Global Ageing: Implications for Women

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Never before have so many people lived so long. Ageing has not yet been defined as an issue in many developing countries, but already two thirds of the net annual increase in the number of older women in the world is occurring in less developed countries. The key features are an increasing life expectancy and increasing proportion of the population who are elderly, the ageing of the older population itself, and the great diversity in ageing between countries, in particular, the rapidity of ageing in developing countries and newly industrialised countries.

The implications for women are considerable since women are more likely to survive to older ages, are more likely to be economically disadvantaged, and because they assume most of the burden of care of infirm elderly people. Changes in the life course of ageing women have significant implications and their health status reflects the compounding effects of age and gender differences as well as the cultural context in which ageing occurs. As yet, there is no clear evidence that women's greater life expectancy has any significant advantage in the proportion of remaining years lived free of disability. The multidimensional determinants of health of older women mean that strategies to improve and maintain health must also address their disadvantaged status. J Epidemiol, 1996; 6: S219-S223.

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Ageing of the population is one of the most significant changes to the social landscape in what remains of this century and the early decades of the next. Increasing emphasis is being directed at concerns of the elderly population and the impact of this small, but growing segment of the population on health services, community services, and the ability of families to provide the care required by those who reach advanced ages in a state of frailty. An emphasis on the quality of life and the related concept of healthy ageing deserves attention. Surveys repeatedly indicate that quality of life in old age is directly related to economic security, psychosocial well being, as well as a sense of being in reasonably good health.

However, each of these qualities reflect prior life long experience, and each impact differently on men and women. In the struggle to bring to the forefront issues related to the elderly, there is a real risk of ignoring the special and unique characteristics which women bring to the ageing experience. Often the special concerns of ageing women are relegated to a scant reference to the greater proportion of women in the "oldest old" categories, or to the greater proportion of women who are widowed, compared with men. In addition, the health of women who are ageing now is in many ways different to that of those who are already older. Ageing has not yet been defined as an issue in many developing countries, but already two thirds of the net annual increase in the number of older women in the world is occurring in less developed countries.

POPCULATION AGEING

The extension of later stages of the lifespan that comes with population ageing in developed countries differs from that of developing countries. The extended time of widowhood in developed countries is also greater - 12 years compared to four. These life course transitions bring major restructuring of family relationships and social roles of ageing women. In developed countries, these roles are well established but are under-
going change. Even more so in developing countries, traditional roles of older women are being overtaken and new norms have yet to emerge. As these impacts will be felt increasingly into the future, particular attention needs to be given to the future cohorts of ageing women, those currently aged from 50 to 60 years.

Most of the world's ageing women are living in developing regions of the world. Already, more than half of the world's women aged 60 years and over live in developing regions, 148 million, compared to 121 million in developed regions (Figure 1).

The future growth in the numbers and proportion of ageing women in developing countries in the future is foreshadowed in the distribution of those now aged 45 to 59 years. Two thirds of the women in this age group, 213 million, live in developing countries and one third live in developed countries, 98 million. The imminent large increase of older women in China and India and other Asian countries is particularly conspicuous.

**DIFFERENCES IN LIFE EXPECTANCY**

Population ageing is accompanied by a greater life expectancy at birth and at older ages for women than for men, although the gap is closing at older ages. In developed countries, women live, on average about six years longer than men ⁹.

Differences in life expectancy between women in countries at different levels of development have received less attention. These differences are in fact greater than differences between men and women within developed countries. Women in developed countries live some 15 years longer than women in middle income developing countries and as much as 30 years longer than women in the poorest countries where life expectancy is as low as 50 years of age ⁸. The disparity in life expectancy of women in rich and poor countries has improved only a little over the past 20 years, and these differences in women's life expectancies represent major inequities that must be addressed (Table 1).

