



Preparing for Ageing Project

Final Report on Preparing for Healthy Ageing

Australian Women's Coalition

**This report was prepared for the Australian Women's Coalition
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Executive Summary

1. The Preparing for Ageing Project

This report brings together the two parts of the Preparing for Ageing Project carried out by the Australian Women's Coalition through 2008. It begins by outlining the context and scope of the Healthy Ageing segment of the Project with reference to AWC's previous work on social inclusion, and the current policy context and opportunities for input to Commonwealth policies and programs. Themes of healthy ageing are then reviewed, and five sets of questions to be addressed in the current project are identified as:

1. What were the priorities for women's health and preparing for ageing in the framework for a new women's health strategy proposed by the Australian Women's Health Network?
2. Why do women need to prepare for ageing, and what preparations need to be made at different transitions that occur across the life course?
3. How can the foundations of healthy ageing be established, and what barriers do women face to adopting a healthy diet, weight and exercise?
4. What initiatives are needed to build on existing healthy ageing initiatives, including preparing for ageing in work, home and community settings?
5. What should be included in any preparing for ageing program and what roles should AWC take in advancing such measures?

The project consultation and survey methods are also detailed in Part 1 of the report. The main part of the project was a survey conducted through 14 AWC member organizations, to which 303 individuals responded. The main characteristic of the respondents is their diversity, and the range of respondents' ages and workforce participation means they saw preparing for ageing from different perspectives at different stages of the life course. Four groups of respondents were defined as: the *younger group* were aged under 50 and in the paid workforce; the *older group* were aged 70 and over and retired; the *working transition group* were aged over 50 and working; and the *retired transition group* were aged between 50 and 70 and retired. These four groups provide a useful framework for making a systematic analysis of the survey data and reporting the findings in a way that encompasses the diversity of women's experiences of ageing and views on preparing for ageing from women in different generations.

The survey came within the category of negligible risk research as defined by the NHMRC. To take account of risks and benefits to research participants, two questions at the end of the survey found that 70% of respondents considered they were preparing for ageing well or very well, and 60% felt that participation in the survey had prompted them to think more about preparing for ageing.

2. Priorities for women's health and preparing for ageing

Part 2 of the report presents an assessment of the priorities for women's health identified within the framework for a new national women's health policy proposed by the Australian Women's Health Network. The priorities identified for preparing for healthy ageing can be readily advanced in the framework presented by the proposed new national women's health

policy. Three health priorities, arthritis and musculo-skeletal problems, cardiovascular disease and cancer, and the action areas of access to publicly funded health services and economic health and well-being were identified as high priorities by all respondent groups. These findings point to the need to address these issues as central to achieving and maintaining health now, for women at whatever age they are, with the benefits of health now leading to healthy ageing over the longer term, and to sustaining initiatives in these areas as women age. The other priority areas – diabetes, mental health, injury and asthma – and the action areas of mental health and well-being, prevention of violence against women and women's sexual and reproductive health were accorded more differential priorities by the four respondent groups, pointing to the need to vary strategies to address these issues in different ways at different stages of preparing for ageing.

3. Key transitions in preparing for ageing

Part 3 of the report covers five key transitions in preparing for ageing over the decades from 40 to 80: reaching middle age, menopause, retirement, widowhood and coming to need care.

The four groups of respondents brought different perspectives to their views of these transitions, and four areas emerged in which adjustments occurred across all transitions: attitudes to and awareness of ageing at each transition, health concerns, changing family relationships and social networks, and financial security. The nature of the adjustments made and attention to preparing for ageing differed at each transition, and increased awareness and action at particular points give some clues for the timing and nature of possible initiatives for promoting health ageing.

Awareness of and actions taken for preparing for ageing at different transitions suggests that respondents held two different views of preparing for ageing. In one view, ageing was an on-going process rather than something that lay in the future, and in the other, ageing was a future state of being aged.

While there was an awareness that actions taken at different transitions had implications for health and well-being in later life, these actions were rarely seen in terms of preparing for ageing and preparing for ageing was very rarely identified as a primary motivation for taking action at any ages. These findings suggest that messages urging health action to prepare for healthy ageing have little resonance and that the emphasis needs to shift to 'health now and for the future'.

Financial security was the main area in which preparation could be made well in advance for the future state of being aged. The need for early action to realise financial security over the long term was widely recognised, but it was equally evident that many other factors affected capacity give effect to this realisation, and the risks of financial insecurity came into much clearer focus as retirement approached.

Family relationships and wider social networks influenced many aspects of ageing as a process, with different life courses set early on for those who were single and childless, those who were married but without children, and those who had children. Preparing for ageing and especially for possible future needs for care meant involving family informally in discussions and making them aware of wishes and preferences, and formally by way of attending to wills, Advance Care Directives and other legal matters.

The varying attention given to attitudes, health, family and social networks, and financial security at different transitions demonstrates the changing balance of concerns over the life

course. The responses reported above show the multiplicity of factors that interact to produce great diversity at each transition, but the predominant shifts in concerns can nonetheless be summarised in Box 1. This matrix enables identification of a number of critical points at which awareness of the need to prepare for ageing was heightened and at which action was more likely to be taken. While these points were triggered by signals of ageing in one area, there was often a flow over effect that prompted respondents to reflect on and review action in other areas of their lives.

- Around age 40, rejoining the workforce when children started school was the first point at which many younger women became aware of saving for retirement. Younger women appeared to be more aware of saving for retirement than those in the 50s, suggesting that compulsory superannuation may have come to be taken for granted. The regular contact between funds and contributors over a long period however makes superannuation a vehicle through which other aspects of preparing for ageing could be promoted at appropriate times, and especially for those who had interrupted employment.
- Around age 50, menopause was widely recognized as the first signal of ageing, and it was described as a powerful signal, a point at which “reality strikes”. Considerable attention was given to physical and mental health at this time, but other aspects of preparing for ageing, particular financial preparation, appeared to receive less notice.
- Around age 60, even though retirement experiences were diverse, it was the transition that was most widely planned for, almost always through informal rather than formal planning. There was widespread recognition of the need to maintain health to enjoy retirement, that adjustments in relationships were likely and that financial security was essential. While attitudes to retirement were positive overall, risks in any of these areas could jeopardize well-being in both the short and long term.
- Around age 70, widowhood or the death of other close associates was associated with reflection and life review, and presented an opportunity for taking stock for the future
- It was only around 80 that care needs were mentioned, and attitudes to accepting care took precedent over other preparations.

Finally, two further factors emerged as affecting preparing for ageing across all transitions and these factors contribute to both the variability of women’s experience of life course transitions and their capacity to prepare for ageing. First, unexpected events that disrupted individual women’s expectations and broadly normative transitions had major and long lasting impacts over the rest of the life course. Second, it is very evident that awareness of and attitudes to ageing have a pervading effect on the need to and likelihood of taking action to prepare for ageing at different transitions. It is however far too facile to say that there is then a need to increase awareness and change attitudes to preparing for ageing. Given the many other concerns on women’s minds through different transitions, it is apparent that many such messages are not salient and are unlikely to lead to action. Instead, attention might better be directed to the points at which awareness of ageing is heightened by one or other factor and prompting review and responses across a wider range of areas to fill what appear to be some conspicuous gaps in preparing for ageing. Rather than leaving action to individuals, there is also a case for social action to create an environment that supports preparing for ageing and reduces the risks of marginalisation and social exclusion in retirement and beyond.

Box 1: Transitions, changing concerns and awareness of preparing for ageing

Transition	Attitudes	Health	Families and social networks	Financial security
Around 40 Reaching middle age	Ageing not on your mind at 40 – too busy with other things	Want to be healthy at 40, but competing demands on time leave little time for exercise	Very diverse family circumstances – facing childlessness, having first child, having last child, establishing a new second family. Stresses of work-life balance a major concern.	Aware of need to save for retirement, but a number of barriers. Awareness of setting up super heightened if returning to work after having children.
Around 50 Menopause	“Reality strikes”	Menopause prompts a review of health on a much wider front. Recognition of inter-relationships of physical and mental health.	Empty nesters. Many involved in caring for grandchildren so their mothers especially can work; need to recognise grandparents’ roles as part of working families.	Little attention to preparing for financial security across this decade.
Around 60 Retirement	Positive attitudes to retirement as a new phase of life, Major upsets to retirement plans may be hard to overcome in short or long term.	Action taken on exercise, diet, health checks etc., for good health in immediate future, not for future ageing. Major health events for self or partner that lead to retirement ahead of plan are one cause of disruption.	Empty nesters, with care roles much more likely to be for grandchildren than children still at home, and some caring for ageing parents.	Approaching retirement focuses attention on incomes in retirement, adjusting to lower incomes and realisation of risks associated with lower incomes.
Around 70 Widowhood	Time for life review and reflection, coming to terms with widowhood and other losses.	More attention to mental health emerges.	Family support very important in coping with losses. Those without family may need more support.	Have to take on more financial responsibility for which many in the current generation may not be well prepared.
Around 80 Needing care	Accepting care from others seen as part of maintaining independence.	Aware of risks of a wide range of major health problems. Need for care only recognised at this transition	Involving family in preparing ahead for care arrangements and making wishes known.	Need for financial security does not diminish. Some concerns about cost of care and choice if without income.

4. Laying the foundations for healthy ageing

Part 4 addresses the foundations for healthy ageing in terms of risk factors associated with diet, weight and exercise, and aspects of home and work environments that had a bearing on preparing for ageing.

Diet, weight and exercise

Investigation of the barriers that women experienced in adopting a healthy diet, maintaining healthy weight, taking adequate exercise and meeting associated costs found that knowledge and information presented few barriers, that behavioural and motivations factors presented mostly minor barriers and the major barriers were associated with structural factors of costs and time limits. It is evident that while knowing what to do is a prerequisite for preparing for healthy ageing, many other barriers prevent women acting on the knowledge they have.

Home environments and housing adjustments

The findings on housing suitability and intentions suggest that while there is a high level of satisfaction with present housing, there is considerable potential for housing change as part of preparing for ageing. Differences between the four respondent groups in part reflect the extent of housing adjustments already made, and realising the potential that is evident for further adjustments will depend on the options available and overcoming a number of barriers to finding suitable home environments. Taken together, the findings on home environments and propensity to change housing as part of preparing for ageing suggest that many women do not expect to remain in the same house as they age and that there is rather considerable potential for moving and recreating their 'own home' in new environments.

Work environments

Work environments are set to become an increasing part of the foundation for healthy ageing as more women come to participate in the paid workforce until their 60s. This changing role is indicated by the diversity in actual and anticipated retirement ages between the four groups, and by the actual and expected impacts of health on retirement decisions.

The diversity of findings on how work environments affect preparing for ageing reflect changing patterns of workforce participation of different generations of women, changes in other factors affecting retirement decisions, such as the increase to age 65 for eligibility for the Age Pension for women, and changes in work environments, especially in occupational health and safety standards. Some of these factors are more readily anticipated than others, but as more women in coming cohorts of women will have had longer periods of employment in the paid workforce, the importance of work environments in shaping retirement transitions in preparing for ageing is set to increase.

The substantial proportions of respondents who indicated that poor health was, or was likely to be a minor or major factor in their decision to retire has considerable implications for preparing for ageing. Many occupational health and safety measures focus on prevention of catastrophic injury and immediate consequences for continued workforce participation, but these findings indicate that for women, more attention needs to be given to chronic injury and to long term effects that many not be felt until after retirement. Women who have to retire because of poor health, or who experience work related health problems early in their retirement are disadvantaged compared to those who make the transition to retirement in

good health. Minimising negative health impacts of work will become an increasingly important part of preparing for ageing as more women come to have longer exposures to occupational health risks before they retire, and some of these impacts may not be felt until after retirement.

Respondents reported a range of ways in which the negative impacts of work environments had been or could be addressed. The solution that was most frequently taken by respondents in both the working and retired transition groups was to change to part time work. Making this change however required an employer who accepted flexible work arrangements. Part time work achieved a much better work-life balance, and some respondents who continued in full time work saw it as a good way of making the transition to retirement in future, but the financial impact of reducing work hours ruled it out for some.

5. Building on the foundations: developing the infrastructure of preparing for ageing

Part 5 of the report turns to ways of building the infrastructure for preparing for ageing by examining the central role of General Practitioners, the sources of information on healthy ageing that women are likely to call on, knowledge and take-up of current initiatives for healthy ageing and the extent to which local communities are socially inclusive.

The central role of general practitioners

The frequency with which most women see their General Practitioner means that GPs are the front line for providing advice on healthy ageing and related health care services. The importance of GP roles is borne out by the high proportions of respondents who report that they are very satisfied or satisfied with the way their GPs manage different aspects of their care. Within this overall high level of satisfaction, there were some variations between the groups and for different aspects of GP care, but very few were dissatisfied with their GP in all areas of care.

Finding information on healthy ageing is widely seen to be a problem, yet the survey findings reported so far suggest that lack of information may be less of a barrier than is seen to be the case. Some sources of information, notably general practitioners, other health professionals and support organizations for different health problems are much preferred over others by all groups. Women's health services, alternative therapy practitioners and local community health services were the next most used sources of information. The internet was more likely to be used by younger respondents, and self help groups appear to be used selectively for different problems. Popular magazines were eschewed by all.

Current initiatives for healthy ageing

While the preceding findings confirm that GPs play a central role in enabling women to prepare for healthy ageing, it has to be recognised that GPs cannot "do it all" and that a range of other services are involved. Initiatives have been taken over recent years to promote healthy ageing thus include some delivered through general practice, some delivered through screening services, some generic and some specific to women's health, and some delivered through community based programs. Take-up and knowledge of these initiatives was high, with variations in both use and knowledge systematically related to the eligibility

criteria applied, the likelihood that different respondents groups have experienced different health concerns, and free or low cost access.

Take-up of free flu immunisation and annual health assessments is very high among those who are age-eligible, and knowledge of these programs is high among others. Screening programs are delivered both through General Practitioners and organised screening programs. In both cases, access is mostly at low or no cost, particularly for older women, and take-up and knowledge of screening programs for cancers and diabetes is again high, with systematic gradients related to age.

Take-up and knowledge of community programs relevant to healthy ageing was more varied and reflected the likelihood of women experiencing different health concerns. Take-up was highest for Medicare funded eye examinations across all respondent groups. The more marked variations found programs providing assessment of falls and balance, medication reviews by pharmacists and continence assessment suggest that use of services is strongly conditioned by emerging health concerns. As lower use was balanced by higher knowledge, it can be expected that take-up would increase over time as individuals as different health problems emerged.

Knowledge and use of programs for managing depression was markedly different to the other services, but broadly consistent with the prevalence of depression in the community. Use of services providing support for depression was highest among the younger group; while use of these services was lowest among the retired transition group, knowledge was highest in this group.

Only a small number of respondents reported on their experience of self management, and diabetes was the condition most frequently mentioned. Two factors that contributed to the success of self management were “having the right attitude” by way of taking responsibility for one’s health, and having back-up from a range of health professionals.

While a lack of access to needed services cannot be ruled out on the part of all respondents, the findings on knowledge and use of current healthy ageing initiatives indicate that pre-requisite knowledge is widespread and likely to lead to access to care as need arises. The only critical concern to be identified is a gap in knowledge of continence assistance on the part of the retired transition group, given the increasing prevalence of continence problems among this age group. The findings do not provide any evidence of a need for large scale, blanket information campaigns. Instead, a strategy that took use of any one healthy ageing service as a starting point to link to other services could provide a better way of increasing take-up.

Socially inclusive communities

The social inclusion segment of the Preparing for Ageing Project identified the importance of continued participation in social groups, outside as well as within the family, and safe environments for healthy ageing. Social inclusion also depended on being able to connect with others, having access to services, having opportunities to be heard and being treated with respect. Taken together, these attributes describe life in a community that is inclusive, not only of women as they age, but of men and women at all ages, and the survey found that local communities are widely regarded as positive environments for ageing, and consistently so by those living in different communities across metropolitan areas, regional centres and rural areas, and across the four groups of respondents. Local communities were almost

universally viewed as offering many opportunities for maintaining social networks and engaging in a wide range of group and individual recreation activities; attitudes to older people and safety in the community were also rated as very positive.

The only exception to these positive views was the assessment of ease of getting about without driving, and the only comment that was made frequently about how to address problems in local communities was to improve public transport. Lack of public transport is a particular concern to women as they grow older, and it reduces the value of public transport concessions, but it is also a major concern to all those who cannot drive or who do not have access to a car.

6. Proposals for preparing for ageing

The final part of the report presents proposals for preparing for ageing by way of initiatives for inclusion in a future program for preparing for healthy ageing, and roles that the Australian Women's Coalition could take to this end.

Proposals for a preparing for healthy ageing program

The initiatives suggested for inclusion in a preparing for healthy ageing program were many and varied, and it is apparent that health aspects of ageing are viewed in a wider context of preparing for ageing. Five clusters of initiatives were identified as follows:

1. In taking account of **attitudes** to preparing for ageing, any program had to be based on recognition of what was normal ageing and what was abnormal, and there was a clear view that ageing *per se* should not be “talked into a problem”, raising anxieties about the future where there was previously little concern. At the same time, respondents felt that some level of preparation was in order, that women should neither just accept what was happening nor suddenly find themselves ill-prepared.
2. Whereas many aspects of ageing were seen to continue over the life course, ensuring **financial security** was the one area in which purposeful action had to be taken early. The generational differences that respondents identified in opportunities to achieve financial independence and security highlight this point. Starting early not only increased the likelihood of achieving financial security but the planning involved also gave a realistic view of what to expect. Those in the transition groups stressed that achieving financial security had to start early and be taken seriously, with regard to pursuing careers well into their 60s as a means of building up superannuation. Many women already in their 60s and 70s were in a different position, observing that neither they nor their husbands had had super long enough to build up security. These respondents were more likely to express concerns about actual costs of living or the impact of anticipated future cost increases; increases in private health insurance premiums were flagged as a specific concern. There were widespread calls for independent and free or at least low cost financial advice and retirement planning sessions. Addressing confusion about changes to superannuation was a high priority. Centrelink was again identified as the agency to take a leading role.
3. Maintaining **social networks** was critical to healthy ageing, and involved a mix of informal, personal networks and participation in more organised community activities. Intergenerational relations were a feature of personal networks, and interaction with

children, grand children and great-grandchildren was seen as a way of keeping young. Although policy discussion of work-family life balance has focused on younger families, grandparents are also very much a part of working families, and achieving a work-life balance was a clear theme through the transition to retirement. Participation in organised groups with people with similar interests, volunteering in different settings, continuing education, and self help groups were all mentioned as avenues for maintaining and expanding social networks.

4. Proposals for **health and community services** to be included in any healthy ageing program emphasised boosting current programs rather than starting new, but under-funded services, and health promotion ahead of treatment services.
 - The most widely proposed options that form the basics of a healthy ageing program are low cost and local, community based fitness programs and classes offering exercise, diet and nutrition advice.
 - More specific areas of health promotion were falls prevention and living with pain, advice on alternative therapies, and assistance with medication management.
 - Advice on home safety, home modifications and use of aids were also recognised as making valuable contributions to preparing for ageing rather than only being relevant to care for frail aged individuals.

Other components of a healthy ageing program could include:

- Dental care as the single health service that was most often mentioned as requiring improved access.
 - A more systematic approach to comprehensive reviews of health at each decade of ageing, rather than waiting until age 75.
 - Two further initiatives were mobile clinics to improve access in rural areas, and better access to cheaper, healthy food in remote areas through community cooperatives.
 - Particular concerns for women's health were promoting awareness of osteoporosis among young women, education about changes in health associated with menopause, increased access to bone density screening, and mental health problems.
 - More attention to the risks that women faced in the "traditional men's health areas" of heart disease and stroke through promoting women's understanding of the risks associated with obesity and the links between diet, exercise, being overweight and health problems.
 - Having more female health practitioners focusing on ageing in all health services, not only aged care, and more attention to ageing in tertiary education.
 - There was a unanimous view that for services to be accessible, they had to be affordable, and for many, affordability meant free at the point of use. Expanding the range of preventative services available under Medicare was a favoured approach.
5. A great many proposals were made about the place of **information and education** in any program for preparing for ageing. The calls for more information however contrast with the survey findings to the effect that lack of knowledge was not a barrier to healthy

ageing or to take-up of existing healthy ageing initiatives, and that respondents could obtain information when they sought it. Saliency, or the lack of it, explains many of the contradictions between different comments made about information in different sections of the survey, and efforts to increase the provision of information could to a large extent be wasted efforts unless the saliency of different kinds of information at different points is given careful consideration. The difference between passive distribution of information and active engagement in education also needs to be taken into account. A multi-layered strategy is needed to make general information broadly available and provide more in-depth education sessions for those seeking more information on particular chronic conditions they were affecting their well-being. The findings that general practitioners were the most widely used source of information calls for greater recognition of their role in strategies to promote information and education on preparing for health ageing.

Strategies

Rather than identifying totally new initiatives or major gaps that needed to be filled, the proposals put forward make it apparent that any healthy ageing program, or program for preparing for ageing more widely, has to proceed by building on and integrating the range of existing approaches. Five themes identified across the many proposals put forward provide some directions for any future program:

1. Healthy ageing is seen as part of preparing for ageing more widely, and within the health domain, the interaction of mental and physical well-being is widely recognised, as is the emphasis on health promotion.
2. Preparing for ageing involves a balance of individual, community and government responsibilities.
3. The time frame of preparing for ageing may be too long and too vague to prompt action; instead. As most of the actions that contribute to preparing for ageing also have more immediate benefits, the rationale needs to emphasise “be healthy now, be healthy for the future”.
4. Over the long course of preparing for ageing, there are a number of critical points at which awareness of ageing is heightened and at which women, and men, might well be prompted to review their preparation for healthy ageing on many fronts.
 - For women, menopause around age 50 provides a starting point for charting the steps to be taken in preparing for ageing in the short, medium and long term.
 - Increasingly women will be accessing their own superannuation, or doing so with their spouse, around age 60. This event provides a critical point not only for financial planning but for reviewing preparation for ageing more widely across health, housing, family and social activities. Superannuation funds and Centrelink may have a role to play in prompting such wide-ranging reviews.
 - Take-up of Seniors Cards issued by state governments is very high and the points at which cards are renewed could provide an opportunity for prompting individuals to review their preparations for ageing in different areas.
5. Information and education strategies for preparing for ageing need to be refined and strengthened to ensure a better match between different agencies and their capacities to

deliver different messages to different audiences. One initiative that could be undertaken by the Office for Women in conjunction with the Office for an Ageing Australia would be to review all Commonwealth information on healthy ageing, whether in leaflet, other written or audio-visual format, and how this information is disseminated, and in consultation with relevant groups, with a view to compiling an Ageing Essentials resource kit.

