

# Health Services and Chronic Conditions

## Selected findings of the Australian Longitudinal Study on Women's Health



Report prepared for the

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## Table of Contents

Take Home Messages .....	8
Overview.....	9
What is the Australian Longitudinal Study on Women’s Health? .....	10
Health Services: Use, Access and Satisfaction.....	13
<i>Use of health services by women in disadvantaged groups</i> .....	13
<b>GP services</b> .....	13
<b>Use of other health services</b> .....	13
<i>Use of health services by women with chronic conditions</i> .....	18
<b>GP services</b> .....	18
<b>Use of other health services</b> .....	22
Responsiveness of health services .....	23
Access to health services .....	23
Satisfaction with the most recent GP visit .....	25
Costs of GP visits, bulk billing and satisfaction with costs .....	28
Continuity of Care.....	30
Continuity of Care.....	31
Preference for female doctors .....	31
Focus on... heart disease .....	34
<i>Mid-age women</i> .....	34
<b>Diagnosis and seeking help</b> .....	34
<b>“Too young to have a heart attack”</b> .....	34
<i>Gendered perception of heart disease</i> .....	35
<i>Older women</i> .....	35
<b>Predicting heart disease among older women</b> .....	35

Focus on... diabetes .....	36
<i>Risk factors for diabetes</i> .....	36
<i>Health Service Costs</i> .....	37
<i>Diabetes Care</i> .....	37
<i>Preventive Care</i> .....	38
<i>Adjustment to diabetes</i> .....	38
Focus on... musculoskeletal conditions .....	39
<i>Arthritis</i> .....	39
<i>Osteoporosis</i> .....	39
Focus on...asthma .....	40
<i>Lay Perceptions of Asthma</i> .....	40
References and Relevant ALSWH publications .....	41
<i>References</i> .....	41
<i>ALSWH publications relevant to health service use and chronic disease (available from the Study team on request)</i> .....	41
Appendix.....	42
<i>Survey items</i> .....	42
<i>Demographic variables</i> .....	42
<i>Chronic Conditions</i> .....	42
<i>Use of GP services</i> .....	43
<i>Access to services</i> .....	43
<i>Satisfaction with services</i> .....	43
<i>Cost of GP visit</i> .....	43
<i>Continuity of care</i> .....	43
<i>Preference for a female doctor</i> .....	44
<i>Weighting</i> .....	44

## List of Figures

Figure 1. Timeline for Main ALSWH Surveys.....	10
Figure 2. Frequent GP visits: percentages of women in various demographic groups reporting frequent GP visits in the last 12 months (Survey 2) .....	14
Figure 3. Specialist visits: percentages of women in various demographic groups reporting visiting a specialist in the last 12 months (Survey 2).....	15
Figure 4. Hospital doctor visits: percentages of women in various demographic groups reporting seeing a hospital doctor in the last 12 months (Survey 2).....	16
Figure 5. Hospital admissions: percentages of women in various demographic groups who reported having been admitted to hospital in the last 12 months (Survey 2).....	17
Figure 6. Prevalence of diagnoses and symptoms of chronic conditions in National Health Priority areas (Survey 2).....	18
Figure 7. Frequent GP visits: percentages of women with chronic conditions reporting frequent GP visits in the last 12 months (Survey 2) .....	19
Figure 8. Specialist visits: percentages of women with chronic conditions reporting visiting a specialist in the last 12 months (Survey 2).....	19
Figure 8. Specialist visits: percentages of women with chronic conditions reporting visiting a specialist in the last 12 months (Survey 2).....	20
Figure 9. Hospital doctor visits: percentages of women with chronic conditions reporting seeing a hospital doctor in the last 12 months (Survey 2).....	20
Figure 9. Hospital doctor visits: percentages of women with chronic conditions reporting seeing a hospital doctor in the last 12 months (Survey 2).....	21
Figure 10. Hospital admissions: percentages of women with chronic conditions who reported having been admitted to hospital in the last 12 months (Survey 2).....	22
Figure 11: Mean out-of-pocket cost per GP consultation per woman 1995-2001, by age group and area of residence.....	29
Figure 12. Cost and satisfaction with costs of most recent GP visit for demographic groups (Survey 2): solid bars represent “no cost”, grey bars represent a cost that was rated “excellent”, “very good” or “good” and the empty bars represent costs rated “fair” or “poor”.....	30
Figure 13. Continuity of GP care for demographic groups (Survey 2) .....	32
Figure 14. Preference for a female GP by demographic groups (Survey 2): the first part of each bar represents a preference for female GPs “all the time”, the next part represents a preference “for certain things” and the remainder of the bar represents no preference. ....	33
Figure 15. Total Medicare/ DVA rebate (\$) per women for services outside hospital .....	37
Figure 16. Quality of diabetes care: At least one HbA1c test per year.....	37
Figure 17. Older diabetic women’s attitudes towards having diabetes (n=650).....	38

## List of Tables

Table 1. Access to health services: percentage of women responding “very good” or “excellent” to each item (Survey 2 data weighted by area of residence).....	23
Table 2. Rating of access to services for demographic groups: only significant results are displayed – those with $p < 0.005$ and $\geq 3\%$ points difference .....	24
Table 3. Satisfaction with GP visit: percentage of women responding “very good” or “excellent” to each item (Survey 1 weighted by area of residence).....	25
Table 4. Rating of satisfaction with the most recent GP visit for demographic groups: only significant results are displayed – those with $p < 0.005$ and $\geq 3\%$ points difference.....	27
Table 5. Profile of respondents in 1996, according to age and diabetes status.....	36
Table A1. Percentages of women in various demographic groups by age (Y=Younger, M=Mid aged, O=Older) and Survey (1=Survey 1, 2=Survey 2); “-“ indicates that SES was estimated using data from the other Survey, a blank indicate the question was not asked. ....	45
Table A2. Use of GP services: percentage of women in demographic groups who visited a GP at least once in the previous 12 months.....	45
Table A3. Frequent use of GP services and any visit to a specialist in the last 12 months: percentage of women in demographic groups (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$ and $\geq 3$ percentage points difference).....	46
Table A4. Visit to a hospital doctor or hospital admission in the last 12 months: percentage of women in demographic groups (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$ and $\geq 3$ percentage points difference).....	46
Table A5. Percentages of women with chronic conditions by age (Y=Younger, M=Mid aged, O=Older) and Survey (1=Survey 1, 2=Survey 2); “-“ indicates the question was to asked. ....	47
Table A6. Frequent use of GP services and any visit to a specialist in the last 12 months: percentage of women with chronic conditions (Survey 2); “-“ indicates question not asked; bold indicates a significant difference from women without this condition ( $p < 0.005$ and $\geq 3$ percentage points difference).....	47
Table A7. Visit to a hospital doctor or hospital admission in the last 12 months: percentage of women with chronic conditions (Survey 2); “-“ indicates question not asked; bold indicates a significant difference from women without this condition ( $p < 0.005$ and $\geq 3$ percentage points difference).....	48
Table A8. Access to medical specialists and hospitals: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$ and $\geq 3$ percentage points difference).....	48
Table A9. Access to after hours care and GPs who bulk bill: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$ and $\geq 3$ percentage points difference).....	49
Table A10. Access to a female GP and rating of hours a GP is available: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$ and $\geq 3$ percentage points difference), “-“ indicates question not asked .....	49
Table A11. Number of GPs to chose from and ease of seeing the GP of choice: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$ and $\geq 3$ percentage points difference).....	50

Table A12. Ease of obtaining a Pap test and access to a counselling service: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 50

Table A13. Access to women’s health/family planning services: percentage of women who rated their access as “excellent” or “very good” (Survey 2) – bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked..... 51

Table A14. Access to medical specialists and hospitals: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 51

Table A15. Access to after hours care and a GP who bulk bills: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 52

Table A16. Access to a female GP and rating of hours a GP is available: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 52

Table A17. Number of GPs to choose from and ease of seeing a GP of choice: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference) ..... 53

Table A18. Ease of obtaining Pap test and access to counselling services: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 53

Table A19. Access to women’s health/family planning services: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 54

Table A20. Satisfaction with location of surgery and waiting time: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 54

Table A21. Satisfaction with the personal manner of the doctor and the doctor’s explanation: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 55

Table A22. Satisfaction with the doctor’s interest in her feelings and the opportunity to ask questions: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked..... 55

Table A23. Satisfaction with the time spent with the doctor and the visit overall: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked ..... 56

Table A24. Satisfaction with the location of the surgery and the waiting time: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women

without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....56

Table A25. Satisfaction with the personal manner of the doctor and the doctor’s explanation: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....57

Table A26. Satisfaction with the doctor’s interest in her feelings and the opportunity to ask questions: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....57

Table A27. Satisfaction with the time spent with the doctor and the visit overall: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....58

Table A28. Cost and satisfaction with cost of most recent GP visit: percentage of women who reported no cost, rated the cost “excellent”, “very good” or “good” (high satisfaction), or rated the cost “fair” or “poor” (low satisfaction) (Survey 2) .....58

Table A29. Cost and satisfaction with cost of most recent GP visit: percentage of women with chronic conditions who reported no cost, rated the cost “excellent”, “very good” or “good” (high satisfaction), or rated the cost “fair” or “poor” (low satisfaction) (Survey 2) ; bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....59

Table A30. Continuity of care: percentage of women in demographic groups who reported “always” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....59

Table A31. Continuity of care: percentage of women with chronic conditions who reported “always” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked .....60

Table A32. Preference for a female doctor: percentage of women in demographic groups who reported preference “always” (Alw), “for certain things” (Cert) or “no” or “don’t care” (No) (Survey 2); bold indicates significant differences between demographic groups ( $p < 0.005$  and  $\geq 3$  percentage points difference) .....60

Table A33. Preference for a female doctor: percentage of women with chronic conditions who reported preference “always” (Alw), “for certain things” (Cert) or “no” or “don’t care” (No) (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference) .....61

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## Take Home Messages

- Women in rural areas are disadvantaged with respect to health services, especially access and costs. The ALSWH will be able to monitor changes in these indicators in response to major policy initiatives to improve health services for people in rural and outer metropolitan areas.
- Women who do not speak English at home report lower levels of access to and satisfaction with health services than women who do speak English at home. The differences, while consistent, are not large and may be due to differences in uses of the response options rather than different experiences.
- Although women with chronic conditions are high users of health services, their levels of access to and satisfaction with these services are similar to those of women without these health problems.
- Women with lower socio-economic status (SES) are relatively high users of health services and they rate their access and satisfaction lower to services lower than other women. As lower SES is often associated with living in rural (and outer urban) areas, initiatives to improve services in these locations may reduce SES differentials.
- Younger women are less likely to be satisfied with services than Mid-aged women, and Older women are most satisfied. This may not indicate that the services they receive are objectively poorer, but rather that their expectations are higher.
- Overall GP services are well regarded by most women, with high ratings given for the personal manner of the doctor and doctors' explanations. The most common complaints relating to the time spent in the waiting room and time spent with the doctor.

## Overview

This report presents information from the Australian Longitudinal Study on Women's Health (ALSWH) on women's access and satisfaction with a range of health services; it also investigates differences by region, socio-economic status (SES), language group, marital status and chronic conditions. Evaluating health services from the point of view of the patient provides information that complements administrative data and professional evaluation of services, and reflects particularly on the perceived responsiveness of the health care system.

This report arose from a series of discussions between members of the ALSWH research team and members of the Commonwealth Department of Health and Ageing. These discussions resulted in the development of policy-relevant questions which ALSWH is able to address. Reports were prepared in response to these questions, and these were discussed in further collaborative meetings before this final technical report, and the associated Summary Report, were prepared.

The questions which arose from these discussions were:

1. How do Australian women evaluate their access to, and satisfaction with, health care services? In particular, what are differences and similarities among women in different age groups; women living in rural versus urban areas; women with different levels of socio-economic status? How do perceptions of access and satisfaction vary depending on major health problems, including diabetes, heart disease, asthma, cancer, poor mental health, and arthritis/joint problems?
2. What are the health care experiences of Australian women with diabetes?
3. What can existing work tell us about the experiences and help-seeking of women with asthma?
4. What can existing work tell us about the experiences and help-seeking of women with heart disease?
5. What can ALSWH tell us about the assessment of socio-economic inequalities in women in three age groups, and what are the associations with health?
6. What is known about the use of Enhanced Primary Care items among older Australian women?

This technical report begins with a brief description of ALSWH, before addressing Questions 1 and 5 above. This section begins by looking at the use of health services by women in disadvantaged groups: women living in rural or remote areas compared with urban women; women who do not speak English at home compared with women who do; women with lower SES compared with more advantaged women; and widows and single women compared with women who are married or in a de facto relationship. The following indicators are used: frequent general practitioner (GP) visits; visits to specialists and hospital doctors; hospital admissions. This is followed by a look at the same indicators of health service use by women with conditions in the national health priority areas.

Questions 1, 3, 4 and 5 are addressed further by examining the responsiveness of the health system to the needs of women – their access to services and their satisfaction with their most recent visit to a GP, for example. The questions are extended by looking at out-of-pocket costs, indicators of continuity of care and preference for a female GP.

In the final sections the report focuses on four of the national priority conditions: heart disease, diabetes, asthma and musculoskeletal conditions. (Question 6 about the uptake of Enhanced Primary Care items is described in a companion report in this series on Health and Ageing).

The report is written with the aim of providing policy-relevant data to the Department, and suggestions for further analysis or interpretation are welcomed by the research team.

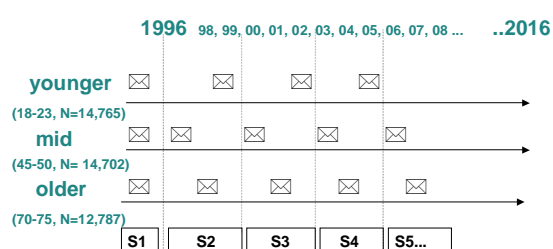
## What is the Australian Longitudinal Study on Women’s Health?

The Australian Longitudinal Study on Women’s Health (ALSWH) – widely known as Women’s Health Australia - is a longitudinal population-based survey, which examines the health of over 40,000 Australian women, randomly selected with deliberate over-sampling of women in rural and remote areas. It provides evidence to the Commonwealth Department of Health and Ageing, for the development and evaluation of policy and practice in many areas of service delivery that affect women. Overviews of the survey, its rationale and methods, can be located on the Study’s website <http://www.newcastle.edu.au/centre/wha> and overview publications include a book targeted at the non-expert level (Lee, 2001) and several academic reports (e.g. Brown et al., 1996; 1998).

The study was designed to explore factors that influence health among women who are broadly representative of the entire Australian population. It goes beyond a narrow perspective that equates women’s health with reproductive and sexual health, and takes a comprehensive view of all aspects of health throughout women’s lives.

Women in three age groups (aged 18-23 years, 45-50 years and 70-75 years in 1996) were selected from the Medicare database. Sampling was random within each age group, with women from rural and remote areas sampled at twice the rate of women in urban areas. This means that the numbers of rural women are large enough for statistical comparisons within and between regions. The study is designed to run for at least 20 years, with each age cohort surveyed once every three years. Figure 1 below shows the timeline for surveys, beginning with Survey 1 of all three cohorts in 1996.

