

Women's health priorities and perceptions of care: a survey to identify opportunities for improving preventative health care delivery for older women

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Abstract

Background: women live longer than men but consistently report poorer health status and health-related quality of life. Information is scarce on what components of care women desire to help them meet the challenges of their later years.

Objectives: to identify older women's priorities for maintaining physical, emotional and social well-being in later years and to measure the extent to which women perceive that these priorities are being met by the health care system.

Methods: a cross-sectional survey of community-dwelling women aged 55–93 years old ($n = 609$, mean age 70). Women attendees of outpatient medical clinics were invited to fill out a written questionnaire on health priorities and perceptions of care. Mismatches between the care that women desired and the care they perceived to be receiving were identified. Predictors of unmet priorities were evaluated.

Setting: the Greater Montreal Area in Quebec, Canada.

Results: in general, respondents were more concerned about preventing disability than with developing certain diseases later in life. Women prioritised feeling validated in the health care relationship and having their health care provider see them as a whole person. Deficiencies in addressing memory loss, preserving mobility and function and treating urinary incontinence were highlighted. Women aged 75 years and older were less likely to perceive that their priorities were unmet compared to women aged 55–74 years (OR 0.571; 95% confidence interval 0.404–0.808), when adjusting for other socio-demographic and health variables.

Conclusions: Opportunities exist to improve the preventive health care that women are receiving to promote healthy ageing. Women aged 55–74 should especially be targeted for interventions to prevent disability in later life.

Keywords: women, healthy ageing, health promotion, health services, priorities

Introduction

Women live longer than men, but consistently report poorer health status and health-related quality of life in later years [1–7]. The reasons for this sex discrepancy remain unclear, although sub-optimal health promotion strategies for older women, inequities in social status, and discriminatory health care delivery may all play a role

[1, 7–12]. Evidence suggests that gaps in medical care for older women exist for many disease states; for instance, older women receive fewer interventions for secondary prevention of heart disease and stroke compared to men [13–15]. Women's psychosocial requirements for health may also be inadequately addressed. Findings from a nationwide survey of the American population indicate that women are twice as likely as men to perceive that

physicians talk down to them during clinical encounters (25% *vs* 12%) and to be told that their problems are 'in their heads' (17% *vs* 7%) [10]. Owing to difficulties in communication, women change physicians more frequently than men (41% *vs* 27%) [10]. It has also been found that clinicians are more likely to attribute women's symptoms to 'over-anxiousness', even in the presence of positive test results indicating an organic disorder [16]. Women's move towards alternative health care as a reaction to the 'medicalisation' of women's health [17, 18], and women's diminished compliance with medical therapy [19] are potential fallouts from this situation that could be contributing to women's poor self-rated health status.

Few studies have sought women's input on the health determinants and components of care older women believe to be important for achieving health. Knowledge of women's health priorities is critical for evaluating whether 'mismatches' between what women want or need, compared with what women are getting from the health care system, could underlie some of the health disparities in this population. Information is lacking on whether older women believe that health care systems are providing them with sufficient resources to appropriately meet the physical and mental challenges of their later years. More favourable health outcomes may be achieved if older women's preferences and concerns are incorporated into their health care experiences; this has been titled patient-centred care [20–24]. A number of randomised controlled trials and analytic studies of physician-patient communication have demonstrated a relationship between patient-centred care and patient outcomes, including patient satisfaction, emotional health, symptom resolution, function, physiologic measures (blood pressure and blood sugar levels) and pain control [22, 23]. Although the majority of these studies were conducted with younger women, it seems reasonable to posit that potential benefits on health outcomes obtained from patient-centred approaches to care in women could be extended to an older female population.

The aims of this study are to identify older women's health priorities for promoting physical, psychological and social well-being, and to determine the extent to which older women perceive that their health priorities are being addressed. This information is important for identifying deficiencies in care and for formulating strategies to improve health and health care delivery for the expanding population of ageing women in our society.

Methods

A survey of health priorities and perceptions of care was conducted among community-dwelling women aged 55 years and older in the Greater Montreal Area in Quebec, Canada.

Subjects

All female community residents aged 55 years and older who were fluent in English or French, who were consumers of health care resources, who were literate and capable of expressing their health priorities were targeted for inclusion in the study. Women who required institutional care or who were sufficiently debilitated either physically or cognitively to require a proxy respondent to answer the self-administered written questionnaire were not eligible. Although we were primarily interested in women aged 65 years and older, we included women aged 55–64 in the sample to compare the effect of age on health care priorities and to determine whether perceptions of care change with advancing decades.