The way in which the elements of a program for preparing for healthy ageing are brought together will be shaped by prevailing policy views of retirement in the context of the wider social inclusion agenda. This project reports positive findings with regard to most aspects of social inclusion. The respondents reported overwhelmingly positive experiences in family relations, including relations between generations, in their wider social networks of friends and personal interests and in their local communities. The exceptions arose where crisis disrupted individual's expected life course transitions and normative transitions, and these disruptions could have enduring effects. Recovery from such events may need to extend beyond short term support in through the immediate crisis.

Security in a paid job for as long as women chose to work, and having a secure income in retirement were central to preparing for ageing and to on-going social inclusion. The project found considerable variation in the ways that women in the two transition groups mix roles at work, in their families and in wider social networks, and that good physical and mental health underpins all these roles, and through to the further transitions of later life. These findings are consistent with a wide range of recent research that shows the transitions of ageing to be increasingly diverse and dynamic for Australian women. A key concern in developing policies and programs for preparing for ageing is then how goals of continued participation in the workforce are to be balanced with goals of enabling women to develop other personal and social roles.

Roles for the Australian Women's Coalition

The final part of the survey sought proposals on the roles that the Australian Women's Coalition was best placed to take in advancing policies and programs that will enable women to prepare for ageing. While identified with reference to the current project, these proposals are likely to apply to AWC roles more widely, and indeed reflect the roles taken in the many other projects in which member organizations and their individual members have participated.

The first and foremost role of AWC was seen to be to **giving women a voice** that would make policies more aware of and responsive to their needs. Consultation through member organizations is the main way in which AWC enables women to be heard. Given AWC's defined role of providing advice to government on the basis of consultation through its member organizations, it was readily recognised that AWC neither could nor should try to do everything itself. Two questions that can guide decisions on which of many possible roles and issues AWC should take up are (a) which other organization are involved? and (b) what can AWC's involvement add? These question are particularly pertinent to the roles that AWC might take in advancing the preparing for ageing project through dissemination and advocacy.

The second role identified for AWC was in **dissemination** of policy information to member organizations. With regard to the present project, many respondents called for the project

report to be made widely available to member organizations, and through them, to individual members. The second means of dissemination was for AWC to hold a program of seminars, possibly delivered in conjunction with programs of member organizations. AWC was seen to have limited capacity and expertise to take on production and dissemination of written information on preparing for ageing and to do so could add to the strongly expressed concerns about information overload. Its role is instead to publicise other existing sources of information available, including via the AWC website. Many respondents wanted feedback on the outcomes that projects had achieved. In providing such feedback, AWC can define the scope of its role as a consultative body and clarify the limits to its role in direct provision of other activities.

The third role assigned to AWC was **advocacy**. Advocacy by AWC was clearly identified as playing an important role in getting women's issues on to the policy agenda, with this role pursued through participation in forums, conducting consultations, making submissions and direct contact with the Minister and officials in the Office for Women. One proposal of particular interest for strengthening its advocacy role was that AWC should prepare "briefs" or short position papers on specific topics and circulate them to relevant government agencies and other organizations. As well as providing a focus for AWC's own advocacy, position statements would also provide a resource to support AWC member organizations in their own advocacy roles for joint action with ageing organizations such as COTA.

Three specific issues were frequently identified as issues for advocacy in preparing for ageing:

- advocacy for the recognition of the value of older women for their positive roles and contributions, so that ageing is not presented only as a problem.
- advocacy for women to have equality with men in general health programs that are currently heavily slanted towards men, such as prevention of cardiovascular disease.
- advocacy for more support for ensuring financial security for women beyond the Age Pension; this report identified a range of measures that could support women in preparing financially for ageing, with different measures required at different stages and for different cohorts of women who have had different participation in the workforce and in superannuation.

The extent to which AWC takes on a advocacy role itself or supports its member organizations to advocate, and the issues of concern that it takes up are matters for future discussion among AWC members.

1. The Preparing for Ageing Project

1.1 Context and Scope of the Healthy Ageing segment of the Project

This report brings together the two parts of the Preparing for Ageing Project carried out by the Australian Women's Coalition through 2008. The main focus of the report is the preparing for healthy ageing segment of the project, with cross references to reports already presented on segment of the project addressing social inclusion, which incorporated financial literacy and financial security.

The current project sits alongside other recent AWC projects on post-acute care, osteoporosis and the sandwich generation of women who care for grandchildren and ageing parents. While recognising the fundamental contribution of housing to well-being as women age, housing is not a major focus of the present project as AWC is also carrying out a project on homelessness in 2008.

Demographic data highlights the significance for preparing for ageing for women in Australia. The Australian Bureau of Statistics projects that the number of women aged 65 and over will increase from 1.5 million in 2006 to 3.357 million by 2036, an increase of 123%. In 2006, 15% of women were aged 65 and over, but by 2036, fully 25% will be in this older age group. The proportion of the total aged population accounted for by women remains stable at just on 54%, largely due to greater improvements in mortality rates for men and convergence towards women's lower mortality rates.

1.1.1 The context of social inclusion

Interest in healthy ageing as part of preparing for ageing more widely has been heightened by the findings of the social inclusion segment of the Project that good health was the prime factor necessary for lifetime social inclusion.

Defining social inclusion

Social inclusion was defined in terms consistent with the current policy view that to be socially included, all Australians must be given opportunities to have a secure job, to access services, to connect with others through life through family, friends, personal interests and local communities, to deal with personal crises such as ill health, change of residence or living conditions, bereavement or the loss of a job, and have their voice heard. The project also took account of the importance of financial literacy and avoiding poverty for social inclusion.

The social inclusion segment of the Project was carried out through a survey of over 200 members of AWC organizations, and two reports were presented, one covering respondents views of factors leading to lifetime social inclusion and the other focusing on factors determining current feelings of social inclusion. The findings of the two reports were very consistent and are summarised together here.

Current feelings of and future concerns about social inclusion

The main conclusions of the project were that respondents for the most part felt socially included and that concerns about social inclusion did not necessarily change with age; at the same time, they were aware that social inclusion could be precarious. In reporting that social exclusion was seen more as a worry than an experience, it was noted that this finding in part spoke to the profile of the women who responded to the survey, and in particular the

fact that they were actively engaged with women's organizations. The findings also emphasised that in the context of ageing, social inclusion should celebrate women's resilience and the good spirits of many older women.

The paramount factor contributing to lifetime social inclusion was being in good health, followed by being financially secure, having strong networks and support, and having access to quality education, knowledge and information. Employment and access to services cut across these areas: employment gave financial security and generated self-worth and mental and emotional well-being, while access to services was necessary to maintaining health, gaining financial knowledge and income, and being involved in the community.

While some of the same factors were associated with current feelings of social inclusion, or the risk of exclusion, they varied in importance for different groups. Access to services and potential poverty were most often cited as areas of particular concern across all age groups. The next highest ranking factors differed by age group. Changes in living conditions were of concern to respondents over 50; those under 50 were concerned about social networks. Employment, including competition with younger women in the workplace, followed as a common concern for those in their 40s, while those in their 30s tended to see social inclusion as something they actively worked for by being assertive and taking responsibility for education and finances. These two younger age groups also saw that motherhood carried some risks of social exclusion.

Policy implications

The theme that emerged most strongly from the social inclusion project was the necessity for women to be financially independent. As well as married women needing to be financially independent from their spouses, the greater risk of poverty faced by single women was highlighted as a precipitator of social exclusion. These conclusions are highly relevant to policies to ensure social inclusion of women as they age given the projected increases in the number of single (never married) women and the much greater likelihood that married women will experience widowhood compared to married men. The two strategies proposed for addressing these concerns were increasing women's equality in the workplace and putting financial education in place from an early age.

Recommendations aimed at other aspects of social inclusion focused on enabling women's community participation at high levels, and developing resources to promote the maintenance of a strong and healthy mind; a particular means to this end was to ensure accessible library services for all communities. A number of other interesting trends were identified as deserving more investigation and policy attention were:

- findings that mothers with young children could be vulnerable to social exclusion warranted a life-stage approach in policy and service development;
- widespread concern about rising inflation raised questions about how adequately costs of living, including basic services, were taken into account in calculating the single Age Pension;
- women in their 50 were the most concerned of all age groups about being heard; and
- rapid changes in modern technology were identified as problematic for older women in many areas of everyday life, such as electronic banking, and assistance through local agencies was needed.

1.1.2 The current policy context and opportunities for input to Commonwealth policies and programs

The stage is set for the AWC Preparing for Ageing Project to make a real contribution to shaping policies for both women's health and healthy ageing. A series of recent events have brought both these areas under active consideration by Commonwealth and State Governments.

Just prior to the November 2007 election:

- Nicola Roxon, now Minister for Health, indicated that an incoming Labor government would develop a national policy on women's health that would encourage specific health services for women and actively promote participation of women in health decision making and management. Of particular relevance to preparing for ageing, she also flagged greater attention to managing the escalating burden of chronic disease that particularly impacts on women's health.
- The ALP Ageing Policy Discussion Paper included the development of a national healthy ageing program among the goals set for activity, quality and security for an ageing Australia. A national healthy ageing program would consolidate a number of existing but fragmented state and national initiatives across a diverse range of activities, including volunteering, promoting accessible and adaptable housing, creating inclusive communities for all ages, addressing social inclusion, extending the Continence Aids Assistance Scheme, celebrating seniors' contributions to their communities, and research.

Three significant developments in 2008 have been:

- The Australian Women's Health Network (AWHN) released a Position Paper, *Women's Health: The New National Agenda* in March 2008 (see www.awhn.org.au). The Position Paper was developed from a discussion paper circulated in mid 2007 and a summit held in Canberra in September 2007. The framework proposed in the Position Paper provided a very useful starting point for the Preparing for Healthy Ageing Project.
- A large body of research findings on women's health and ageing is now available from the Australian Longitudinal Study of Women's Health which began in 1996 and is planned to continue at least until 2016.
- The Council of Australian Governments (COAG) for Ministers of Ageing, and the overall COAG health reform agenda, provide opportunities for bringing together the various State policies on women's health and healthy ageing, and the diverse range of services that give effect to these policies, to forge national strategies.

1.1.3 The healthy ageing context

As well as taking up the themes identified in the social inclusion project and using a life-course approach to investigating how women were preparing for healthy ageing, the current project aimed to address three major paradoxes that arise in discussion of women's health and ageing:

1. While women live longer than men, there are wide variations in life expectancy for women, although not as wide as the variations in men's life expectancy. The gap between life expectancy of indigenous Australians and the rest of the community is widely recognised, but there are also wide variations in life expectancy among all Australian women; while the 20% who live longest live to 90 or older, 10% die before they reach 60. Women's longer life expectancy is characterised by higher rates of severe disability than men experience, and these rates increase steeply with age: only 10% have a severe limitation at age 60-64, but by age 85 and over, 65% have this level of limitation. There are thus substantial differences between the healthy majority of older women and the minority who experience high levels of disability and premature death.
2. While specifically "women's health issues", notably breast and cervical cancer, attract considerable attention, the major causes of chronic illness, disability and death are the same for women and men: heart disease and stroke far outstrip "women's cancers" as causes of disability and death.
3. Health care services have contributed to improvements in women's health and life expectancy, but not all parts of the health care system contribute as much as they might to preparing for ageing. Support for healthy ageing has to come mainly through health primary health care, including general practitioners and community health services, and health promotion activities.

To address these issues and link the findings to social inclusion, the healthy ageing segment of the project canvassed five sets of questions:

1. What were the priorities for women's health and preparing for ageing in the framework for a new women's health strategy proposed by the Australian Women's Health Network?
2. Why do women need to prepare for ageing, and what preparations need to be made at different transitions that occur across the life course?
3. How can the foundations of healthy ageing be established, and what barriers do women face to adopting a healthy diet, weight and exercise?
4. What initiatives are needed to build on existing healthy ageing initiatives, including preparing for ageing in work, home and community settings?
5. What should be included in any preparing for ageing program and what roles should AWC take in advancing such measures?

Before presenting findings on these questions, the project consultation and survey methods are detailed. The main body of the report focuses on the survey findings rather than reviewing research more widely, but a number of boxes through the report highlight relevant findings from reports from the Australian Longitudinal Study of Women's Health (ALSWH) and papers published in the Australasian Journal on Ageing (AJA) over the last five years. The selection of research studies particularly aimed to enable the findings of the present study to be compared with findings based on large scale, representative samples.

1.2 The Preparing for Healthy Ageing Survey and the respondents

The main part of the Preparing for Healthy Ageing Project was a survey conducted through AWC member organizations. Organizations distributed the survey form and guide to their members for return directly by email or post, and some organizations arranged consultations at which members completed the survey. The respondents to the survey are characterised by diversity in both the range of AWC organizations to which they belonged, the states and localities in which they live, and their ages and workforce participation.

1.2.1 Member organizations of the Australian Women's Coalition

Respondents came from 14 member organizations of the Australian Women's Coalition and a number of other organizations. The 20 consultations arranged by AWC member organizations contributed a large share of all responses; although not all those attending each consultation belong to the respective organization, and some participants sent in responses after the consultations, around two thirds of the responses came from consultations and one third directly from individuals via email or post.

- Three organizations accounted for just on half the total responses: Mothers' Union with 75 respondents from 5 states; Zonta International with 46 respondents, all from NSW, and the Salvation Army with 41 respondents, from NSW and Victoria.
- There were between 10 and 20 responses from six organizations, mostly from NSW, Victoria and the ACT: Australian Church Women, Guides, the Muslim Women's National Network of Australia, the National Council of Women, the Pan Pacific and South East Asia Women's Association of Australia, and Soroptimists International.
- While only small numbers of respondents identified themselves as belonging to another 6 organizations - Conflict Resolving Women's Network Australia, Catholic Women's League, the Australian Federation of Medical Women, UNIFEM Australia and View Clubs, it is evident that consultations arranged by these groups included many of the 41 respondents who indicated that they belonged to 'other' organization or did not belong to any organization but participated as interested individuals. By way of example, over 20 women attended four consultations organised by the Conflict Resolving Women's Network of Australia, but only 5 identified themselves as members of CRWNA, and a single report was submitted on a fifth consultation attended by around 20 women who did not complete individual surveys.

Respondents came from all states except the Northern Territory and from metropolitan areas, regional centres and rural and remote areas, as detailed in Table 1.1. While broadly matching the balance of population between the states and localities, two features of the geographic pattern of responses need to be noted:

- The ACT is over-represented and the number of ACT respondents reporting that they were from a regional centre (rather than a metropolitan area) increases the share of all responses from regional centres.
- In Queensland, regional centres were over-represented and Brisbane was under-represented.

Table 1.1: Respondents by state and locality

State	Metropolitan	Regional Centre	Rural/ remote	Total	
				No.	%
NSW	92	25	12	129	42.6
Victoria	25	17	14	56	18.5
Queensland	12	25	2	39	12.9
South Australia	21	2	1	24	7.9
Western Australia	5	3		8	2.6
Tasmania	2		4	6	2.0
ACT	26	15		41	13.5
Total No.	183	87	33	303	
%	60.4	28.7	10.9		100.0

The survey findings are reported for all respondents and not analysed by locality. Research findings show that while there are some differences in ageing for women in different localities, there are more similarities, so the account presented in this report can be taken as typical of women's experiences in metropolitan and regional areas.

<p>Research findings on older women and ageing in urban, rural and remote Australia</p>	<p>This study used data for 8,647 women in the Australian Longitudinal Survey on Women's Health, who were aged 70-75 in 1996 and who were tracked to 2002, using a number of standard measures. 11% had died or become too frail to participate and another 12% withdrew or had been lost to the study. There were no differences in death rates between areas and there was very little movement between types of areas. Over the period, health related quality of life declined for physical health, and more at older ages, but mental health remained stable. There were no differences in alcohol use or smoking over time or between areas. Exercise declined, and those living in remote areas were less likely to exercise than others. Urban women made more use of GPs and other health services, but there were no differences in hospital admissions. Medication use increased over time with advancing age, but again, there were no differences between areas. Caregiving increased considerably and women's own need for help also increased, uniformly across areas. Women in rural and remote areas were more likely to use respite, nursing and community health services and to attend social groups. It appears that women in rural and remote communities substitute other services for GPs and draw more on community services. Being widowed and living alone increased, although women in remote areas remained more likely to be married. Housing moves indicated both need and ability to adapt. The 11% of non-urban women who relocated to urban areas are identified as a group who may be particularly vulnerable if they were adjusting to health needs, but they made lower use of community services and had less social support than in their previous homes. While suggesting possible disadvantage for this group, cause and effect is hard to establish. More evident are the wide similarities in women as they age in all areas.</p>
<p>Byles, Powers, Chojenta & Warner Smith. 2006</p>	

Notwithstanding the diversity of respondents, there are some limitations in the coverage of the survey. The main limitation is that respondents were overwhelming Anglo-Australians, with fully 88% identifying this background. Indigenous women accounted for 3.3% of respondents, and they came from five states.

Women from culturally and linguistically diverse backgrounds (CALD) were markedly under-represented; compared to 25% of the total population, only 8% of respondents identified themselves as being from a CALD background, and 20 of these 24 respondents were from NSW. One source of these responses was a consultation organized by the Muslim Women's National Network of Australia. Although it was not able to hold a consultation, the Hindu Women's Council of Australia provided some comments on the very marked differences in experiences of ageing of the generation of Hindu women who were now aged and the coming cross-cultural generation who had spent their youth and adult life in Australia. Drawing attention to the cultural needs of the older generation of Hindu women raises the issues of the distinctive nature of ageing in other cultures more widely, and of the need for recognition of these cultural considerations in preparing for ageing.

1.2.2 Respondents perspectives on preparing for ageing

A total of 314 responses were received. Only 11 forms could not be used due to missing data on half or more items, mostly by way of non-response to whole sections of the survey. Data from the 303 valid survey forms are presented in the tables through this report. As there were some non-responses to scattered items in the valid responses, there are some minor variations in the totals from one table to another.

The main characteristic of the respondents is their diversity. Ages ranged from under age 30 to 94. Most were older rather than younger: one third were under 60, one third were aged 60-69 and one third were 70 and older. Workforce participation was also varied: just over 25% worked full time, close to 20% worked part time and over half were retired, including those who had either never worked or not been in the paid workforce for decades.

The range of respondents' ages and workforce participation means they saw preparing for ageing from different stages of the life course. Table 1.2 shows consistent relationships between age and workforce participation, and respondents are classified into four groups who can be expected to bring different views to preparing for ageing on the basis of their age, experience of paid work and other roles, and the transitions that women experience as they age.

These groups are:

1. Respondents aged under 50 who were working, most of them full time, present a prospective view of preparing for ageing. This *younger group* accounts for 14.5% of respondents. Ageing is something that lies in the future for this generation of women who have a high level of involvement in the paid workforce; long term contributions to superannuation and other aspects of workforce participation will make their experience of ageing very different to previous generations of women.

Table 1.2: Respondents by age, workforce participation and perspectives on preparing for ageing

Age	In workforce		Retired	Total		Perspective on preparing for ageing
	Full time	Part time*		No	%	
20-29	4	1		5		Prospective
30-39	11	4		15	14.5	
40-49	15	10		25		
50-59	32	19		51		Working-transition
60-69	20	15		35	31.1	
70+	1	7		8		
50-59			9	9		Retired-transition
60-69			57	57	21.9	
70+			98	98	32.5	Retrospective
Total No.	83	56	164	303		
%	27.2	18.5	54.3		100.0	

* includes 10 who reported that they were in the workforce but not currently working

2. Women aged 70 and over who were retired, including a number who reported specifically that they had never been in the paid workforce, present largely a retrospective view of preparing for ageing. This *older group* accounted for one in three respondents. While women's long life expectancy means that many will live well into their 80s, many felt they were able to look back on how they had already prepared for ageing rather than still preparing for their future ageing. Their perspectives are those of a generation of women who had lower levels of participation in the paid workforce and very few had access to superannuation. In terms of intergenerational relations, this group includes women who are the mothers of those under 50, and grandmothers to the children of these younger women.
3. Women aged over 50 who were working can be labelled a *working-transition group*. This group accounted for some 30% of respondents. While most of this group are aged 50-60 and are working full-time, their transitional status is indicated by the higher proportion who are working part-time compared to the under 50 age group, and within the group, part-time work is more common among those aged over 60 compared to 50-59. In particular, 6 of the 8 women over 70 who are included in this group on the basis of their workforce participation are working part-time.
4. Women aged between 50 and 70 who have retired, or who did not participate in the paid workforce through their middle years, are labelled a *retired-transition group*. This group is smaller than the working-transition group, accounting for just over 20% of respondents. These respondents are distinguished from the working-transition group on the basis of having made one of the major transitions in ageing by way of having left the paid workforce, and their retirement decisions are also likely to be associated with differences in other circumstances and roles that have a bearing on preparing for ageing, particularly roles relating to younger and older family members.

These four groups provide a useful framework for making a systematic analysis of the survey data and reporting the findings in a way that encompasses the diversity of women's experiences of ageing and views on preparing for ageing from women in different generations.