Figure 1. Timeline for Main ALSWH Surveys



The age groups were selected in order to follow women through life stages which are likely to be critical to their health and well-being. When the study began, the Younger age group were in the early stages of transition from adolescence to adulthood, so that they can be tracked as they move into the work force, enter adult relationships, and become mothers. At Survey 1, the majority of these young women were living with their families of origin (51%) or in shared housing (24%). Almost half (48%) were students; 79% were single; and 92% had no children. By Survey 2, 48% were living with a partner (23% were married and 20% in long-

term de facto relationships) although only 17% were mothers. Two-thirds (67%) had post-secondary educational qualifications and 59% were in full-time paid employment.

The Mid-age group was selected to examine menopausal transitions and the social and personal changes of middle age. At Survey 1, the majority (75%) were married; 37% had full-time and 31% part-time employment. While 91% were mothers, only 58% had children aged under 16 living with them. Middle age is a time of relative demographic stability, so the picture was relatively similar at Survey 3, with 78% married, 37% in full-time work and 23% in part-time work, although the percentage with children living at home had fallen to 37%.

The Older group were in their early 70s when selected, in order to recruit older women who are generally still active, involved members of the community. These women are being tracked to obtain information on predictors of continuing well-being and independence in older adult life. At Survey 1, the majority of older women (58%) were married, but widows increased from 36% to 41% of the sample by Survey 2. Over 80% of these women are pensioners, although 35% have superannuation or other private income.

The study assesses:

- Physical and emotional health (including health-related quality of life, major diseases and conditions, symptoms)
- Use of health services (GP, specialist and other visits, access, satisfaction)
- Health behaviours and risk factors (diet, exercise, smoking, alcohol, other drugs)
- Time use (including paid and unpaid work, family roles, and leisure),
- Socio-demographic factors (location, education, employment, family composition)
- Life stages and key events (such as childbirth, divorce, widowhood).

As well as the main surveys, women are invited to participate in sub-studies which address specific issues or target specific groups. For example, women who reported having diabetes, asthma or heart disease have provided additional information about their diagnosis, treatment and well-being.

Participants are also invited to consent to linkage of survey responses with unit records from the Medicare database. Under present legislation, individual signed consent is required for access to individual data, and approximately half the women have provided consent. This enables us to access information about type of service, characteristics of the provider, and out-of-pocket costs for every Medicare-eligible service, and to link this information to Survey data. Aggregated unidentified data are also available for those who have not consented to access to individual records.

The project has been able to retain a very high proportion of the original participants. Among the Younger women, 72% responded to Survey 2 in 2000, a retention rate which compares well with other surveys of this highly mobile age group. Retention rates have been much higher among the Mid-age women; 92% and 85% of Mid-age women respectively responded to Survey 2 in 1998 and Survey 3 in 2001. Of the Older women, 91% responded to Survey 2 in 1999 and 83% to Survey 3 in 2002.

ALSWH will provide a valuable opportunity to examine associations over time between aspects of women's lives and their physical and emotional health. In this way, it can provide information that will assist the Commonwealth Department of Health and Ageing – as well as other Commonwealth and State Departments - to plan for the future and to develop policies which are most appropriate to Australian women of all ages.

These reports have been prepared following meetings between the research team, and staff of selected Sections and Divisions of the Commonwealth Department of Health and Ageing. Initial discussions, held in October and November 2002, addressed policy needs and their

match with existing data. On this basis, specific topics were selected for the preparation of syntheses of existing research, supplemented by some new analysis of existing data. Drafts were presented to these same staff in February/March 2003, and the final reports prepared on the basis of feedback from this process. Further analyses can be conducted on request.

Further information is available from Joy Eshpeter, email [Joy.Eshpeter@health.gov.au](mailto:Joy.Eshpeter@health.gov.au) or visit the website <http://www.newcastle.edu.au/centre/wha>

## Health Services: Use, Access and Satisfaction

### *Use of health services by women in disadvantaged groups*

To examine the experiences of the health system by women in potentially disadvantaged groups we compare data for the three age cohorts categorising participants by the following demographic characteristics:

- Area of residence: urban, large rural centres, small rural centres, and remote areas;
- Socio-economic status: in three or four strata based on education and occupation, using different definitions for the Younger, Mid-aged and Older cohorts;
- Whether or not they speak English at home;
- Marital status – again using different definitions for the three cohorts and with particular interest in the widows in the Older group.

The definitions and detailed tables are given in the Appendix.

### **GP services**

At each survey women were asked how often they visited their GP in the last 12 months. At Survey 1, 96% of the Older women reported visiting a GP (at Survey 2, this figure was 98%) and about one third had more than 8 visits in a year. The Mid-aged women reported fewer GP visits with 92% having had at least one visit (Surveys 1 and 2) and the top third of users having more than 4 visits in a year. Among the Younger women, 94% reported at least one visit at Survey 1 and 97% at Survey 2 with a third having more than 6 visits. Figure 2 shows the demographic characteristics of women who were frequent users of GP services.

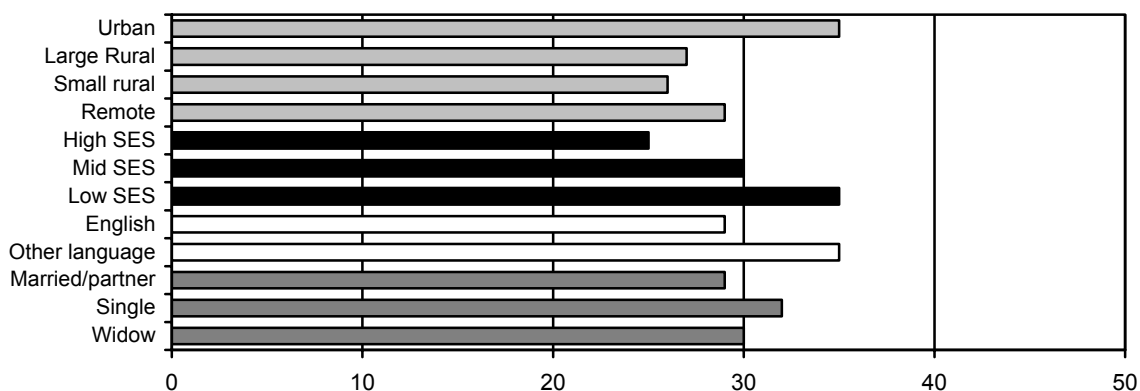
Women with lower SES, or for the Younger women those with the lowest level of education, were higher users of GP services than women with higher SES. So were women living in urban areas (except for the Younger women for whom there were few geographic differences). Younger women with partners reported more GP visits than other Younger women, while in the Mid-aged group those women without partners reported higher use. In the Older and Mid-aged groups, women who spoke a language other than English at home were more likely to be high users of GP services.

### **Use of other health services**

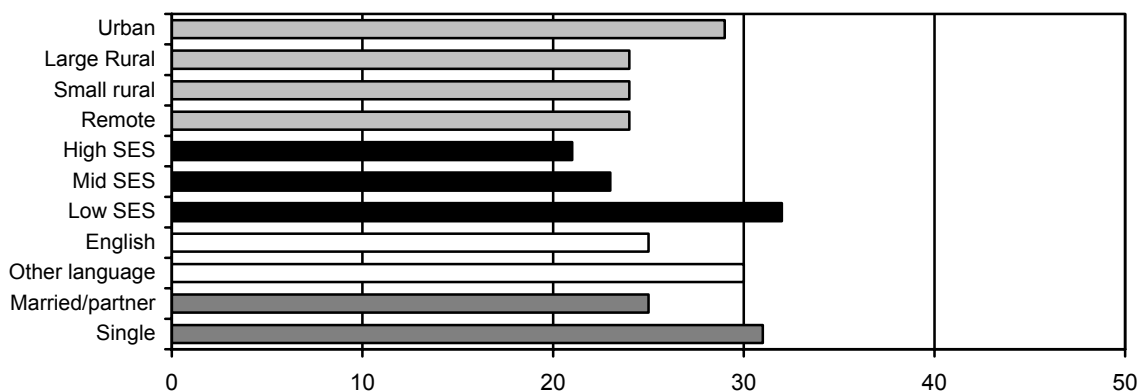
Figure 3 shows the percentages of women in each cohort who saw a specialist at least once in the 12 months before Survey 2. Visits to specialists were more common among urban women, women with higher SES (except in the Younger group) and among women who do not speak English at home. In contrast, seeing a hospital doctor was more common in remote areas, reflecting different types of services (see Figure 4). Women with lower SES were also more likely to see a hospital doctor; among the Younger women this probably relates to pregnancy and childbirth. For the same reason there were marked differences in hospital admissions for Younger women (Figure 5). There were relatively fewer differences in hospital admissions among Older women in different demographic groups (and this item was not asked in Survey 2 for the Mid-aged women).

Figure 2. Frequent GP visits: percentages of women in various demographic groups reporting frequent GP visits in the last 12 months (Survey 2)

a) Older women: percentage with more than 8 visits



b) Mid-aged women: percentage with more than 4 visits



c) Younger women: percentage with more than 6 visits

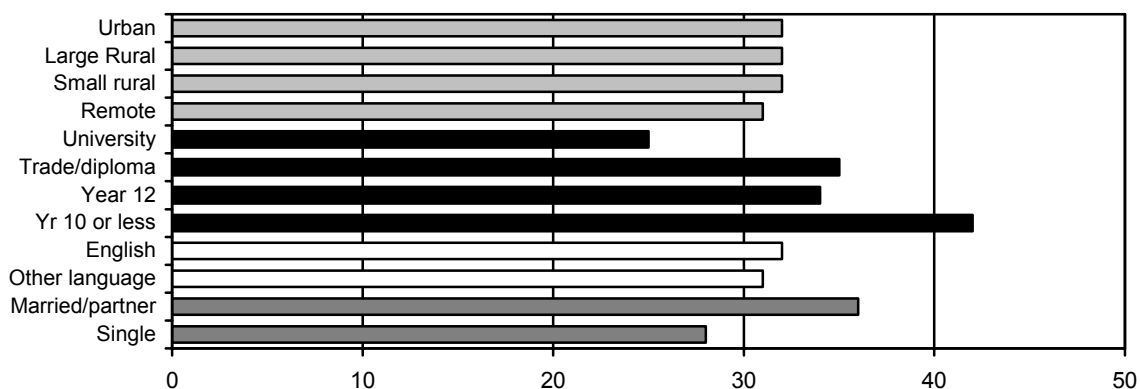
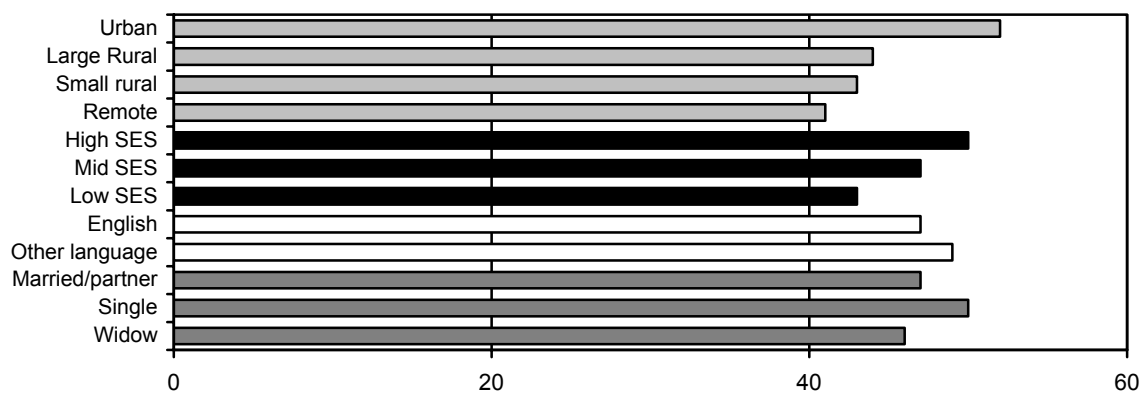
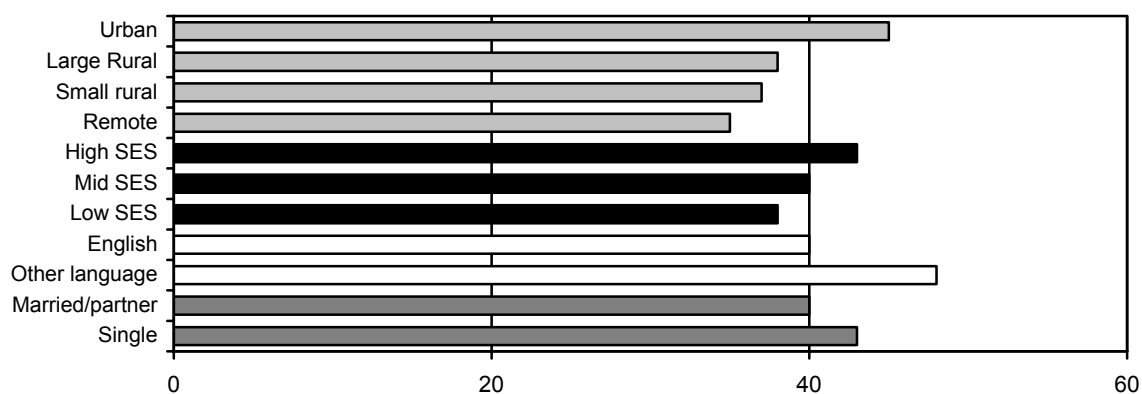


Figure 3. Specialist visits: percentages of women in various demographic groups reporting visiting a specialist in the last 12 months (Survey 2)

a) Older women



b) Mid-aged women



c) Younger women

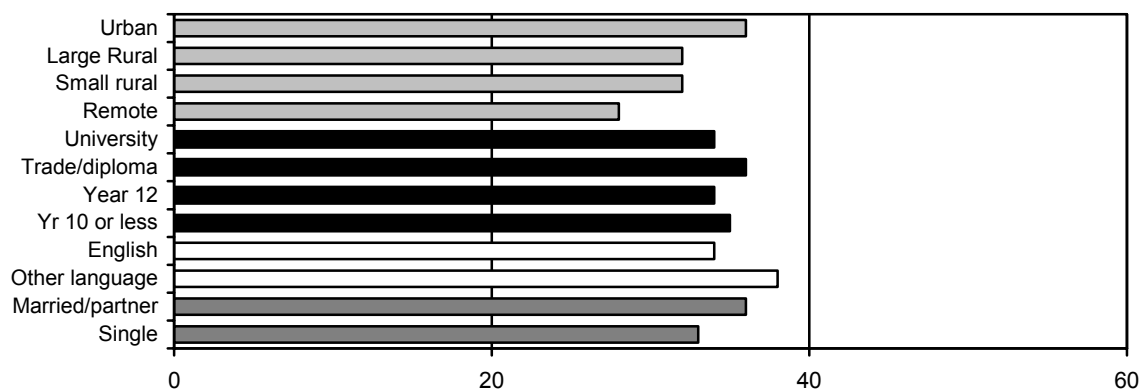
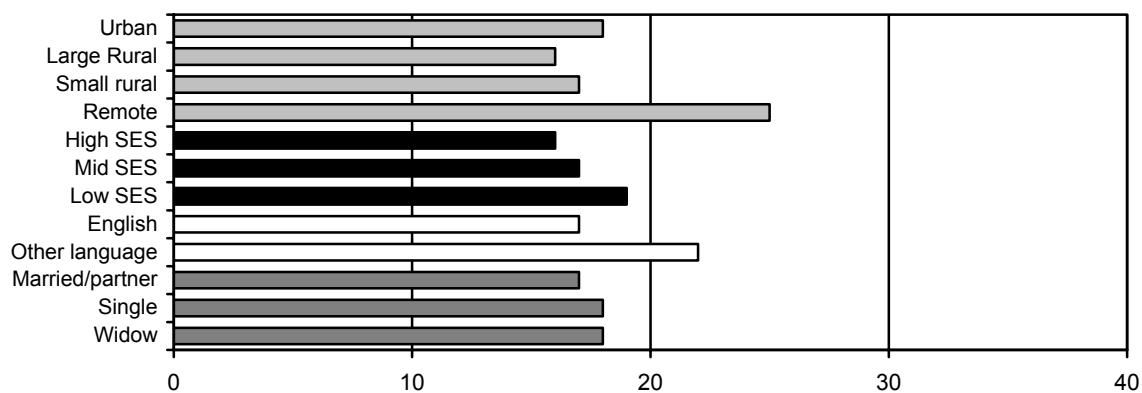
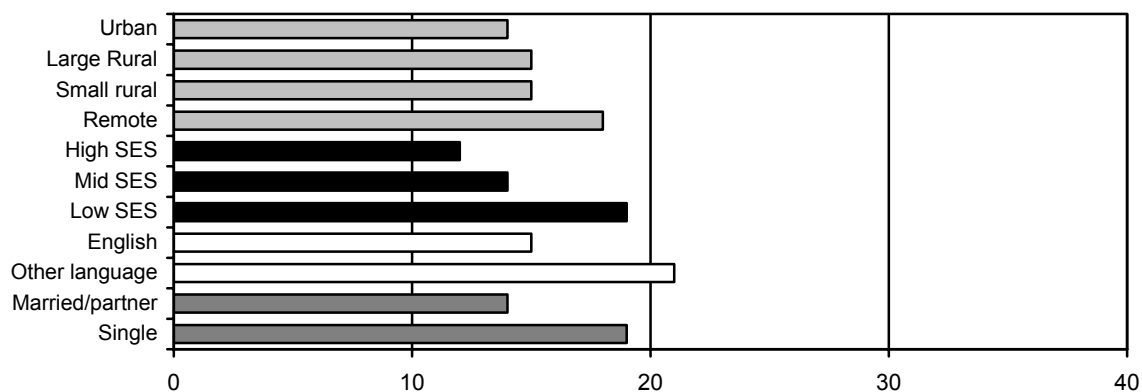