In order to sample a heterogeneous group of women, survey participants were recruited from three geographically distinct health care sites located in the Greater Montreal Area in Quebec, Canada. These sites were (a) the ophthalmology clinics of a university-affiliated tertiary care hospital-centre located in a culturally diverse residential area on the island of Montreal (the Sir Mortimer B. Davis Jewish General Hospital, a McGill University Hospital); (b) the outpatient clinic registration area of a rural non-university affiliated primary care hospital located on the South Shore off the island of Montreal (the Centre Hospitalier Anna Laberge); and (c) a private general rheumatology practice located in the downtown Montreal area (the Rheumatic Disease Centre of Montreal). These sites and specialties were chosen because they are frequently consulted by older women (ophthalmology, rheumatology), and seeking care for such problems (i.e. visual impairment, osteoarthritis) is common and likely independent of the presence of other gender-related health conditions. This is particularly true in Canada where there is universal access to health care. It was anticipated that this combined group of subjects would comprise a good representation of the spectrum of health perceptions, independent of financial considerations. Ethical approval from the McGill University Institutional Review Board and the respective ethics committees at the different hospital sites was obtained prior to study commencement.

All consecutive female attendees at the recruitment sites (patients, spouses of patients or companions) were approached by a research assistant and invited to participate in a women's health survey from May 2002 to September 2002. Research assistants rotated sites according to a fixed schedule so that all sites would be equally represented. After written informed consent was obtained, participants completed a self-administered written questionnaire and returned it in a sealed envelope.

Response rates

Approximately 2500 women were approached to participate in the study, but only 1000 women consented to receive the questionnaire. No socio-demographic data

was collected on subjects who refused to participate. Among the women to whom questionnaires were distributed, 609 women (60%) completed and returned the questionnaire in its entirety. Response rates were higher from the Rheumatic Disease Centre of Montreal (106/147, 72%) and the ophthalmology academic clinics (299/433, 69%) than from the rural, non-academic outpatient clinics (204/405, 50%). Baseline characteristics, health and functional status of the ≥65-year-old sample of women are presented in Table 1. Normative data for Quebec and Canadian women are listed to evaluate the representativeness of the sample. Comparison of our study sample with expected population norms shows similar health status and health-related quality of life, but higher levels of education, functional limitation, and medication usage in our subjects. Participants from the Rheumatic Disease Centre reported poorer health status and a higher prevalence of functional disability compared to the other two groups (data not shown), but otherwise the patients were similar from all three recruitment sites.

Measures of health perceptions

Health priorities and perceptions of care were measured through the use of a written questionnaire that was self-administered at one point in time. Health priorities were divided into disease-related priorities (8 items), disability-related priorities (8 items) and psychosocial-related priorities (8 items) according to findings from qualitative focus group studies with community-dwelling women [25] and content validation by an independent group of subjects. Disease-related priorities were defined as the age- and sex-related diseases for which evidence-based screening techniques are available to detect these diseases or their risk factors (breast cancer, heart disease, stroke, Alzheimer’s

disease, colon cancer, hip fracture, diabetes, pneumonia – for which preventive influenza and pneumococcal vaccines are available). Disability-related priorities were defined as the conditions for which preventive management strategies are available to curtail the symptoms or negative effects of common age-related phenomena (urinary incontinence, muscle weakness, falls, memory problems, vision loss, pain, mobility problems, depression). Psychosocial-related priorities were defined as the issues for which women seek information, education or reassurance for anxieties associated with ageing (expectations for normal ageing, end-of-life issues, exercise and nutritional counselling, resources for social services, medication side-effects, spending enough time with the health care provider, and validation during the health care experience).