<p>Research findings on changing perspectives on retirement</p>	<p>This literature review examines baby boomers expectations in regard to their health and care needs, housing, work and income needs, and how they ascribed responsibility for meeting these needs. The review found far more opinion on these matters than fact, with widespread assumptions about baby boomers being a different kind of older persons than previous generations. Contradictions were also found between opinions on expectations expressed in policy documents and a range of empirical data on trends in the relevant areas. Specifically focusing on women, conflicting views were reported about women rejecting traditional caring roles in retirement in favour of continuing their current interests, yet being as likely as the preceding generation to expect to do unpaid household and community work. Women's expectations about retirement were strongly conditioned by their partners decisions, while women with lower incomes and part time employment in semi-skilled jobs were least likely to expect to retire early. To the extent that employers based hiring decisions on the age of their customers, more workforce opportunities could become available. While issues of baby boomers views of responsibility for old age were not widely explored, a gap between government policies emphasising self-provision in old age and capacity to make adequate provision was evident, especially on the part of older women.</p>
<p>Quine & Carter. 2006</p>	

1.2.3 Benefits of participating in the survey

The survey came within the category of negligible risk research as defined by the NHMRC, and the following statement was circulated with the survey:

<p>The Preparing for Ageing Survey carries negligible risk in terms of the risk levels set out in the National Statement on Ethical Conduct in Research Involving Humans published by the National Health and Medical Research Council in 2007 (see www.nhmrc.gov.au). The expression 'negligible risk research' describes research in which there is no foreseeable risk of harm or discomfort; and any foreseeable risk is no more than inconvenience.</p> <p>Your participation in the survey is voluntary and it is assumed that you have an adequate understanding of the purpose, methods, demands, risks and potential benefits of the research. Completion of the survey implies your informed consent. Data collected through the survey will be presented as summary descriptive statistics and qualitative comments. No statistics or comments will be attributable to identifiable individuals.</p>

The issue of risk also has to take account of benefits to research participants, and to addresses this issue, two questions at the end of the survey asked respondents how well they considered they were preparing for ageing for ageing and whether participation in the survey had prompted them to think more about preparing for ageing. The results in Table 1.3 show:

- Fully 70% of respondents considered that they were preparing for ageing quite well or very well. Only 4% felt they were not preparing very well, and another 25% reported that their preparation was minimal.

- Overall, participation in the survey prompted 60% to think more about preparing for ageing. Those whose preparation was minimal were most likely to be prompted to think more, and conversely, those who felt they were already very well prepared were least likely to report they had to been prompted to think further.

Table 1.3: Has participating in the survey made you think more about preparing for ageing?
(n=275, 91% of 303 valid responses)

How well do you think you are preparing for ageing?	Has participating in the survey made you think more about preparing for ageing?		Total	
	No	Yes	No	%
Not very well	3	9	12	4.3
Minimally	15	55	70	25.2
Quite well	59	82	141	51.4
Very well	34	18	52	19.1
Total No	111	164	275	
%	41.0	60.0		100.0

The four respondent groups varied in the extent to which they were preparing for ageing and were prompted to think more.

Younger group: 60% rated their preparation as minimal and were prompted to think more. Some made comments about being prompted to think in general and others were promoted to specific action such as seeking health tests applicable to their age group.

Working-transition group: Few felt that they had prepared either not very well or very well. Between these extremes, 30% were minimally prepared and three out of four of these respondents were prompted to think more, and of the 50% who were preparing quite well, six out of 10 were prompted to think more. Comments included “Being prompted to think in advance is invaluable”, “ I realise time is moving on – I feel around 35 until I look into the mirror”.

Retired-transition group: Not only were 11 of the 12 who were minimally or not very well prepared prompted to think more, but two out of three of those who were preparing for ageing quite well were prompted to think more. Thinking more focused on measures that individuals could take themselves to prepare for ageing.

Older group: Even though over 80% reported they were preparing (or had prepared) for ageing well or very well, just on half were prompted to think further. Rather than thinking about what more they needed to do to prepare further, comments reflected on “how lucky I am to be as well prepared as I am”, or “glad to have prepared early so can decide for myself”. Those who were not promoted to think more made comments along the lines “I’m already there”. Although only 11 of this group were minimally prepared, all but two said they were prompted to think more.

As well as indicating that the majority of women gained some benefits from their participation in the survey, these outcomes have three implications for developing strategies for preparing for ageing:

- even a small intervention can prompt thinking about preparing for ageing;
- strategies for preparing for ageing have to be made salient to women who are at different stages of the life course; and
- different strategies are likely to have a cumulative effect and reinforce each other as women age.

2. Identifying priorities for women's health and preparing for ageing

2.1 The new national women's health policy framework

Priorities for preparing for healthy ageing were identified within the framework for a new national women's health policy proposed by the Australian Women's Health Network. The framework has three main elements:

1. Five criteria for developing a new women's health policy:
 - adopting a social model of health,
 - incorporating diversity analysis to take account of all groups of women, including older women and rapid ageing of the population,
 - developing priority areas,
 - adopting a gendered approach in the already agreed national health priorities, and
 - using an inclusive and accountable process for policy development and implementation.
2. Seven already agreed national health priorities, and
3. Five key areas of women's health as priorities for action

As strategies for healthy ageing need to be cast within the policy framework for women's health more generally, an assessment of the relevance of the priorities and key areas identified for women's health provided the starting point for the preparing for ageing project. The survey asked respondents to rate the importance of the identified priorities and action areas in preparing for ageing, and the results are set out in Table 2.1

2.1.1 Priority areas

Three distinct patterns are seen in the ratings of the seven priority areas for preparing for healthy ageing in Table 2.1A.

- Over 90% rated arthritis and musculo-skeletal problems, cardiovascular disease and cancer as very high or high priority (bold in Table 2.1A).
- Around 80% rated diabetes mellitus rate and mental health problems as very high or high priorities.
- The two remaining areas, asthma and injury and poisoning, including suicide, rated far lower: half rated these areas as high or very high priority and half rated them as low or very low priority.

Table 2.1: Importance of women's health priorities and action areas for preparing for healthy ageing

A. Health priorities	% rating priority as				Total	
	very low	low	high	very high	%	No.
Arthritis and musculo-skeletal problems	0.3	6.2	44.3	49.1	100.0	291
Cardiovascular disease	0.0	7.1	37.6	55.3	100.0	295
Cancer	1.4	5.8	42.6	50.2	100.0	291
Diabetes Mellitus	3.8	12.6	45.5	38.1	100.0	286
Mental health problems	4.8	14.5	45.9	34.8	100.0	290
Injuries and poisoning, incl. suicide	14.7	29.4	35.3	20.6	100.0	286
Asthma	13.5	32.4	38.1	16.0	100.0	281
B. Key action areas						
Access to publicly funded health services	0.3	3.0	26.9	69.7	100.0	297
Economic health and well-being	0.0	2.7	35.2	62.1	100.0	298
Mental health and well-being	0.3	5.4	45.3	49.0	100.0	296
Prevention of violence against women	3.8	12.3	45.1	38.9	100.0	293
Women's sexual and reproductive health	5.9	29.4	42.9	21.8	100.0	289
C. Low priorities	% of group rating priority/action area as very low or low					
Low rating health priorities	Younger	Working transition	Retired transition	Older	Total	
Diabetes Mellitus	27.3	18.4	15.0	9.9	16.4	
Mental health problems	16.3	20.9	28.2	13.0	19.3	
Injuries and poisoning, incl. suicide	70.1	42.2	49.2	29.3	44.1	
Asthma	69.8	55.0	44.1	26.1	45.9	
Low rating key action areas						
Prevention of violence against women	27.3	19.6	12.5	9.7	16.0	
Women's sexual and reproductive health	34.1	35.9	32.7	37.0	35.3	

2.1.2 Action areas

The rating of the action areas in Table 2.1B showed marked differentials.

- Access to publicly funded health services and economic health and well-being were identified as universal priorities. Some 97% of respondents rated these action areas as high or very high priorities, with overwhelming majorities according them very high priority.
- Mental health and well-being was also rated a high or very high priority by close to 95%, but a lower proportion rated this action area as very high priority.
- Fewer respondents rated the remaining two action areas as very high or high priority, 84% for prevention of violence against women and 65% for sexual and reproductive health. The proportions rating these as low or very low priorities was also distinctly higher.

Research findings on mental health	A Perth survey of people aged 65 and over found that 7% reported severe loneliness and 31.5% reported feeling lonely sometimes; higher levels of loneliness were associated with being single, living alone, and worse self rated health. Social networks were protective more likely. Prevalence of loneliness should be of concern to mental health practitioners. Only limited gender differences were reported, and consistent with other studies. Social relationships with children and close friends were especially related to protecting women from loneliness, and self rated health was also more strongly related to loneliness for women than for men. Neither education level nor ability to manage on current income were associated with loneliness.
Steed, Boldy, Grenade & Iredell. 2007	

2.1.3 Differing perspectives on priorities

- The differential ratings of both the health priorities and the action areas is useful in showing that not everything is as important as everything else in consider preparing for ageing.
- The three health priorities of musculo-skeletal problems, cardiovascular disease and cancer were accorded high priority almost universally by all four groups, as were the action areas of access to publicly funded health services and economic health and well being. As these areas are identified as high priorities for all groups, they have to be seen as central to achieving and maintain health at all ages, not only in terms of preparing for ageing.
- To investigate whether the lower ratings for the other four priorities reflected different perspectives on healthy ageing, the proportions of the four respondent groups rating these priorities as very low or low was examined. These proportions reported in Table 2.1C show different patterns for the different areas:
 - Diabetes mellitus showed a marked age gradient: three times as many of the younger group rated it as a lower priority than the older group, with the two transition groups in between.
 - Injury and asthma were more likely to be rated as very low or low priority by the younger group than the older group.

- Mental health problems and mental health and well being showed interesting differences. The two transition groups were most likely and the older group were least likely to accord mental health problems lower priority as a health priority, mental health and well-being was rated equally highly as an action area by all groups.
- The lower overall rating for the two action areas stemmed from very different shifts in ratings. Sexual health was consistently rated lower by all four groups, whereas there was a marked age gradient in the rating of prevention of violence against women.
- It is evident that the younger group were more likely to differentiate in their ratings of some of the health priorities and action areas than the other groups. Thus, the younger group see asthma and prevention of violence against women as lower priorities for ageing than the other areas, and possibly as priorities for younger rather than older age groups. On the other hand, the older group are more likely to be aware of the importance of injury related to ageing, especially falls, and so accord this area higher priority than the younger group. In the area of mental health, it was women in the transition group who were more likely to accord mental health problems a lower priority than other health areas, while the older group may be more aware of dementia as a mental health problem of advanced old age.

These differences between groups point to the changing salience of different health concerns at different life course stages. The response to these differences is not to reshape women's views of priorities for preparing for ageing but to develop initiatives that address these changing concerns.

2.1.4 Implications

The priorities identified for preparing for healthy ageing can be readily advanced in the framework presented by the proposed new national women's health policy.

Three health priorities - arthritis and musculo-skeletal problems, cardiovascular disease and cancer - and the action areas of access to publicly funded health services and economic health and well-being were identified as high priorities by all respondent groups. These findings point to the need to address these issues as central to achieving and maintaining health now, for women at whatever age they are, with the benefits of health now leading to healthy ageing over the longer term, and to sustaining initiatives in these area as women age.

The other priority areas – diabetes, mental health, injury and asthma – and the action areas of mental health and well being, prevention of violence against women and women's sexual and reproductive health were accorded more differential priorities by the four respondent groups, pointing to the need to vary strategies to address these issues in different ways at different stages of preparing for ageing.

3. Key transitions in preparing for ageing

3.1 When do women become aware that they need to prepare for ageing?

This section of the survey set out five transitions that commonly occur in women's lives over the decades from 40 to 80: reaching middle age, menopause, retirement, widowhood and coming to need care. Respondents were asked to identify any other transitions and to comment on how aware they were of ageing at each transition, the health concerns that emerge at each time and the steps that could be taken to prepare for healthy ageing.

The four groups of respondents brought different perspectives to their views of transitions across the life-course, and the proportion who responded to this section of the survey and the detail in the comments they made reflect their differing experiences and concerns about preparing for ageing at each transition.

- Close to half of the respondents in the retired transition group (45%) made comments; this high level of response can be attributed not only to their own recent experience of leaving the paid workforce but also the experience of partners' retirement and the associated adjustments.
- These changes were still in the future for the transition group who were still working, and the response rate was somewhat lower (38%).
- The level of responses was the same for the older group.
- Just over a third of the younger group made comments (35%) and their responses provide a good view of the diversity of experience of reaching middle age, with perspectives on future transitions expressed in terms of the range of possibilities they foresaw, what they expected and what might happen. While some stated that they could not comment on transitions they had yet to reach, others drew on the experiences of their mothers and grandmothers to highlight how their own lives would probably be different.

Four areas in which adjustments occurred across all transitions emerged: attitudes to and awareness of ageing at each transition, health concerns, changing family relationships and social networks, and financial security. The nature of the adjustments made and attention to preparing for ageing differed at each transition, and all aspects of the transition to retirement showed it to be a very dynamic time. Increased awareness and action at particular points give some clues for the timing and nature of possible initiatives for promoting health ageing.

3.2 Transitions and preparing for ageing across the life course

3.2.1 Around 40: reaching middle age

Attitudes around 40

Respondents in all groups said they had no thoughts of ageing around age 40. Typical responses of “getting old is a long way off”, “not me yet”, “too busy to think about ageing” all showed that many other immediate concerns prevailed over thoughts of preparing for ageing.

Reaching 40 was overwhelmingly seen as a time for developing mid-life roles; even though doing so could lay the foundations for healthy ageing, these longer term implications were rarely thought about. Some said they were more concerned with staying young than preparing for later stages; again, staying young can be a way of preparing for ageing.

The focus was on career choices, with most women saying they were not very conscious of ageing at all as they were too busy trying to keep up with the demands of jobs, family and personal concerns. Many recognised that they could be pulled in different directions in their 40s as work and family life changed and they sought to establish new balances.

Positive views of this transition were expressed in terms of “reaching 40 can be liberating as have more confidence”, “be aware that this is your peak”, and “if you do start to think about ageing, think positively about what you can put in place”. Some looked to the experiences of their mothers who are around 25 years older; the realisation that the next 20-30 years until they reached their mother’s current age would go quickly reinforced a focus on the present rather than looking to ageing in the future. Only a small minority of comments hinted at less optimistic outlooks, mentioning becoming invisible and fear of an unknown future.

There was a cross-generational view that age groups were changing; 40 was no longer seen as middle aged. One older respondent observed that looking back, she saw that for women who were actively involved in the workforce, which was more likely now, thoughts about ageing were farther removed.

Some respondents indicated that while not concerned about ageing at 40, they did recognise that awareness would increase at later transitions. One younger respondent comments at the different transitions were that she “would be much more aware (around 50) as health problems started to arise”, then foresaw “an enormous change in lifestyle at retirement, as yet unprepared”, by her 70s she “would need to be watchful of signs of physical and mental health problems”, and “possible loss of independence after age 80 made many frightened”. Another wrote that around 40, she was “not really thinking ahead”, but by her 50s, she “expected to be coming more conscious, preparing a little and looking ahead”, and by her 60s, she would be “becoming very aware of needs and issues due to looking at others, experiencing life with older people, and that some are planning and others are not”.

Health around 40

Outwards changes - wrinkles, going grey, being less physically flexible, needing glasses – made women aware that they were ageing. These outward changes did not however prompt steps to prepare for ageing, and in particular, several comments suggested that cosmetic anti-ageing measures were not taken seriously.

Emerging health concerns of weight gain, the onset of diabetes and being less active, were widely recognised. Actions to address these issues included regular contact with general practitioners, accessing screening programs, maintaining a healthy diet and exercise. While all these measures contribute to healthy ageing, the focus was on maintaining health in the present to keep up the pace of a busy lifestyle, which itself could leave little time for exercise and relaxation. Respondents highlighted the importance of having the support of a good general practitioner through major health events, such as breast cancer or difficult late childbirth, and in establishing self management of other problems such as early and severe arthritis.

Responses from the younger group indicated that they were more knowledgeable about health problems occurring across the lifespan than older respondents, most of whom only learned about particular problems when they experienced them. A number of older respondents looked back on chronic health problems - asthma, breast cancer, severe food allergies - that dated from their 40s and had negative effects on their health ever since. One respondent now in her 60s said “I was wearing out fast even then.”

Few respondents raised mental health concerns, although those who did flagged depression as a problem that could occur at any age. Onset of depression could be precipitated by a mid-life crisis or family break up, and early detection was essential to restore health. Other pressures on mental health came from stress at work and busy lives that left little time for personal interests outside work and family.

Families and social networks around 40

Families of women in their 40s presented a very varied scene:

- Some were coming to terms with childlessness, often with regrets and depression, but also acceptance, whatever the reason.
- Others were older first time mothers who found that “going to play groups with younger mothers highlights age differences”.
- Others were dealing with difficult teenagers.
- Some were forming new families, adjusting to a second marriage after a decade of early widowhood or divorce and managing as a single parent
- Those who had married and had children in their 20s were becoming empty nesters and facing loneliness.
- A few were caring for an ageing parent or parent in law, and found it a bigger burden if there were still teenagers at home. Awareness of family illnesses prompted these respondents to have checks on their own health.
- A few women faced major adjustments when they had to deal with early retirement of their husband due to disability and living on the disability pension.

This diversity of family structures and the transitions they demonstrate raised two sets of wider issues that both have a bearing on preparing for ageing, but also explain why more immediate concerns took priority. First, the potential for change in families was evident in comments that many respondents made on the way that relationships could change at any decade, especially through divorce or separation, or early widowhood, well before

widowhood at a later age. Many expressed concerns about potential relationship failures, and divorce in middle age, in long standing marriages, was seen as having very lasting impacts, including lack of income and coming to terms with a future alone. Many respondents said that it was only support from family and companionship from friends that enabled them to see these changes through.

Second, whatever their family circumstances, women in their 40s had very busy lives. For many with children, their social networks revolved around their family, and realising a better work-life balance came a long way ahead of thinking about preparing for ageing.

Financial security around 40

Many younger respondents were aware that their 40s was the time to set up their retirement finances and start putting money away. Women who were returning to work as their children become independent were especially promoted to consider financial planning for retirement at the same time.

But respondents also identified many factors that limited their capacity to save for retirement in their 40s. Many were still paying off a mortgage and other demands on incomes were associated with financing children's education, a demand that could continue for many years through tertiary studies. A further limitation that delayed action was a lack of knowledge about what retirement would cost.

3.2.2 Around 50: Menopause

Attitudes around 50

The view that ageing was not at all on their minds in their 40s changed around 50 when menopause was the first signal of ageing. It was a powerful signal, a point at which "reality strikes", that was widely recognised across all respondent groups. One respondent expressed this signal succinctly "It is a time of heightened awareness of physical and mental changes – a very key time for taking a longer term view". Others commented that becoming more aware of health issues meant that menopause was a time for them to review their readiness for retirement and to work towards independence when they stopped working. Making such a life review was a solution for those who felt that they were stuck in a rut. A few respondents noted that early menopause had triggered thinking about ageing, but their concerns were about finance more than health

Attitudes to menopause itself ranged from "thank heavens!" to expressions of panic, but most recognised that while it could be quite a disturbing time with changing emotions and loss of sexual urge, it was something that they would get through. A large number of diverse comments were made about managing menopause. Older respondents pointed out that menopause was much more openly discussed now than in the past, and this view was supported by other respondents. Indeed, many commented that the excess of information on symptoms of menopause and how to deal with them, much of it conflicting, had become a problem. Lack of knowledge about how to minimise symptoms was a concern, with some respondents reporting difficulties in recognising the extent of the impact of symptoms such as hot flushes and emotional swings, and dealing with these symptoms.

Getting early advice, especially through talking to other women, was widely recommended, as was consulting with a sympathetic general practitioner who did not label women who asked a lot of questions “neurotic”. Younger respondents wanted more women’s health programs as a means to dealing with menopause, and GPs who were sensitive to problems that may arise. Cultural issues were also raised; one women from an ethnic background said “I was in the dark – did not know where to get practical advice” and others noted that some health professionals from different background were reluctant to talk about menopause. Several comments were made about HRT: they covered the need for information on HRT vs. natural therapies, side effects that meant HRT was not for everyone, the media hype about HRT, and inappropriate medication that could make matters worse

The experience of menopause varied from “uneventful” or “I did not suffer from it” to comments focusing on sexuality, but as one respondents put it “everyone goes through it”. Respondents recognised that they had less energy and were not as nimble as they used to be, and that it was harder to loose weight, but also emphasised capacity for an active and enjoyable life, including sex life.

The experience of menopause was compounded by other major life events such as death of a parent, divorce or widowhood, and other relationship adjustments. Respondents who faced these events noted that being at work and having supportive colleagues helped them find new strengths and they welcomed being able to make their own decisions.

Health around 50

Many respondents commented that menopause and its consequences such as increased risks of osteoporosis should not dominate over awareness of other health risks. Many comments were made to the effect that instead of attributing all changes in their health to the menopause, women and their doctors had to recognise and investigate problems by checking for signs of heart disease, too high or too low blood pressure, continuing mammograms and screening for other cancers.

