and nations. In fact the New Zealand Ministry of Health notes that less than one in twelve of the older disabled population is cared for in institutions and aged care facilities. Indeed some studies have indicated older adults tend to report being more satisfied with their lives than younger people and research findings on activity and bodily limitations further underscore the point that many older adults, even with increased levels of disability, function well in the community and look positively on their own health.

# Locating the idea of good health with a particular age group or gender does not necessarily reflect the reality of health care costs and youth is not necessarily always associated with happiness or good health. Nor should age be equated with an inability to contribute to society. We should not discuss the healthcare demands and what are considered acceptable health outcomes of this growing group are often discussed with an increasing problematising of aging and focus on perceived economic and other burdens. It is important that access to health care as a basic human right be reflected across age groups and genders.

# The Health of Older People Strategy should include objectives that enable full and equal participation in society and encouraging intergenerational solidarity and respect. This includes dispelling misconceptions, negative attitudes and stereotypes about women and aging, improving opportunities for all women to engage in work when they want or need to, supporting intergenerational connection, respect and cooperation and recognizing, valuing and supporting the unpaid work that women including older women, do in the home and community. In addition, if any section of our society is seen a burden or disposable their rights may be eroded. Supporting the social inclusion of all ageing women and involving older women in decision-making related to political, social, spiritual and economic issues and reducing the isolation of older people by creating environments that enable their continued physical and social involvement in community life.

# Older person’s health strategy and intersecting strategies ensure gender and age sensitive health care practice and research

# Another important challenge in constructing health policies for older women is the gender bias of health research. Indeed researchers have noted women have been excluded from much of the health care research that guides policy development and argue that much of what is known in medical research is characterised by gender blindness. This illustrates the importance of focusing on the specific needs of older women and bringing women’s health to the forefront of the research agenda.

# Direct to consumer marketing of pharmaceuticals (for example statins and bisphosphonates) makes obtaining objective health information more difficult. Both the internet and print media are vulnerable to industry influence and when the manufacturers standing to profit deliver the medical information, accessing unbiased health care advice becomes more challenging. In all older people, multiple medications and fragmentation of care may mean serious side effects can go unreported. Similarly, the age based stereotyping may mean symptoms are wrongly identified as age related. Other health challenges include prescribing of drugs that have not been adequately tested on elderly women and a failure to recognise that women are more likely to experience drug reactions than men.

# As health care has become more complex, health literacy and obtaining independent, evidenced based information can be difficult. Lack of informed consent procedures, media based misinformation, medication or treatment-induced illness, unsubstantiated statistics (for example mortality rates following hip fracture) along with patient disempowerment, all add to health challenges for older women.

# Incorporating age and gender based perspectives into all policy and research allowing sex and gender and age differences to be taken into account in the provision of all health care including prescribing medications, treating mental health problems such as depression, and dealing with health problems related to violence and abuse. Government statistical data and the data of organisations such as ACC and HDC must be disaggregated by sex and age to provide gender specific information about health.

# Gender sensitive research is also required into cost-effective ways to help older people remain in their homes in the community and address the specific issues faced by women in particular, including safety and mobility; their expectations and experiences of long-term care options; effective policy options and legal guidelines for providing dignified long-term and end-of-life care, the differential use of medications by older women and men and the impact of health care reform on gender equity .

# The Older person’s health strategy and intersecting strategies address high risk illnesses and chronic disabilities experienced by women as well as men by developing gender sensitive health interventions

# Illnesses that contribute to chronic disability in ill health in older women such as migraine, osteoarthritis or domestic violence require gender based research and specific interventions. For example, research shows development of services specifically suitable to the needs of older women who experience domestic violence is vital. It is also important that health care professionals in all service segments understand the help-seeking barriers that older victims face and replace myths and stereotypes about the nature and prevalence of domestic violence among older people. Mental and primary health services, for example, must “pay special attention to women who have experienced elder abuse or other forms of violence”.

# The Older person’s health strategy and intersecting strategies include measures that enhance quality of life and support independence

# One of the challenges of getting older is the fear of becoming a burden on others and losing independence. In a 1996 study help with housework was the most common identified need and family and friends were the most likely people to be helping older people with everyday tasks. Increasingly a greater number of the older population may not have children and together with continued lower fertility rates this will mean that there are fewer children of older people to share the caring role. Strategies include support for changes in work practice that enable older women to remain in both the formal and informal labour markets and support voluntary and gradual retirement and the work of unpaid carers. Simply transferring formal care to the unremunerated care provided by ageing women without providing compensation for lost wages and community support services is discriminatory. Priority setting in health care services should be based on evidence that is free from systematic gender-and age biases.