Future cohorts of older women will be very different to the current generation. A cohort approach which follows each particular generation or age group over time, is essential for developing social and health policies for women as they age. Encouraging each cohort to consider its own future health is an important means of altering policies for health promotion to these different problems and potentials. Cohort shifts can take place rapidly. For example, in Japan shifts to separate living arrangements for older people have occurred very quickly as the desire to retain an independent life becomes a preferred, and increasingly feasible, option. Sustaining this trend will require the development of more options for housing for inde-

| Country     | Life expectancy at birth, 1991 | Increase in life expectancy 1970-91 |
|-------------|--------------------------------|------------------------------------|
|             | Female | Male | Female | Male |
| Bangladesh  | 52     | 53   | 8      | 7    |
| India       | 60     | 60   | 11     | 10   |
| Philippines | 67     | 63   | 8      | 7    |
| Korea       | 73     | 67   | 11     | 9    |
| Australia   | 80     | 73   | 5      | 5    |
| Japan       | 82     | 76   | 7      | 7    |

Figure 1. Distribution of the world's older women (millions) in developing and developed countries, by age group.
dependent elderly women and for care arrangements for those who become dependent. Providing independent living options within a larger supportive environment will be an important means of promoting wider social involvement.

The changes in the life course of ageing women and the diversity of experience of later life, have significant implications for the health of ageing women. Above all, the greater life expectancy for women in developed countries sets the basic goal for strategies for the health of ageing women globally, namely to reduce the inequities in life expectancy of women in developed and developing countries. These inequities are not measured simply in the number of years of life, but reflect underlying inequities in the determinants of health and the quality of life that must be addressed if life expectancies are to be improved. As yet there is no clear evidence that women’s greater life expectancy has any significant advantage in the proportion of remaining years lived free of disability. If longer lives for women are to be healthier lives, policies must be directed to ensuring the quality of life of women as they age.

HEALTH PRIORITIES FOR WOMEN AS THEY AGE

The criteria adopted for defining a health issue as a priority for ageing women cover three dimensions:

- The scale of the problem means it is of major significance in both developed and developing countries, of high prevalence in women over age 50 compared with younger women, and of greater impact in ageing women than men.
- The nature of the problem is such that it has a progressive impact on women as they age if not addressed; and is amenable to prevention and self care management.
- The presentation of the problem is overstated in some cases, under-rated in others, or generally under researched; often at risk of over medicalisation or inappropriate interventions; and already recognised in some countries, but requires a greater focus on ageing women.

When these criteria are applied to a wider range of health problems, a number of conditions are identified: major preventable conditions such as heart disease, stroke and cancer; as well as communicable diseases, especially in developing countries; major chronic disabling conditions such as musculo skeletal conditions, osteoporosis, and incontinence; and mental health including depression and dementia.

As the major preventable conditions all develop over extended time periods, primary prevention strategies will be most effective when initiated as early as possible. These strategies are also applicable to older women, and where problems are already apparent at older ages, secondary prevention and self care strategies are also relevant. The initiation of preventative strategies in mid-life provides the most effective means of reducing chronic disability in older women. Where problems are already apparent at older ages, secondary prevention can still have a major impact on reducing the disabling effects of chronic illnesses.

There are common factors contributing to each of the priority conditions affecting the health of ageing women. It follows that broad based strategies that address these common causes will have far more widespread and beneficial outcomes than specific disease focused strategies. The adverse effects of smoking, poor nutrition and poor physical fitness, due either to lack of exercise or the damaging effects of excessively arduous physical labour, have been repeatedly identified as causes of the major health problems. Preventive population strategies directed to these areas would achieve positive outcomes in several problem areas simultaneously.

Even in the developing countries, the major health problems of older women stem from non-communicable diseases. Primary and secondary prevention strategies offer several advantages in addressing these health problems. First and foremost, they give women the opportunity to avoid many health problems that might otherwise arise as they age, and to be involved in managing the problems they do experience. Second, they provide low cost, population wide means of reducing the prevalence of sickness and disability in the future. Third, they present an orientation to health that ageing women can identify with and participate in, whether at an individual level, a community level, or a wider policy level. Primary health care approaches emerge as the most feasible and valid approach in both developed and developing countries.