<p>Research findings on heart disease in mid-aged women</p>	<p>A sample of 125 women aged 49-54 who self reported heart disease was selected from the ALSWH and interviewed to investigate gendered aspects of diagnosis and management of their condition. 25% had been diagnosed with ischaemic heart disease and most of these had had a heart attack and most had two or more risk factors. Fully 81% of the heart attack victims did not however recognise their symptoms as cardiac related and delays in diagnosis were evident in some cases. Both the women themselves and their health care practitioners has gendered views of the risk of cardiac disease. Doctors perceived that these women were too young to be having a heart attack, and much rehabilitation material was directed to older patients. While 57% of the women recognised that both men and women are at risk of heart disease, others indicated the stereotypical view that heart disease primarily affected middle aged and overweight men. Information on heart disease needed to be reviewed with regard to representing women as victims of heart disease themselves rather than primarily as responsible for maintaining their spouses’ cardiac health.</p>
<p>Guillemin 2004</p>	

Particular attention had to be given to testing for conditions such as late onset diabetes that became common around age 50 but which could be easily masked by post-menopausal changes. Rather than accepting weight gain as normal, one respondent highlighted the musculoskeletal problems that could follow and other risks of uncontrolled weight gain that lead to obesity. Problems of poor eyesight and hearing that could reduce enjoyment of life also needed to be addressed.

Exercise and healthy living were identified as the means to maintaining health through the 50s; low cost community group options as an alternative to more costly gyms, and natural remedies as alternatives to medication were flagged.

Very few respondents raised mental health concerns: apart from more fatigue, increased risk of mental health problems was noted ahead of actual experience of these problems.

While women's awareness of health problems and action to address them in their 50s went well beyond the menopause, the focus was on the more immediate post-menopausal period rather than longer term preparation for ageing. The overall view of health at this time was summed up by the comment that women in their 50s should "Take care of health but don't become obsessed".

Families and social networks around 50

While fewer responses commented on changes in families occurred around age 50, the changes that did occur often raised awareness of ageing. Those who were in good health could enjoy most these changes and ageing *per se* was not seen as an issue.

Becoming a grandparent was a very welcome transition; grandchildren added another dimension to life and respondents felt they needed to be healthy to enjoy grandchildren and participate in their activities. This focus on the present rather than the future is consistent with perspectives on other transitions that place preparing for ageing in the background.

While a common sentiment was that "grandchildren are a joy", some respondents commented that they could also increase financial and mental burdens if women were caring for grandchildren full-time so their parents could work. This theme became even more pronounced as retirement approached.

Three other changes in family roles that usually occur in sequence saw children moving away and leaving empty nesters, and leading to loneliness for some, becoming a carer of an elderly parent, and the death of parents. The last event was a trigger for reassessing roles in the family, for attending to legal matters such as making a will and an Advance Care Directive, and ensuring that next of kin were informed about future informed decisions.

Financial security around 50

Far fewer comments were made about financial security around age 50 than at either around age 40 or around age 60. The comments that were made recognised financial planning as an important part of preparing for ageing. It should be noted that all respondents in this age group were working, the majority full-time, and so were possibly in a better position financially than the wider population of women of this age.

There was a recognition of the need to plan for money and activity in retirement before leaving work, and that having an income from part time employment was good for self-esteem as well as for financial security. Attending retirement planning seminars was identified by a handful of respondents as a means of preparing for financial security, with further comments emphasising the need for independent and free financial advice at such seminars.

The only other financial matter noted was about continuing ability to fund private health insurance premiums.

The limited concerns expressed by respondents about financial security in their 50s contrast with research findings from the Australian Longitudinal Women’s Health Study summarised below. Compared to the ALSWH, a much higher proportion of the respondents in their 50s were in the paid workforce, 85% compared to 65%, and hence are likely to be more financially secure. However, although most of the retired transition group of respondents were older than the mid-aged women (aged 53-58) in the ALSWH in 2004, the factors affecting their retirement decision and their concerns about financial security in retirement echo many of the experiences found to be associated with financial insecurity in the ALSWH.

<p>Research findings on financial security in mid life</p>	<p>This report focuses on the experiences of paid work and planning for retirement of women aged 53-58 at the time of the 4th ALSWH survey in 2004. Trends in entry to and exit from the workforce over time among this cohort, and the associations of these trends with health point to very considerable diversity in the transition to retirement. Two thirds were not yet retired, and continued workforce participation was associated with being separated or divorced, having more occupational or educational qualifications, and not having dependent children still at home. There was considerable uncertainty about age of retirement, and whether retirement would be possible at the preferred age: only 10% thought they would retire before 60 although 30% wanted to. Those in lower status occupations had less definite ideas about when they expected to retire. Women’s own health and their financial security were the two most important factors affecting decisions to retire and they were equally important. More of those who continued to work expected to need some income support from government when they retired compared to women who had retired. Women who were currently partners were less likely, and women working in low status occupations were more likely to expect to need government income support. Those who expected to be able to call on other sources of retirement income had better physical and mental health than those who expected to be reliant on government funding. Analysis of movements in and out of the workforce in the four waves of surveys between 1996 and 2004 found complex interactions. Compared to women who were in paid work over all this time, women who had left the workforce and retired early were more likely to have difficulty in managing on available income, to be providing care for someone, to have a partner who had retired in the preceding year, to rarely feel rushed and to have seen a general practitioner more often. The findings of the study highlight the precarious financial situation of many women in their 50s, and the associations between being in paid work and better health.</p>
<p>Warner-Smith, Powers & Hampson</p>	

3.2.3 Around 60: Retirement

Attitudes around 60

Retirement was a diverse and changing transition, with differences in experiences between the older and transitions groups, and different expectations on the part of the younger group. Some younger respondents were of the view that the changing nature of retirement for women was not widely recognised at a societal level even though many more women were continuing to work until they were in their 60s. Retirement was even becoming a transition that some younger respondents did not expect to face: their comments to this effect ranged from “still working and loving it – retirement is still in the future” and “not really planning to retire – will combine part time work with volunteering” to “in denial - not going to retire”.

Respondents overall were aware that retirement would bring, or had brought, real changes in their lifestyle and that they needed to adapt to these changes. Many commented that they became more aware of ageing at this time for many reasons, some because they needed to continue working, others because of health problems. There was however little indication that most respondents felt they had or would face difficulties in making the transition to retirement.

Some tension was apparent between making adjustments in some areas of life and maintaining stability in others. Loss of some roles was anticipated or had been experienced; respondents reported feeling a loss of purpose in life on giving up professional roles, a shock and loss of energy and reluctance to be involved in other activities. One respondent said “Be prepared for a sudden feeling of not being needed, but it soon passes”. This positive attitude was expressed by others who saw retirement as bringing freedom; those who were looking to taking life a bit easier or who were enjoying life more in retirement were focused on making the most of this time of life, for themselves and with their partner.

Financial circumstances was the area in which there was the widest recognition that retirement would bring or had brought changes. Several comments indicated that financial changes could compound other changes: “need to feel worthwhile but facing financial issues”, “not seeming very useful to anyone once come out of the workforce and particularly if finance is a problem”. One younger respondent thought that stopping working would mean a loss of independence, especially financial independence.

The nature of retirement means that for most, it is something that can be planned for, and planning was seen as a good way of dealing with problems that might arise. Planning by way of making purposeful changes in routine and having a definite program in life was recommended as the means to making retirement a relaxed and enjoyable time, and avoiding depression and feelings of rejection. Flexibility in approaching retirement was seen as highly desirable, and a switch to part time work was the main step that gave such flexibility. Anticipating and planning in advance on all fronts – physical and social activity, family and social networks – involved planning with a small ‘p’. No respondents mentioned formal Retirement Planning other than in the context of financial planning as discussed below.

Research findings on retirement expectations	A survey of ~200 members of a public sector super fund found that 23% intended to retire at 55 and 36% at 60; women with partners intended to retire about 2 years earlier than men or women without partners. Only 7% intended working until 65. Only 23% began planning retirement income in their 40s, but 46% began in their 50s (indicates need for accelerated savings plans). The main reason for retirement was a sense of “it’s time” 74%, and 86% wanted to do things other than work and have more time for family (80%). There were no differences in reasons for retirement by gender. If given totally free choice, half would still retire at the same age, but 29% earlier and 24% later, but again no gender differences. There were many significant gender differences in planned retirement activities. Women were much more likely to intend studying, especially if they had no partner, and in creative pursuits, in community, voluntary or political life, indicating interest in volunteering, and reading. Retirement was viewed positively, in line with a model of retirement as a new beginning. While there were some marked gender differences, there were similarities in many areas, and having a partner moderated gender differences. Evidence of a new story about women’s retirement is emerging.
Onyx & Baker 2006	

Health around 60

Approaching or recent retirement was a trigger to recognising health concerns and acting to address them, and the number of comments on health concerns peaked at this transition. It was a time to “do everything to keep fit so can enjoy retirement when it comes”. Action was likely in three areas:

- Actively pursuing a healthy lifestyle and fitness by taking more exercise and maintaining a healthy diet; one respondent mentioned yoga, other “started walking every morning after retirement – had time at last”. A longer term time horizon was also evident in some responses that saw exercise as a means to remaining supple, warding off falls and hip problems. Even one obviously active respondent was more aware of ageing, noting the need to be “more cautious when skiing and mountain climbing – body slower to heal after cuts and breaks”. Recognition that the cost of previously expensive physical activities could be a worry prompted respondents to look for other ways to be active and have fun, such as walking with local groups.
- Having hearing and sight tests, and searching for low cost options for care in these areas and dental care.
- Having regular GP check-ups for problems that could have severe effects if left undetected: cardiovascular disease, skin cancer and diabetes were highlighted.

Research findings on hearing and vision impairment	Among a sample of 240 self selected community dwelling older people aged 60-93, people with sensory losses were found to have more intense networks with fewer contacts outside their immediate inner circle, but neither objectively measured sensory loss nor self reported sensory difficulties were associated with significant change in network size which averaged 16 contacts. Those with both vision and hearing loss (19%) did however report fewer frequent contacts.
Lind, Hickson & Worrall. 2003.	

Mental health concerns, and the associations between mental and physical health, were also identified more often than at the earlier transitions. Some respondents reported that wanting to work but not being physically able to do heavier tasks lead to psychological problems and a loss of self worth. The risks of isolation, lower self esteem, depression and other mental health problems were seen to increase at retirement, especially if the transition did not proceed as planned. Self help approaches to avoiding both mental health problems were proposed, as was the case for maintaining physical health.

<p>Research findings on well-being in retirement</p>	<p>A follow up study of a panel of 601 people who retired in 1998-99, selected from a survey of 7,000 mature age workers investigate how choice in retirement affected subsequent well-being. 47% of the sample were women. Lack of choice and involuntary retirement was most strongly associated with being made redundant and other workplace factors, followed by age, poor health and spouse retirement. High choice was strongly associated with positive well being since retiring on a wide range of outcomes and low choice was strongly associated with negative perceptions of changes in health, physical activity, social activity, diet, happiness and marital satisfaction since retirement. Negative psychological and emotional consequences of being forced to retire persisted for some time after retirement. The conditions under which retirement occurs, and the bounded choices shaping decisions are important in predicting adjustment to retirement and well-being, particularly immediately after retirement. High choice was associated with older age, indicating that early retirement was often less a matter of choice, with being financially and psychologically ready to retire, and low on work ethic notwithstanding satisfaction with work life. Child care responsibilities (by way of grand-parenting) were also associated with less choice. Low choice individuals appear to be trapped in having to continue to work in unsatisfying conditions or experience unsatisfying retirement.</p>
<p>Quine, Wells, de Vaus & Kendig. 2008</p>	

Families and social networks around 60

Three changes in families reported around age 60 gave many illustrations of the observation that “It isn’t always the physical ageing process that has to be negotiated through life, but often the concomitant process of social adjustments that continue throughout life.”

The change that had the greatest impact on respondents’ lives was their partners’ retirement as relationships changed when both were at home. Some respondents described having to adapt to unwanted changes in partners’ circumstances and partners who were not handling retirement well. Respondents commented that while doing some things together was a way of coping with a partner’s intensified needs, it was equally important to have interests of their own, and to have family and friends close by for ready contact. The focus on spouses was intensified by losses of family members, older members through death and younger members leaving home and moving away, although a few still had adult children on their hands.

Expansion of families came by way of grandchildren. Caring for grandchildren was mostly very fulfilling, but some hinted that it could come to occupy too much space and again, there was a need to have their own interests. It was only child-minding by grandmothers that allowed many adult daughters to work and these respondents very much saw themselves as part of “working families” and questions of work-life balance spanned both generations.

Caring for ageing parents could also be demanding but fulfilling, and in most cases occurred only after children had reached adulthood and were independent.

While most respondents adjusted positively, the retirement transition did present some with major challenges by way of choices over where they wanted to live, in some cases driven by deteriorating health of a partner, older parents or other relatives. Moving as part of the retirement transition was usually a move of choice and those who made a move often saw it as a preparation for ageing, taking the opportunity to combine a move to a favoured locality with down-sizing and moving closer to family and/or friends.

Research findings on retirement relocation	This study of social capital among older residents in three coastal resort areas surveyed 103 residents. Average time living in the area was 14 years, and was longer for older residents. There was no association between how long residents had lived in the area and proximity to close relatives; two out of three reported that their closest relative lived more than 50km away or interstate. The great majority were married and lived only with their spouse, but these proportions were higher for men and younger ages: the proportion living alone increased from 4% of men aged 60-64 to 32% of women at age 80-84. Similar age and gender gradients were evident in use of independent transport, going out and activities, but these differences were less pronounced for feelings of safety and being able to get help. Around 90% of men and women in both younger and older age groups reported belonging to clubs (although only just over half attended regularly), feeling safe at home and after dark, and being able to get help from family and friends. It was concluded that those living in a retirement resort area had continuing strong bonds with family even at a distance and built strong new networks with friends. But very older women were more vulnerable to circumstances of reduced social capital through widowhood, loss of friends, living alone and less access to independent transport.
Barr & Russell 2007	

It was only at the retirement transition that social networks outside the family became a topic for comment, and they became very important. Respondents thought it was essential to develop interests and activities before retiring, and to maintain established social networks which were often connected with physical activity. Keeping up interests outside the home and outside work meant that in retirement, women did not have to rely on their husband and family for their social scene and keeping mentally and physically active. Other options for building up social networks involved finding new activities, connecting with new groups and picking up old hobbies when retirement gave time to enjoy them.

Involvement with others, whether grandchildren or through volunteer work was widely seen as the best way of combating feelings of loss of purpose that might be experienced on retirement. Looking back at 70, one respondent said “I never retired from the work I did with voluntary organizations.”

Research findings on paid and unpaid work	This study compared samples of 1,359 baby boom women (aged 50-65) and 1,707 older women on unpaid caring work and volunteering. 17% of the former and 21% of the later group women were involved in volunteering, but this difference disappeared once hours of work were taken into account. There was no difference between the groups in future interest in volunteering, but those who were already volunteering at any age were 2.5 time more likely to indicate future interest in volunteering more than those who were not volunteering, suggesting continuity of involvement. Good health and higher education were associated with future interest in volunteering but not any other factors including country of birth or marital status. Having more time was a main predictor once hours of work were taken into account. Motivations for voluntary work included a sense of caring for family and community, meaningful and useful activities in later life and giving something back to the community.
Merkes & Wells 2003	

Financial security around 60

There was growing realisation of the importance of financial security around age 60, on the part of women who were still working and those who had retired. While the common view was that finances should be organised by this age, other comments made it equally apparent that not all had been able to prepare for financial security in retirement or had adequate superannuation, and that economic circumstances could change, sometimes dramatically, around the time of retirement.

Those who were still working were most likely to recognise the need to set themselves up financially by building up their superannuation, and some continued to work for this express purpose. Working longer was seen by many as a means to financial security, especially if they had little opportunity to save earlier on.

Those who had retired expressed concerns as to how well their finances would last and were starting to plan their finances for life in retirement. Some thought about moving and down-sizing, and were looking at the availability of more suitable housing as a means of stretching resources. Several respondents commented that financial preparation did not end at retirement but continued through to having enough financial knowledge regarding options for drawing on superannuation and the best options for investment once they took out their super. Economic preparations by way of getting information and putting finances in order could be stressful as risks had to be faced.

A number of respondents reported very difficult situations of having lost their job before they wanted to retire and finding it very hard to regain employment in a workforce environment that often dismissed this age group. Others had little savings or assets due to long term low incomes, and for some, divorce or poor health had set their retirement plans awry. Post retirement solutions involved learning how to economise, or down-sizing as part of a lower cost lifestyle.

Just as financial security gave some certainty for the future, lack of money was a cause of stress, and anxieties arose about finances for the future and fear of not having enough money to live on. “The thought of no more pay packets is scary” is how one respondent summed up these fears.

Many of the current transition generation will come to rely on at least a part Age Pension as they do not have a long superannuation history or large balances, and the single Age Pension was widely viewed as inadequate.

3.2.4 Around 70: Widowhood

Attitudes around 70

Older respondents were very aware of impacts of widowhood as they had experienced it directly, and many of the transition and younger groups had seen the impact on an older parent.

Despite the loss, grief and loneliness associated with widowhood, attitudes showed an acceptance of a change in lifestyle, with support from family, friends and services enabling this transition. While not something that could be planned for, several comments highlighted an underlying recognition of widowhood as a normal part of ageing: respondents wrote “from the time you marry, you are aware that this will happen to one of you” and “no-

one plans for widowhood, and you hope it does not happen for a long time, but you know that it will and you accept it”.

Those who were still married focused on enjoying life with their partner and many faced the prospect of widowhood after a long marriage with equanimity, seeing it as presenting opportunities to learn a new way of living. While widowhood is not part of the life course of women who had never married, respondents reported many other losses, such as the death of a close sibling, that had similar impacts and that required similar adjustments.

This transition was a time for reflection on the past and the future. Several respondents commented that they became aware of mortality, that nearing the end of life was a very real prospect. For some, their faith was a source of support in coming to terms with their own death or the death of another.

Health around 70

Having recognised that they were now ageing, respondents reported that they were in good health. Typical comments were “I’m over 70, have a few stiff joints but otherwise well, no medication, keep walking”, “I have no problem with ageing – a bit slower but still do everything I want the same as when younger”.

As major life events, widowhood and similar late life losses were recognised as bringing changes in dependence and interaction based on lifetime partnerships and relationships that imposed stresses on health, especially mental health.

Respondents recognised increased risks of a range of physical health problems, noting osteoporosis and falls, heart problems and changes in blood pressure, and the need to adopt preventative measures. This transition was a time to have checks on all areas of health, and health providers needed to be alert to early signs of depression and isolation that could follow widowhood and other losses. Loss of hearing was specifically noted as having an impact on social life.

<p>Research findings on coronary heart disease at 70+</p>	<p>In a random sample of 1,075 SA residents aged 70 years and older, 58% were women, and 15% of women had CHD compared to 24% of men., difference greater at 70-74 but less over 75. The lower prevalence compared to other Australian studies may be due to the diagnostic criteria used. Women were at lower risk of CHD than men but the same risk factors were identified. It was noted that the population aged 70 and over are also a survivor population without those who have died from CHD at earlier ages.</p>
<p>Harris, Giles, Finucane & Andrews. 2007</p>	

Mental health problems as a consequence of widowhood and other losses were raised much more frequently at this transition, but often expressing how respondents had come to terms with the risks of isolation and the need for social support: “being on my own for the first time was a major challenge”, “being alone was a whole new, positive experience”. Interaction of mental and physical health was widely recognised: “loneliness can lead to poor physical health and neglect of diet”, “maintain exercise for both”, “need mental stimulation and physical stimulation”.

<p>Research findings on well-being at 70+</p>	<p>This study examined the relationship between psychological characteristics and self rated health in the cohort of 9,501 women aged 73-78 at the second wave of the ALSWH and the influence of socio-economic characteristics on these relationships. Optimism was associated with better general health, mental health, physical and social functioning, vitality, emotional and physical role performance and lower stress, but not with bodily pain. Positive hardiness was also related to these outcome measures.</p>
<p>Smith, Young & Lee 2004</p>	<p>Socio-economic circumstances, social support, physical illness and access to health services contributed significantly to the variance in subjective health, indicating the need to take more account of the contextual factors to avoid over-estimating the effects of psychological factors on outcomes. As in other studies of older women, socio-economic status was not significantly related to well-being, but physical health, neighbourhood satisfaction and social support did contribute to well-being. A sense of optimism was likely to contribute to and arise from high levels of well-being. To the extent that optimism and hardiness in older women are learned, they need to be promoted at all stages of the life course. Experiences that have a negative effect on these psychological characteristics in the short-term may also lead to lower levels of well-being in older age.</p>

Maintaining friendships as well as family contacts was important, and mixing with younger people was a way of avoiding being maudlin. Involvement in the community and taking up one’s own interests after the loss of a partner could bring relief. But the main remedy was “time will heal”.

Finally two very different comments were made about health services: one raised concerns about access to hospital care, the other saw value in phone support services for keeping in touch with those who lived alone and could be at risk of isolation.

Families and social networks around 70

Women’s family roles often underwent considerable changes in their 70s. Prior to widowhood, some had experienced a heavy load caring for their husband and needed carer support to back up family. Women in this situation often only came to think about their own health when this caring role came to an end.

Respondents at all ages recognised a good family network as the main source of support in widowhood; some younger respondent noted that other family members may be aware of and want to discuss issues of isolation and help more than the widowed parent realised. Those without children were seen to be at greater risk of isolation, and a lack of grief support services was identified.

Widowhood prompted respondents to think about whether they would stay in the family home, which may have already been an empty nest for many years. Some made inquiries about services available to help them stay in their own home while others considered the possibility of moving to be closer to their family for support: “I started to listen to my daughter’s suggestions to move closer to where she lives while I was still able to move.”

Transitions of widowhood and needing care could occur close together. Those who experienced a loss of personal independence shortly after widowhood were likely to need more support through both transitions.