# Strategies such as creating housing designs that enable multigenerational living and assistance with home modifications and repairs, accessible housing; hazard-free streets and buildings; safe, accessible public transportation; creating public spaces that encourage active leisure and socialization along with age-friendly cities and communities and education about new technologies can address many of the factors in the physical environment that help determine the state of older women’s health. They will also improve the health of the rest of the population.

# The Older person’s health strategy and intersecting strategies pay attention to Human Rights and the social determinants of health

# “As they age, women and men share the basic needs and concerns related to the enjoyment of human rights such as shelter, food, access to health services, dignity, independence and freedom from abuse. The evidence shows however, that when judged in terms of the likelihood of being poor, vulnerable and lacking in access to affordable health care, older women merit special attention”. The ageing of our population also has implications for how we protect the human rights implications particularly for the frail, disabled or ill elderly.

# Older women who are poor or disabled or belong to minorities often experience multi‐sectored discrimination. Similarly, older women in prison, older sex workers and older disabled women can face neglect and abuse or financial insecurity. Many older women face neglect as they are considered no longer economically or reproductively useful, and are seen as a burden on their families. Prohibitive costs, lack of transport or the absence of geriatric medicine, primary health or mental health services often prevent older women from enjoying their human right of access to health care.

# Each year, New Zealand’s Age Concern’s Elder Abuse and Neglect Prevention (EANP) services receive over 1000 referrals about people who may be facing elder abuse or neglect. Two thirds of abused older people are women. EANP notes that older people who are dependent on others are particularly vulnerable to abuse and that for many their health was significantly affected by the abuse they experienced. About a quarter experience long-term consequences and two out of every 5 abused people experienced a significant reduction in their independence, loss of confidence and self-esteem, and reported feeling very frightened or anxious and emotionally distressed. Abuse of elderly people by care services is not uncommon but abuse by family members is most common. Age Concern New Zealand (ACNZ) data shows that referrals have been increasing steadily for some time, and that services are not always able to respond to this demand.

# There are significant gender interaction effects that mean that women are penalized by their participation in family life, employment and where they live. There are few New Zealand studies about the impact of poverty on women over 65 but there is evidence in the international literature that there are gender differences in levels of poverty amongst older people. Because Women are living longer and because of their traditional lack of financial retirement planning, they are prime candidates for poverty. Many older women who a lack of financial security such as superannuation or savings, or not owning their own home, may also experience financial insecurity which in turn means they may try to live very frugally - cutting costs on heating, quality food, activities that promote social connectedness, or health care. These women might not experience poverty per se but are 'living poor'. In addition, the health care reforms of the last decade have also had a negative effect on poorer people, including the closing of acute-care beds, and early release from hospital without a corresponding increase in support in the community which has left ageing women with an increased and unrecognized burden of caring for partners and other family members who are ill or frail.

# Health strategies must take a human rights approach to health care and address issues such as income support and access to appropriate housing and transport and put in place specific monitoring strategies to protect the frail elderly from abuse, financial exploitation or violence.

# Conclusion

# Aotearoa New Zealand has an increasingly diverse population of women over 55. While a disease based approach can highlight the major health challenges faced by this group in general, it does not take into account issues such as poverty, ethnicity, migration or the effects of colonisation or discrimination and how these affect the health of diverse groups of women. Similarly, a focus on mortality of women in general does not reflect the significant changes and differences in the lives of New Zealand women over the last century.

# While women who are now in their eighties may be living longer as a result of medical improvements or because of having healthier diets earlier in life and less sedentary lives, they are living longer with disabilities. Nor can we expect that women in their 60s who may have been exposed to other risk factors such as increased drug use, including tobacco and alcohol and the increased availability of processed foods and a sedentary lifestyle, will necessarily live as long as their mothers. Evidence also points to poverty as an increasingly significant influence on women’s health and mortality.

# The United Nation’s “Between gender and aging” report recommends certain strategies for addressing older women’s health including a life course approach, providing supportive policies and activities at key transition points in a one’s life, addressing gender and age discrimination and addressing the underlying determinants of health . The studies we have reviewed suggest similar strategies and that we must take more than a disease based view if we are to ensure all women in Aotearoa New Zealand enjoy good health when they are older and appropriate health care when they face illness or disability.

# We hope these factors will be taken into consideration when developing a new Health of Older People strategy. We have attached a copy of our discussion document and research on the health of older women.