Respondents were asked to gauge their level of concern (greatly, somewhat, a little, or not at all concerned) for developing the different diseases listed, and to indicate the degree of importance they assign to preventing different disabilities and including different psychosocial priorities in their care (very, somewhat, a little, not at all important). An even number of categories (4) was chosen for the Likert scale so as not to allow a neutral position and to force respondents to commit themselves to one side or the other. Women were then asked to indicate whether or not they were receiving the screening techniques, counselling, and other components of care from their health care providers to specifically address all the different health priorities (yes/no). Women were defined as having certain priorities if they indicated that items were ‘very important’ or ‘somewhat important’ to them (as opposed to ‘a little bit important’ or ‘not at all important’). Comparison of women’s stated priorities with their perceptions of the care received to address each of these priorities (yes/no) allowed a match – or mismatch – to be calculated between care desired and perceived care received. Women who indicated that a certain item was a priority for them, and who perceived that care was not being delivered to address this priority, were labelled as having an ‘unmet priority’ for this item. Health status was measured using the Measuring Outcomes Study: Short-Form-12 (SF-12) survey and the EQ-5D [2, 26–29]. Standard questions on age, living arrangements, language, culture, highest educational qualification, lifestyle habits, medical history and medication usage were also included.

Table 1. Representativeness of the study sample of women aged 65 (*n* = 408) and older in comparison to normative data for Canadian women aged 65 and older

	Study sample	Normative data
Lives alone ^a	37%	40%
University education ^a	28%	10%
Perceived health status*		
Excellent	5%	11%
Very good	34%	25%
Good	40%	42%
Fair	18%	19%
Poor	3%	3%
Functional limitation ^a	48%	20%
SF-12 ^b		
Mean physical summary (PCS)	42.1	43.7
Mean mental summary (MCS)	51.1	53.7
EQ-5D mean thermometer rating ^c	72.4	71.9
Medication use ≥7 drugs/day ^d	16.5%	5.6%

^aNormative data for women [48].

^bNormative data for women [2].

^cNormative data for *men and women* [49].

^dNormative data for women [50].

Sample size and statistical analysis

Data from the completed questionnaires was entered on the computer and checked for accuracy and errors. Statistical analyses were conducted using the SAS software package (version 8.2, SAS Institute, Cary, NC). Baseline characteristics of the study sample were compared using χ^2 analysis and analysis of variance to determine whether there were any differences according to age group. The main analysis then comprised estimating the proportion of women with various health priorities and perceptions of care. Based on mismatches between stated priorities

and care received, proportions of women with unmet priorities were calculated. Analysis of variance was used to evaluate the effect of age on individual unmet disease-related, disability-related, and psychosocial-related health priorities. With a total sample size of 609, and with greater than 150 subjects in each age group of interest (55–64, 65–74, 75+), the probability that the proportions estimated are within 8% is 95%. Significance was determined at the $P < 0.05$ level.

To estimate the impact of age, health status, functional limitation, and health care utilisation on the probability of perceiving that health priorities were unmet, we defined our dependent variable as the proportion of priorities that were unmet for each individual. We chose to use this definition to obtain a normal distribution for the outcome and to account for the total number of priorities identified by each subject. Women who did not identify any priorities were excluded from the analysis. We first explored the relationship between our dependent variable and each independent variable of interest using linear regression models. For example, linear models using proportions of unmet priorities and age as continuous variables yielded a significant beta estimate for age ($\beta = -0.374$, $P = 0.0002$: women's unmet priorities decreased by 3.7% for every decade increase in age), however, the clinical relevance of this model was difficult to interpret.

To facilitate the interpretation of our findings, we categorised our outcome in an ordinal fashion according to the quintiles of the distribution for proportions of unmet priorities in our sample (30.8, 47.1, 56.3, 66.7), and used proportional odds ordinal regression to evaluate the effect of different covariates of interest on the probability of perceiving that a greater proportion of priorities were unmet [30]. Using the quintiles as cut-points, an odds ratio for each of the covariates of interest was calculated for each cut-point, and the consistency of the odds ratios across different cut-points was verified by inspection and a test for homogeneity (χ^2) of the cumulative odds ratio. Covariates included age, living alone, language, educational level, functional limitation, perceived health status, the physical component summary score of the SF-12 (PCS-12), the mental component summary score of the SF-12 (MCS-12), having a family doctor as the primary health care-provider, and indicators of frequent health care use (heart disease, emergency room visits and admissions to hospital in the past year). In general, variables were coded so that a higher value indicated more of the characteristic being measured (0 *vs* 1). For binary variables, a baseline value of 0 referred to the absence of a certain characteristic (i.e. no functional limitation, does not live alone), or, in the case of language, French was coded 0 and English was coded 1. Age was originally divided into 3 categories (55–64, 65–74 and 75+, with the youngest age category being used as the reference), but as the probability of perceiving that a greater proportion of priorities were unmet was not significantly different between the 55–64 and 65–74 year age groups (OR 1.122, 95% CI 0.786–1.602), these two groups were combined.

