Building systems to address functional decline and dependence in ageing populations

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A gender perspective on long-term care

Alicia Williams

Working document

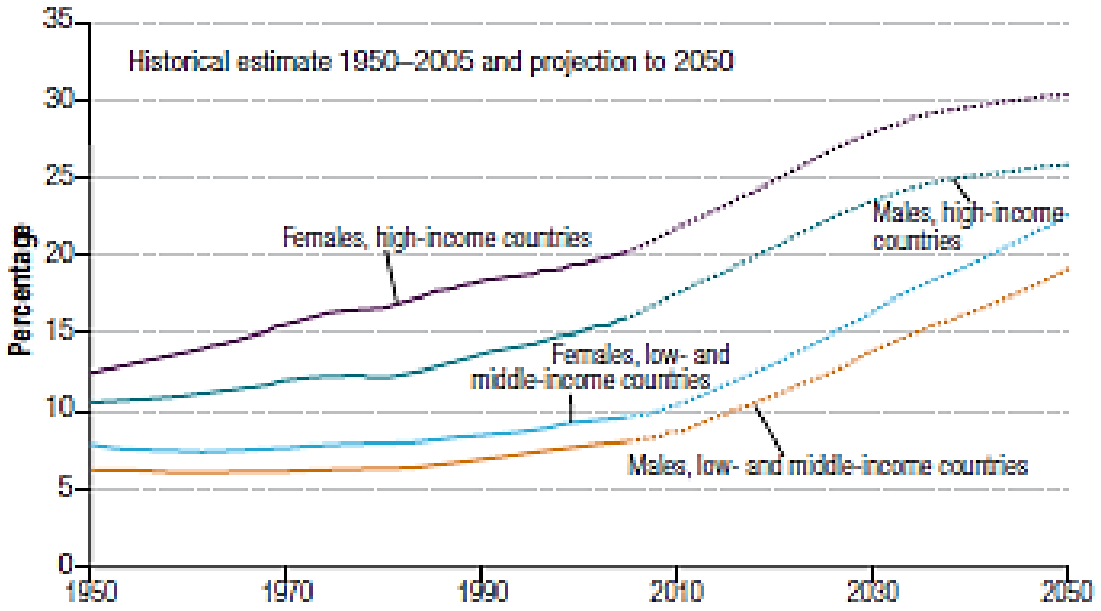
Introduction

The aim of this paper is to provide an overview of some of the challenges of health and social care for women. Outlined are the demographics of older women, women being both disproportionate givers and recipients of care, and some proposals for discussion. The proposals at the end should be considered within the context of particular countries, as health systems, social and cultural norms vary widely. When gender inequalities do exist, these have often been present throughout life, but have become exacerbated in old age.

Demographic Changes and Disease Burden in Older Women

Worldwide improvements in sanitation, vaccination, accident prevention and healthcare have enabled an increase in life expectancy such that most countries have an increasingly significant population over the age of 65. These populations are frequently now classified as the "young old," 65-74 years of age; the "old," 75-84 years of age; and the "old-old," or "oldest old," 85 years and over (National Institute of Aging, 1984). In most countries, women outlive men, hence women represent a growing proportion of all older people: 53% of the "young-old", 58% of the "old", and 66% of the "oldest old".

Figure 1: Males and females over the age of 60 as a percentage of the population in high- and middle- and low-Income Countries, 1950-2005 and projected to 2050.