<p>Research findings on widowhood</p>	<p>The health and social needs of recently widowed women were investigated; the sample comprised 231 participants in the ALSWH who had been widowed in the three years prior to the survey. While most had remained in the family home, one in five had moved since being widowed. While most did not experience a worsening of financial status, the areas in which assistance was most often needed were financial matters, home repairs and maintenance, and legal advice. Post widowhood contact with GPs was reported to be very supportive and most had maintained or increased their social contact. 10 health-related quality of life scores showed little change pre- and post widowhood, and the only statistically significant changes were a decline in physical functioning and improvements in emotional role functioning and better mental health scores. Coping and transition were persistent and recurring themes, particularly in relation to needs for support, networks and resources.</p>
<p>Feldman, Byles, Mishra & Powers. 2002</p>	

Financial security around 70

Widowhood brought two changes in financial matters. The first was taking on more financial responsibilities, a task that was harder for women who had little personal experience of managing their own affairs. Early preparation and using the skills that women already had to manage financial affairs was seen as the best way of ensuring security and being able to manage money independently, but where this had not occurred, advice could come from family members, support groups and outside agencies.

The second change, and one that could be more difficult, was a shift to the single Age Pension. Poverty was seen as a real risk and the experience of tightening of economic circumstances and loss of financial support, in extreme cases requiring sale of the family home, could lead to neglect of personal well-being, disengagement from the community and more frequent medical problems. The importance of knowing about low cost services for tasks that could be costly, such as home maintenance, was flagged.

3.2.5 Around 80: maintaining independence and accepting care

Attitudes around 80

Three main attitudes characterised responses about transitions around age 80.

First, it was at this age, not 40, that respondents thought they were ageing, or rather, had reached a state of being aged: “at 79 you realise that you are ageing”.

Second, reaching 80 did not mean a transition to a passive old age but was a time at which women could still make many active adjustments. One 92 year old respondent commented that she had to re-establish herself following late widowhood, after a long period of caring for an even older spouse; the many changes that ensued made her feel very acutely that “old age had finally arrived”. Recognising that staying on one’s own home depended on the suitability of the home, such adjustments included simplifying lifestyle by moving to a smaller house and garden, or to a retirement village, and installing a personal security system so that help could be summoned quickly if needed.

A strong emphasis on staying as independent as possible meant not only self care but having a positive attitude to accepting care from others, whether family or formal services, when it became necessary to have help. Respondents indicated that they were preparing for a time when they might need help by letting others know their care preferences and making

arrangements ahead of time; such advance care planning could include making a formal Advance Care Directive.

Third, a sense of vulnerability was evident: respondents expressed their actual or anticipated concerns about no longer being in control, losing authority in decision making, having to rely on others, and not being sure what to do.

There was considerable diversity in experiences of needing care. A number of respondents in their late 80s or 90s were still be caring for someone else, and not needing care; at the same time, some who were caring for a spouse at a very advanced age realized that they were not well prepared for this stage, with particular reference made to staying too long in housing that was unsuitable rather than moving earlier. Those who were living alone also stated their concerns about losing their independence: “I started to realise that I needed help at home at 80”.

Health around 80

While one respondent simply wrote “86 and still in independent living”, others identified a long list of health problems that had come forward or were expected by this age: stroke, heart disease, cancer, bone problems, diabetes, loss of mobility, loss of energy, incontinence, and mental health problems, especially Alzheimer’s disease, but also boredom and isolation. Dental and optical expenses were on-going at this age, and the need to continue prevention programs, such as falls prevention, through to this age group was flagged. Respondents also saw becoming very dependent, and dealing with death and dying, as raising physical and mental health issues.

Notwithstanding these many problems, respondents reported that they continued to exercise and emphasised thinking positively and keeping as healthy as possible, physically and mentally. As one 30 year old respondent commented on her experiences with very old people “old age seems to vary so much, some reach this age oblivious to the prospect of ageing”.

It was only at this transition that care needs were mentioned, and as reported above, attitudes to accepting care took precedent over other preparations. Thinking about needing care, one respondent probably spoke for many in saying “we never believe this will happen to us, until it does, and even then we are often in denial”. Positive actions that were mentioned included finding out what is available locally, making oneself known to care services and contacting new health professionals.

Agreeing to have help from others was seen as a way of maintaining independence, not surrendering it. Some thought they would feel worthless when not able to look after themselves, but others welcomed the chance to be looked after for a change, and after a lifetime of looking after others. A number of respondents reported that rehabilitation centres linked to hospitals and other services available from councils and other agencies were very helpful. Those who experienced slow recovery from injuries such as a hip fracture commented that family and social support was as important as physical care.

Family relationships came to the fore in making preparations for care. Many respondents based their comments on experience of their parents’ health problems in advanced old age, some saying that this lead them to “an acceptance of the inevitability of needing care”. One respondent recommended “talk to your family so that they and you are prepared”, another said “I hope it will be reasonably managed without too much stress on my children”.

Involving family in making arrangements beforehand, dealing with the bureaucracy of getting care or help and having paperwork well and truly in place could relieve the stress of the transition to care when it arose.

Finally, respondents recognised that ability to access suitable care, particularly nursing home care, might depend on their economic situation and the support of family. Equally, attention was drawn to the need for care to be respectful regardless of capacity to pay.

Families and social networks around 80

Family relationships changed again when women reached their 80s, and especially if they came to need care. Family roles in preparing for ageing at this stage involved discussing responsibilities for care, getting information for family carers, being aware of the need for possible changes, and seeking help if it was needed. Some respondents also recognised that the time had come for them to relinquish some responsibilities, including financial responsibilities, to family members.

Other social networks also tended to shrink as friends as well as spouses died, and some friends moved away. Although smaller, social networks could become stronger: the friends who remained became more important as capacity to make new friends diminished. Continued social involvement could be self affirming, and maintaining friendships could help in adjusting to a new environment if care needs made this necessary. As one respondent put it, she needed “company as well as care”.

Financial security around 80

Concerns about financial security did not go away around 80. Rather, the risk and experience of poverty at this age were both very real.

There was also considerable concern about the cost of care should the need arise. Some felt that they would have to make compromises in the care options they could choose unless they had a lot of money. Those who were better off were concerned about the cost of care and not being able to leave their home to their adult children. Respondents in their 50s and 60s drew attention to the need to plan for their ageing parents, especially when the elderly parents had limited resources and the adult children did not have enough money to help.

Those with no family, or where family relationships had been long absent, asked “Who will look after you when you need care?”. There was widespread recognition of the role of government assistance as well as family in aged care. A number of respondents at this age expressed the view that preparing for ageing could not be left to individuals but society needed to prepare for larger numbers of older people, and it would be easier for individuals to prepare for ageing in a such a social context.

3.3 Awareness and action for preparing for healthy ageing at different transitions

3.3.1 Views of preparing for ageing

Awareness of and actions taken for preparing for ageing at different transitions across the life course suggests that respondents held two different views of preparing for ageing.

In one view, ageing was an on-going process rather than something that lay in the future, and in the other, ageing was a future state of being aged.

While there was an awareness that actions taken at different transitions had implications for health and well-being in later life, these actions were rarely seen in terms of preparing for ageing. As well as identifying some health concerns that continued across almost all the transitions and others that arose more at one transition than another, there was a strong recognition of the relationships between physical and mental health. More than seeing health issues in terms of preparing for ageing however, respondents' primary interest was being in good health whatever their age. Although generally aware of the longer term benefits of health actions, preparing for ageing was very rarely identified as a primary motivation for taking action at any ages. These findings suggest that messages urging health action to prepare for healthy ageing have little resonance and that the emphasis needs to shift to 'health now and for the future'.

Financial security was the main area in which preparation could be made well in advance for the future state of being aged. The prospect of reduced income was widely recognised, as was the need for early action to realise financial security over the long term, and the risks of financial insecurity came into much clearer focus as retirement approached. Rather than indicating that respondents who were close to retiring or who had recently retired had left their preparations too late, the findings reflect the many factors that limited their capacity to prepare for financial security as early or as well as they might wish to. While it was also recognised that the higher level of sustained workforce participation among the younger group in particular had the potential to make for a very different experience of financial security in retirement, it was equally evident that many other factors would affect their capacity to realise this potential.

Family relationships and wider social networks influence many aspects of ageing as a process, with different life courses set early on for those who were single and childless, those who were married but without children, and those who had children. Experiences of ageing across the generations, such as widowhood of a parent or caring for a frail parent, were commonly identified as shaping views of ageing, but often with a caveat recognising generational change. Preparing for ageing and especially for possible future needs for care meant involving family informally in discussions and making them aware of wishes and preferences, and formally by way of attending to wills, Advance Care Directives and other legal matters.

<p>Research findings on expectations and plans for retirement</p>	<p>Expectations and plans for retirement were investigated through semi-structured discussion covering a common set of topics in 12 focus groups, 6 of women only, 5 of men only and 1 mixed, all had been in the paid workforce and most were still employed, about half of them full time. Staying in the workforce was important for economic security in retirement, but other reasons and incentives for staying varied, and gender differences were evident as well as SES differences. Males in full time, low SES employments reported least enjoyment from work. Work gave structure to life, and the need to restructure life in retirement was widely recognised. Stress was reported as a reason for leaving work by self employed men, with high SES and working full time, and by low SES women who faced competing roles and who had less control over their working hours or conditions. Lower SES workers had far less option to scale down their work, and were disadvantaged by age and disability; they has less control over planning for retirement and were more dissatisfied about their work and future prospects. For high SES men, age meant experience and more active planning for retirement. Few under age 55 had made any plans, for any SES group. Many older subjects also felt they would manage on a reduced income, again regardless of SES. Some high SES respondents felt uncertainty in the long run, and low SES respondents called on government to take more responsibility. Private health insurance was rejected by many on the grounds that they had paid their taxes, that it was a government responsibility and it was too costly, and none were satisfied with private health insurance, especially gaps in cover. Few had planned for retirement and none had thought about very old age, and did not want to. As well as SES, age affected likelihood of planning, but gender differences were not marked. There was a strong sense of unfairness among all participants that they had not been given the opportunity to accumulate more superannuation, and self funded retirees were especially sensitive to possible future changes in the pension rules.</p>
<p>Quine, Bernard & Kendig 2006</p>	

3.3.2 Signals for preparing for ageing

The varying attention given to attitudes, health, family and social networks, and financial security at different transitions demonstrates the changing balance of concerns over the life course. The responses reported above show the multiplicity of factors that interact to produce great diversity at each transition, but the predominant shifts in concerns can nonetheless be summarised as in the matrix in Table 3.1. Reading across each row shows the balance of concerns at each transition, with the main concerns highlighted in bold, while reading down each column gives a picture of the shifts in each concern through the transitions.

This matrix enables identification of a number of critical points at which awareness of the need to prepare for ageing was heightened and at which action was more likely to be taken. While these points were triggered by signals of ageing in one area, there was often a flow over effect that prompted respondents to reflect on and review action in other areas of their lives.

- Around age 40, rejoining the workforce when children started school was the first point at which many younger women became aware of saving for retirement. Younger women appeared to be more aware of saving for retirement than those in the 50s, suggesting that compulsory superannuation may have come to be taken for granted. The regular contact between funds and contributors over a long period however makes superannuation a vehicle through which other aspects of preparing for ageing could be promoted at appropriate times, and especially for those who had interrupted employment.

Table 3.1: Transitions, changing concerns and awareness of preparing for ageing

Transition	Attitudes	Health	Families and social networks	Financial security
Around 40 Reaching middle age	Ageing not on your mind at 40 – too busy with other things	Want to be healthy at 40, but competing demands on time leave little time for exercise	Very diverse family circumstances – facing childlessness, having first child, having last child, establishing a new second family. Stresses of work-life balance a major concern.	Aware of need to save for retirement, but a number of barriers. Awareness of setting up super heightened if returning to work after having children.
Around 50 Menopause	“Reality strikes”	Menopause prompts a review of health on a much wider front. Recognition of inter-relationships of physical and mental health.	Empty nesters. Many involved in caring for grandchildren so their mothers especially can work; need to recognise grandparents’ roles as part of working families.	Little attention to preparing for financial security across this decade.
Around 60 Retirement	Positive attitudes to retirement as a new phase of life, Major upsets to retirement plans may be hard to overcome in short or long term.	Action taken on exercise, diet, health checks etc., for good health in immediate future, not for future ageing. Major health events for self or partner that lead to retirement ahead of plan are one cause of disruption.	Empty nesters, with care roles much more likely to be for grandchildren than children still at home, and some caring for ageing parents.	Approaching retirement focuses attention on incomes in retirement, adjusting to lower incomes and realisation of risks associated with lower incomes.
Around 70 Widowhood	Time for life review and reflection, coming to terms with widowhood and other losses.	More attention to mental health emerges.	Family support very important in coping with losses. Those without family may need more support.	Have to take on more financial responsibility for which many in the current generation may not be well prepared.
Around 80 Needing care	Accepting care from others seen as part of maintaining independence.	Aware of risks of a wide range of major health problems. Need for care only recognised at this transition	Involving family in preparing ahead for care arrangements and making wishes known.	Need for financial security does not diminish. Some concerns about cost of care and choice if without income.

- Around age 50, menopause was widely recognized as the first signal of ageing, and it was described as a powerful signal, a point at which “reality strikes”. Considerable attention was given to physical and mental health at this time, but other aspects of preparing for ageing, particularly financial preparation, appeared to receive less notice.
- Around age 60, even though retirement experiences were diverse, it was the transition that was most widely planned for, almost always through informal rather than formal planning. There was widespread recognition of the need to maintain health to enjoy retirement, that adjustments in relationships were likely and that financial security was essential. While attitudes to retirement were positive overall, risks in any of these areas could jeopardize well-being in both the short and long term.
- Around age 70, widowhood or the death of other close associates was associated with reflection and life review, and presented an opportunity for taking stock for the future
- It was only around 80 that care needs were mentioned, and as reported above, attitudes to accepting care took precedent over other preparations.

Finally, two further factors emerged as affecting preparing for ageing across all transitions, and these factors contribute to both the variability of women’s experience of life course transitions and their capacity to prepare for ageing.

First, events that brought disruptions to individual women’s expectations and broadly normative transitions had major and long lasting impacts over the rest of the life course. Such events included mid-life divorce, early widowhood or untimely death of other close associated, severe illness and disability on the part of the woman herself or a partner. There was a strong sense that most respondents got through such disruptions, some better than others, but at the same time, recognition of their long-lasting effects prompted a concern that those who experienced such disruptions needed more support in preparing for ageing. Capacity to manage and recover from a crisis is one element of social inclusion, and preparing for ageing calls attention to the need to look at outcomes over the longer term rather than just immediate crisis management. A study of older women who had assumed custodial responsibility for grandchildren demonstrates the effects of what is an exceptional situation and one that has long term consequences.

<p>Research findings on custodial grand-parenting</p>	<p>This focus group study of grandparents who had custody of their grandchildren identified nine themes that indicated how this intensive form of grand-parenting differed from both other grand-parenting and parenting. This exceptional form of grand-parenting contrasted with normative patterns. Grandparents’ lifestyles changed; their ‘dreams went out the window’ and social lives were curtailed. Their main concern was the future for the grandchildren, especially in the light of parent’s problems. The conclusions indicate confusion and tension around the extent to which grandparents wanted to be recognised as parents, and in government treatments of them as parents. The need for counselling and other support services to address these tensions is not well addressed as this group are not sufficiently recognised in policies and programs. While becoming a grandparent is valued by society, grandparents becoming parents is less positively perceived by those concerned because it is unexpected and unrelieved.</p>
<p>Orb & Davey 2005</p>	

Second, it is very evident that awareness of and attitudes to ageing have a pervading effect on the need to and likelihood of taking action to prepare for ageing at different transitions. It is however far too facile to say that there is then a need to increase awareness and change attitudes to preparing for ageing. Given the many other concerns on women's minds through different transitions, it is apparent that many such messages are not salient and are unlikely to lead to action. Instead, attention might better be directed to the points at which awareness of ageing is heightened by one or other factor and prompting review and responses across a wider range of areas to fill what appear to be some conspicuous gaps in preparing for ageing. By way of example, while menopause prompted a wide ranging review of health, the 50s seemed to be a decade in which little attention was paid to preparing for financial security. It may be that for the majority of women who are in the workforce feel complacent and leave financial preparation to their own compulsory superannuation or their partner's. Rather than leaving action to individuals, there is also a case for social action such as increasing the level of compulsory superannuation; an increase from age 50 could in turn serve to heighten awareness of other actions that might be taken to prepare for ageing and to reduce the risks of reduced income and consequent marginalisation and social exclusion in retirement and beyond.

<p>Research findings on socio-economic gradients in mid-aged and older women's health</p>	<p>Changes in women's well-being and use of health services over two waves of the ALSWH at a three year interval were examined in relation to socio-economic status (SES) and age. Data for 12,328 mid aged women (45-50) and 10,430 older women (70-75) were analysed. There were consistent gradients between SES and health scores in both cohorts in both survey waves. Better health was also related to lower use of health services, with the exception of hospital doctor consultations by older women in the second survey. SES-related differences in health outcomes were lower among the older cohort than the younger cohort, but the differences in all cases were greater for lower compared to higher SES women. Over time, lower SES mid-aged women had significantly greater declines in health outcomes of physical functioning, general health perceptions and pain but among older women, there was no significant relationship between SES and change in health outcomes. Declines in health over time among lower SES women were associated with more GPs visits in both cohorts, and older lower SES older women had significantly higher mortality. The findings suggest that SES related differentials in health outcomes widen in mid-age women but diminish among older women. One explanation for reduction in health differentials among older compared to mid-aged women is that the associations between health and SES circumstances are weaker among older people due to reductions in disparities in income and increased access to subsidised health care. This explanation was seen to be more tenable than alternative explanations of the older cohort being more homogenous or the effects of selective mortality. The changing gradients in health and SES across the lifespan point to scope for interventions at critical points to prevent widening of existing health disparities.</p>
<p>Mishra, Ball, Dobson & Byles 2004</p>	

4. Laying the foundations for healthy ageing

4.1 Diet, weight and exercise

4.1.1 Risk factors

While specifically women's health issues, notably breast and cervical cancer, justifiably attract considerable attention, the major causes of chronic illness, disability and death are the same for women and men: heart disease, stroke and dementia outstrip breast cancer and other women's cancers as causes of disability and death. The main risk factors are also the same for women and men: poor diet, being overweight and lack of exercise. The Australian Institute of Health and Welfare cites data from the latest National Health Survey showing that high proportions of women reported these three risk factors:

- 84% consumed inadequate fruit and vegetables
- 45% were overweight or obese
- 33% did not undertake sufficient physical activity.

While most women are aware that diet, weight and exercise are important to health now and into the future, the evidence shows that rather than diminishing, these problems are becoming more widespread. Rather than being the experience of a small minority, the adverse consequences of poor diet, overweight and lack of exercise will increasingly be experienced by the majority of women as they age unless urgent action is taken.

While still a major risk factor, smoking is far less common among women than men and has declined steadily over time, with less than 20% of women now smoking. The impacts of alcohol and drug abuse are severe for those who engage in these risk behaviours, but very small proportions of women do so to dangerous levels.

Variations in life expectancy and well-being at older ages are the result of barriers to healthy ageing that women have experienced at different times earlier in their lives, and the survey sought to investigate the nature and strength of these barriers.

Research findings on risk factors and socio-economic position	Relationships between socio-economic position (SEP) and cardio-vascular risk factors were investigated in a three cohorts of women in the ALSWH. SEP was measured by education, occupation and ability to cope on current income and risk factors were smoking, obesity and physical inactivity. Overall, adverse risk factors were lower among the most advantaged women, but some distinct cohort differences were evident. Among the oldest women (70-75), smoking were associated with high educational attainment, but the opposite was found mid-aged and younger women.
Lawlor, Tooth, Lee & Dobson. 2005	High SEP older women were least likely to be physically inactive, but in mid-aged and younger cohorts, education had little effect on physical inactivity, and mid aged women were more likely than younger women to be physically inactive at all levels of education levels. The differences in smoking behaviour reflect historic patterns of tobacco use in Australia, but the evidence of social class cross-overs suggests that socio-economic inequalities in health outcomes are not as entrenched as may have been thought and as well as addressing risk behaviours among disadvantaged groups, socio-economic inequalities need to be directly addressed to improve health outcomes.

4.1.2 Barriers to healthy ageing

The survey asked respondents whether they experienced 13 common barriers to healthy ageing. The results in Table 4.1 show some consistent and interesting patterns depending on whether particular barriers were concerned with knowledge, with personal behaviours or with wider social structures.

The survey asked respondents to rate the barriers that they saw women generally facing as well as the barriers they faced themselves. Respondents consistently saw others facing greater barriers than they did themselves but these responses are not reported in detail as it is not possible to determine whether this difference reflects real differences between respondents and the wider population or whether it is simply due to attributing more problems to others.

Barriers to adopting a healthy diet

With 82% reporting that lack of information on healthy foods was *not* a barrier, it is evident that there is little need to increase knowledge of healthy foods. In contrast, around half identified the behavioural barrier of changing eating habits, and the structural barrier of difficulties of buying healthy basic foodstuffs.

More women acknowledged barriers in this area compared to diet. Around two out of three reported barriers by way of personal beliefs and behaviours, namely, not worrying about gaining a few kilos and believing that some weight gain was normal with ageing. In contrast, three out of four indicated that lack of awareness of the health risks associated with being overweight was a not barrier, again indicating a high level of knowledge about health risks.

Barriers to adequate exercise

Some two out of three respondents reported minor or major barriers associated with lack of time and lack of motivation; while motivation is a behavioural factor, time barriers reflect more structural constraints on women's lifestyles. Fewer women reported barriers due to personal limitations such as injury or illness.

Cost barriers

Cost are the only barriers that were reported by a majority of respondents. Just on half reported barriers associated with the cost of healthy food and over-the-counter health items, and close to two out of three reported cost barriers to engaging in organised physical activities and accessing non-subsidised allied health services.

Taken together, the findings on barriers to healthy ageing indicate that more attention needs to be directed to structural barriers by way of costs and time limits. Knowledge of risk factors and aspects of healthy ageing, which is already relatively high, and behavioural factors were identified as minor rather than major barriers.