SOCIAL DETERMINANTS OF OLDER WOMEN’S HEALTH

The major health problems of ageing women stem from economic, social, cultural and political factors, as well as biological factors (Figure 2). The poorer health status of women compared to men and older people compared to younger people is attributable to multiple disadvantages in these areas. The health status of ageing women reflects the compounding effects of these age and gender differences. These factors are in common in developed and developing countries but there are variations in their effects.

For example, lack of financial autonomy and reliance on children places older women in some countries, in rural areas in particular, in a dependent position. Increasing urbanisation contributes to deteriorating living conditions of both ageing women who have been left behind in rural areas to face increasing responsibility for cultivation of crops, and those who migrate to urban areas only to find traditional roles and reciprocal support no longer available to them. At the same time, the established urbanisation of younger women is creating future cohorts of ageing women in urban settings who will have a different set of needs.
Three social determinants have significant effects on the health of ageing women. The first, education and literacy, is the product of earlier life experience. The second and third are major and widely experienced events that occur in the later life course: the likelihood of caring for a disabled spouse or relative, and widowhood. These experiences can be regarded as normal in so far as there are social and cultural norms governing roles and expectations. These events can have both positive and negative impacts on health, and the individual experiences of older women vary widely even within the same society.

**WOMEN, CAREGIVING, AND CHANGING FAMILY STRUCTURES**

A striking feature in all countries is the proportion of older women who are carers: many older women not only look after other older people, but often care for younger people. It is evident that "family care" generally means women's care. It is the relative absence of family support for older women in developed countries that underlies their higher rates of use of residential care. Support within the family largely rests on the spouse; ageing women are more likely to care for their older husbands than the reverse. When a spouse is unavailable, it is largely women, usually adult daughters and daughters-in-law, who fill this role; many of these women are themselves aged 50 years and over, caring for parents, usually mothers, who are in their late 70s or 80s. Ageing women also act as caregivers for disabled adult children and for younger children.

Ageing women everywhere are far more likely to be widowed than older men, but some countries have greater numbers of widowed women than others. Although most women can expect widowhood as part of their normal adult life, few are prepared for this role. The vast majority of ageing women in developing countries live in extended family households, although growing mega-cities which give rise to urban slums, often results in the lack of support by extended families. While giving access to family support and the opportunity to contribute to the household in practical ways, this situation can result in dependency on the younger family members.

**PREVENTIVE STRATEGIES**

Strategies directed at major preventable health problems of ageing women need to recognise that heart disease and stroke are priorities for ageing women as much as for ageing men; smoking is as much an issue for future cohorts of older women as current cohorts, and as much an issue for developing countries as developed countries; cervical cancer and breast cancer are priorities for older women as much as younger women; non-communicable diseases are the major problems of health of older women in developing countries as well as in developed countries; and communicable diseases are continuing problems for older women in developing countries.

Broad based preventive programmes are encouraged that will simultaneously address several priority health areas by way of the development of preventive strategies for non-communicable diseases - heart disease and stroke in particular - by supporting nutrition programmes and encouraging improved physical fitness as integral to healthy ageing; in developing countries this means reducing the adverse effects of hard physical labour, and in developed countries, it means promoting exercise and making information on other self-care activities available. Global efforts to halt the spread of the tobacco related epidemics in developing countries and the introduction of comprehensive legislation controlling cigarette smoking are essential.
CONCLUSION

Women's experience of ageing and their health status as they age will be profoundly influenced by the cultural context in which this occurs. Attitudes of others towards older women, attitudes of ageing women towards themselves and attitudes towards menopause and ageing in women all influence expectations of health in later years. Fostering positive attitudes to ageing women is critical to maintaining positive public policies. The benefits for mental and physical health that flow from these outcomes in turn enable continuing personal development and involvement in the wider society. The multi-dimensional determinants of health of older women mean that any strategies to improve and maintain health must be equally broad based. Multisectoral action is required not only to address the disadvantaged status of many ageing women, but also to recognise and support their continuing contributions, taking account of changing social situations in both developed and developing countries.

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