Perceived health status was divided into 2 categories (excellent, very good and good *vs* fair and poor), and was coded 0 and 1 respectively. The basic analytic strategy was to regress the outcome variable on each of the covariates listed above, and then build multivariate models adjusting for possible confounders [variables that were significantly ($P < 0.1$) related to the outcome as well as the variable of interest in univariate tests]. Highly correlated variables (functional limitation and PCS12, Pearson's correlation coefficient $r = -0.81$) and variables that were causally linked (emergency room visits and admissions to hospital) were not included in the same models.

Results

Characteristics of the study sample by age group are presented in Table 2. The frequency of the various disease-related priorities, disability-related priorities and psychosocial-related priorities for all women in the sample are shown in Figures 1, 2 and 3 respectively. Corresponding perceptions of health care providers' performances in addressing or meeting these priorities are illustrated for each item.

Vision loss, mobility problems, knowledge of medication side-effects, being seen as a whole person, and spending adequate time with the doctor, were the most frequent health priorities identified by the women. Physicians' performances in addressing women's priorities were perceived as strongest in the areas of screening for cardiovascular disease and breast cancer and in providing

Table 2. Characteristics of the study participants according to age group

	Age 55–64 <i>n</i> = 201	Age 65–74 <i>n</i> = 226	Age 75+ <i>n</i> = 182	<i>P</i> -value
Marital status				<0.0001
Never married	8%	8%	6%	
Married	63%	62%	42%	
Widowed	12%	21%	46%	
Divorced	17%	10%	5%	
Lives alone	22%	32%	43%	0.0003
Language				0.0008
English	42%	51%	59%	
French	57%	46%	36%	
Other	0.6%	3%	5%	
Education				
Completed high school	80%	73%	66%	0.021
Completed university	47%	30%	24%	<0.0001
Current smoker	14%	6%	5%	<0.0001
Functional limitation	41%	46%	49%	0.342
Perceived health status				0.070
Excellent	8%	6%	4%	
Very good	36%	39%	28%	
Good	36%	39%	40%	
Fair	17%	14%	24%	
Poor	1%	3%	4%	
Mean PCS-12	44.3	43.6	40.4	0.0042

Table 2. (Continued)

	Age 55–64 <i>n</i> = 201	Age 65–74 <i>n</i> = 226	Age 75+ <i>n</i> = 182	<i>P</i> -value
Mean MCS-12	50.7	51.1	51.0	0.927
Identified family doctor as main MD	75%	79%	80%	0.459
Heart disease	11%	22%	27%	0.0012
Diabetes	13%	16%	12%	0.538
Visited the ER in the past year	33%	33%	39%	0.351
Admitted to hospital in the past year	19%	20%	22%	0.709
Mean number of priorities (max 24)	16.2	15.9	14.5	0.029
Disease-related (Max 8)	2.3	2.8	2.3	0.098
Disability-related (max 8)	6.4	6.0	5.6	0.096
Psychosocial-related (max 8)	6.5	6.6	6.2	0.032
Mean number of unmet priorities (max 24)	7.6	7.7	5.9	0.0002
Disease-related (max 8)	0.8	0.8	0.6	0.026
Disability-related (max 8)	2.4	2.4	2.0	0.086
Psychosocial-related (max 8)	4.2	4.3	3.1	<0.0001
Mean proportion of unmet priorities				
Disease-related	51.6%	51.7%	44.9%	0.0013
Disability-related	34.6%	32.7%	26.0%	0.0501
Psychosocial-related	74.4%	74.2%	58.8%	0.0005

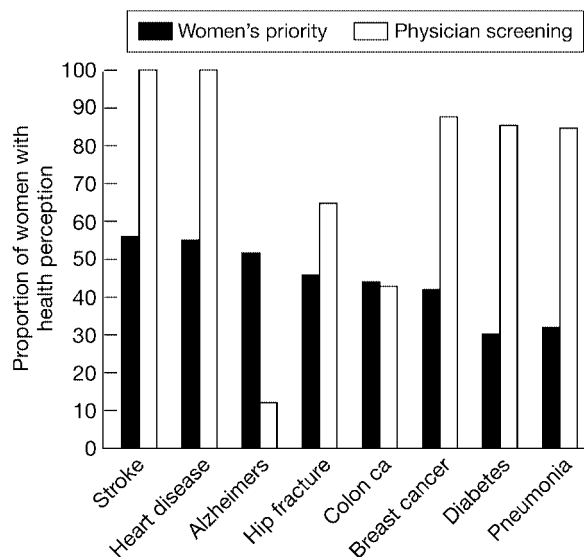


Figure 1. Prevalence of disease-related health priorities and perceptions of physician screening.