Figure 4. Hospital doctor visits: percentages of women in various demographic groups reporting seeing a hospital doctor in the last 12 months (Survey 2)

a) Older women



b) Mid-aged women



c) Younger women

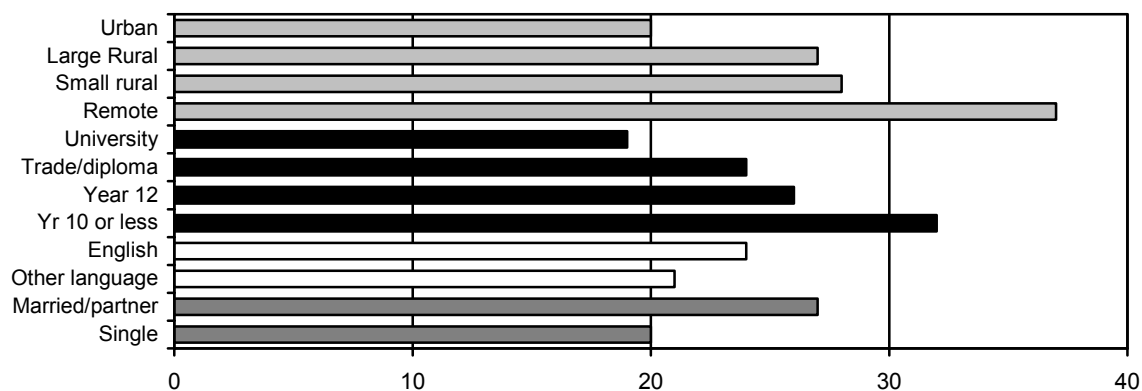
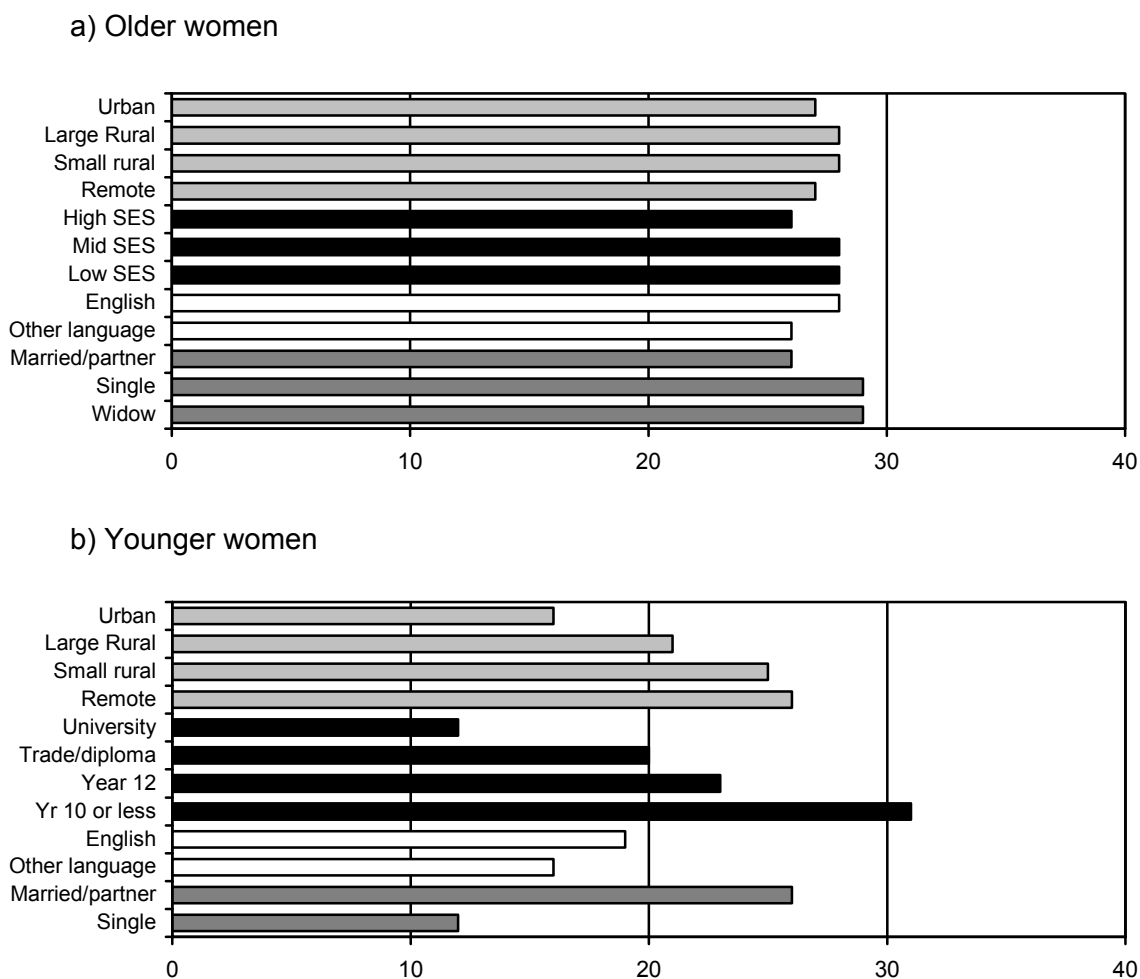


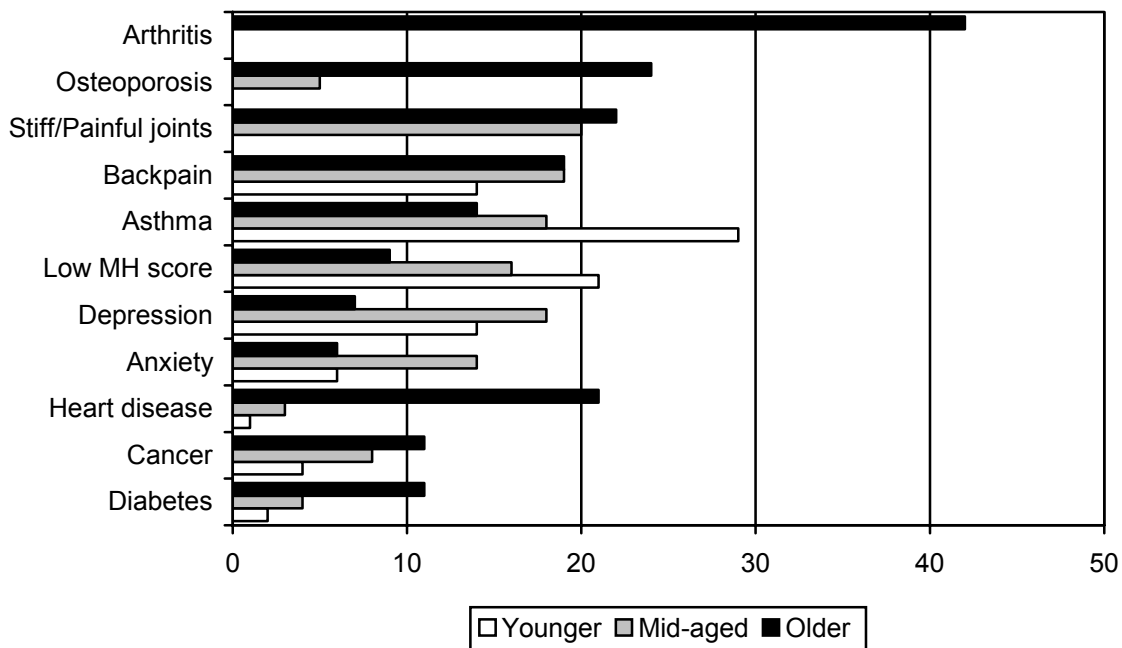
Figure 5. Hospital admissions: percentages of women in various demographic groups who reported having been admitted to hospital in the last 12 months (Survey 2)



### Use of health services by women with chronic conditions

Prevalence of conditions in the National Health Priority areas is shown in Figure 6, based on data from Survey 2. The most prevalent conditions were musculoskeletal disorders, especially arthritis (42% in the Older women). Osteoporosis was also common (24% of the Older women and 5% of the Mid-aged group). Asthma prevalence decreased with age: 29% in the Younger women, 18% in the Mid-aged women and 14% in the Older women. Among the mental health conditions, low scores on the mental health scale of the SF-36 measure of health related quality of life (MH < 53) and depression diagnosed by a doctor were both highest in the Younger cohort and decreased with age; while the proportion of women reporting a diagnosis of anxiety was highest in the Mid-aged group. Prevalence of heart disease was also high at 21% in the Older women.

Figure 6. Prevalence of diagnoses and symptoms of chronic conditions in National Health Priority areas (Survey 2)

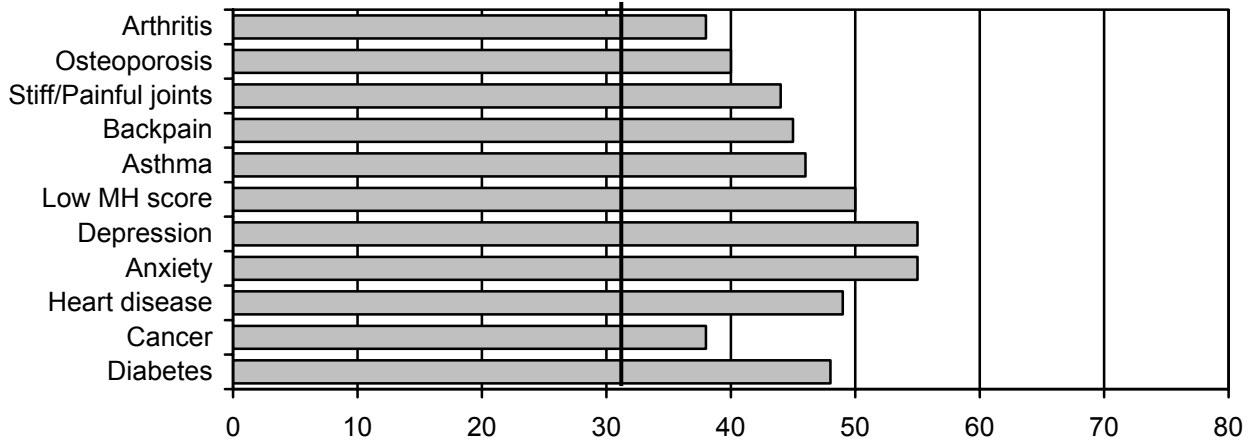


### GP services

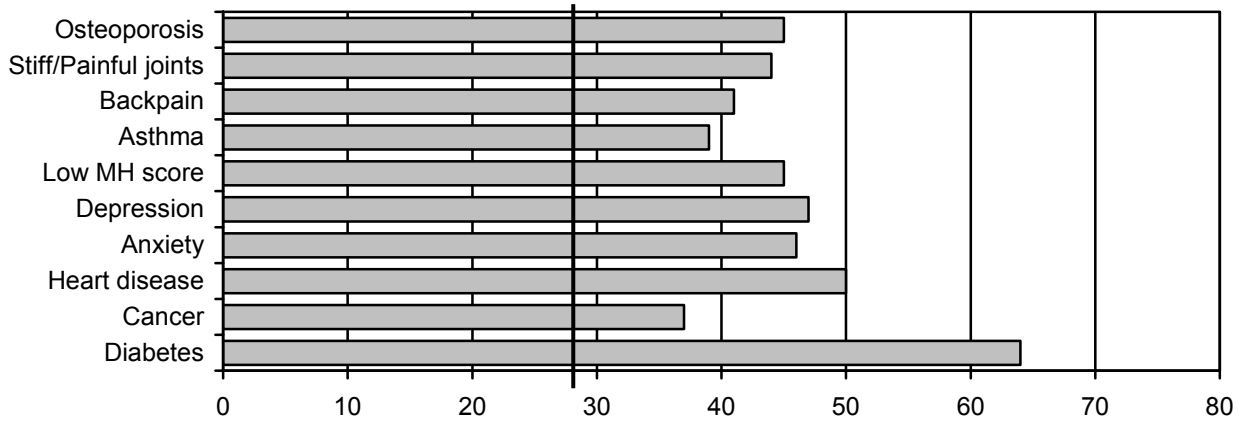
As may be expected, women with diagnosed chronic conditions generally visited their GPs more often than other women; this was true for each of the selected chronic conditions (see Figure 7). Among women with chronic conditions, Mid-age women with diabetes were the most likely to have high GP use (60-64%) – this may relate to diagnosis and monitoring as well as treatment (see a later section for more details about health care for women with diabetes). Women with mental health problems were particularly likely to make frequent visits to GPs, especially Younger and Older women with anxiety and Older women with depression. High use of GP services was also associated with symptoms such as back pain, stiff and painful joints and low mental health scores.