Table 4.1 Barriers to healthy ageing for women

	% reporting barrier*		
	Not a barrier	Minor barrier	Major barrier
Barriers to adopting a healthy diet			
1. Lack of information on healthy foods	82	14	4
2. Difficulty buying basic foodstuffs such as cereals that do not have added sugar/salt	57	32	11
3. Hard to change poor eating habits	49	35	16
Barriers to maintaining healthy weight			
4. Not worried about putting on a few kilos as will be able to lose them later	31	42	27
5. Belief that cannot do much as it is normal to gain weight as women grow older.	45	50	15
6. Not aware that being overweight is a major risk factor for heart disease, stroke, diabetes etc.	72	14	14
Barriers to taking adequate exercise			
7. Lack of time due to work and family commitments	40	31	28
8. Lack of motivation/ lack of peer support	39	42	19
9. Limitations due to chronic illness, disability or previous injury.	58	25	17
Cost Barriers			
10. Cost of healthy foods, especially fresh fruit and vegetables	54	25	22
11. Cost of over the counter medication and related items	47	26	27
12. Cost of engaging in sports/ going to a gym or exercise group	37	31	31
13. Cost of podiatry, allied health etc when not subsidised	35	29	26

* Valid response range from 92% to 95% for different items.

4.1.3 Implications

This account of barriers to healthy ageing shows that large proportions of the respondents faced barriers to healthy ageing, and that behavioural and structural barriers were more common and more pronounced than knowledge barriers. It is evident that while knowing what to do is a prerequisite for preparing for healthy ageing, many other barriers prevent women acting on the knowledge they have. The implications for healthy ageing initiatives are taken up below.

4.2 Home environments

Moving house at any age is a major life adjustment, and the survey questions sought to provide two views of how women see such a major adjustment in the context of preparing for ageing. The first view focuses specifically on assessments of the suitability of present housing in the face of future changes in housing needs. The second view provides an indication of preparedness to consider alternative living environments, including retirement villages, as an environment for ageing.

The findings on housing suitability and intentions reported in Table 4.2 suggest that while there is a high level of satisfaction with present housing, there is considerable potential for housing change as part of preparing for ageing. Realising this potential will depend on the options available and the barriers that women face in finding suitable home environments.

4.2.1 Consideration of moving as part of preparing for ageing

The younger group were least likely to have considered moving as part of preparing for ageing; this group may however move for other reasons before making ageing-related moves. Of the other three groups, more than half of the working transition group (54%) indicated that they had seriously considered moving or planned to move. The lower proportions among the retired transition and older groups (around 40%) may be due in part to some having already, confirming that housing adjustments are a likely part of preparing for ageing.

Factors that prompted respondents to think about moving were associated with four areas: housing that was too large or had stairs, gardens that were too large to maintain, moving closer to family and moving to a preferred locality for retirement living that also offered good access to services.

4.2.2 Suitability of present housing in changed personal circumstances

Respondents were asked to assess the suitability of their present housing if they found themselves in the situation of turning 80 tomorrow, living alone, suffering severe arthritis and no longer able to drive. While this hypothetical situation presents multiple difficulties, it is not totally unrealistic.

The two transition groups and the older group were most likely to assess their present housing as very unsuitable in the event of such changed personal circumstances, and the younger group were least likely. Two out of three of the working transition group were likely to assess their housing as very unsuitable or unsuitable, compared to just over half of the retired transition group; the higher proportion of the latter group who assessed their housing as suitable or very suitable likely reflects some having adjusted their housing as part of their transition to retirement.

The older group were least likely to assess their present housing as very suitable, a combination of this advanced age group being likely to occupy older housing and also their greater awareness of factors that made housing less suitable in the face of limitations in personal circumstances. This finding contrasts with the previous finding that this group were least likely to be planning to move, suggesting that this group especially face barriers in relocating to more suitable housing environments.

Table 4.2: Housing intentions and suitability, by respondent group

1. Have you ever considered moving house as part of preparing for ageing?					Total	
Group	Never	Occasionally	Seriously	Plan to move*	%	No.
Younger	46.7	31.1	6.7	15.6	100.0	45
Working transition	19.8	35.2	18.7	26.4	100.0	91
Retired transition	20.6	25.4	33.3	20.6	100.0	63
Older	24.7	37.0	24.7	13.6	100.0	81
Total %	25.7	32.9	21.8	19.6	100.0	
No.	72	92	61	55		280
2. How suitable would your present housing be if you turned 80 tomorrow, were living alone, had severe arthritis and could no longer drive?						
Group	Very unsuitable	Unsuitable	Suitable	Very suitable	%	No.
Younger	27.3	25.0	11.4	36.4	100.0	44
Working transition	36.0	31.5	12.4	20.2	100.0	89
Retired transition	38.5	15.4	20.0	26.2	100.0	65
Older	36.2	22.3	23.4	18.1	100.0	94
Total %	35.3	24.0	17.5	23.3	100.0	
No.	103	70	51	68		292
3. How do you view retirement villages as an environment for ageing?						
Group	Very negatively/ Negatively	Neutral	Positively	Very positively	%	No.
Younger	21.4	21.4	50.0	7.1	100.0	42
Working transition	24.7	14.6	42.7	18.0	100.0	89
Retired transition	7.7	30.8	46.2	15.4	100.0	65
Older	14.0	24.7	48.4	12.9	100.0	93
Total %	17.0	22.5	46.4	13.8	100.0	
No.	13	36	65	134		289
4. Do you know/have you visited someone living in a retirement village?						
Group	No		Yes		%	No.
Younger	24.4		75.5		100.0	45
Working transition	14.3		85.7		100.0	91
Retired transition	9.2		90.8		100.0	65
Older	11.9		88.1		100.0	92
Total %	14.0		86.0		100.0	
No.	41		252			293

* includes 7 who had moved, all in Group 3 and 4.

4.2.3 Retirement villages as an environment for ageing

The purpose of asking whether respondents knew or had visited someone living in a retirement village and their own views of retirement villages as environments for ageing was to assess openness to future possibilities that are different to present environments as much as interest in retirement villages *per se*. The question referred to retirement villages as an environment for ageing and not residential aged care homes as settings for care.

Overall, 86% of respondents knew or had visited someone living in a retirement village. Even among the younger group, three out of four had some contact with someone living in a retirement village, and this proportion reached 91% for the retired transition group. It is quite likely that experience of retirement villages on the part of the two transition groups may have related to older family members as much as consideration of their own futures.

Half of all respondents viewed retirement villages positively as environments for ageing, and around another 15% viewed them very positively. Around a quarter had neutral views and only a minority viewed them negatively or very negatively; the proportion with negative views was around twice as high among the younger and working transition groups as among the retired transition and older groups.

Further analysis shows some two thirds of those who had personal contact with someone living in a retirement village viewed them positively compared to just under half of those who did not have such personal contact. There was however no difference in the proportions expressing negative or very negative views and the difference was instead made up by more reporting neutral views. These findings suggest that views of retirement villages depend on acquaintance and may change over time, depending on both personal experience and the range of options available.

Research findings on moving to retirement villages	This study reports a survey of quality of life of 3 groups of 40 residents of each of a resident-funded village, a non-government villages and a group who had considered but not moved into retirement villages. Quality of life of those in villages had improved since they moved, whereas those who remained in the community reported worsening quality of life. The findings indicate that retirement villages enhanced quality of life by way of improvements in social activity, home maintenance, physical security, health support, housing costs, well-being and independence. Retirement villages enabled movers to achieve a better "person-environment fit" and greater autonomy compared to those who considered but decided against moving, mainly due to concerns about financial aspects of retirement villages.
Gardner, Browning & Kendig 2005	

4.2.4 Implications

Taken together, the findings on home environments and propensity to change housing as part of preparing for ageing suggest that many women do not expect to remain in the same house as they age and that there is rather considerable potential for moving and recreating their 'own home' in new environments.

4.3 Work environments

Continuing participation in the paid workforce lays the foundation for healthy ageing not only by enabling women to add to their savings for retirement income but by maintaining social networks and engagement. Many factors including the current high demand for labour and the increase in the age of eligibility for the Age Pension to age 65 for women are driving women's continued participation in the workforce. Health status is a major determinant of workforce participation, yet women's occupational health has received relatively little attention.

4.3.1 Age at retirement

Response rates to the question about the age at which respondents had retired or expected to retire were markedly lower than for other items in the survey. Only 60% of the older group responded, likely reflecting lower participation in the paid workforce by this group and hence fewer identifying an age at which they retired. Around 25% of the other groups did not respond; comments made by respondents indicate that non-response may be due to past or expected retirement being gradual, involving a shift from full to part time work, making it difficult to nominate an exact age of retirement. A small number in the other groups also indicated that they could not envisage retiring.

Retirement ages of those who did nominate an age at which they had or expected to retire showed considerable diversity and differences between the four groups.

- The older group who had worked and retired had the most even spread of retirement ages: around one third retired before age 55, one third between age 55-60 and one third by age 65.
- The retired transition group were the most likely to have retired at earlier ages rather than later: one third had retired by age 55 and 45% between age 55-60, with the remaining 25% retiring by age 65.
- The working transition group in contrast were least likely to anticipate retiring early: only a small minority, 6%, expected to retire by age 55, four out of 10 expected to retire by age 60, and almost 6 out of 10 expected to retire between 60 and 65.
- The younger group, for whom retirement was most distant, were divided between some 40% who expected to retire before 55 and 40% who expected to retire between 60-65, with the remaining minority retiring between 55-60.

4.3.2 Health and retirement decisions

The ways in which health affected retirement decisions was investigated through three questions, and some marked differences were apparent in responses from the four groups as reported in Table 4.3. In interpreting these findings, it should be noted that the response rate overall was only 80% and varied from 77% for the working transition and older groups to 84% for the younger group and 90% for the retired transition group.

Table 4.3: Work environments and healthy ageing

Group	Was or is poor health likely to be a factor in your decision to retire?			Total	
	Major	Minor	Not a factor	%	No.
Younger	29.7	21.6	48.6	100.0	37
Working transition	19.4	19.4	61.1	100.0	72
Retired transition	16.9	15.3	67.8	100.0	59
Older	10.5	13.2	76.3	100.0	76
Total %	17.6	16.8	65.6	100.0	
No.	43	41	160		244
Group	<i>If still working, is poor health likely to cause retirement before your planned retirement age?</i>			Total	
	Very likely/ Likely	Not likely	Not at all likely	%	No
Younger	36.6	39.0	24.4	100.0	41
Working transition	30.6	36.1	33.3	100.0	72
Retired transition	-	-	-		
Older	-	-	-		
Total %	32.7	37.2	30.1	100.0	
No.	37	42	34		113
Group	Since you retired, has your health			Total	
	Improved	Stayed the same	Worsened	%	No.
Younger	-	-	-		
Working transition	-	-	-		
Retired transition	24.6	62.3	13.1	100.0	61
Older	15.4	52.6	32.0	100.0	78
Total %	19.4	56.9	23.7		
No.	27	79	33	100.0	139

Overall, two out of three respondents reported that poor health had not been a factor in their decision to retire or they did not expect it to be, but there were considerable differences between the respondents groups.

- Somewhat surprisingly, the younger group were most likely to report that poor health was likely to be a major or minor factor in their retirement decision, with half giving this response. In comparison, only some 40% of the working transition group thought that poor health was likely to affect their retirement decision, and poor health was less likely again to have affected decisions of the retired transition group, with around 30% indicating that it had been a factor. The older group were least likely to report that their health had affected their retirement decision, and very few in this group reported poor health as a major factor.
- Responses of those who were still working confirmed that close to 40% of the younger group and 30% of the working transition group thought that poor health was likely to cause them to retire ahead of their planned retirement age. This finding is of heightened concern given the high proportions in these two groups who expected to remain in the workforce to age 65, and suggests that many will either have to change their level of workforce participation or be forced to retire earlier than they want to.
- Turning to those who had retired, one in three overall reported a worsening in health since retirement. The much lower proportion of the retired transition group who reported worse health post-retirement compared to the older group suggests however that this outcome may be due as much to advancing age as a consequence of retirement.

4.3.3 Work related factors affecting health

Work-related health problems

Work was generally seen in very positive terms, and was usually very satisfying, but a number of negative impacts of work environments that affected physical and mental health were identified. Some of these were so severe as to cause respondents to retire ahead of the time they planned to, while others affected health after retirement. A particular concern among those who had retired was that some long term impacts of occupation health only showed up after they had left work but they no longer had access to the same treatment and rehabilitation services they would have had while in the workforce.

Work-related injuries stemmed from poor physical environments and the nature of work done. Poor ergonomics, poor air conditioning, especially in computing work areas, heat in kitchens, and unsafe and polluted work environments with chemical hazards were all mentioned as having negative impacts on health. Older respondents had worked in environments that were not smoke free and at a time when lower standards applied in other areas of occupational health and safety. A great diversity of specific work related injuries were reported, from the effects of years of heavy farm work, long hours of computer work affecting eyesight and joints, and constant driving. Many women worked in child care and health care, where occupational risks were associated with on-going exposure to infection and lifting.

Poor management practices were also a source of stress and other negative impacts of pressures at work. Respondents commented on the effects of poor interpersonal staff

relations and increasing expectations from employers but little support and inadequate supervision; unrealistic expectations with too many, too short deadlines; long hours and shift work, and long travel times to work. Age discrimination was also noted, including young managers who lacked understanding of older workers needing to go on working for financial reasons.

Measures to address work health problems

Respondents reported a parallel range of ways in which the negative impacts of work environments had been or could be addressed.

Physical environments could be improved through air quality checks, safeguards for hazardous materials, new equipment and aids to assist lifting and avoid injury.

Management changes focused more on the need for more attention to be given to ageing of the workforce: better education of personnel management on issues such as the value of more flexible work hours, more awareness of health problems of ageing workers and how to accommodate these changes, more OH&S checks, including physiotherapy and eye checks for desk workers, promoting physical activity and lunchtime exercise or walking programs for sedentary workers.

The solution that was most frequently taken by respondents in both the working and retired transition groups was to change to part time work. Making this change however required an employer who accepted flexible work arrangements. Part time work achieved a much better work-life balance, and some respondents who continued in full time work saw it as a good way of making the transition to retirement in future, but the financial impact of reducing work hours ruled it out for some. Other actions taken by respondents included switching from careers that were too stressful and working closer to home.

<p>Research findings on women's work hours</p>	<p>The ALSWH included questions on work hours and satisfaction with hours worked in the 1998 survey, and this study examined relationships between these variables and physical and mental health scores on the SF-36, a well validated health profile. 8,346 women aged 47-52 at the time of the survey were included. One third were not in paid work. Of those who were, the 33% who worked part time for 16-35 were most satisfied. Those working fewer hours wanted more work, but the proportion wanting to work fewer hours increased rapidly above 35 hrs. Reasons for wanting to work fewer hours were related to family caring, health and wanting more time for leisure, for self, or to do other things. Women working in more skilled and managerial occupations were happier with longer hours, and more of those in manual work were happy working fewer hours. Irrespective of hours worked, women who were happy with their hours had better physical health, and this association was even stronger for mental health. Long part time work hours (25-34 hrs) were the most favoured and social policies that facilitated such arrangements were identified as making a crucial contribution to both women's employment and health.</p>
<p>Warner-Smith & Mishra 2002</p>	

4.3.4 Implications

The diversity of findings on how work environments affect preparing for ageing reflect changing patterns of workforce participation of different generations of women, changes in other factors affecting retirement decisions, such as the increase to age 65 for eligibility for the Age Pension for women, and changes in work environments, especially in occupational health and safety standards. Some of these factors are more readily anticipated than others, but as more women in coming cohorts of women will have had longer periods of employment in the paid workforce, the importance of work environments in shaping retirement transitions in preparing for ageing is set to increase.

The substantial proportions of respondents who indicated that poor health was, or was likely to be a minor or major factor in their decision to retire has considerable implications for preparing for ageing. Many occupational health and safety measures focus on prevention of catastrophic injury and immediate consequences for continued workforce participation, but these findings indicate that for women, more attention needs to be given to chronic injury and to long term effects that may not be felt until after retirement. Women who have to retire because of poor health, or who experience work related health problems early in their retirement are disadvantaged compared to those who make the transition to retirement in good health. Minimising negative health impacts of work will become an increasingly important part of preparing for ageing as more women come to have longer exposures to occupational health risks before they retire, and some of these impacts may not be felt until after retirement.

5. Building on the Foundations: Developing the infrastructure for preparing for ageing

5.1 The central role of General Practitioners

The frequency with which most women see their General Practitioner means that GPs are the front line for providing advice on healthy ageing and related health care services. The importance of GP roles is borne out by the high proportions of respondents who report that they are very satisfied or satisfied with the way their GPs manage different aspects of their care. The strength of these findings is enhanced by the very high response rates, at over 90% for all four items.

- Around 40% of respondents overall were very satisfied with each of the areas of GP care that were asked about, and another 40% were satisfied. Within this overall high level of satisfaction, there were some variations between the groups and for different aspects of GP care.
- The older group were most likely to be very satisfied; fully two thirds were very satisfied with their GP's management of mental health and over half were very satisfied with the other areas.
- Where women were very dissatisfied with their GP's role, it was usually in one or another area compared to satisfaction with others. Very few were dissatisfied with their GP in all areas of care.
- Reports of being very dissatisfied were more likely from the younger group, but there were marked variations for the different aspects of GP care. This group were four times as likely to be very dissatisfied with the extent to which their GPs looked beyond their immediate health problem (16% compared to 4.5% overall), three times more likely to be very dissatisfied with annual check-ups (21.4% compared to 6.2%) and twice as likely to be very dissatisfied with referral to a range of other services (12% compared to 6%).
- The high proportion reporting they were very satisfied with their GP's management of mental health, either directly or through referral, was common to all four groups; the younger group in particular reported higher levels of satisfaction with this area of care than other areas.

<p>Research findings on older peoples' encounters with general practitioners</p>	<p>Analysis of approx. 100,000 GP encounters found that over 90% of older Australians attend their GP at least once a year, and those aged 65 and over accounted for 25% of encounters. Two thirds had a Health Care Card and another 12% a DVA card. Women predominated; 57% at age 65-74 and 61% at age 75 and over, and had more encounters than men: 8 and 10 per year for the two age groups compared to 7 for men at both ages. Circulatory conditions were most frequent, and cardiovascular medication the most frequent management. Compared to those aged 65-75, those aged 75 and over received investigations and non-pharmacological treatments significantly less often. Evidence of healthy ageing strategies was reported especially for patients 65-74, including advice on nutrition, weight and exercise, with a different focus in encounters for older patients. The rate of treatment of hypertension has not changed over since 1990-91 but the rate of immunisation has doubled.</p>
<p>O'Halloran & Britt 2004</p>	

Table 5.1: Satisfaction with aspects of General Practitioner care

Satisfaction with extent to which my GP	% reporting				Total	
	Very dissatisfied	Dis-satisfied	Satisfied	Very satisfied	%	No
1. looks beyond my immediate health problems to look at my longer term health	4.5	15.1	43.8	36.6	100.0	292
2. makes time for a thorough check on my health once a year	6.2	15.2	37.2	41.4	100.0	290
3. is able to provide good access to other mental health practitioners, e.g. psychologist/ counsellor (in own practice or by referral)	5.1	8.3	36.8	49.8	100.0	277
4. makes referrals to a wide range of community services (beyond other health services) that can contribute to preparing for ageing	5.5	13.2	41.5	39.7	100.0	272

Table 5.2: Preferred sources of information on health problems

Sources turned to for information on a particular health problem	% reporting				Total	
	Very likely	Likely	Unlikely	Very unlikely	%	No.
General practitioner	61	30	5	4	100	291
A support organization concerned with the problem e.g. the Arthritis Foundation	31	47	10	12	100	258
Another Health Professional	22	47	23	7	100	245
The internet	37	23	16	24	100	251
A women's health centre/service	19	36	27	18	100	247
An alternative therapy practitioner	13	30	31	26	100	239
A local community health centre/service	12	27	41	20	100	244
A local self help group	8	27	38	27	100	241
A popular magazine	5	21	24	50	100	234

5.2 Information and more information

Finding information on healthy ageing is widely seen to be a problem, yet the survey findings reported so far suggest that lack of information may be less of a barrier than is seen to be the case. Comments were made at several points in survey responses to the effect that the because there is such an array of information available, it is difficult to know just how accurate and reliable different sources of information are. Some information is too technical and so not easily understood, some is not practical, and some is misleading and alarmist.

To explore information issues further, respondents were asked to indicate how likely they were to turn to each of seven different sources of information. The results in Table 4.2 show that some sources are much preferred over others, and that some are unlikely to be used at all by many women. Response rates followed the same trend, with higher response rates for sources that were more likely to be used.

Five different sets of responses were apparent:

- Respondents were far more likely to turn to their General Practitioners than to any other source of information; fully 9 out of 10 said they were very likely or likely to ask their GP. The minority who were unlikely to turn their GP included a small number of respondents who commented that they did not have a regular GP, in some cases because they attended clinics, but in other cases because they very rarely needed to see a doctor.

Research findings on information in general practice	This study of older patients' requests for information involved 50 GPs and 188 community dwelling older people in Brisbane and focused on written material. 46% of GPs had not given any written material to patients and while 50% of patients reported receiving written material, only half of these had discussed it with their GP. Patients were more positive than GPs about the value of written educational material. 20% of patients wanted more written material. Some GPs believed that older patients preferred verbal material and only gave written material when they perceived patient interest. Patients need to be more assertive in asking for written information and GPs need to offer it to more older patients.
McKenna, Tooth, King et al	

- Respondents were also highly likely to turn to support organizations and other health professionals, each nominated by some 70%.
- The internet was identified as a highly likely source of information by 6 out of 10 respondents, but close to a quarter said it was a very unlikely source. This polarised pattern of responses reflects a difference between the younger group who were highly likely to use the internet and the older group who were mostly very unlikely to use it.