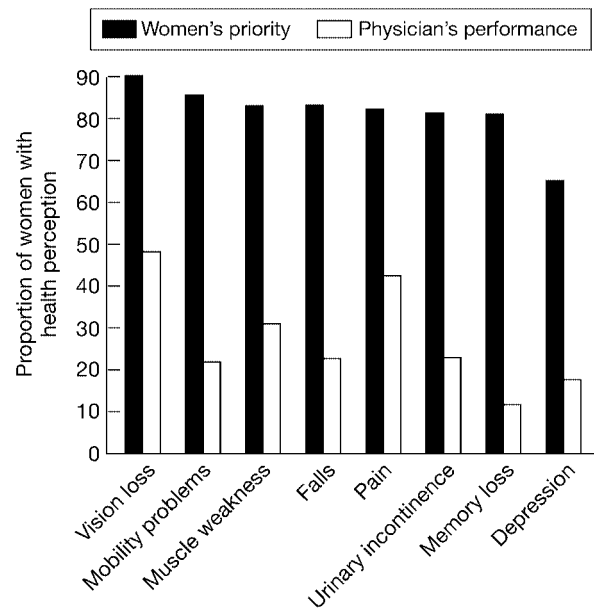


Figure 2. Prevalence of disability-related priorities and perceptions of physician counselling.

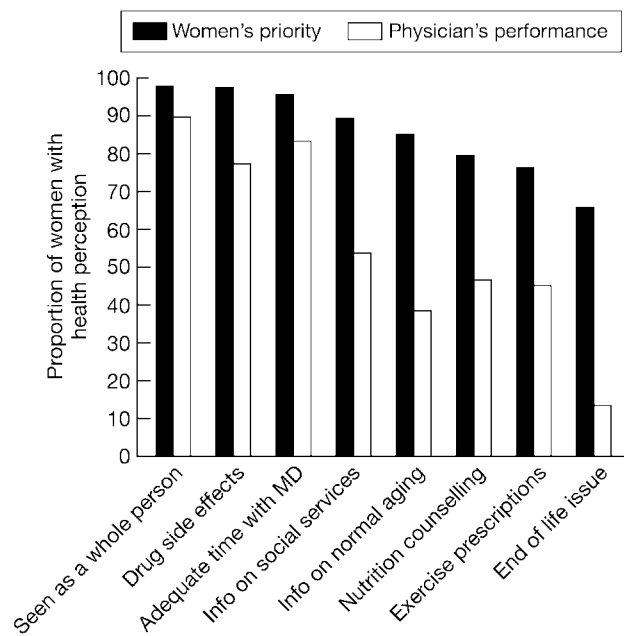


Figure 3. Prevalence of psychosocial-related health priorities and perceptions of physician's performances.

women with feelings of validation and information on medication side-effects and health resources. Physicians were perceived as being weakest in administering screening tests for Alzheimer's disease and memory loss, screening for depression and counselling on end of life issues.

Figure 4 shows the top ten unmet health priorities identified by women in this study. A higher proportion of women aged 55–74 perceived deficiencies in meeting priorities compared to women aged 75 and older. The most

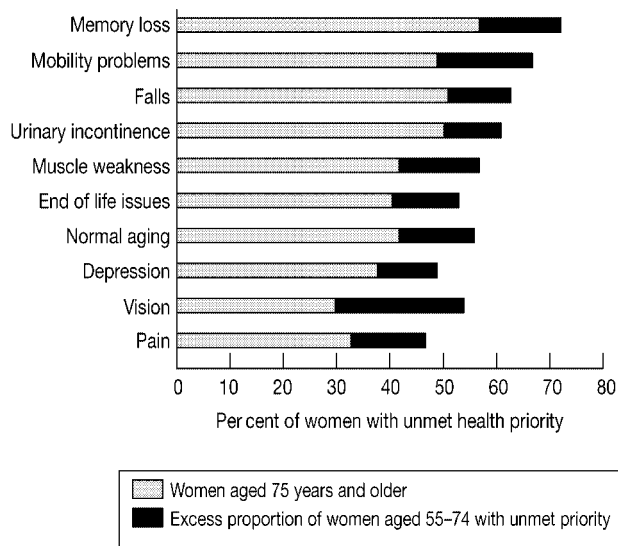


Figure 4. Proportion of women with the top ten unmet priorities by age group: younger women aged 55–74 years have an excess of unmet priorities compared to women aged 75 years and older. *All differences are significant at the $P < 0.01$ level with chi-square test for proportions.

common unmet priority was screening and reassurance about memory loss. Both the older and younger groups had similar frequencies of unmet priorities, except for fall prevention, expectations for normal ageing, and pain control, which were more commonly identified by women aged 75 years and older.