Figure 7. Frequent GP visits: percentages of women with chronic conditions reporting frequent GP visits in the last 12 months (Survey 2)

a) Older women: percentage with more than 8 GP visits, vertical bar shows percentage for all older women (32%)



b) Mid-aged women: percentage with more than 4 GP visits, vertical bar shows percentage for all Mid-aged women (27%)



c) Younger women: percentage with more than 6 GP visits, vertical bar shows percentage for all Younger women (32%)

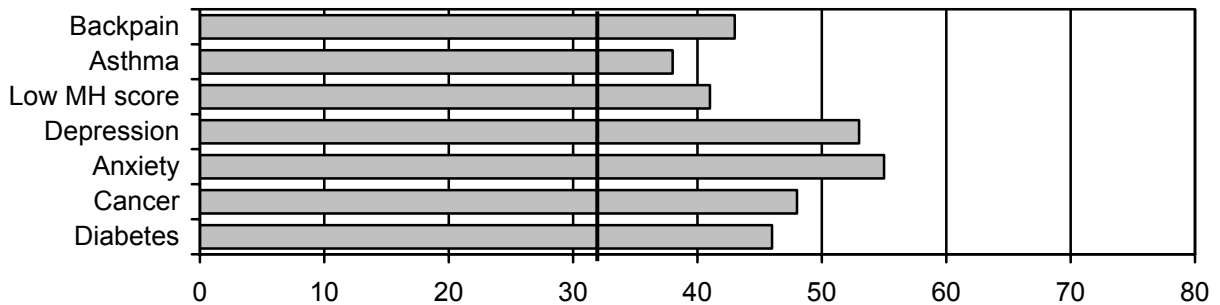
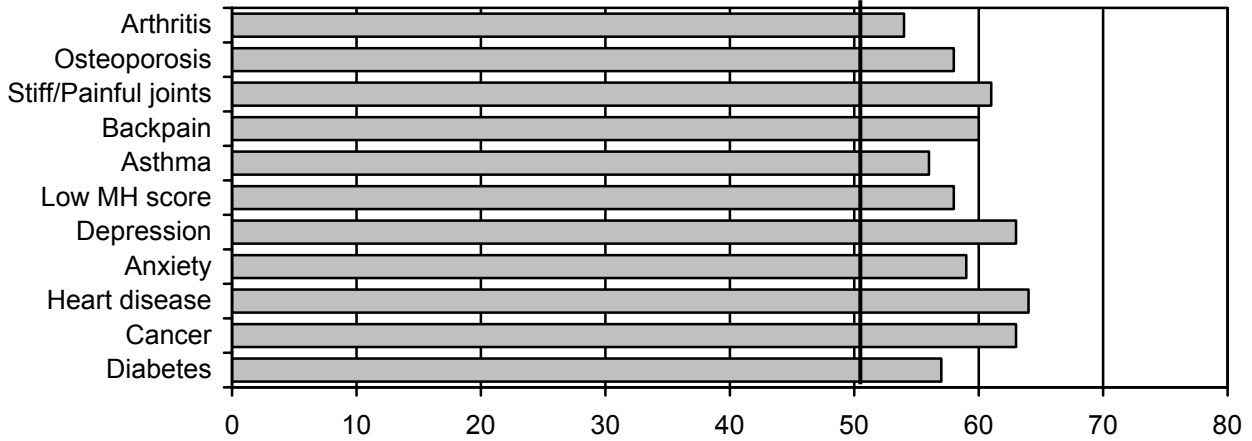
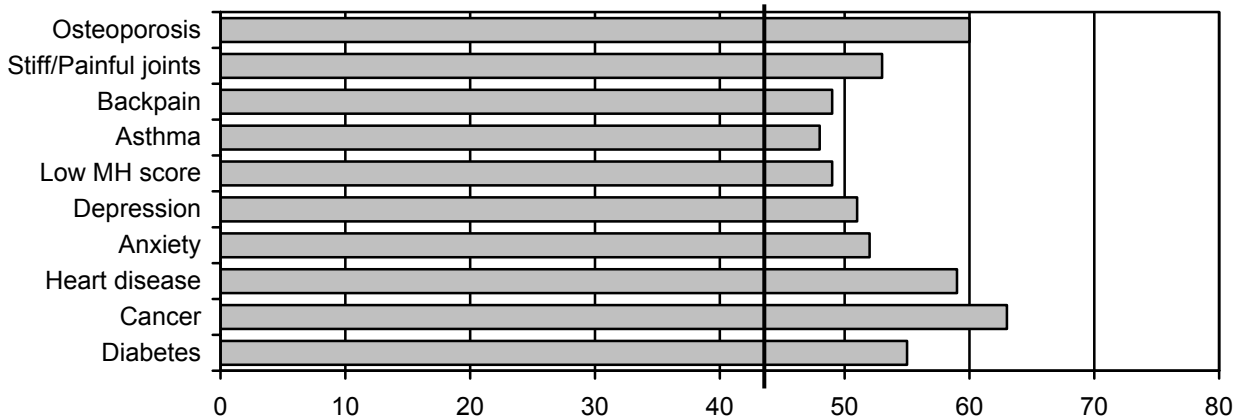


Figure 8. Specialist visits: percentages of women with chronic conditions reporting visiting a specialist in the last 12 months (Survey 2)

a) Older women: vertical bar shows percentage for all older women (50%)



b) Mid-aged women: vertical bar shows percentage for all Mid-aged women (43%)



c) Younger women: vertical bar shows percentage for all Younger women (34%)

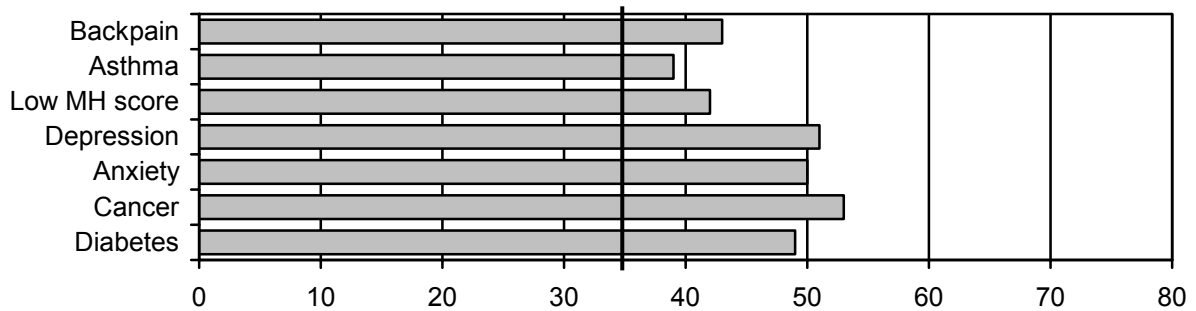
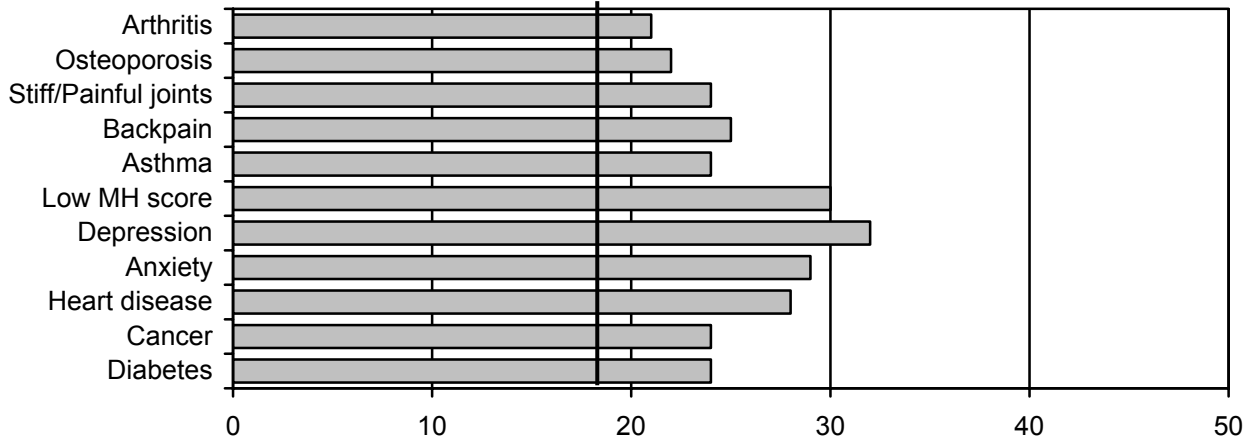
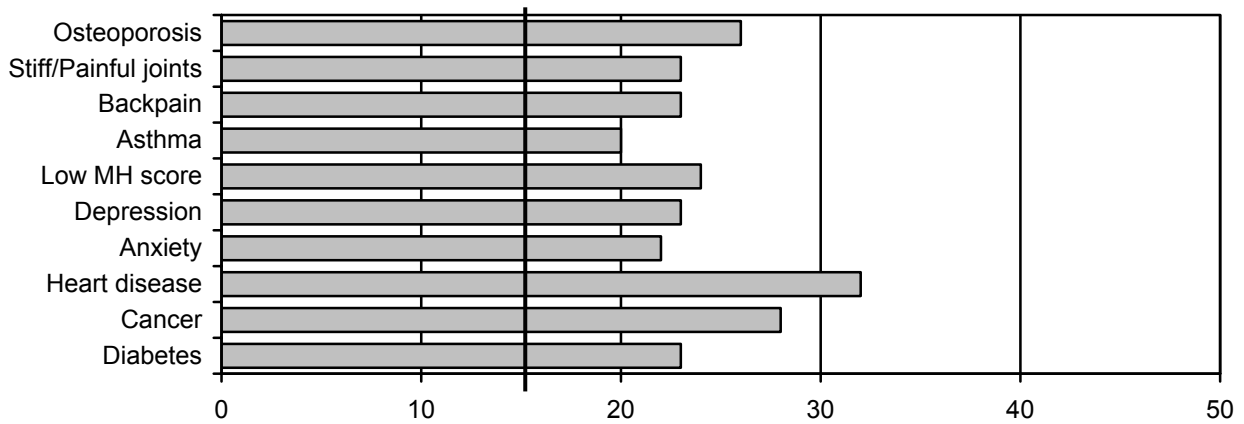


Figure 9. Hospital doctor visits: percentages of women with chronic conditions reporting seeing a hospital doctor in the last 12 months (Survey 2)

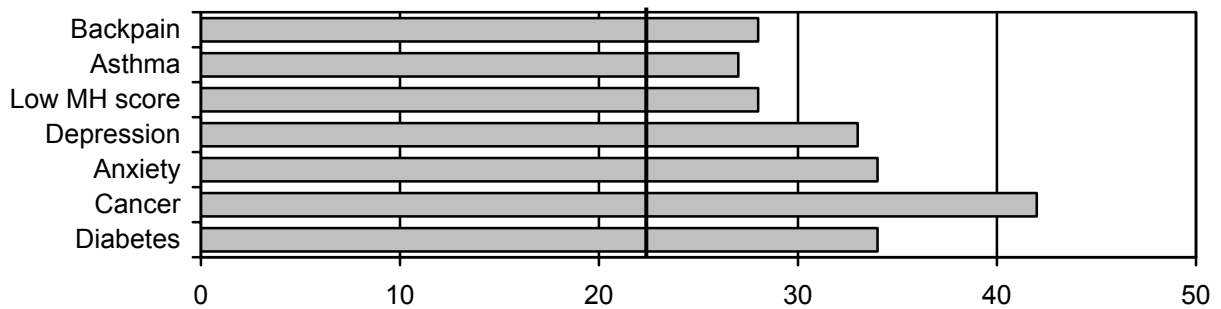
a) Older women: vertical bar shows percentage for all older women (18%)



b) Mid-aged women: vertical bar shows percentage for all Mid-aged women (15%)



Younger women: vertical bar shows percentage for all Younger women (23%)

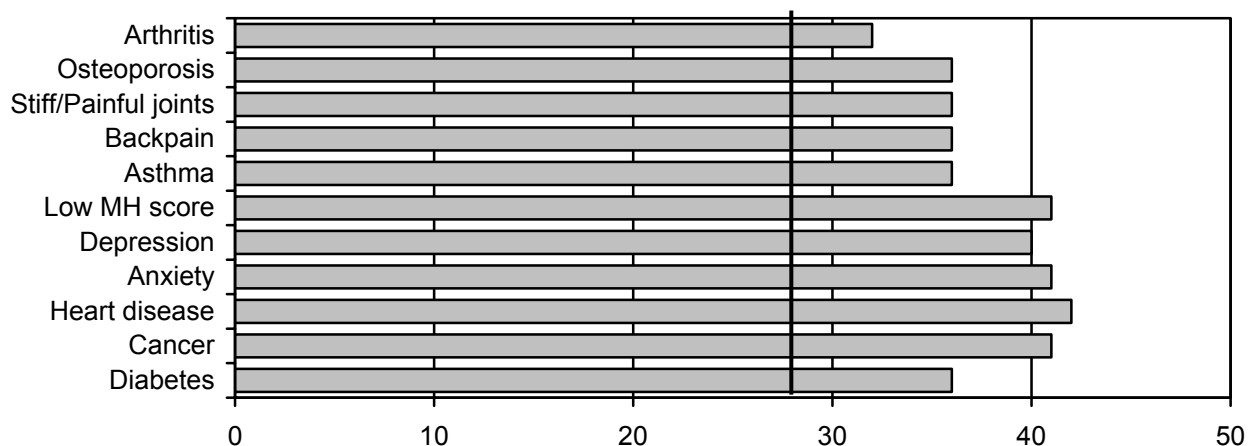


### Use of other health services

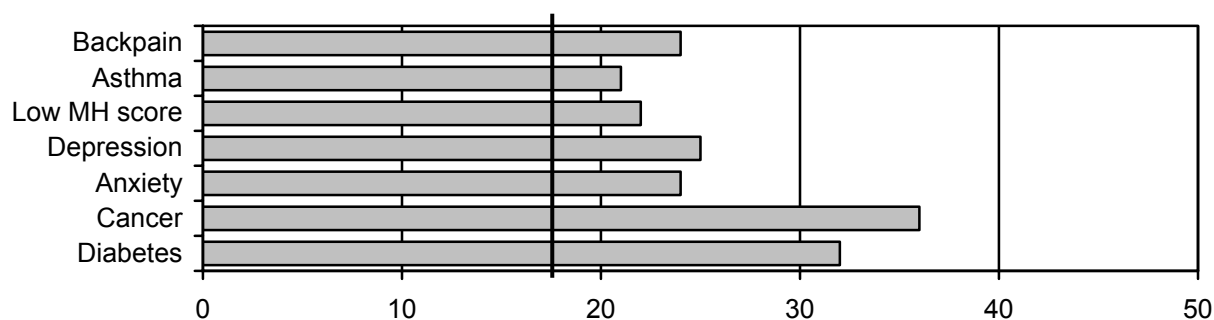
There were not substantial differences among women with different chronic conditions in their use of specialists (Figure 8), hospital doctors (Figure 9) or hospital admissions (Figure 10).

*Figure 10. Hospital admissions: percentages of women with chronic conditions who reported having been admitted to hospital in the last 12 months (Survey 2)*

a) Older women: vertical bar shows percentage for all older women (28%)



b) Younger women: vertical bar shows percentage for all Younger women (19%)



## Responsiveness of health services

Patients’ satisfaction with health services is a complex issue influenced by perceived need, expectations and past experiences of care (De Silva and Valentine, 2000). It is a subjective characteristic of the individual and is most often limited to clinical encounters in a specific health care setting, for example a GP visit. In contrast responsiveness is a more objective concept which is concerned with the health system as a whole and how well it meets the needs of patients in a range of non-clinical domains such as prompt attention, quality of facilities, confidentiality and respect for individuals and their dignity (Murray et al, 2001)

The ALSWH surveys primarily measure patient satisfaction. For example, in Survey 1 women rated their most recent GP visit on aspects ranging from the time spent in the waiting room to the doctor’s explanation and interest in their feelings. These questions capture women’s response to a specific clinical interaction. In Survey 2, however, women were asked to rate their access to various elements of the health system including access to hospital, specialist or a GP who bulk bills. These access questions together with questions about continuity of care indicate the responsiveness of the health system as a whole.