Research findings on internet use by older people	Internet use was found to decline rapidly with age, from 75% for 18-24 year olds to 26% at age 55-64 and 9% at 65 and over, due mainly to lack of familiarity or opportunities on the part of older people. But older users are the fastest growing group. Internet use had no effect on frequency of other communication and internet use supplements interaction with others and improved access to economic, social and political institutions and services, and hence improved quality of life. While this small study of older users explored internet use in relation to social capital, by way of 'bonding' in personal relationships and 'bridging' in building formal ties to voluntary organizations, the findings are relevant to use of the internet as a source of health information.
Russell, Campbell & Hughes	

- Women’s health services, alternative therapy practitioners and local community health services were each nominated as a very likely or likely source by around half the respondents, but as many were unlikely or very unlikely to use these sources.
- Self help groups and popular magazines were not widely used sources of information. Response rates fell to below 80% for these sources, further indicating that they were not preferred sources of information. Self help groups are likely to be used more selectively by women seeking information and support with particular problems, and provide a useful response, but comments indicated that while popular magazines are ubiquitous, much material in them is by way of sales promotion and they are not regarded as a source of credible health information.

5.3 Current initiatives for healthy ageing

While the preceding findings confirm that GPs play a central role in enabling women to prepare for healthy ageing, it has to be recognised that GPs cannot “do it all” and that a range of other services are involved. The variety of initiatives taken over recent years to promote healthy ageing thus includes some delivered through general practice, some delivered through screening services, some generic and some specific to women’s health, and some delivered through community based programs.

The survey results reported in Table 5.3 show that take-up and knowledge of these initiatives is high. Variations in both use and knowledge are systematically related to the eligibility criteria applied, the likelihood that different respondents groups have experienced different health concerns, and free or low cost access. The findings are strengthened by the high response rates, at above 90% for 10 of the 11 initiatives, and 87% for the remaining one.

5.3.1 Programs with age eligibility criteria

Take-up of free flu immunisation and annual health assessments is very high among those who are age-eligible, and knowledge of these programs is high among others.

Free flu immunisation

Just on 90% of the older group had received free flu immunisation and the remaining 10% had heard of this service. While lower proportions of the working transition and retired transition groups had received flu immunisation, the levels of coverage at 23% and 44% respectively are consistent with more of the latter group being aged 65 and over and hence age-eligible. None in the younger group were eligible for free flu immunisation, but close to half reported knowing of the service.

Table 5.3: Take-up and knowledge of current initiatives for healthy ageing

Delivered through	Not elig./ relevant	Not heard of	Heard of / not used	Used	Total	
					%	No.
General Practitioners						
Free flu immunisation for 65 and overs	17.8	2.7	32.9	46.6	100.0	298
Annual Health Assessment for 75 and overs	35.7	20.0	26.4	17.9	100.0	
Screening services						
Cervical cancer/PAP	11.6	1.1	15.8	71.6	100.0	285
Skin Cancer	4.7	5.8	36.7	52.7	100.0	275
Bowel Cancer	5.7	5.0	43.2	46.1	100.0	280
Ovarian cancer	12.2	12.2	57.4	18.3	100.0	263
Diabetes	4.6	3.9	38.4	53.0	100.0	281
Community programs						
Continence	28.6	28.9	36.6	5.9	100.0	273
Eye examination	6.0	21.8	17.2	55.1	100.0	285
Medication Review	14.6	28.8	37.6	19.0	100.0	274
Depression	27.0	12.4	48.2	12.4	100.0	274
Falls	17.9	23.7	43.0	15.4	100.0	279

Annual health assessments for those aged 75 and over

The age limit of 75 years and over means that not even all those in the older group would be eligible. With 53% of this group reporting that they had had a health assessment, coverage is seen to be high, and a further 20% knew of the service. Knowledge was as high as 25-30% among the other groups, but the majority of these responded that the service was not applicable to them.

Research findings on health assessments	Take up of the Medicare Benefits Schedule Item that provides free health assessments for people aged 75 and over was examined using data from the ALSWH. The data covered 4,646 women aged 75 and over in November 1999 who gave consent for their Medicare and DVA claims data to be accessed. Take-up increased over the 4 year study period and 48% had at least one annual assessment. Women in metropolitan areas and regional centres were more likely to have assessments than women in rural and remote areas. Take-up was also associated with having more visits to the GP, taking more medications, being in hospital or being injured in a fall in the last 12m, having a GP consultation at no cost, satisfaction with GP availability, and being born overseas. The findings did not indicate any strong socio-economic inequity in utilisation of assessments other than in outlying rural and remote areas. As take-up was strongly associated with access to GPs, GPs need to consider ways of encouraging health assessments for older people who they see less frequently
Byles, Young & Wheway 2007	

5.3.2 Screening programs

Screening programs are delivered both through General Practitioners and organised screening programs. In both cases, access is mostly at low or no cost, particularly for older women.

Screening for cancers

Take-up of the four cancer screening programs covered in the survey ranged from a high of 72% for cervical cancer/PAP smears, through around 50% for bowel and skin cancer, to just under 20% for ovarian cancer.

There were different age related gradients in take-up of different screening services.

Whereas cervical cancer screening was highest among the younger group at just on 90% and fell to under 60% among the older group, the trend was the reverse for skin cancer screening which increased from 40% among the former group to 60% of the latter, and for bowel cancer which increased from 20% to some 60% across the groups.

Most of the remaining respondents had heard of these screening programs, with the exception of screening for ovarian cancer, which just on 25% had either not heard of or considered was not relevant to them. This finding is in accord with ovarian cancer screening being recommended only on medical advice and not on a population basis.

Diabetes screening

Just over half of all respondents had been screened for diabetes and most of the others had heard of the program. There was a marked age gradient, from 30% of the younger group having had screening to 70% of the older group.

5.3.3 Community programs

Take-up and knowledge of community programs relevant to healthy ageing was more varied and reflected the likelihood of women experiencing different health concerns.

Medicare funded eye examinations

Take-up was highest for Medicare funded eye examinations, at 55%, and ranging from close to 40% for the younger group to over 70% for the older group. It is evident that eye examinations are readily accessible, and fewer than 10% of all groups regarded eye examinations as not applicable or relevant. While some 20% overall and 30% of the younger group had not heard of the service, it is difficult to judge whether lack of knowledge is because of lack of need or whether some who are in need of eye examinations are missing out on this available service.

Research findings on vision screening	Testing of a sample of 442 clients of residential and community care services aged 65 and over in a suburban Melbourne LGA found 38% had vision impairment but only 24% of these were under care and 76% were referred for further examination, most often to an optometrist. A vision screening kit that could be used by a wide range of staff allowed for ready screening and although recommended for routine inclusion in many assessment processes, time limitations precluded use by staff. Better integration in community health settings together with distribution of eye health promotion material to senior centres etc. are both needed to improve eye health and quality of life.
Carnicelli, Keeffe, Martin et al. 2003.	

Programs for age-related conditions

Programs providing assessment of falls and balance, medication reviews by pharmacists and continence assessment all address ageing-related health concerns, and take-up and knowledge of these services varied across the groups accordingly.

Falls and medication review programs were used by around 15-20% of respondents overall, and knowledge of these programs was high at around a further 40%. Age gradients suggest that knowledge and use of services is strongly conditioned by emerging health concerns. One in three of the older group had used each of these programs, while among the two transition groups, lower use was balanced by higher knowledge.

Among the younger group, 60-75% reported that these three programs were either not relevant to them or they had not heard of them. This finding has to be interpreted in relation to the findings for the other groups, and rather than reflecting actual or potential lack of access to needed care, the explanation for low use and limited knowledge lies in a lack of salience to their own health needs, and it can be expected that knowledge and take-up would increase over time to levels commensurate with the other groups.

Depression

Knowledge and use of programs for managing depression was markedly different to the other services, but broadly consistent with the prevalence of depression in the community. Use of services providing support for depression was highest among the younger group, at just under 25%, and then fell to around 10% for the older group. Use of these services was lowest, but

knowledge highest, among the retired transition group, and this finding is consistent with other findings of the survey that indicate that the majority of this group are indeed ageing well.

Just on half of the older group reported that services providing support for depression were not applicable to them. Interpreting this finding as indicating a lack of awareness of need on the part of older women is countered by the 40% who reported that they had heard of these services but not used them, the same proportion as among the working transition group. It is also consistent with lower prevalence of depression and better mental health at older ages compared to younger ages.

5.3.4 Self management of chronic conditions

Only a small number of respondents reported on their experience of self management.

Diabetes was the most common condition that respondents managed themselves, or were involved in managing with their partner or a child with diabetes. Respondents adopted a range of self management strategies, and while acknowledging that it was sometimes difficult to stick to the required diet, the combined benefits of diet and gentle exercise were especially recognised when they helped with other chronic health problems. One respondent managed her multiple problems of high blood pressure, sleep deprivation and hypothyroidism.

Other conditions mentioned by individual respondents were chronic obstructive airways disease, asthma and arthritis. Education and information had enabled good management and reduced the need for medication for these conditions.

Two factors that were identified as contributing to the success of self management were “having the right attitude” by way of taking responsibility for one’s health, and having back-up from community nurses, the GP and pharmacists reviewing medications.

5.3.5 Implications

While a lack of access to needed services cannot be ruled out on the part of all respondents, the findings on knowledge and use of current healthy ageing initiatives indicate that pre-requisite knowledge is widespread and likely to lead to access to care as need arises. The only critical concern to be identified is a gap in knowledge of continence assistance on the part of the retired transition group, given the increasing prevalence of continence problems among this age group.

The findings do not provide any evidence of a need for large scale, blanket information campaigns. Instead, a strategy that took use of any one healthy ageing service as a starting point to link to other services could provide a better way of increasing take-up.

5.4 Socially inclusive communities

The social inclusion segment of the Preparing for Ageing Project identified the importance of continued participation in social groups, outside as well as within the family, and safe environments for healthy ageing. Social inclusion also depended on being able to connect with others, having access to services, having opportunities to be heard and being treated with respect. Taken together, these attributes describe life in a community that is inclusive, not only of women as they age, but of men and women at all ages.

While older people are sometimes portrayed in the media as being highly concerned about matters of personal safety and safety in public places, this view is not supported by research and its persistence in the media may be more a cause for alarm.

<p>Research findings on perceptions of safety at home and in local communities</p>	<p>Data on questions about feeling safe in the home and in the neighbourhood from the Older Persons Health Survey were analysed; the OPHS was a random sample of 8,881 residents aged 65 and over across the whole of NSW were analysed. 95% felt safe at home and 90% in the community; men were slightly more likely to feel safe all the time but this was balanced by the proportion of women who felt safe most of the time. There were no significant differences over the age range. Other predictors of perceptions of safety at home and in the neighbourhood were examined for men compared to women: metropolitan/non-metropolitan residence, living alone, socio-economic status, health status, emotional well-being and future outlook and personal mobility. Few significant associations were found between variables, and associations were mixed for men and women, and in home and neighbourhood safety. The findings do not support the common view that older people are greatly concerned with their personal safety, and show that feelings of safety flow across home and neighbourhood settings. Fears that were expressed focused on personal health and general matters such as the economy and politics; fears about being a victim of crime were not expressed and only 3% stated concerns about law and order. The findings show a consistent and positive picture of older people's perceptions of safety and refute the image of older people as fearful and disproportionately targeted as victims of crime.</p>
<p>Quine & Morrell. 2008.</p>	

The survey asked respondents to rate their local communities on six attributes that made for positive environments for ageing. The results in Table 4.4 show that local communities are widely regarded as positive environments for ageing. These findings are strengthened by response rates close to 100% for this part of the survey, the consistency of responses from those living in different communities across metropolitan areas, regional centres and rural areas, and across the four groups of respondents.

Fully 90% rated their community as good or very good in terms of availability of places to meet friends and socialise, and over 80% gave similarly high ratings to facilities for indoor and outdoor recreation, attitudes to older people and their treatment by others in the community, and safety at home and in public places. Taken together, these findings provide a view of local communities as being highly inclusive and offering many opportunities for maintaining social networks and engaging in a wide range of group and individual recreation activities.

The only exception to these positive views was the assessment of ease of getting about without driving, which was rated as poor or very poor by 42%. The only comment that was made frequently about how to address problems in local communities was to improve public

transport. Lack of public transport is a particular concern to women as they grow older, and it reduces the value of public transport concessions, but it is also a major concern to all those who cannot drive or who do not have access to a car.

Table 4.4: Quality of local communities

Rating of aspects of the local community as a place for ageing	% reporting				Total	
	Very poor	Poor	Good	Very good	%	No
1. Places to meet friends and socialise (cafes, movies, etc.)	1	9	61	29	100	301
2. Facilities for indoor activities and recreation, including libraries, clubs etc.	2	12	59	28	100	299
3. Facilities for outdoor activities/recreation, for solitary and passive enjoyment as well as sporting clubs and facilities	2	15	62	21	100	296
4. Attitudes to older people and treatment by others in the community.	4	13	63	20	100	299
5. Safety at home and in the streets and public places	2	18	61	19	100	296
6. Ease of getting about without driving	17	26	41	17	100	300

6. Proposals for preparing for ageing

6.1 Towards a program for preparing for healthy ageing

The initiatives suggested for inclusion in a preparing for healthy ageing program were many and varied, and it is apparent that health aspects of ageing are viewed in a wider context of preparing for ageing. The following summary of the proposals under five main clusters demonstrates the scope of areas that a possible program concerned with preparing for ageing might cover. While many of the issues raised are of importance to men and women as they age, issues of particular concern to women are highlighted.

The proposals summarised below indicate very clearly that preparing for ageing goes well beyond addressing health issues. Many of the areas put forward for inclusion in a future program already exist, and few gaps were identified. It is readily apparent that action to integrate existing provisions into a coherent program takes priority over new, separate initiatives. To this end, a number of common themes that emerge across the five clusters are drawn together to provide some overall directions for possible program development.

6.1.1 Attitudes to preparing for ageing

Attitudes towards preparing for ageing were positive. The common view being that ageing was something that women should take in their stride and that women who had capably managed busy lives would continue to do so with the natural progression of ageing in a whole of life course perspective. Acceptance of a natural progression of ageing was based on recognition of what was normal ageing and what was abnormal, and there was a clear view that ageing *per se* should not be “talked into a problem”, raising anxieties about the future where there was previously little concern. An outward looking attitude and maintaining relations with family, friends and others in the community was valued as contributing to mental health and stimulation.

At the same time, respondents felt that some level of preparation was in order, that women should neither just accept what was happening nor suddenly find themselves ill-prepared. The main circumstance in which women found themselves unprepared, namely management of finances on the death of a husband who had looked after these matters, is taken up further below in discussing financial security.

Among the factors that equipped women for ageing were an awareness of their rights and how to exercise them, being empowered through positive role models, and building confidence. Within this area, specific mention was made of making wills, Power of Attorney, Medical Power of Attorney and related matters. Other themes were that the focus on maintaining independence had to be supported by measures that enabled seniors to live their lives to the fullest capacity regardless of disability, and a recognition that those with disabilities in middle age may need assistance in planning for ageing.

A final note on positive attitudes was summed up in the response “Don’t forget how to laugh”.

6.1.2 Financial security

Whereas many aspects of ageing were seen to continue over the life course, ensuring financial security was the one area in which purposeful action had to be taken early. The generational differences that respondents identified in opportunities to achieve financial independence and security highlight this point.

Starting early not only increased the likelihood of achieving financial security but the planning involved also gave a realistic view of what to expect. Those in the transition groups stressed that achieving financial security had to start early and be taken seriously, with regard to pursuing careers well into their 60s as a means of building up superannuation. A timely comment from one respondent was that “paid maternity leave will help keep women in the workforce by helping them return to work instead of dropping out, and so stop them having big holes or gaps in superannuation”.

Many women already in their 60s and 70s were in a different position, observing that neither they nor their husbands had had super long enough to build up security. These respondents were more likely to express concerns about actual costs of living or the impact of anticipated future cost increases; increases in private health insurance premiums were flagged as a specific concern. Many of the older respondents pointed to the need for younger women to be involved in financial planning rather than leaving it to their husband, or even assuming that their partner was undertaking the necessary planning, and to learn financial management skills so they would be able to manage when they on a lower income and when they had to take over financial management in the event of widowhood.

There were widespread calls for independent and free or at least low cost financial advice and retirement planning sessions. Addressing confusion about changes to superannuation was a high priority. Centrelink was again identified as the agency to take a leading role.

That financial security underpins health was summed up by the respondent who said “I cannot stress enough the importance of forward financial planning so that women feel safe and secure in their own next. If they do, good health will follow.”

6.1.3 Social networks

Maintaining social networks was critical to healthy ageing, and involved a mix of informal, personal networks and participation in more organised community activities. Continuation on from activities and groups that respondents were involved in prior to retirement and taking up new interests were equally important, as was keeping both minds and bodies active. As well as financial considerations, many felt that women who have stayed in the workforce found it easier to maintain networks.

Intergenerational relations were a feature of personal networks, and interaction with children, grand children and great-grandchildren was seen as a way of keeping young. Although policy discussion of work-family life balance has focused on younger families, grandparents are also very much a part of working families. Two sets of responses showed that achieving a work-life balance was a clear theme through the transition to retirement. Respondents in the transition groups noted the need to make more time for non-work activities while working and not letting work take over life for women in their 40s and 50s, and several wanted more information on opportunities for non-work community engagement in clubs and societies in their local community. Some in their 50s and 60s reported having

to balance competing pressures of contributing to child care for their adult sons and daughters who were working and staying in the workforce themselves.

Participation in organised groups with people with similar interests contributed to building confidence and combating social isolation, and also provided vehicles for healthy ageing initiatives. Groups mentioned covered a wide range of interests, from computing courses to diverse opportunities for volunteering. Continuing education, particularly through U3A, was identified as a means of active engagement in getting information, and involvement in group programs on retirement planning and financial literacy and competency were specifically noted. Volunteering could especially enable skills to be used in community settings and keeping connected across generations: examples given included assisting with reading in schools, in health centre programs, and foster grand-parenting.

Self help groups that sit between personal networks and organised groups emerged as most relevant to areas of well-being where sharing experience provided support, such as coping with grief and loss and taking on caregiving. Mutual support at these times could help in taking a long term view beyond the immediate concerns and attend to spiritual and emotional needs.

Finally, a particular insight into the need to promote women's networks came from one comment that identified a barrier to engagement: husbands who did not share their wives' interests and did not encourage them to pursue their own interests.

6.1.4 Health and community services

Proposals for health and community services to be included in any healthy ageing program emphasised boosting current programs rather than starting new, but under-funded services, and health promotion ahead of treatment services. Several respondents argued that throwing more money at problems would not solve them and wanted more attention to be given to cost effective options including self help and community group initiatives.

Fitness programs and classes offering exercise, diet and nutrition advice were very widely proposed and form the basics of a healthy ageing program. Many called for expansion of low cost and cost effective options already available in local settings. Programs operated by local government or community groups, such as all age walking groups, had advantages by way of providing peer support that recognised relationships between physical and mental health, individually and as a member of the community. While some proposed subsidies for gym membership, others proposed that private services should be encouraged to offer discounts for seniors. As one respondent put it, "I can't go past no cost walking and my weekly low cost exercise group for keeping fit".

<p>Research findings on physical activity and emotional well-being</p>	<p>Changes in physical activity and emotional well-being over 3 yrs were analysed for 6,472 women included in both survey waves who were aged 70-75 at the beginning of the ALSWH. A composite mental health outcome measure and four subscales of emotional well-being covered vitality, social functioning, emotional role and mental health, were analysed. Cross sectional analysis found that all these scores with increases in exercise and physical activity. Changes over time were compared using the 'sedentary' group as a baseline. Those who ceased exercise experienced significant decreases in vitality, social functioning and mental health whereas those who maintained or adopted exercise showed positive changes on all four measures of well-being. While noting that changes in physical health over time that may have caused some older women to cease exercise may also have had a negative effect on their well-being illness, those who were able to maintain and particularly those who increased activity experienced higher levels of well-being. Differences in ability to engage in physical activity (rather than actual activity) do not explain differences in emotional health which may rather be associated with physically active women experiencing physiological effects of activity, having larger social networks and engaging in more pleasurable activities. Physical activity in older women was predictive of future emotional well-being, and while it is not possible to determine the direction of any causal link, the promotion of physical activity among older women is identified as a valuable health promotion goal.</p>
<p>Lee & Russell 2003</p>	

More specific areas of health promotion that were mentioned were falls prevention and living with pain, advice on alternative therapies, and assistance with medication management, including attention to the affects of prescription drugs on ageing bodies. Echoing the importance of home environments as reported above, advice on home safety, home modifications and use of aids were recognised as making valuable contributions to preparing for ageing rather than only being relevant to care for frail aged individuals. Promoting accessibility through adoption of universal design principles was also proposed as a means of enhancing access more widely in local communities, together with improved public transport.

<p>Research findings on falls prevention programs</p>	<p>Even though 80% of the 75 respondents aged 60 and over were physically active and confident about walking, 25% had fallen in last 6m, and only 54% were aware of strategies to prevent falls. Preferred strategies each reported by around 60% were exercise programs, educational talks about health issues and vision examinations, delivered at a centre. Osteoporosis screening and nutrition advice ranked next, around 40%. Incentives to attend were a referral from a doctor or a friend who had attended. The most common barrier was transport, reported by 20%. It appears that those with some experience of falls were more aware of prevention strategies, raising questions of salience and timing of early interventions.</p>
<p>Snodgrass & Rivett 2005</p>	

The single health service that was most often mentioned as requiring improved access was dental care. Other specific services mentioned were one to one appointments with dieticians, and enhanced access to screening services, including removal of age limits that applied to some services.