Increasing age, living alone, the presence of functional limitations, worse physical health status (PCS-12 score), identifying a family doctor as the main health care provider, and indicators of frequent health care use (heart disease, emergency room visits and admissions to hospital in the past year) were all significantly ($P < 0.1$) associated with a lower probability of perceiving that health priorities were unaddressed in univariate ordinal regression models (Table 3). In multivariate models, only increasing age, living alone, identifying the family doctor as the main care provider and having been admitted to hospital in the past year remained independently associated with a lower probability of perceiving that health priorities were unmet when adjusted for other confounding and related variables (Table 3).

Discussion

Older women in our study prioritised health maintenance strategies that were critical to improving and sustaining function and quality of life. Women were more concerned, in general, with living with disabilities than with developing common diseases. They also placed a high value on feeling validated by the health care team, and on actively participating in health promotion. Although participants reported that their physicians were good at ‘seeing

Table 3. Cumulative odds ratios associated with individual predictors on the probability of perceiving that a greater proportion of health priorities are unmet

Predictors	Odds ratio (95% CI)
Age (75+ versus 55–74)	
Crude	0.553 (0.396–0.772)
Adjusted for living alone	0.581 (0.415–0.814)
Adjusted for living alone, functional limitation	0.571 (0.405–0.805)
Adjusted for living alone, admitted to hospital	0.588 (0.419–0.827)
Adjusted for living alone, functional limitation, admitted to hospital	0.571 (0.404–0.808)
Living alone	
Crude	0.571 (0.413–0.790)
Adjusted for age	0.612 (0.439–0.853)
Adjusted for age, functional limitation	0.594 (0.423–0.834)
University education	
Crude	1.270 (0.922–1.749)
Adjusted for age	1.168 (0.843–1.619)
Language (English versus French)	
Crude	0.875 (0.645–1.189)
Adjusted for age	0.946 (0.692–1.294)
Adjusted for living alone	0.875 (0.644–1.189)
Adjusted for functional limitation	0.882 (0.646–1.204)
Functional limitation	
Crude	0.715 (0.525–0.973)
Adjusted for age	0.735 (0.538–1.004)
Adjusted for age, living alone	0.769 (0.562–1.053)
Adjusted for age, family doctor	0.688 (0.502–0.943)
Adjusted for age, ER visits	0.757 (0.549–1.042)
Adjusted for age, hospital admissions	0.814 (0.591–1.122)
Adjusted for age, heart disease	0.781 (0.565–1.079)
Perceived health status (poor, fair versus good, very good, excellent)	
Crude	1.008 (0.693–1.465)
Adjusted for age	0.948 (0.648–1.387)
Adjusted for age, ER visits	0.848 (0.573–1.255)
Adjusted for age, hospital admissions	0.842 (0.570–1.244)
Adjusted for age, heart disease	0.881 (0.596–1.301)
Identified family doctor as main doctor	
Crude	0.666 (0.463–0.959)
Adjusted for age	0.630 (0.434–0.916)
Adjusted for functional limitation	0.652 (0.444–0.958)
Heart disease	
Crude	0.681 (0.466–0.994)
Adjusted for age	0.705 (0.480–0.916)
Adjusted for age, functional limitation	0.753 (0.503–1.127)
Adjusted for age, visits to ER	0.765 (0.516–1.133)
Adjusted for age, hospital admissions	0.803 (0.543–1.188)
Adjusted for age, functional limitation, hospital admissions	0.830 (0.551–1.250)
Visited ER in past year	
Crude	0.682 (0.495–0.940)
Adjusted for age	0.742 (0.536–1.076)
Adjusted for age, functional limitation	0.777 (0.555–1.089)

Table 3. (Continued)