The ALSWH has examined the issue of health care costs in relation to GP visits. Cost has been investigated both objectively, through linkage to Medicare data, and subjectively through survey questions about women’s satisfaction with these costs.

These aspects of access, satisfaction and responsiveness are summarised in the following sections for women classified by demographic characteristics and chronic conditions.

## Access to health services

In Survey 2 women were asked “Thinking about your own health care, how would you rate the following: access to medical specialists if you needed them”, and similarly for other services. Response options ranged from excellent to poor and don’t know. The highest ratings were for access to a hospital if you needed it (all cohorts), ease of obtaining a Pap test (only asked for the Younger and Mid-aged women) and a GP who bulk bills (Older women). The lowest ratings were for the hours a GP is available, after hours care and, for the Younger and Mid-aged women, access to a GP who bulk bills – see Table 1.

*Table 1. Access to health services: percentage of women responding “very good” or “excellent” to each item (Survey 2 data weighted by area of residence)*

	Younger	Mid-age	Older
Access to medical specialists	46	65	64
Access to hospital	54	67	63
Access to after-hours care	32	62	45
Access to GP who bulk bills	51	45	74
Access to female GP	46	55	-
Hours GP is available	33	47	55
Number of GPs to choose from	43	55	57
Ease of obtaining Pap test	64	78	-
Ease seeing GP of choice	36	53	66
Access to counselling service	39	49	-
Access to Women’s Health/ Family Planning services	39	50	-

“-“ indicates that the question was not asked

Table 2. Rating of access to services for demographic groups: only significant results are displayed – those with  $p < 0.005$  and  $\geq 3\%$  points difference

a) Older women

	Rurality	SES	Language
Medical specialists	U>LR>SR>RM	H=M>L	E>O
Hospital		H=M>L	E>O
After-hours care	LR>U>SR=RM		E>O
GP who bulk-bills	U>LR>SR>RM	M>H=L	E>O
Hours GP available	U=LR>SR>RM		E>O
Number of GPs to choose from	U=LR>SR>RM		E>O
Ease of seeing GP of choice	U>LR>SR>RM	H>M>L	E>O

b) Mid-aged women

	Rurality	SES	Language
Medical specialists	U>LR>SR>RM	H>M>L	E>O
Hospital	U=LR>SR>RM	H>M>L	E>O
After-hours care	LR>U>SR>RM	H>M>L	E>O
GP who bulk-bills	LR>U>SR>RM	H=M>L	E>O
Female GP	U>LR>SR>RM	H>M>L	
Hours GP available	U=LR>SR>RM		
No. GPs to choose from	U=LR>SR>RM	H>M=L	
Ease of seeing GP of choice	U=LR>SR>RM		
Pap smear	U=LR>SR>RM	H=M>L	E>O
Counselling service	U>LR>SR>RM		
Women’s health/Fam Planning	LR>U>SR>RM		

c) Younger women

	Rurality	SES	Language
Medical specialists	U>LR>SR>RM	H>M1=M2>L	
Hospital	U=LR=SR>RM	H>M1=M2=L	
After-hours care	LR>U>SR>RM	H>M1=M2=L	E>O
GP who bulk-bills	LR>U>SR>RM	H>M1=M2=L	O>E
Female GP	U>LR>SR>RM	H>M1=M2=L	
Hours GP available	U>LR=SR>RM		
No. GPs to choose from	LR>U>SR>RM		E>O
Ease of seeing GP of choice	U=LR>SR>RM	L>M1=M2>H	
Pap smear	U=LR>SR>RM		E>O
Counselling service	U=LR>SR>RM		
Women’s health/Fam Planning	LR>U>SR>RM		

Notes: Rurality: U = urban, LR = large rural, SR = small rural, RM = remote  
 Socio-economic status: H = higher, M = mid, L = low, for the Older and Mid-aged women; and H = university, M1 = trade/diploma qualification, M2 = Year 12 only, L = Year 10 or less, for the Younger women  
 Language spoken at home: E = English, O = other

Interpretation: the top row shows that among the older women those who lived in urban areas rated their access to medical specialists significantly higher than did women living in large rural centres, who in turn rated their access higher than women in smaller rural centres, and so on.

Table 2 summarises major differences in access ratings by women in various demographic groups (only differences which are statistically significant and are greater than 3 percentage points are shown). In all cohorts women living in urban and large rural centres were more likely than women in small rural centres and remote areas to rate their access as excellent or very good compared to good, fair or poor. This finding applied for every access item listed in the questionnaire. Access was also rated higher by women who spoke English at home than women who spoke another language, for all three cohorts and many items. In addition women with higher SES rated their access higher than other women. There were few major or consistent differences in access ratings among women with different marital status (detailed results are shown in Appendix Tables A8-A13).

In contrast to the large differences in access ratings by women with different demographic characteristics, there were fewer differences in ratings by women with various chronic conditions (see Tables A14-A19 in the Appendix). The only consistent and notable findings were that women with mental health problems and those reporting symptoms of back pain and stiff and painful joints rated their access lower. The lower ratings may reflect disappointment about treatment and outcomes for women with these conditions.

## Satisfaction with the most recent GP visit

At Survey 1 women were asked to rate their satisfaction with various aspects of their most recent GP visit. These data are summarised in Table 3.

*Table 3. Satisfaction with GP visit: percentage of women responding “very good” or “excellent” to each item (Survey 1 weighted by area of residence)*

	Younger	Mid-age	Older
Convenience of location of surgery	73	71	70
Time in waiting room	33	40	50
Personal manner of doctor	68	78	87
Doctor’s explanation	59	72	80
Doctor’s interest in your feelings	54	68	78
Opportunity to ask questions	61	72	80
Time spent with doctor	50	65	72
Visit overall	56	67	78

Older women were the most satisfied and Younger women the least satisfied with all aspects of their visit, with the exception of the convenience of the location of the surgery, for which similar high levels of satisfaction were reported across the age groups. Women rated the personal manner of the doctor highly, and were least satisfied with the amount of time spent in the waiting room and the time they spent with the doctor.

As mentioned above, reports of satisfaction are subjective ratings and will be influenced by the expectations and attitudes of the individual. Thus the lower satisfaction of the Younger women may not necessarily indicate a lower level of service but rather may reflect higher expectations of Younger women and a greater willingness to criticise.

Table 4 summarises major differences in levels of satisfaction by women in various demographic groups. The most consistent finding was that satisfaction was greater for women who spoke English at home than for women who spoke other languages in all cohorts and for almost all aspects of their GP visit. Women who spoke other languages were consistently less satisfied, but among these women the same patterns of dissatisfaction as those seen in the total study group were observed and the differences were not large in absolute terms (see Tables A20-A23 in the Appendix). For example, the Older women were the most satisfied, and the Younger women the least. Time spent in the waiting room and time spent with the doctor were the least satisfactory aspects of the visit, and the personal manner of the doctor received the highest ratings of satisfaction.

Satisfaction with GP visits did not differ greatly by area of residence. In the Younger cohort, urban women were the most satisfied with the location of the surgery and the time they waited to see the doctor, and women living in remote areas were the least satisfied with these aspects of their visit. In the Older group it was the women in urban and large rural areas who were least satisfied with the convenience of the location of the surgery, and those in small rural areas who were most likely to be satisfied with this. Women in the Younger and Older cohorts registered similar levels of satisfaction with their visit overall, regardless of where they lived. In the Mid-age cohort, those in urban areas were more satisfied than other women with their visit overall.

In the Older cohort, women with low SES were consistently less satisfied with all aspects of their GP visit compared to those in higher SES groups. However this SES effect was not present in the Mid-age group and it was not readily estimated for the Younger women because SES was classified from data obtained later, in Survey 2.

While high levels of satisfaction were reported for personal aspects of care such as the manner of the doctor, the opportunity to ask questions and the doctor's explanation, women in all age groups were least satisfied with the time spent in the waiting room and the time spent with the doctor in consultation. This time-pressure effect is reflected in the access ratings where women reported difficulty with the hours GPs are available and problems accessing after-hours care. Women do report however, that the current health system provides good access to hospital when needed and easy access to Pap screening.

Although women with chronic conditions were high users of health care services, their levels of satisfaction were similar to those of other women, with some exceptions (details are given in Tables A24-A27 in the Appendix). For example, the convenience of the location of the surgery received lower satisfaction ratings from women with osteoporosis, diabetes, heart disease and cancer than from women without these conditions. Older women with heart disease were also less satisfied with their visit overall, compared with Older women without this diagnosis.

While chronic conditions generally did not seem to affect satisfaction, symptoms of back pain, stiff and painful joints, and low mental health scores were related to level of satisfaction. Women with any of these conditions were generally less satisfied with all aspects of their GP service than were other women.

Table 4. Rating of satisfaction with the most recent GP visit for demographic groups: only significant results are displayed – those with  $p < 0.005$  and  $\geq 3\%$  points difference

a) Older women

	Rurality	SES	Language
Convenience of surgery location	SR>RM>LR=U	H=M>L	E>O
Time in waiting room		H=M>L	E>O
Personal manner of doctor		H=M>L	E>O
Doctor’s explanation		H=M>L	E>O
Doctor’s interest in your feelings		H=M>L	E>O
Opportunity to ask questions		H=M>L	E>O
Time spent with doctor		H>M>L	E>O
Visit overall		H=M>L	E>O

b) Mid-aged women

	Rurality	SES	Language
Convenience of surgery location	SR>RM=LR=U		E>O
Time in waiting room			E>O
Personal manner of doctor			E>O
Doctor’s explanation			E>O
Doctor’s interest in your feelings			E>O
Opportunity to ask questions			E>O
Time spent with doctor			E>O
Visit overall	U>LR=SR=RM		E>O

c) Younger women

	Rurality	Language
Convenience of surgery location	U>SR>LR=RM	E>O
Time in waiting room	U>LR=SR>RM	
Personal manner of doctor		E>O
Doctor’s explanation		E>O
Doctor’s interest in your feelings		E>O
Opportunity to ask questions		E>O
Time spent with doctor		E>O
Visit overall		E>O

Notes: Rurality: U = urban, LR = large rural, SR = small rural, RM = remote  
 Socio-economic status: H = higher, M = mid, L = low , for the Older and Mid-aged women; SES was not tabulated for the Younger women because it was based on data from Survey 2  
 Language spoken at home: E = English, O = other

## Costs of GP visits, bulk billing and satisfaction with costs

The cost of a GP visit can affect both access and satisfaction with the service. Data relating to costs are obtained in the ALSWH from two sources: the women themselves responding to specific items in the regular Surveys, and Medicare data on the costs (the latter only for those women who consent to linkage between their survey data and Medicare data).

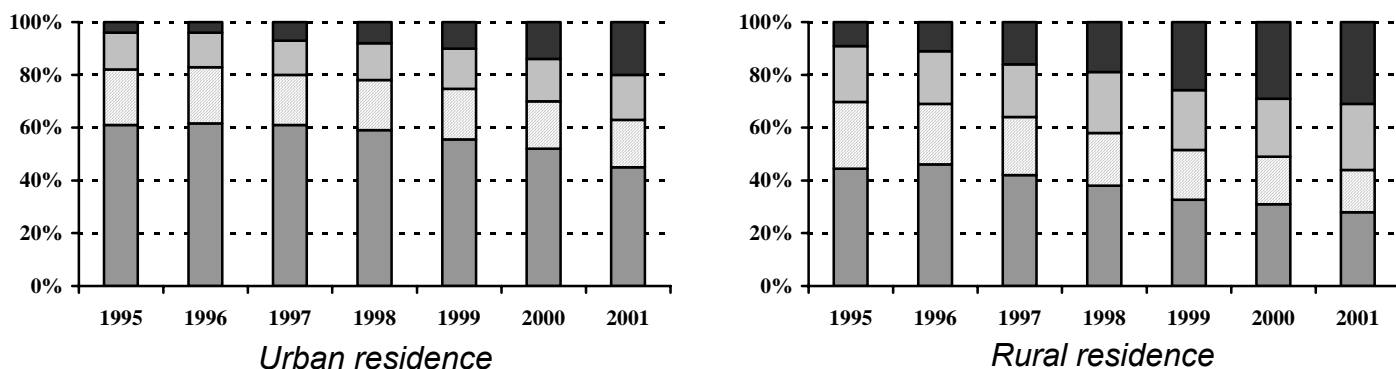
Young et al. (2000, 2002) reported on the out-of-pocket costs of GP visits for the study participants. Figure 11 shows the decline in bulk billing (\$0 per visit) and the increasing out of pocket costs between 1995 and 2001 using the Medicare data. For each age group and year studied, the use of bulk billing was lower in rural areas than in urban areas. For example, in 2000 the percentage of women in rural and urban areas who had all their GP consultations bulk billed was: Younger women 31% vs. 52%, Mid-aged women 24% vs. 45%, Older women 58% vs. 79%. There was a steady decline in bulk billing for GP consultations in rural areas. The average out-of-pocket cost per consultation for women in rural areas was higher and continuing to increase, compared to women living in urban areas. These regional differences persisted even for women in poor health and lower SES. After adjusting for age, health and socio-economic factors, women living in urban areas were two and a half times more likely to have all their consultations bulk billed than women living in rural areas.

In Survey 2 women were asked about the cost of their most recent GP visit – whether they had incurred a cost and if so how they rated it. Consistent with the Medicare data, Older women were much less likely to have incurred a cost than the Younger or Mid-aged women. For the Older women 74% had no cost, 18% had a cost that they rated as “excellent”, “very good” or “good”, while 7% incurred a cost that they rated “fair” or “poor”. The corresponding percentages for the Mid-aged women were: no cost 42%, cost rated “very good” or “good” 21%, and cost rated “fair” or “poor” 37%; for the Younger women 47%, 33% and 20%.

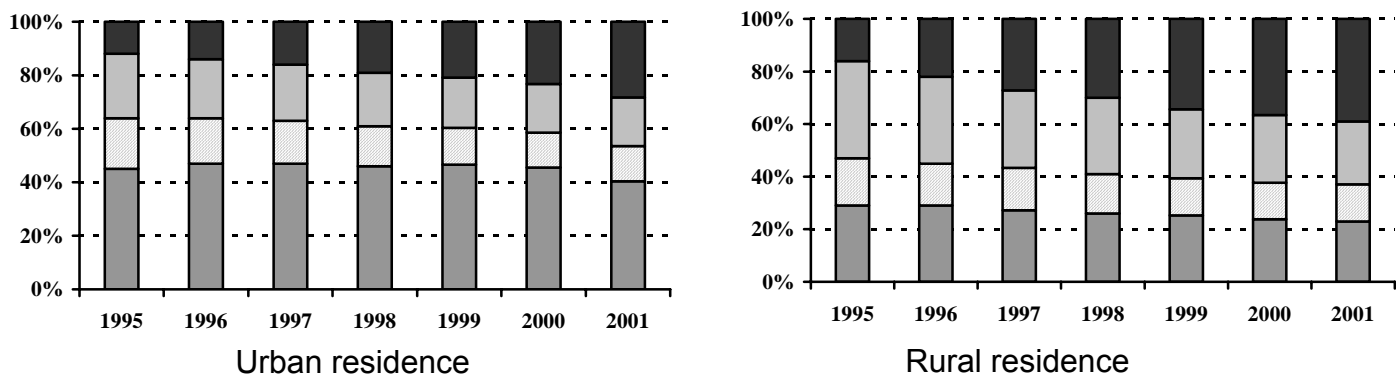
Figure 12 summarises the Survey responses for women in each age group according to their demographic characteristics. As for the Medicare data, across all age groups women in urban areas were least likely to report having incurred a cost and generally those in large and small rural centres were most likely to have had a cost. Married women (and those in a de facto relationship) and those who spoke English at home were more likely to have had a cost at their most recent visit. Cost was related to SES only for the Mid-aged women. Among those women who did incur a cost proportionately more Younger and Older women in rural areas rated the cost as “excellent”, “very good” or “good”.