Research findings on use of dental care	Data from a longitudinal study of 993 community residents aged 65 and over found that only 1/3 had visited a dentist in the last 12m, and 40% had not visited a dentist for 5 years or more. In contrast, 95% had seen a doctor in the last 12 months. The proportion visiting a dentist recently is consistent with, but a little lower than found in studies in 1988 and 1990. Higher income, higher education, higher social support and higher well-being and younger age were associated with more recent use of oral health; holders of a Health Care or Pensioner Benefit card was also more likely to have visited a dentist. While no gender analysis was reported, these findings suggest that older women, especially very old women, are less likely to visit a dentist, given more older women have lower incomes and lower education. Other factors that contribute to likelihood of visiting a dentist were self assessed oral health, perceived barriers, and prior use of dental care services. The contrast with use of medical services highlights the lack of publicly funded dental services and the large waiting lists for non-emergency dental care pose further barriers to access.
Marino, Browning & Kendig 2007.	
Kruger, Tennant, Smith & Peachy. 2007.	Oral examinations were carried out in a community centre in rural WA, using standard WHO procedures. Of the 80 participants, 65 were women, and the mean age was similar for men and women, at 73 overall. There were no significant differences between men and women in the proportion who were edentulous, 40%, having dentures or dentate status of those with remaining teeth. Treatment needs were identified in 66%, and in both dentate and edentulous groups. Over half had been to the dentist in the last two years and around 20% had not been for 5 years or more. While 80% held a relevant concession care, the most common reason for not visiting a dentist was cost, reported by 25%. Dental anxiety was not widespread, but not feeling dental care was necessary or long waiting times were each reported by 20% as reasons for not seeing a dentist. The findings are generally comparable with studies in other urban and rural communities in Australia.

A more systematic approach to comprehensive reviews of health at each decade of ageing was widely proposed. Rather than waiting until age 75, health assessments at 50, 60 and 70 were proposed, accompanied by a standard record that could be regularly updated.

Research findings on using a health check log	The health check log (HCL) was developed after surveying 200 older people in NSW on healthy lifestyle decisions, a literature review and consultations. Participants were asked to use the HCL once a month for 12m, to record health concerns and actions they took to address their concerns, and monthly phone interviews were conducted as well as focus groups at the end of the project. The majority of the 35 subjects in the evaluation were women living with their spouses. A wide range of health concerns were recorded on the HCL and actions taken showed considerable variation for consultation, treatment, satisfaction, follow-up and continued self monitoring for different concerns. The project found increased self confidence in requesting health screening and self-monitoring rather than depending on health professionals, but recognised the contact interviews may have contributed to this outcome. There was evidence that non-life threatening symptoms were not considered causes for concern even though they could have long term effects on health and well-being and ability to engage in community life. The HCL was seen to be a useful vehicle for raising awareness of these factors when used in conjunction with 1 to 1 follow-up, and further research was underway to assess how this support affected maintenance of the HCL.
Sheriff & Chenoweth	

The two issues raised specifically for rural areas were improving access to services through mobile clinics, and better access to cheaper, healthy food in remote areas through community cooperatives.

Areas that were highlighted as particular concerns for women were programs to promote awareness of osteoporosis among young women, education about changes in health associated with menopause, increased access to bone density screening, and mental health problems. There were also proposals for giving more attention to the risks that women faced in the “traditional men’s health areas” of heart disease and stroke through promoting women’s understanding of the risks associated with obesity and the links between diet, exercise, being overweight and health problems.

A key means of addressing these concerns was to have more female health practitioners focusing on ageing in all health services, not only aged care. More attention to ageing was needed in tertiary education; just as the growth of courses in child development had resulted in increased numbers of well-trained staff, parallel action was needed for broad based courses in late life development that went beyond health care.

There was a unanimous view that for services to be accessible, they had to be affordable, and for many, affordability meant free at the point of use. Expanding the range of preventative services available under Medicare was a favoured approach.

6.1.5 Information and education

A great many proposals were made about the place of information and education in any program for preparing for ageing. When these proposals are considered in the light of findings on take-up of healthy ageing initiatives and the information sources that women turn to, the need to consider salience of information and the difference between information and education is apparent.

Salience

The paramount issue in addressing information is the need to recognise the salience of different kinds of information at different times. On one hand, information that is not salient to the individual’s concerns is largely disregarded, and on the other, there was little evidence that lack of information relevant to particular concerns posed a barrier to access. Salience, or the lack of it, explains many of the contradictions between different comments made about information in different sections of the survey. Lack of information was not widely identified as a general problem, nor did it appear to pose a major barrier to take-up of services as use of healthy ageing initiatives was high when eligibility, cost and other access considerations were taken into account. The priority was for better rather than more and potentially conflicting information; “better” meant accurate and standardised information, and health promotion, not sales promotion.

Salience can also explain why some respondents put forward proposals for services that already existed but which they had no reason to be aware of. Given that the survey found little evidence to show that respondents could not obtain information when they sought it, efforts to increase the provision of information could to a large extent be wasted efforts.

Active engagement in learning

More effort has to go into education in which individuals actively engage in learning rather than passive distribution of information. To this end, information strategies needed to be more differentiated so that individuals and groups can get the information they needed as and when they need it, rather than being overloaded with information that has little or no relevance to their circumstances. A multi-layered strategy is needed to make general information broadly available and provide more in-depth education sessions for those seeking more information on particular chronic conditions that were affecting their well-being. Centrelink was widely identified as the agency best placed to take the lead role in providing general information.

It was also noted that information could become outdated quite quickly and there were also variations from area to area. Because of these risks, widely distributed general information needed to include pointers on where to go for further detailed and localised advice. The main agencies through which more localised information was likely to be obtained were local government, community health services and support organizations, such as Carers' Associations.

The findings that general practitioners were the most widely used source of information calls for greater recognition of their role in strategies to promote information and education on preparing for healthy ageing. Rather than directing information only to individuals, involving spouses or partners and younger family members was proposed as a effective way of improving understanding of diet and exercise and bringing about lifestyle changes. This approach is relevant to several of the topics on which more health promotion information was needed, namely menopause, osteoporosis and falls prevention, the health consequences of obesity, diabetes, nutrition generally and specifically the benefits or otherwise of different nutrition supplements. It is also likely to be the general practitioner or another health professional who engages with other family members as well as the individual.

Research findings on nutrition supplements	Results from a national survey of 1,263 aged 65+ found women were significantly more likely to use supplements than men (52% compared to 35%), and gender was the most predictive determinant of supplement use. Self rated health status was not related to use of supplements, but the main reasons for taking supplements were associated with maintaining health and vitality and protection from illness.
AJA 11	Supplement use appears to have little to do with perceptions of dietary or nutrient adequacy, nor an attempt to compensate for poor health. Concerns arise in relation to the high use of medications in this population, particularly as only one third regularly reported use of supplements to their doctor. Poor communication was attributed to apprehension about revealing use on the part of older individuals and doctors not routinely inquiring about use, and it was concluded that health care professionals needed to take greater responsibility in this area.

6.1.6 Strategies

Rather than identifying totally new initiatives or major gaps that needed to be filled, the proposals put forward make it apparent that any healthy ageing program, or program for preparing for ageing more widely, has to proceed by building on and integrating the range of existing approaches. Such an approach is consistent with the findings of widespread knowledge and take-up of existing healthy ageing initiatives, and the wide range of sources of information already drawn on, as reported in Section 5. Five themes identified across the many proposals put forward provide some directions for any future program:

1. Healthy ageing is seen as part of preparing for ageing more widely, and within the health domain, the interaction of mental and physical well-being is widely recognised, as is the emphasis on health promotion.
2. Preparing for ageing involves a balance of individual, community and government responsibilities.
3. The time frame of preparing for ageing may be too long and too vague to prompt action; instead. As most of the actions that contribute to preparing for ageing also have more immediate benefits, the rationale needs to emphasise “be healthy now, be healthy for the future”.
4. Over the long course of preparing for ageing, there are a number of critical points at which awareness of ageing is heightened and at which women, and men, might well be prompted to review their preparation for healthy ageing on many fronts.
 - For women, menopause around age 50 provides a starting point for charting the steps to be taken in preparing for ageing in the short, medium and long term.
 - Increasingly women will be accessing their own superannuation, or doing so with their spouse, around age 60. This event provides a critical point not only for financial planning but for reviewing preparation for ageing more widely across health, housing, family and social activities. Superannuation funds and Centrelink may have a role to play in prompting such wide-ranging reviews.
 - Take-up of Seniors Cards issued by state governments is very high and the points at which cards are renewed could provide an opportunity for prompting individuals to review their preparations for ageing in different areas.
5. Information and education strategies for preparing for ageing need to be refined and strengthened to ensure a better match between different agencies and their capacities to deliver different messages to different audiences. The success of “one stop shop” Seniors’ Information Centres that provide internet access as well as hard copy information, and that offer individual and small group session on a range of aspects of preparing for ageing, makes them a model for expansion. One initiative that could be undertaken by the Office for Women in conjunction with the Office for an Ageing Australia would be to review all Commonwealth information on healthy ageing, whether in leaflet, other written or audio-visual format, and how this information is disseminated, and in consultation with relevant groups, with a view to compiling an Ageing Essentials resource kit.

The way in which the elements of a program for preparing for healthy ageing are broad together will be shaped by prevailing policy views of retirement in the context of the wider social inclusion agenda. This project has reported positive findings with regard to most aspects of social inclusion. The respondents reported overwhelmingly positive experiences in family relations, including relations between generations, in their wider social networks of friends and personal interests and in their local communities. The exceptions arose where crisis disrupted individual's expected life course transitions and normative transitions, and these disruptions could have enduring effects. Recovery from such events may need to extend beyond short term support in through the immediate crisis.

Security in a paid job for as long as women chose to work, and having a secure income in retirement were central to preparing for ageing and to on-going social inclusion. The project found considerable variation in the ways that women in the two transition groups mix roles at work, in their families and in wider social networks, and that good physical and mental health underpins all these roles, and through to the further transitions of later life. These findings are consistent with a wide range of recent research that shows the transitions of ageing to be increasingly diverse and dynamic for Australian women. A key concern in developing policies and programs for preparing for ageing is then how goals of continued participation in the workforce are to be balanced with goals of enabling women to develop other personal and social roles.

<p>Research findings on models of retirement</p>	<p>In this qualitative study conducted as part of the ALSWH, two groups of mid aged women (aged 53-58 and 65-70) participated in interviews and focus groups in which they discussed their work and family histories, and their expectations, preparations, concerns and experiences of retirement. The findings confirm the significance of a transitional stage for women in diverse family and work situations, and three models of retirement were developed to accommodate these retirement lifestyles and concerns. The gateway model described a traditional pattern of retirement; while work life ended, there was strong continuity in other activities and most passed through the gateway to retirement with relative ease. In contrast, husbands seemed to have more difficulty in adjusting even though their retirement was likely to follow this gateway model. The transition model saw women slow down, test the waters and ease out; working part time was a feature of this model as a means to achieving a better balance in lifestyle and the transitional period was used to build up life outside work. The third transformative model involved continuing work, although often different work, into retirement; some transformations were strategically planned but others were more co-incident, and this model had particular appeal for women who still working and concerned about their financial situation in retirement. The two main themes that emerged were achieving a desired retirement lifestyle with greater autonomy and control, and economic concerns that could see "the time of their lives" turn into uncertainty and fear. The different policy implications raised by the three models of retirement call for more flexible views of retirement that went beyond the work/non-work dichotomy and also a recognition that many women have little choice about work or in retirement.</p>
<p>Everingham, Warner-Smith & Byles 2007</p>	

6.2 Roles for the Australian Women's Coalition

The final part of the survey sought proposals on the roles that the Australian Women's Coalition was best placed to take in advancing policies and programs that will enable women to prepare for ageing. While identified with reference to the current project, these proposals are likely to apply to AWC roles more widely, and indeed reflect the roles taken in the many other projects in which member organizations and their individual members have participated.

6.2.1 Giving women a voice

First and foremost, the role of AWC was seen to be to give women a voice that would make policies more aware of and responsive to their needs. Consultation through member organizations is the main way in which AWC enables women to be heard and putting forward reports on consultations is its main means to ensuring that policies are inclusive of women's interests.

To be able to give voice to women's concerns and represent women's interests, respondents wanted AWC to encourage women to be actively involved in community affairs and to take responsible positions not only in women's organizations but community organizations in general.

It was also recognised that AWC and its member organizations had limited resources and that their efforts would be more effectively concentrated by tackling a smaller number of issues in greater depth than attempting to take on too many issues.

Given AWC's defined role of providing advice to government on the basis of consultation through its member organizations, it was readily recognised AWC neither could nor should try to do everything itself. Two questions that can guide decisions on which of many possible roles and issues AWC should take up are (a) which other organization are involved? and (b) what can AWC's involvement add? These questions are particularly pertinent to the roles that AWC might take in advancing the preparing for ageing project through dissemination and advocacy.

6.2.2 Dissemination

The first step in dissemination that was called for in the current project was to make this report widely available to member organizations, and through them, to individual members. Electronic distribution through AWC's website could be accompanied by a number of links to other sites with information on preparing for ageing. Consideration needs to be given to making printed copies available to members who do not have internet access.

A frequent proposal was for AWC to arrange seminars to discuss reports on projects that were undertaken and assist member organizations conduct sessions in different locations. A program of seminars of this kind, possibly delivered in conjunction with programs of member organizations, would achieve wide dissemination of project findings and provide feedback to AWC.

While there were also suggestions that AWC should develop a wider program of forums and workshops on preparing for ageing, or areas covered in other projects, its capacity to do so is limited and the more effective approach would be to provide links to activities available through agencies, such as the Councils on the Ageing and Carers' Associations. One way

in which AWC could contribute to the activities of these other organizations is to identify women involved in AWC member organization who were interested in speaking on different topics and provide a Speakers Bureau through which other organizations could find speakers for their own events.

The same considerations of capacity and expertise apply to the roles that AWC can take on in producing and disseminating written information. The strongly expressed concerns about information overload indicate that AWC should not produce further pamphlets on aspects of preparing for ageing, and this caution may well apply to other areas it tackles. Its role is instead to publicise other existing sources of information available in written form and through one to one sessions, and the AWC website is a means to this end.

The final aspect of dissemination that was sought by many respondents was feedback to members on the outcomes that projects had achieved. In providing such feedback, AWC can define the scope of its role as a consultative body and clarify the limits to its role in direct provision of other activities. With reference to the present project, AWC does not have a role in provision of education for retirement planning or health promotion. Instead, feedback should identify opportunities for member organizations to pursue such issues through other relevant organizations such as Councils on the Ageing, U3A and major support organizations.

6.2.3 Advocacy

The prime advocacy role of AWC was clearly identified as getting women's issues on to the policy agenda, with this role pursued through participation in forums, conducting consultations, making submissions and direct contact with the Minister and officials in the Office for Women.

One proposal of particular interest for strengthening AWC advocacy role was that AWC should prepare "briefs" on specific topics and circulate them to relevant government agencies and other organizations. Preparation of briefs could provide an effective means of following up larger projects and for ongoing advocacy on recommendation made, and would be an effective way of adding value to all projects that had been undertaken.

Preparation and dissemination of position statements would provide a response to the many proposals that were made urging AWC to lobby on a wide range of measures that would contribute to preparing for ageing and linking into other current policy debates. A case in point is the link between the concerns about financial security identified in the present project and wider community debate about the adequacy of the single Age Pension. Other issues on which lobbying was urged included increasing the Age Pension, affordable medication and maintaining the PBS, more preventative health measures, more research on ageing issues, and more support for carers and others. As well as providing a focus for AWC's own advocacy, position statements would also provide a resource to support AWC member organizations in their own advocacy roles for joint action with ageing organizations such as COTA.

Three specific issues were frequently identified as issues for advocacy in preparing for ageing:

- advocacy for the recognition of the value of older women for their positive roles and contributions, so that ageing is not presented purely as a problem.

- advocacy for women to have equality with men in general health programs that are currently heavily slanted towards men, such as prevention of cardiovascular disease.
- advocacy for more support for ensuring financial security for women beyond the Age Pension; this report identified a range of measures that could support women in preparing financially for ageing, with different measures required at different stages and for different cohorts of women who have had different participation in the workforce and in superannuation.

The extent to which AWC takes on an advocacy role itself or supports its member organizations to advocate, and the issues of concern that it takes up, are matters for future discussion among AWC members.

List of research studies

The research studies listed have either been published in the Australasian Journal on Ageing (AJA) since 2003, or are reports from the Australian Longitudinal Study on Women's Health (ALSWH) published in a range of journals. ALSWH surveyed three cohorts of women: at the first survey, young women were aged 18-23, mid-aged women were 40-45 and older women were 70-75. Surveys at three year intervals meant that by the third survey, the mid aged women were 47-52. As this age group corresponds with the working transition group defined in this project, the selection of papers below focuses on studies that included longitudinal data to the third survey.

Barr F & Russell C. Social capital among older residents of a coastal resort: A survey of social resources and vulnerabilities. AJA. 26, 2. June 2007. 94-96.

Brownie S & Myers S. Dietary and health supplement use among older Australians. AJA 22 4 Dec 2003. 171-79.

Byles J, Young A & Wheway V. Annual health assessments for older Australian women: Uptake and equity. ANZ Journal of Public Health, 31, 2007. 170-173.

Byles J, Powers J, Chojenta C & Warner Smith P. Older women in Australia: ageing in urban, rural and remote environments. AJA. 25, 3. Sept 2006. 151-157.

Carnicelli A, Keefe J, Martin K et al. Vision screening for older people: the barriers and the solutions. AJA. 22, 4. Dec 2003. 179-85.

Everingham C, Warner-Smith P & Byles J. Transforming retirement: Rethinking models of retirement to accommodate the experience of women. Women's Studies International Forum. 30. 2007: 512-22.

Feldman S, Byles J, Mishra G & Powers J. The health and social needs of recently widowed older women in Australia. AJA. 21, 3. 2002. 135-40.

Gardner IL, Browning C and Kendig H. Accommodation options in later life: retirement village or community living? AJA. 24, 4. Dec 2005. 188-95.

Guillemain M. Heart disease and mid-age women: Focusing on gender and age. Health Sociology Review. 13, 1. 2004. 7-13

Harris J, Giles L & Finucane P. Prevalence of coronary heart disease and cardiovascular risk factors in a sample of older Australians: Australian Longitudinal Study of Ageing. AJA 23. 1 March 2004. 25-32.

- Kruger E, Tennant M, Smith K & Peachy J. The oral health and treatment needs of community dwelling older people in a rural town in Western Australia. AJA. 26, 1. March 2007. 15-20.
- Lawlor DA, Tooth, L, Lee C & Dobson A. A comparison of the association between socio-economic position and cardiovascular risk factors in three age cohorts of Australian women: Findings from the Australian Longitudinal Study of Women's Health. J of Public Health. 24, 4. 2005: 378-87.
- Lee C & Russell A. Effects of physical activity on emotional well-being among older Australian women: Cross-sectional and longitudinal analysis. Journal of Psychosomatic Research. 54. 2003. 155-160. 155-60.
- Lind C, Hickson L, Worrall L, et al. Hearing and vision impairment and the social networks of older Australians. AJA. 22, 1. March 2003. 20-25.
- Marino R, Browning C & Kendig H. Factors associated with self-reported use of oral health services among older Melbournians. AJA. 26, 3. Sept 2007. 141-44.
- McKenna KT, Tooth LR, King DB, et al, Older patients request more information: a survey of use of written patient education materials in general practice. AJA 22, 1. March 2007. 15-19.
- Merkes M & Wells Y. Women of the baby boom generation and unpaid work – What are the indications for the future? AJA. 22, 4. Dec 2003. 186-190.
- Mishra GD, Brown WJ & Dobson AJ. Do socio-economic gradients in women's health widen over time and with age? Social Science and Medicine. 58, 9. 2004: 1585-95.
- O'Halloran J & Britt H. General practice encounters with older Australians. AJA. 23, 1. March 2004. 7-12.
- Onyx J & Baker E. Retirement expectations: gender differences and partner effects in an Australian employer funded sample. AJA. 25, 2. June 2006. 80-83.
- Orb A & Davey M. Grandparents parenting their grandchildren. AJA. 24, 3. Sept 2005. 162-68.
- Quine S, Bernard D & Kendig H. Understanding baby boomer's expectations and plans for retirement: findings from a qualitative study. AJA. 25, 3. Sept 2006. 145-50.
- Quine S & Carter S. Australian baby boomers' expectation and plans for their old age. AJA. 25, 1. March 2006. 3-8.
- Quine S, Morrell S. Perceptions of personal safety among older Australians. AJA 27, 2. June 2008. 72-77.

- Quine S, Wells Y, de Vaus D & Kendig H. When choice in retirement decisions is missing: Qualitative and quantitative findings of impact on well-being. *AJA*. 26, 4. Dec 2007. 173-79.
- Russell C, Campbell A & Hughes I. Ageing, social capital and the Internet: Findings from an exploratory study of Australian “silver surfers”. *AJA*. 27, 2. June 2008. 78-82.
- Sheriff JN & Chenoweth L. Promoting healthy ageing for those over 65 with the health check log: a pilot study. *AJA*. 25,1. March 2006. 46-49.
- Smith N, Young A & Lee C. Optimism, health related hardiness and well-being among older Australian women. *Journal of Health Psychology*. 9, 6. 2004. 741-752
- Snodgrass S & Rivett DA. Perceptions of older people about falls injury prevention and physical activity. *AJA*. 24, 2. June 2005. 114-118.
- Steed L, Boldy D, Grenade L, Iredell H, The demographics of loneliness among older people in Perth, Western Australia. *AJA*. 26, 2. June 2007. 81-86.
- Warner-Smith P, Powers J & Hampson A. Women’s experiences of paid work and planning for retirement. Report to the Office for Women, from the Australian Longitudinal Study of Women’s Health. FHCSIA. 2007.
www.ofw.facsia.gov.au/publications/experiences_planning.htm
- Warner-Smith P & Mishra G. ‘Happy hours’: Women’s well-being and their satisfaction with paid work. *Health Sociology Review*. 11, 1 & 2. 2002: 39-48.