



**SUBMISSION TO THE NATIONAL WOMEN'S HEALTH POLICY
DEVELOPMENT PROCESS**

Prepared by National Policy Office

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INTRODUCTION

COTA National—Council on the Ageing is the national peak seniors' body, whose member organisations work with over 500,000 older people living in Australia. Its members are eight State and Territory Councils on the Ageing in NSW, Queensland, Tasmania, South Australia, Victoria, Western Australia, ACT and the Northern Territory.

COTA National has a focus on national policy issues from the perspective of older people as citizens/consumers. Its prime objective is to promote, improve and protect the circumstances and wellbeing of older people in Australia, of which there are over 6 million, not just its members, and particularly the vulnerable and disadvantaged. Its work draws on views of today's seniors and on concerns for future generations of Australians.

Members of COTA National adhere to the following five policy principles that inform all the work we do:

- maximise the economic, social and political participation of older Australians;
- promote positive views of ageing, reject ageism and challenge negative stereotypes;
- promote sustainable, fair and responsible policies;
- redress disadvantage and discrimination; and
- protect and extend services and programs that are used and valued by older people living in Australia.

COTA adopts the World Health organisation's definition of health as a state of total wellbeing, not just the absence of sickness. Health is everything about our lives—physical, emotional, spiritual, political, economic, social and financial.

COTA is disappointed that there were not more consultations around the discussion paper to ensure there was a wider set of views on this important issue. We would have liked to see more consultations in regional areas; e.g. in NSW there were only two consultations and these were both on the eastern coast which limited the range and number of participants who could contribute. We would also have liked to see a specific consultation around the needs of older women.

OLDER WOMEN'S HEALTH

Despite the compelling evidence of population ageing, it is disappointing that the Consultation paper places little emphasis on older women. COTA supports the five principles that underpin the Policy but believes there needs to be a cohort/generational analysis within each not just in the life course approach.

The health issues of ageing women remains a critical issue and within that there needs to be some attention to the diversity of women's life experiences and equity issues between older women and between different generations of women. As well it needs to be explicitly recognised that the other priority issues all have significance for older women as well as women of working age and young women.

Many older women live alone, partly due to the death of their spouse or divorce, and are dependent on the single age pension, the health implications of these issues need to be addressed in any discussion on women's health.

The added complexity of older women as carers also needs to be included. There is a body of evidence that suggest that carers often neglect their own health needs, This is exacerbated for Grandparent Carers who often have little access to respite care to enable them to deal with their own health issues.

Health cannot operate in isolation to deliver benefits to the community; there are a wide range of stakeholders that need to be engaged in the development and delivery of services to older women. These include local government, GP Networks, planning and infrastructure developers and urban designers all contribute to the physical and built environment which is a critical enabler of health and well being.

Gender equity

Greater emphasis should be given to developing health programs and information on a gendered and age basis, for both men and women. For example, the types and course of chronic disease affecting women and men are different. Women and men may present with different symptoms. One example of this is heart disease where the presenting symptoms for women are quite different from those described in most textbooks which are based on men's symptoms. This leads to women's angina and heart attacks often being either misdiagnosed or not diagnosed at all even though they are one of the leading cause of death for women. For women the risk of heart disease increases with age and so this is of greater importance for older women.

Women, and their health professionals, need to have information about the types and way disease manifests for women, particularly after menopause. This requires changes to the information provided at training and is significant enough, in the case of heart disease at least, to require retraining for health professional already practising.

Current cohorts of older women suffer particular disadvantage because they usually have had interrupted paid working lives, have little superannuation, and live longer than men. Therefore they often have fewer financial and other resources to fall back on as they age. Lack of financial resources has a significant effect on older women's mental and physical health, their ability to take preventative measures, or to buy aids to compensate for

deteriorating faculties (such as hearing aids, walking aids, and scooters) and their ability to participate in community life.

Health equity between women

COTA endorses the list of women who may be at higher risk of a range of health problems. COTA recommends that older women should be added to this list as well as considered within each of the other groups.