Predictors	Odds ratio (95% CI)
Adjusted for age, heart disease	0.772 (0.554–1.074)
Adjusted for age, heart disease, functional limitation	0.797 (0.566–1.21)
Admitted to hospital in past year	
Crude	0.456 (0.310–0.672)
Adjusted for age	0.481 (0.324–0.713)
Adjusted for age, functional limitation	0.512 (0.339–0.774)
Adjusted for age, heart disease	0.498 (0.334–0.742)
Adjusted for age, heart disease, functional limitation	0.523 (0.345–0.793)
PCS-12 (change of +1)	
Crude	1.018 (1.004–1.033)
Adjusted for age	1.015 (1.000–1.030)
Adjusted for age, hospital admissions	1.009 (0.994–1.024)
MCS-12 (change of +1)	
Crude	0.911 (0.779–1.065)
Adjusted for age	0.991 (0.976–1.007)

them as a whole person’ and at screening for diseases, most women identified a number of additional areas where improvements could be made to optimise health and reduce their anxieties about ageing. Specifically, reassurance about what constitutes normal memory loss with age, and strategies to preserve mobility, prevent falls, treat urinary incontinence, and maintain muscle strength and function, were highlighted as being particularly desirable.

Women younger than 75 years of age were more likely to perceive deficiencies in having their disability-related priorities met compared with women aged 75 years and older. This may reflect the fact that 60-year-old women are generally not targeted for interventions to pre-empt the classical geriatric syndromes such as falls, incontinence and frailty. However, women’s concern for preventing functional decline during the earlier postmenopausal years could be viewed as a window of opportunity to begin preventive care early and engage younger mature women in lifestyle changes that support healthy ageing. Our respondents reported that less than 50% of physicians regularly counselled them on exercise and nutrition. The benefits of a combined regimen of aerobic exercise, strength training, and balance training for preserving function and improving mobility, as well as for preventing heart disease, are well documented [31–34]. Behavioural interventions with pelvic floor exercises have been shown to effectively reduce and even cure urinary incontinence [35, 36]. Health care professionals are not without the tools to help older women maintain health and prevent future declines, but they may not be prescribing these interventions in an optimal or timely fashion. Perhaps unknowingly, women are asking that exercise and nutrition guidelines be incorporated into their usual preventive health care as routinely as blood pressure screening is administered to prevent heart disease and stroke. The challenge is to familiarise health care providers with these strategies and have them be integrated at the primary care level. A multidisciplinary approach uniting training,

education, and participation of the whole team of allied health care professionals is essential for implementing changes in the current model of health care delivery to support women’s efforts to maintain autonomy in old age.

Our study suggests that interventions may be warranted to address a number of other unmet needs. Respondents perceived that their health care providers were least likely to screen for Alzheimer’s disease, memory loss, depression, and preferences for end of life care. This is not surprising. Both the US and Canadian Preventive Task Force guidelines state that there is insufficient evidence to recommend for or against routine screening for dementia in asymptomatic persons since the value of interventions for mild memory loss without dementia is uncertain [37, 38]. Clinicians are encouraged to remain alert for possible signs of declining cognitive function in older patients and evaluate mental status only in patients who have problems performing daily activities. Also, general practitioners find that existing screening instruments such as the Mini-Mental State Examination are unsatisfactory and tend not to use them [39, 40]. Other obstacles for addressing memory loss include general practitioners’ embarrassment to conduct a cognitive exam and lack of time [39]. Nonetheless, this is the primary concern voiced by older women. Reassurance that perceived memory loss is negligible or within normal limits has tremendous value to women whose main concern is the development of Alzheimer’s disease. When these fears are not addressed, women can experience persistent anxiety and a lower health-related quality of life [25]. Women should at least be given concrete examples of activities that could potentially increase brain health, such as certain intellectual pursuits and exercise [41].

With respect to depression, the burden of unrecognised or inadequately treated depression in older women is substantial [42]. Women aged 65 years and older are twice as likely as men to be depressed. Efficacious treatments are available and aggressive approaches to diagnosis and treatment are necessary to minimise suffering, improve overall functioning and quality of life, and limit inappropriate use of health care resources [42]. Programme development to heighten awareness of depression in older women and increase screening for this disorder remains desperately needed. Older women also want their physicians involved in advanced care planning. Studies suggest that women are more satisfied when end-of-life care is discussed [43]. Our study confirms that such discussions are uncommon [44]. Preoccupations with dying and how one is going to die are very anxiety provoking for older women [25]. Discussions about end-of-life care should be initiated even with younger mature women, as all women can benefit psychologically and emotionally from having this issue addressed out in the open.