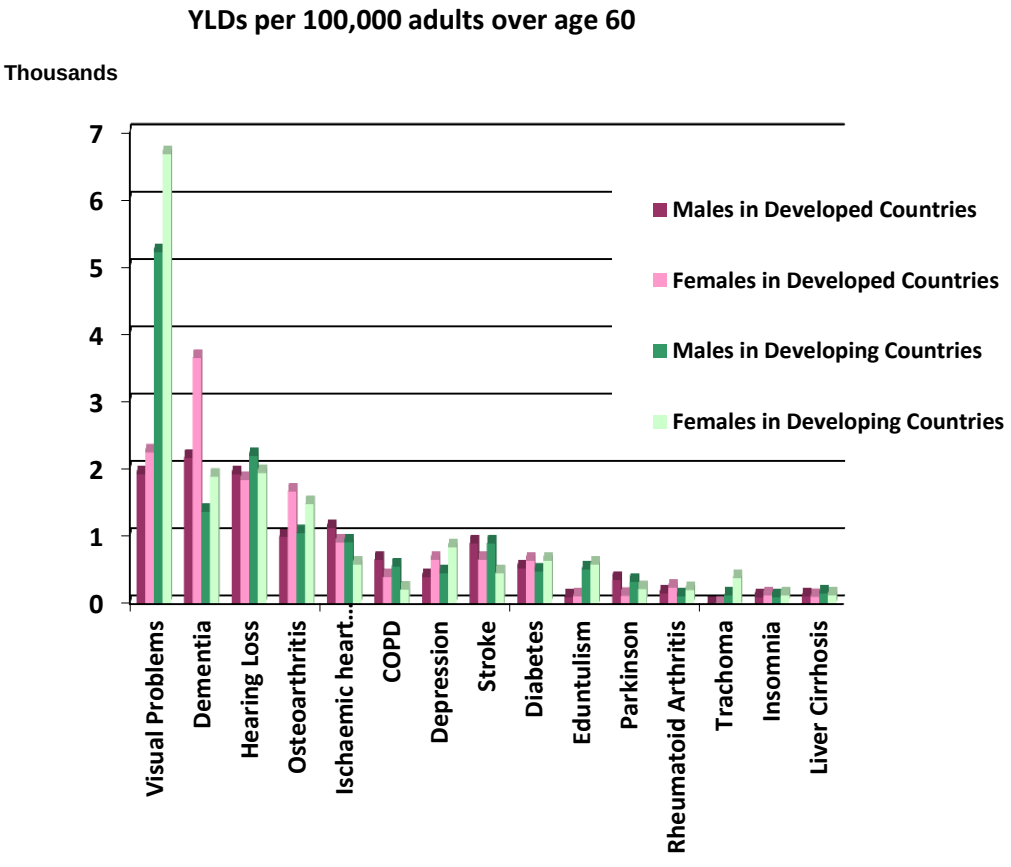
Source: United Nations Population Division[2]

The ageing of the population is occurring at a more rapid rate in low- and middle-income countries than those of high-income. As demonstrated by the slopes of the curves in figure 1, from now until 2050, women in low-and middle-income countries are estimated to have the largest increase as a percentage of the population.

Health Issues of Older Women

These demographic changes result in women being increasingly burdened with non-communicable diseases. The four biggest causes of disability in older women are vision and hearing impairment, dementia and osteoarthritis (see Fig 2). Every year, more than 2.5 million older women lose their independence through visual impairment. In low-income countries, trachoma is a significant but preventable cause of blindness that affects women in particular. Much of this burden could be avoided if these women had access to the necessary care, particularly surgery for cataracts. However, women face disproportionate difficulty in getting the care they need. Women over the age of 60 in low-income countries are nine times more likely to be blind than women in high-income countries, primarily due to cataracts and uncorrected refractive errors (Women and Health. © World Health Organization 2009).

Figure 2: Years lost due to disability in adults over age 60 by condition.



Source: © WHO Reanalysis of Global Burden of Disease 2004

The term “geriatric syndrome” is used to capture those clinical conditions in older persons that do not fit into distinct disease categories. Some syndromes, such as incontinence and falls, are particularly important for women and their impact on quality of life and disability is substantial.

Globally, the leading causes of death among women over age 60 are ischemic heart disease, stroke, and chronic obstructive pulmonary disease. Together, these conditions account for 45% of deaths in women over 60 worldwide. A further 15% of deaths are caused by cancers- mainly cancers of the breast, lung and colon. Although most of these conditions are the same as those encountered by older men, there are particular challenges encountered by older women. For example, women with acute coronary syndromes are often undiagnosed, in part because they often show different symptoms from men. Women are also less likely than men to seek medical help, and therefore do not get appropriate care until later when intervention is necessary but less likely to be successful (Women and Health. © World Health Organization 2009).

Care Needs of Older Women

Due to these longer life expectancies and higher disease burden, women have greater health care needs. However, at the same time, older women have lower social and financial security than older men. Although women’s educational attainments and labor force participation have increased older women are more likely to be poor than older men in all countries (Smeeding T et al). This is a result of many factors, including that women are more likely to have worked part-time or in the informal sector and spent fewer years in the workforce. (Lee W.K.M. et al, Wong J.D. et al). These factors also contribute to lower probability of health insurance coverage in later life, which can make chronic disease management more difficult.