Among women with chronic conditions, only those with mental health problems or musculoskeletal symptoms reported differences in costs compared women without health problems. Importantly, where there were differences, women with these conditions were more likely to have no costs or low costs associated with their most recent GP visit.

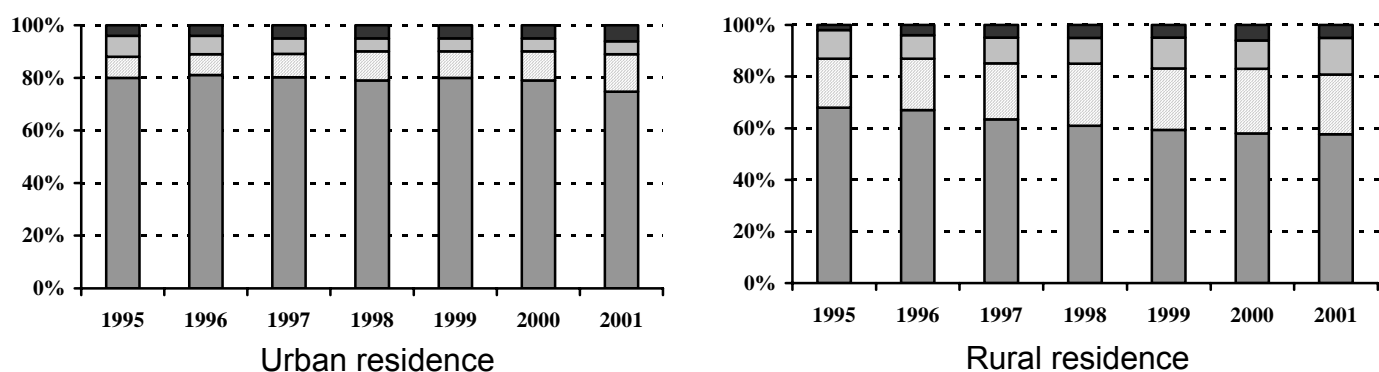
Figure 11: Mean out-of-pocket cost per GP consultation per woman 1995-2001, by age group and area of residence.



Young women (aged 17-22 in 1995 to 23-28 in 2001)



Mid age women (aged 44-49 in 1995 to 50-55 in 2001)



Older women (aged 69-74 in 1995 to 75-80 in 2001)

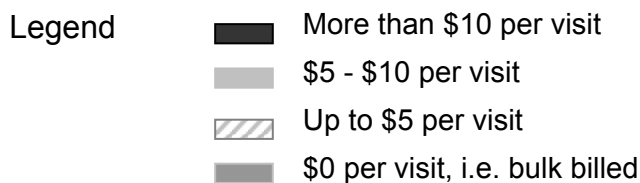
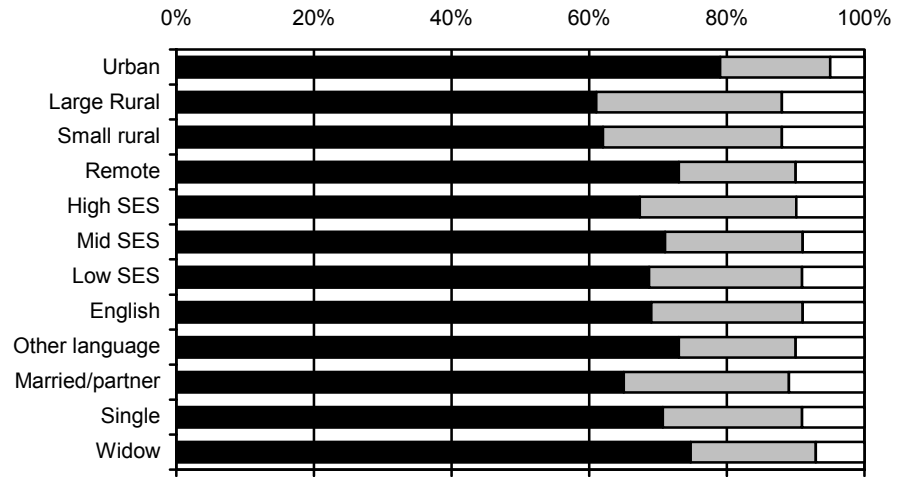
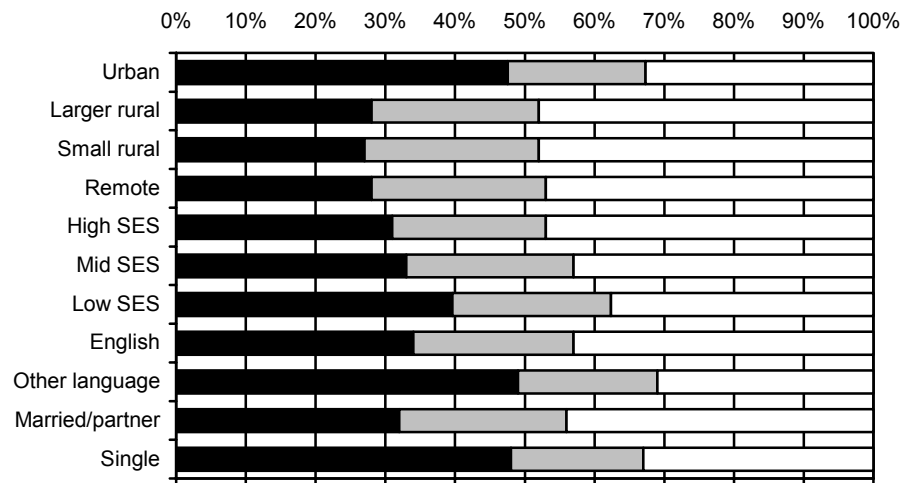


Figure 12. Cost and satisfaction with costs of most recent GP visit for demographic groups (Survey 2): solid bars represent “no cost”, grey bars represent a cost that was rated “excellent”, “very good” or “good” and the empty bars represent costs rated “fair” or “poor”.

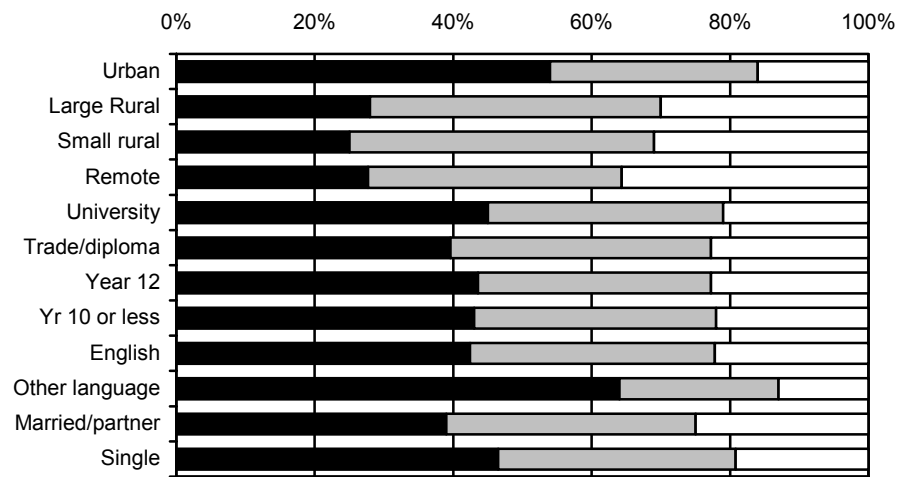
a) Older women



b) Mid-age women



c) Younger women



## Continuity of Care

Continuity of care is one aspect of quality of GP service and Australians have been encouraged in recent times to develop a relationship with one GP who knows them and their history. Mid-aged and Younger women (but not the Older women) were asked at Survey 2 “When you go to the GP, do you usually go to the same place? Do you see the same doctor?”. The Mid-aged women were significantly more likely than the Younger women to always go to the same place (71% vs. 44%) and to always see the same GP (47% vs. 28%).

Figure 13 shows these two measures of continuity of care for women in various demographic groups. Women in large or small rural centres were more likely than women living in urban or remote areas to go to the same place and see the same doctor. Also women with lower SES in both age groups were more likely to go to the same place and see the same doctor (but this could be because they were also more likely to live in rural areas).

Mid-aged women with a history of heart disease or cancer reported always seeing the same GP more often than other women did, but other chronic conditions did not seem to be associated with greater continuity of care (see Table A31 in the Appendix).

## Preference for female doctors

The Commonwealth Government recognises that some women prefer to see female doctors and has expressed a commitment to improve access to female GPs. In ALSWH surveys women are asked if they prefer to see a female GP with response options: “yes, always”, “yes, but only for certain things”, “no” or “don’t care”.

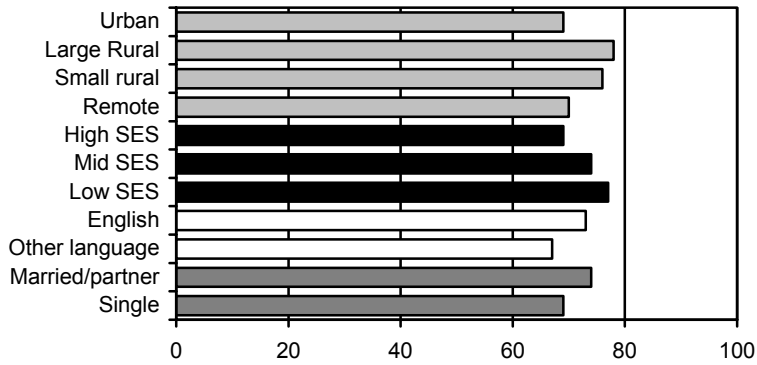
Preference for a female GP was strongest among the Younger women and weakest among the Older women. At Survey 2, 63% of the Younger women said they preferred to see a female GP either all the time or for certain things, compared to 44% for the Mid-aged women and 34% for the Older women. The corresponding percentages of women preferring to see a female GP all the time were: 18% for the Younger women, 17% for the Mid-aged women and 12% for the Older women.

Preferences for a female GP differed between demographic groups – see figure 14. In all age groups urban women reported stronger preferences for a female GP than women in rural areas. Women in the highest SES category had stronger preferences than other women. The most marked preference for a female GP, especially “for certain things”, were expressed by women who did not speak English at home.

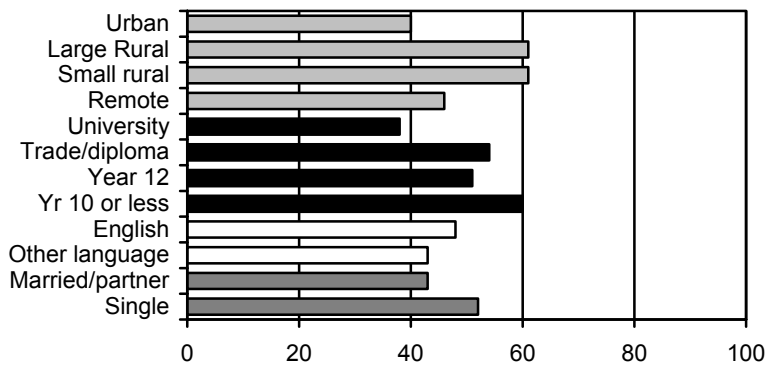
Women with mental health problems had stronger preferences for female GPs than other women did. However, women with other chronic conditions had no distinct preferences for a female GP.

Figure 13. Continuity of GP care for demographic groups (Survey 2)

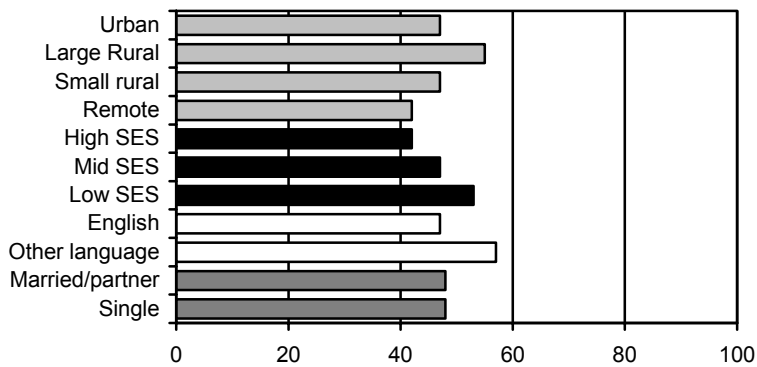
a) Mid-aged women: percentage who always go to the same place



b) Younger women: percentage who always go to the same place



c) Mid-aged women: percentage who usually see the same GP



d) Younger women: percentage who usually see the same GP

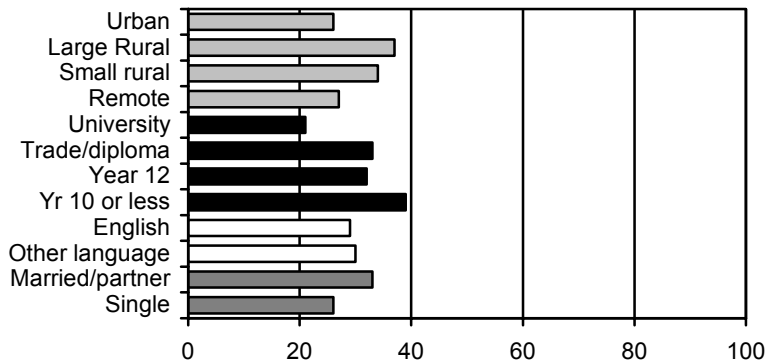
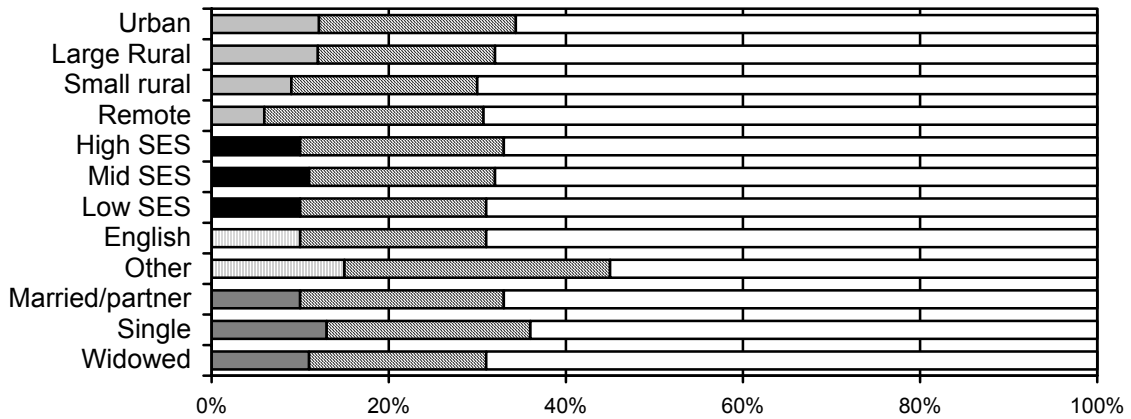
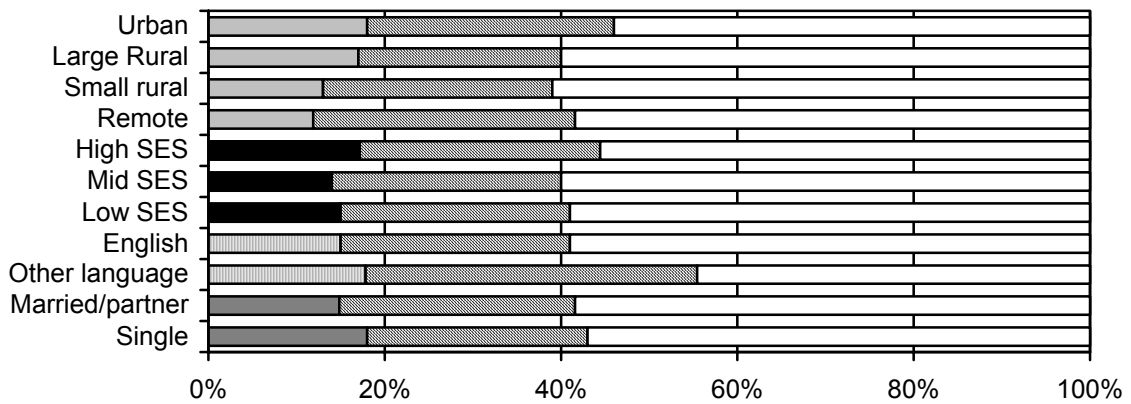


Figure 14. Preference for a female GP by demographic groups (Survey 2): the first part of each bar represents a preference for female GPs “all the time”, the next part represents a preference “for certain things” and the remainder of the bar represents no preference.