Our expectation that women over age 75 would have more unmet priorities was not upheld. This may be because older women are less demanding of their health-care providers or because their health needs are indeed being addressed. The fact that older women have lower

expectations regarding ageing may also influence the importance they place on addressing health priorities to achieve higher health states [45]. Living alone and having been admitted to hospital in the past year were also associated with a lower probability of having more unmet priorities. Again, this seems counterintuitive: women who live alone presumably have less social support and higher needs. Women who have been recently admitted to hospital may be sicker and frailer, and require more attention. Our interpretation is that once the health care system identifies older women as being 'at risk' for poor outcomes – either because of their age, their living arrangement or their health status – they are targeted to receive increased services and are better connected within the system to have their needs and priorities met. As such, they have fewer unaddressed priorities compared with women who have less frequent contact with health care resources and different members of the health care team. Having a family doctor as the main health-care provider also appears to be more advantageous for having priorities addressed since primary prevention is the main objective of the primary care physician. Specialist care is by nature more fragmented, and usually focuses on secondary and tertiary prevention of the diseases for which the original referral was made.

The generalisability of our findings to other countries and health care systems could be questioned. The present study was carried out in Quebec, Canada, and further research is needed to ascertain whether Canadian women have different health perceptions or disease-, disability- and psychosocial related priorities compared to women from other industrialised countries. As health care for all Canadians is government-funded and there is equal and universal access to all primary care physicians and health care specialists, our findings may be most relevant to other health care systems with similar sources of health care funding, such as the UK or Sweden. For countries such as the US, the impact of economic issues as a barrier to receiving satisfactory health care may play a more important role in determining women's health priorities.

Potential biases in our findings must be acknowledged. It may be that the women in our sample were somehow different from other women. It is estimated that up to 70% of older women in Canada have low literacy skills and these women may have been reluctant to participate and fill out a written questionnaire for this study [46]. This could account for why our study sample was more educated than the population average. Also, 50% of our sample was recruited from ophthalmology clinic attendees and this could have influenced the fact that vision loss was the most common health priority for women. However, vision loss has been reported as one of the most feared disabilities among the ageing population [47]. The high prevalence of functional limitation in our sample could be a result of recruiting patients with vision loss and arthritis. However, for these particularities to bias our results, women included in our study would have to have completely different health priorities

and differ in their perceptions of the preventive health care they receive. As the overall health status of our sample was comparable to norm-referenced measures, it is unlikely that women in our study would have health priorities that are completely different from women who were not in this study, or that they would perceive their preventive health care to be poor or excellent; it is more likely that there is a distribution across the whole spectrum of perception. Also, to our knowledge, there is not necessarily a relationship between health status and women's perception of what should or should not be done by health care professionals to keep older women healthy.

A second potential limitation of our findings is that women's perceptions of the care they receive may not be an exact reflection of the care delivered. However, the focus of this study is women's perceptions of physicians' performances in meeting health priorities – the study was not designed to capture actual health care delivery. Our goal was to capture areas where improvements could be made in delivering effective health care to older women. Even if physicians are prescribing exercise recommendations, for example, but women perceive that this is not the case, then changes must be made in the way physicians are prescribing exercise so that the message becomes clearer and the intervention more effective.

Conclusion

Women's health priorities reflect concerns about preventing disability and preserving function in later years. Women perceive that these priorities are inadequately addressed by the current health care system, especially for those mature women who are younger. Many opportunities exist to provide women with the tools they desire to promote healthy ageing. Preventative health care for older women must start earlier. Providing women with reassurance about what constitutes normal memory loss with age, and prescribing strategies to preserve mobility, prevent falls, treat urinary incontinence, and maintain muscle strength and function, will be of paramount importance in the coming years.

Key points

- Older women are more concerned about living with disabilities than with developing certain diseases.
- Older women perceive deficiencies in preventive health care to address concerns about memory loss, mobility, falls, urinary incontinence, and maintaining muscle strength and function in their later years.
- Women report that less than half of health care providers provide exercise and nutrition counselling.
- According to participants, only 20% of physicians screen for depression and discuss end-of-life care.
- Women aged 55–74 are more likely to have unaddressed health priorities compared to women aged 75

years and older. The ideal time to promote preventive health care for older women should start earlier.

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