The overwhelming majority of older women, whether fully independent or not, prefer to stay in their homes (and most do), receiving assistance from family and friends (as unpaid or “informal” caregivers). This support is often provided even when relatives and friends are not within close proximity of the care recipient. The positive influence of social support on the health of the elderly is well documented; in particular, emotional support from offspring is positively associated with a higher degree of well-being and less distress and cognitive impairments among older people without a spouse (Pejner M.N. et al, Okabayashi H et al). Not all older people have a support network, which can lead to social isolation. This loneliness is not just a ‘social’ issue, as loneliness in old age has been suggested to be a risk factor for worse health and even death (Luo Y et al). These challenges can particularly impact on women given their increased chance of outliving a spouse and the shift from extended to single generation families. In some European countries, nearly 50 percent of women aged 65 or older now live by themselves.

However, this provision of social support has its own cost. When the demands for care exceed the limitations of the caregiver, this results in caregiver strain. In spite of higher prevalence of multigenerational households in developing countries, levels of caregiver strain may be at least as high in the developed world. In addition, informal caregivers in these settings sometimes have inadequate knowledge and training for their expected roles (Carmichael, F et al ; Prince et al, Shaji et al).

Institutional care needs

Women usually constitute more than 60% of nursing home residents and are usually widowed, divorced or single, as studies have shown that the presence of a spouse is protective against nursing home admission. (Gaugler JE et al 2006). Women have an increased risk of institutionalization when they lack home ownership. (Luppa M et al).

Personal variables which accelerate admission are low self-rated health status, functional impairment and cognitive impairment. (Luppa M et al). In a multinational study across Australia, USA, Japan and South Korea, women consistently had a lower self-rated health status than men. (French DJ et al).

Owing to increased long-term care expenditure, costs of formal care for females exceeded costs for males at more advanced age, with those with dementia needing care at 10 years earlier than others (Prince M. et al). After admission to a long-term care institution, such as a nursing home, length of stay is 50% longer than for men. Hence, total expenses from the age of 65 years until death are 17 to 37 % greater for women than for men, depending on the age of death (Carmichael, F et al). However, studies from high-income countries show that nursing home residence is associated with lower probability of in-hospital death, which may lead to overall cost saving. (Kelley AS et al).

Women as Caregivers

Due to social and cultural norms in most countries, women often partner with older men. As a result, women are more likely to be caregivers to their partners. Women who lose a partner are also less likely to repartner than men who do so, further decreasing the chances of support. (Shaji KS et al). They are therefore particularly affected by home and community care policies and practices. Much of the work being done by these older women (e.g. household chores) has been their responsibility throughout their lifespan, and is sometimes not viewed as caregiving.

The gender bias of informal caregiving is well-documented. Informal caregiving responsibilities fall more heavily on women, many of whom are older with health problems of their own. Caregiving responsibilities also come with economic costs, as caregivers often reduce or adjust their working hours to accommodate these responsibilities.

The paid long-term care workforce is also overwhelmingly female. Almost all nurses and home care aides in both institutional, home and community-based settings are women. There are also large flows of migration within nursing care, usually from less developed to more developed regions. (McElmurry B.J. et al).

Both male and female carers bear indirect costs in that they are less likely to be in paid work than otherwise similar non-carers and when they are in paid work they earn significantly less. (Gaugler JE et al 2006, Lopez-Ortega M et al). However, women are disproportionately affected since they are more likely to be carers. Changing educational patterns and social expectations among women, particularly in low- and middle-income countries are likely to influence their availability and roles as carers. However, findings to date are inconclusive. Some studies show an extended time to nursing home placement for older people with a higher level of education (Smith GE et al, Gilley DW et al). This would result in a

lower rate of institutionalization due to universal increases in the education of girls. However, some studies showed that caregivers who are employed, had a higher level of education or a higher income institutionalized their care recipients sooner. (Pot AM et al, Gaugler JE et al 2006, Gaugler JE et al 2007).

Abuse and Neglect

Older women are at increased risk of abuse and neglect, which is usually inflicted by persons whom they know (Melchiorre M.G. et al). Older women are more susceptible to abuse for a number of reasons. Some of these include: they are more likely to have experienced a history of emotional, physical or sexual abuse; they are usually smaller than their male partners or relatives; they are more likely to have disabling conditions; they are more likely to be widowed or live alone. These vulnerabilities are compounded by lower financial resources of older women, making them more reluctant to leave an abusive relationship. Abuse and neglect also occurs in institutional care.

Summary and questions for the meeting

The necessary gender-sensitive research is more than simply counting women and men; it also means understanding the social drivers and consequences that influence both care needs and provision. The demographic and social changes that are occurring globally will have dramatic consequences for society, as health and social care systems must respond to the challenges.

Some questions that may be addressed during the meeting are:

- What social changes are occurring in your country that might influence the role of women as caregivers?
- What challenges might this create and how can these be overcome?
- How do we ensure systems of care are sensitive to the specific needs of older women?

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