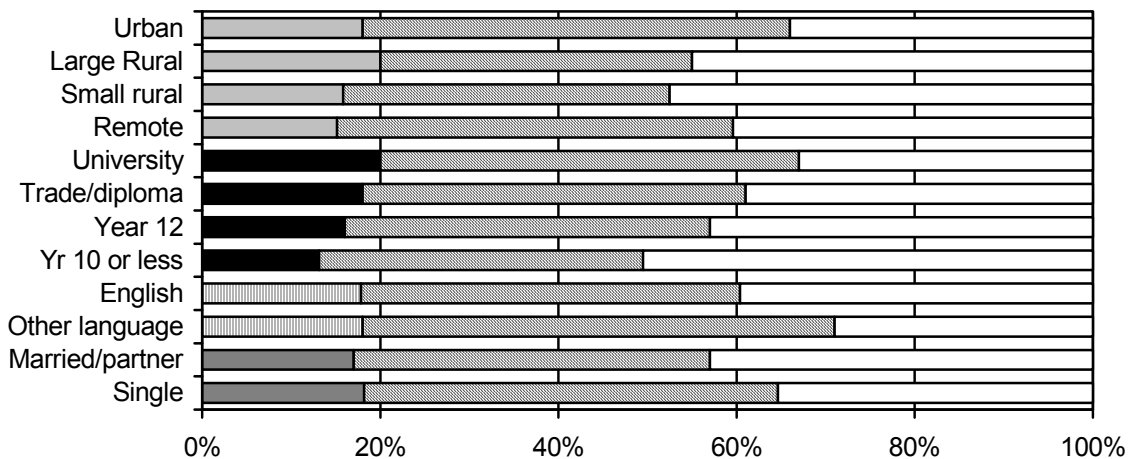
a) Older women



b) Mid-aged women



c) Younger women



## Focus on... heart disease

### *Mid-age women*

Research in other countries has shown that women’s experiences of diagnosis and treatment of cardiovascular disease are often quite different from men’s. For Mid-age women in particular, their condition may be less likely to be recognised quickly by medical staff. This means that women – particularly those who might be considered “too young” to have heart disease - may receive less than optimal treatment and may be sicker than men by the time they receive hospital treatment.

In ALSWH, at Survey 1, 2.3% of Mid-age and 17% of Older women reported having been told by a doctor that they had heart disease. At Survey 2, 3% of the Mid-age women and 21% of Older women reported heart disease. While cardiovascular disease is more prevalent in older women, it is also a health concern for Mid-age women.

Marilys Guillemin conducted a sub-study of Mid-age ALSWH participants who reported they had been told by a doctor they had heart disease. A written survey was administered to 125 participants from around the country, and 32 women from Victoria women also participated in an in-depth interview to provide more detailed information on their experiences.

### **Diagnosis and seeking help**

Of the women in the sub-study, 26 (21%) had had a heart attack (myocardial infarction; MI) and their experiences suggested that delay in diagnosis was common, and that accessing local specialist help at the time of MI was problematic, especially for rural women.

*“Beverley”, 46, living in a large rural town*

*...I started getting chest pain, which continued in the night, and two days later it just kept coming and going. So I went to the doctor, but thought, no don’t be ridiculous you won’t be having a heart attack or anything like that. He did an ECG which showed nothing...the pain got worse and worse... We went to the hospital, where they gave me Valium and sent me home... the pain never stopped... on the Saturday morning we went to (another local hospital)...they put me straight through... the doctor, who came down and met me in the lift... later told me another two minutes and I wouldn’t have made it.*

### **“Too young to have a heart attack”**

Mid-age women frequently reported that both their own and their health care practitioners’ perception that they were “too young to be having a heart attack” contributed to their delayed diagnosis.

They also commented on their rehabilitation experiences and noted their relative youth compared to others with similar conditions. They reported a lack of appropriate material particularly in relation to managing with work and family responsibilities:

*I'd sit there and think well that's fine but what about me...I'd think well that fits if you're not working and you are sort of older.*

### **Gendered perception of heart disease**

21% of the women with heart disease believed that men were more likely than women to be affected by heart disease.

*It's funny we grew up thinking it was only men who had heart problems. It wasn't something you associated with women.*

*A fat overweight man with a gut and a red nose. That's the picture I get...That's been the portrayal over the years.*

The perception that heart disease can only affect men and older people may contribute to women's failure to recognise their symptoms as cardiac related. This lack of recognition by the patients exacerbates the reported delay in diagnosis by medical practitioners. In this study this problem was further aggravated for women in rural and remote areas, where access to specialist care was difficult.

#### **Implications for health care practice, health promotion and disease prevention:**

- ❖ Health care practitioners need to be educated to question their age- and gender-related assumptions regarding heart disease.
- ❖ Education and prevention materials need to be re-examined to ensure they address the needs of different age groups, and of both men and women.
- ❖ More targeted prevention strategies are required, as many women at risk do not consider themselves as potential victims of heart disease.

### **Older women**

#### **Predicting heart disease among older women**

In the three years between Surveys 1 and 2, 503 new cases of diagnosed heart disease (diagnosed by a doctor with angina or heart attack) were reported by Older women who had reported no heart disease at Survey 1. Esben Strodl investigated psychosocial and other risk factors that predicted a new diagnosis of symptomatic coronary heart disease (CHD).

The findings suggested that a low score (< 53) on the mental health (MH) subscale of the SF-36, poor social support, and moderate to high levels of perceived stress may be important predictors of the new onset of symptomatic manifestation of CHD. Of these variables, it was found that perceived stress was associated with newly diagnosed CHD even after adjustment for established risk factors (such as obesity) and the frequency of GP visits.

A detailed study of the adequacy of medical care for Older women in ALSWH with cardiac conditions, funded by NHMRC, has just begun.

## Focus on... diabetes

The importance of diabetes at a population level is illustrated by the finding that 2% of Younger, 4% of Mid-age and 11% of Older ALSWH participants have reported being told by a doctor they had diabetes. Between Survey 1 and Survey 2, 554 new cases of diabetes were reported. Women with diabetes were high users of GP services (compared with other women and women with other chronic conditions), and those in the Mid-age and Older cohorts were more likely than other women their age to need help with daily tasks. Mid-age women with diabetes found it harder than others to obtain a Pap test, while both Mid-age and Older women with diabetes rated the convenience of the location of their GP lower than other women.

A sub-study funded by Diabetes Australia and carried out by Anne Young and other members of the research team has investigated the quality and accessibility of health care for women with diabetes. Some of the preliminary results of this sub-study are presented below.

### *Risk factors for diabetes*

Survey 1 and Survey 2 data from the Mid-age and Older cohorts indicated clear differences in the levels of risk factors for diabetes, such as overweight and inactivity, and low SES, as well as poorer health and higher use of health services (see Table 5). These effects were found for women who already had diabetes at Survey 1 and for those who developed diabetes between surveys.

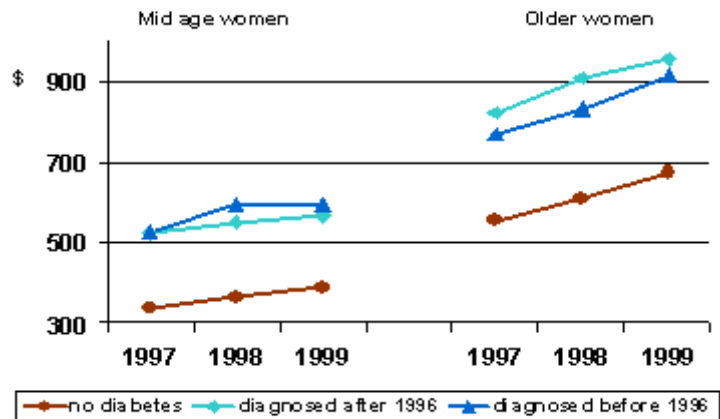
*Table 5. Profile of respondents in 1996, according to age and diabetes status.*

	Mid-age women			Older women		
	Diabetes before Survey 1 (n=236)	Diabetes after Survey 1 (n=141)	No diabetes (n=11853)	Diabetes before Survey 1 (n=840)	Diabetes after Survey 1 (n=266)	No diabetes (n=9315)
	%	%	%	%	%	%
<b>Demographic variables</b>						
Urban residence	35	41	36	37	38	40
Indigenous	4	4	1	0.5	0.8	0.3
No educational qualification	27	24	17	43	41	31
Impossible/difficult to manage on income	56	52	42	33	22	25
Private hospital insurance	42	40	49	38	37	48
<b>Comorbidity</b>						
Hypertension	46	40	20	66	62	46
Heart disease	6	6	2	31	19	15
Eyesight problems	53	54	44	59	51	46
<b>Risk factors</b>						
Body mass index >30	48	52	17	26	27	13
Inadequate physical activity	57	70	58	64	63	55
Current smoker	17	19	17	5	6	7
Alcohol (some risk)	6	4	6	1	5	4

### Health Service Costs

Analysis of Medicare records showed an increased use of GPs, specialists and pathology services outside of hospitals by the women with diabetes. The Medicare/ DVA rebate per woman for non-hospital services is shown in the Figure 15. The amount spent by Medicare for services increased over time as the women aged, and those with diabetes or who developed diabetes accounted for higher expenditure per person than women without diabetes.

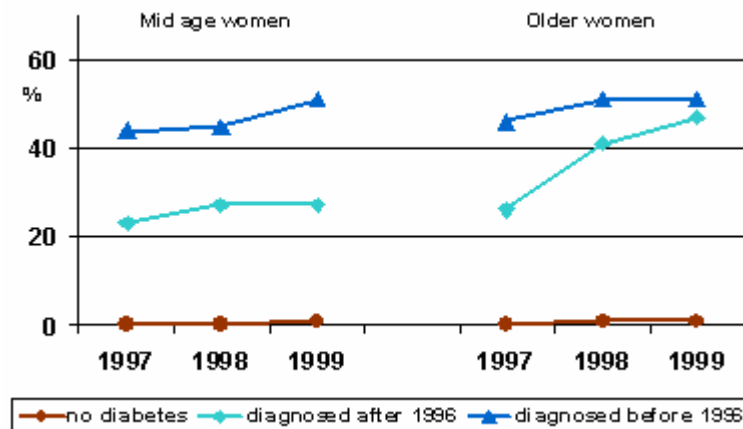
Figure 15. Total Medicare/ DVA rebate (\$) per women for services outside hospital



### Diabetes Care

There is an increasing number of guidelines for diabetes care, including a focus on regular monitoring for those with established diabetes. HbA1c is one of the most useful objective measures of the adequacy of treatment of a person with diabetes and predicts the risk of developing complications of the disease. It is recommended the test be performed at least annually. Figure 16 shows the percentage of women receiving Medicare claimable HbA1c tests each year, demonstrating that use of the test appears to be increasing over the three years, but the frequency of testing is considerably less than the recommended rate (only half the women had had a HbA1c test at least annually). Similarly, lipid measurement tests among women with diabetes were less frequent than recommended use of these pathology tests, although it should be noted that some women may have received in-hospital tests which are not Medicare claimable.

Figure 16. Quality of diabetes care: At least one HbA1c test per year



## Preventive Care

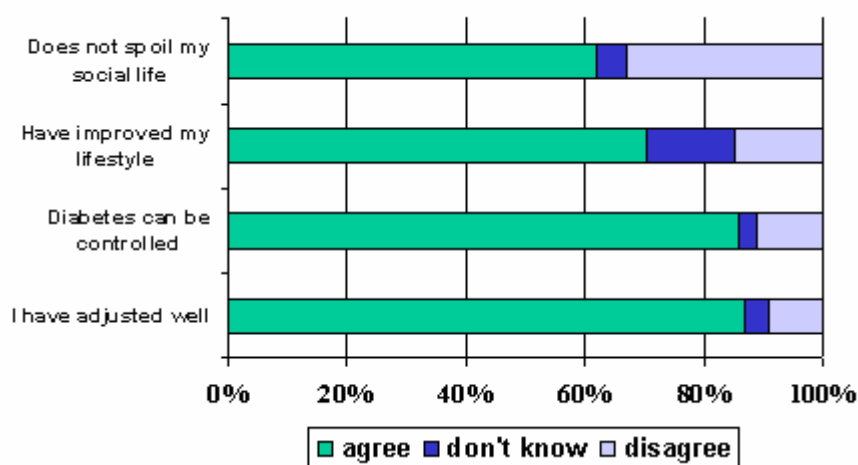
On the basis of these analyses, a sub-study was conducted in which a specific survey was used to collect more detailed information from women with a diagnosis of diabetes. Most women reported testing their blood glucose levels at home, and two-thirds had been to a Diabetes Education Centre. However, many women were not using the full range of preventive and support services that should have been available to them. The Mid-age women reported lower rates for retina examination and foot examination than the Older women, but both cohorts reported sub-optimal rates of these and other preventive screening activities.

## Adjustment to diabetes

Women with diabetes were also asked about how they had adapted to having diabetes; 25% of Older women and 35% of Mid-age women believed that the proper control of diabetes involves a lot of sacrifice and inconvenience. 35% of women in both groups reported that they did not like being told what to eat, when to eat and how much, while one woman in five avoided letting people know she had diabetes – a decision which might interfere with their ability to access help when needed.

Despite the challenges, most women believed they had adjusted well to the demands of having diabetes and many also agreed that having diabetes had encouraged them to improve their lifestyle (see Figure 17).

Figure 17. Older diabetic women’s attitudes towards having diabetes (n=650)



## Focus on... musculoskeletal conditions

### *Arthritis*

Arthritis was the one of the most commonly reported chronic conditions in both the Mid-age and Older cohorts of women; 23% of Mid-age and 42% of Older women reported “having been told by a doctor they had arthritis” in the most recent surveys. Women reporting having arthritis were more likely to need help with daily tasks, and had higher use of health services, including GPs, specialists, and hospital doctors. Older women with arthritis rated their access to medical specialists as less satisfactory than did other women, and also had lower rating of the ease of seeing their GP of choice. 18% of Mid-age women reported having taken medication for arthritis in the previous month. Two-thirds of these women took medication prescribed or recommended by a doctor, while the remainder took other medications for arthritis. 25% of Mid-age women and 49% of Older women with arthritis also reported having visited an alternative practitioner (including acupuncturists, osteopaths and chiropractors) in the past twelve months.