We support the need for special efforts and resources for disadvantaged women, including older women. Accumulation of grief through loss partner/siblings/children/friends and loss of individual capacity and identity (ageism) and transition to residential care are also equity issues and have a disproportionate impact on older women.

There is evidence that older women may receive fewer services because of attitudes of decision-makers and budget decisions. For example older women (over 70) do not get recall notices for breast screening or Pap smear on the grounds that if there are no problems at age 69 any cancers developing after that age will not have an adverse impact within the remaining lifetime and thus they are not in a high risk group. Given increasing longevity this is likely to be a further 20+ years, more than adequate time for a cancer to develop.

Naturally there are specific health concerns for isolated women in rural, regional and remote areas that need to be considered. However women can be socially isolated in metropolitan areas and this group needs additional attention.

The needs of culturally and linguistically diverse and Aboriginal and Torres Strait Islander older women need special attention. For many of these women, poor accessibility of mainstream services has denied them access to a wide range of services and activities throughout their life course. This is particularly important for women who have poor English language skills and require culturally and linguistically appropriate services and programs to enable their participation. In some cases it is essential that specific, tailored programs are also available.

For older women of non-English speaking background, loss of English language skills can be a significant barrier to accessing services and information. Ageing brings with it a reversion to one's first language even if they had functional levels of English in their younger years.

The discussion paper combines the needs of immigrant and refugee women. COTA believes there needs to be a disaggregation of immigrant and refugee women given the very significant differences between these groups that make a single analysis inappropriate and may obscure significant equity issues. For example migration patterns have altered over time so that the demographic and social profile of older

immigrant women varies from current cohorts of immigrants. The socio-economic status of various categories of immigrants is markedly different from that of most refugee women. In addition it is not helpful to imply that all issues for immigrants relate to a non-English speaking background when so many immigrants are from English speaking countries. Refugees may have issues such as grieving the loss of country, family and often survive torture and trauma which adds to the complexity of mental and physical health and wellbeing needs.

Focus on prevention

Prevention and early intervention must be at the forefront of any Women's Health Policy. Prevention should occur at any age and whilst it would be great if we had programs across the whole of one's life there must be programs that work with current generations of older people and not just focus on young people. COTA believes the Women's Health policy should include a comprehensive program for active ageing to decrease the risk factors and increase protective factors for chronic disease and functional decline.

For older women it is imperative to ensure accessibility to a wide range of programs and services that encourage physical activity and inclusion. As well as targeted or specific programs mainstream services need to consider the particular needs of older women, such as age friendly environments and access to transport to maximise the opportunities for participation.

There is growing evidence that older women are subject to domestic violence, often lifelong patterns of abuse and violence by a spouse or family members. The issue that needs to be addressed is that the domestic violence sector is not well versed in understanding the specific needs of older women. A comprehensive National Women's Health Policy needs to address this issue.

A Life Course Approach

COTA supports the life course approach as there are clearly some health problems that are specific to certain age groups and so need targeted responses. However many conditions/problems can be experienced by women of any age and there is a need to ensure that all health services work to be inclusive of all ages.

Longevity brings its own issues for women given the accumulation of the impacts of broad social features including sexism and ageism, socio-economic characteristics, and bio-medical factors and diverse life experiences. Differing cohorts and generations of older women have experienced these impacts in different ways and this cohort effect needs to be taken into account in developing services for them.

CONCLUSION

COTA is supportive of the principles and the general directions as outlined in the discussion paper.

COTA believes the policy should include the following

- the identification of older women as a priority group with both specific targeted services and improvements to the services provided through the mainstream;
- a more explicit recognition of the gender differences in how some diseases and conditions behave and a commitment to ensuring health professionals understand these differences and take them into account in diagnostic and treatment regimes; and
- a cohort analysis of needs and services designed around those cohorts rather than the current life course approach.

COTA recommends that there be more consultation when the draft policy is developed and offers to use our extensive networks across the States and Territories to assist with ensuring older women from a wide range of backgrounds and localities get involved in those consultations.