### *Osteoporosis*

Between Surveys 1 and 2, Mid-age and Older women reported a total of 703 new cases of osteoporosis. The prevalence of osteoporosis has increased markedly among the Mid-age cohort. Of those who have remained in the study over the three surveys, 4% reported having osteoporosis at Survey 1 (45-50 yrs old), by Survey 3, 14% had reported having been told by a doctor they have osteoporosis (50-55 yrs old). In the Older group, 21% reported osteoporosis at Survey 1, and by Survey 2, 30% had been told by a doctor they had this condition. Having osteoporosis was associated with needing help with daily tasks, and higher use of health services, including GPs, specialists and hospital doctors. While women with osteoporosis were high users of GP services, they were often less satisfied with convenience of the location of the surgery and the time spent in the waiting room, especially in the Older cohort.

## Focus on...asthma

Asthma was one of the most commonly reported chronic conditions, with 7565 women reporting at Survey 1 that they had “ever been told by a doctor they had asthma”. Between Survey 1 and Survey 2, 945 new cases of asthma were reported. Asthma was most common in the Younger cohort (29% at Survey 2) and least common among the Older women (14% at Survey 2). Women with asthma were more likely to be high users of GP services than other women in the same age cohort, and their satisfaction with their most recent GP visit was similar to women without asthma. Women with asthma were more likely than others to have been admitted to hospital, have seen a specialist and have seen a hospital doctor; they rated their access to these services at a similar level to other women. Younger women with asthma were more likely to visit an alternative practitioner (including acupuncturists and naturopaths) than women without asthma. Use of alternative practitioners was more common among women with asthma than those with diabetes, cancer or heart disease (except in the Older cohort). Having asthma was associated with a higher likelihood of needing help with daily tasks for the Older women, but not for the Mid-age and Younger women. A diagnosis of asthma was associated with lower SF-36 Physical Component Scale scores for Mid-age and Older women, but not for Younger women. Asthma was not associated with SF-36 Mental Component Scale scores in any age group.

### *Lay Perceptions of Asthma*

Gabrielle Rose has been conducting doctoral research on the experiences of women with asthma. The following is a summary of the published results of a sub-study of 348 women in the mid aged group who reported having ever been told by a doctor that they had asthma (Rose & Manderson, 2000). These women responded to a survey, and 35 also participated in in-depth interviews to investigate women's personal experience of asthma, how they diagnose asthma, their treatment and management strategies.

The women interviewed understood and defined asthma in ways that differed from the dominant medical and technical understanding. Not all had received even the most basic information about their condition from their doctors. For example, one articulated conflict between her own and her doctor's understanding of her condition:

*“...he wanted me to do a lot of peak-flow measures, and I said “Look, peak-flow measures have never shown me anything about my asthma. I assess my asthma in a different way”... I tried to explain controlled pauses to him... I very infrequently take a preventative but I would if my controlled pauses went down. I use controlled pauses as a gauge for my asthma, just as doctors use peak flows.”*

Another was struggling for any consistency of diagnosis:

*“It doesn't seem to matter how many different doctors I go to, they all seem to say different things. One... said I have indigestion. The new one here says I have allergic asthma. When I go to the hospital the doctor there says I have intrinsic asthma whatever that is. Who knows what I have?”*

As a chronic condition, asthma is often discussed in terms of “managing the illness” But it has been argued that medical perspectives remove the disease experience from the individual. But many of the women interviewed commented on the conflict between themselves and their doctor over asthma management:

*I'm taking well over 40 puffs of various medications a day and if anything goes wrong, I'm to blame for neglecting to take my medication.*

## References and Relevant ALSWH publications

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## Appendix

### *Survey items*

The ALSWH questionnaires are available on the website [www.newcastle.edu.au/centre/wha](http://www.newcastle.edu.au/centre/wha)

### *Demographic variables*

Marital status was assessed at each survey, but categorized differently between the three cohorts. For the Younger and Mid-aged cohorts, the categories were combined to form two groups: widowed, separated, divorced, never married or single (Single); and married or living in a de-facto relationship (Married). Marital status for the Older cohort was classified into three categories: Widowed; separated, divorced and never married (Single); and married or living in a de-facto relationship (Married).

Language spoken at home was asked for each age cohort and categorized as English or other language. This was asked at Survey 1 for each age cohort and also used for analysis of data from Survey 2.

The SES variables for Older and Mid-aged women were composite measures of occupation and education using responses about the woman’s age when she left school, her highest qualifications and main occupation. This variable was calculated differently for each cohort and then categorized into approximate tertiles. For Younger women, many of whom were still full-time students at Survey 1, SES was defined as highest level of education attained by Survey 2; this was categorized as: Year 10 or less, Year 12, trade qualification or diploma, university degree.

### *Chronic Conditions*

Women were identified as having certain chronic conditions based responses to questions of having ever been told by a doctor that they had the condition. Questions about chronic conditions were asked at each survey, with some variation in the type of conditions; for example, Mid-aged and Older women were asked about osteoporosis but the Younger women were not. Survey 2 for all cohorts included questions about diagnosis by a doctor of depression or anxiety; these items were not asked in Survey 1.

Where Survey 2 results are reported, these are inclusive of women who have ever reported the chronic condition; for example, women were classified as having heart disease if they said “Yes” in Survey 1 or “Yes” in Survey 2.

For cancer the results exclude skin cancer.

For diabetes results include type 1, type 2 and gestational diabetes.

Symptoms of back pain and stiff and painful joints are given for women who reported having experienced these symptoms “often” in the past 12 months (other response options were “sometimes”, “rarely” and “never”).

Low MH score refer to the scores on the Mental Health Index, a five-item measure of mental health from the MOS 36 – item Short-form Health Survey. A score of less than 53 on this scale is an indicator of possible clinical depression (Ware and Gandek, 1994).

## **Use of GP services**

For each age cohort, the number of visits to a family doctor or another general practitioner, within the last 12 months, was asked at both surveys, although the wording of the question and the response options varied slightly. In Survey 1 the Younger women were asked how many times they had visited the family doctor in the past 12 months. In Survey 2 for this age group the question was split into two parts which asked about visits to the family doctor in the past 12 months for Pap tests, contraception or routine pregnancy checks and for all other reasons. This change at Survey 2 may have resulted in an increased number of GP visits being reported.

In other surveys the question wording remained consistent, however the following different response options differed.

Women were categorized as high users based on their number of visits to the GP relative to their cohort. The cut point for high use was chosen so that approximately 30% of GP users at each survey were classed as frequent or high users. The following cut-points were used at Survey 2: for the Older women > 8 visits, for the Mid-aged women > 4 visits, and for the Younger women > 6 visits.

## **Access to services**

In Survey 2 there were items about access to various health services ranging from medical specialists to women's health or family planning services. The response options were: excellent, very good, good, fair and poor. The analyses are based on the percentages of women responding "excellent" or "very good".

## **Satisfaction with services**

At Surveys 1 and 2 questions were asked about satisfaction with aspects of the woman's most recent GP visit. They covered issues from waiting times to the personal manner of the doctor. In this report Survey 1 results are given because the question wording was similar for all cohorts – however the results from Survey 2 showed the same patterns. Analyses were based on responses of "excellent" or "very good".

## **Cost of GP visit**

Results are reported for a Survey 2 question which asked women to rate the cost of their most recent visit to the GP; the wording of this question and the response options varied somewhat between cohorts. For the Younger and Older women the response options were "no cost", "excellent", "very good", "good", "fair", or "poor" and Mid-aged women the response options were "no cost to me", "good", "fair", "poor", "don't know". Response categories used for analysis were: no cost; excellent, very good or good; fair or poor.

## **Continuity of care**

At Survey 2 Mid-aged and Younger women were asked about aspects of continuity of care – whether they went to the same place and saw the same doctor. The analysis is based on the response category suggesting best continuity of provider.

### *Preference for a female doctor*

In both surveys women were asked “In general, do you prefer to see a female GP/ doctor?”, response options were “yes, always”, “yes , but only for certain things”, “no” and “don’t care”. For analysis the last two categories were combined and labelled “no”.

### *Weighting*

Where tables indicate weighting by area of residence percentages are weighted for over-sampling in rural and remote areas in order to provide national estimates of prevalence. Figures and tables in the text comparing women in different demographic groups and with chronic conditions (and the corresponding Appendix tables) are based on unweighted data.

*Table A1. Percentages of women in various demographic groups by age (Y=Younger, M=Mid aged, O=Older) and Survey (1=Survey 1, 2=Survey 2); “-“ indicates that SES was estimated using data from the other Survey, a blank indicate the question was not asked.*

	O 1	O 2	M1	M2	Y1	Y2
Number of respondents	12940	8652	14099	12338	14779	9685
Area of residence						
Urban	71	70	72	72	76	74
Large rural	6	6	6	6	6	6
Small rural	21	22	19	20	15	16
Remote	2	2	3	2	3	3
Socio-economic status						
High (Y - university)	29	-	29	-	-	40
Medium (Y - trade/diploma)	44	-	36	-	-	24
(Y - year 12)					-	24
Low (Y - yr 10 or less)	27	-	35	-	-	11
Language spoken at home						
English	90	94	90	95	92	93
Other	10	6	10	5	8	7
Marital status						
Married, de facto	55	51	81	81	20	43
Single, separated, divorced	10	8	19	19	80	57
Widowed	35	41				

*Table A2. Use of GP services: percentage of women in demographic groups who visited a GP at least once in the previous 12 months*

	O 1	O 2	M1	M2	Y1	Y2
Total	96	98	92	92	94	97
Area of residence						
Urban	97	98	92	92	97	97
Large rural	96	99	92	91	96	96
Small rural	96	98	90	90	96	96
Remote	94	97	90	88	98	98
Socio-economic status						
High (Y - university)	96	98	90	89	-	96
Medium (Y - trade/diploma)	96	98	91	91	-	96
(Y - year 12)					-	96
Low (Y - yr 10 or less)	96	98	92	91	-	96
Language spoken at home						
English	96	98	91	91	94	97
Other	96	97	90	92	91	95
Marital status						
Married, de facto	96	98	91	91	97	98
Single, separated, divorced	95	97	92	91	93	95
Widowed	96	98				

*Table A3. Frequent use of GP services and any visit to a specialist in the last 12 months: percentage of women in demographic groups (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	High use of GP			Visited specialist		
	O	M	Y	O	M	Y
Total	30	26	32	47	40	34
Area of residence						
Urban	<b>35</b>	<b>29</b>	32	<b>52</b>	<b>45</b>	<b>36</b>
Large rural	<b>27</b>	<b>24</b>	32	<b>44</b>	<b>38</b>	<b>32</b>
Small rural	<b>26</b>	<b>24</b>	32	<b>43</b>	<b>37</b>	<b>32</b>
Remote	<b>29</b>	<b>24</b>	31	<b>41</b>	<b>35</b>	<b>28</b>
Socio-economic status						
High (Y - university)	<b>25</b>	<b>21</b>	<b>25</b>	<b>50</b>	<b>43</b>	34
Medium (Y - trade/diploma)	<b>30</b>	<b>23</b>	<b>35</b>	<b>47</b>	<b>40</b>	36
(Y - year 12)			<b>34</b>			34
Low (Y - yr 10 or less)	<b>35</b>	<b>32</b>	<b>42</b>	<b>43</b>	<b>38</b>	35
Language spoken at home						
English	<b>29</b>	25	32	47	<b>40</b>	34
Other	<b>35</b>	30	31	49	<b>48</b>	38
Marital status						
Married, de facto	29	25	36	47	40	36
Single, separated, divorced	32	31	28	50	43	33
Widowed	30			46		

*Table A4. Visit to a hospital doctor or hospital admission in the last 12 months: percentage of women in demographic groups (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	Hospital doctor			Hospital admission		
	O	M	Y	O	M	Y
Total	18	15	23	28	-	19
Area of residence						
Urban	<b>18</b>	14	<b>20</b>	27	-	<b>16</b>
Large rural	<b>16</b>	15	<b>27</b>	28	-	<b>21</b>
Small rural	<b>17</b>	15	<b>28</b>	28	-	<b>25</b>
Remote	<b>25</b>	18	<b>37</b>	27	-	<b>26</b>
Socio-economic status						
High (Y - university)	16	<b>12</b>	<b>19</b>	26	-	<b>12</b>
Medium (Y - trade/diploma)	17	<b>14</b>	<b>24</b>	28	-	<b>20</b>
(Y - year 12)			<b>26</b>			<b>23</b>
Low (Y - yr 10 or less)	19	<b>19</b>	<b>32</b>	28	-	<b>31</b>
Language spoken at home						
English	17	<b>15</b>	24	28	-	19
Other	22	<b>21</b>	21	26	-	16
Marital status						
Married, de facto	17	<b>14</b>	<b>27</b>	26	-	<b>26</b>
Single, separated, divorced	18	<b>19</b>	<b>20</b>	29	-	<b>12</b>
Widowed	18			29		

Table A5. Percentages of women with chronic conditions by age (Y=Younger, M=Mid aged, O=Older) and Survey (1=Survey 1, 2=Survey 2); “-“ indicates the question was to asked.

	O 1	O 2	M1	M2	Y1	Y2
Arthritis	-	42	-	-	-	-
Osteoporosis	20	24	4	5	-	-
Stiff & painful joints	32	22	20	20	-	-
Back pain	24	19	20	19	12	14
Asthma	13	14	16	18	25	29
Low mental health score	11	9	16	16	22	20
Depression	-	7	-	18	-	14
Anxiety	-	6	-	14	-	6
Heart disease	17	21	2	3	0.5	1.3
Cancer	8	11	5	8	1.5	3.7
Diabetes	9	11	3	4	1	2

Table A6. Frequent use of GP services and any visit to a specialist in the last 12 months: percentage of women with chronic conditions (Survey 2); “-“ indicates question not asked; bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference)

	High use of GP			Visited specialist		
	O	M	Y	O	M	Y
All women	32	27	32	50	43	34
Arthritis	<b>38</b>	-	-	<b>54</b>	-	-
Osteoporosis	<b>40</b>	<b>45</b>	-	<b>58</b>	<b>60</b>	-
Stiff & painful joints	<b>44</b>	<b>44</b>	-	<b>61</b>	<b>53</b>	-
Back pain	<b>45</b>	<b>41</b>	<b>43</b>	<b>60</b>	<b>49</b>	<b>43</b>
Asthma	<b>46</b>	<b>39</b>	<b>38</b>	<b>56</b>	<b>48</b>	<b>39</b>
Low mental health score	<b>50</b>	<b>45</b>	<b>41</b>	<b>58</b>	<b>49</b>	<b>42</b>
Depression	<b>55</b>	<b>47</b>	<b>53</b>	<b>63</b>	<b>51</b>	<b>51</b>
Anxiety	<b>55</b>	<b>46</b>	<b>55</b>	<b>59</b>	<b>52</b>	<b>50</b>
Heart disease	<b>49</b>	<b>50</b>	-	<b>64</b>	<b>59</b>	43
Cancer	<b>38</b>	<b>37</b>	48	<b>63</b>	<b>63</b>	<b>53</b>
Diabetes	<b>48</b>	<b>64</b>	<b>46</b>	<b>57</b>	<b>55</b>	<b>49</b>

*Table A7. Visit to a hospital doctor or hospital admission in the last 12 months: percentage of women with chronic conditions (Survey 2); “-“ indicates question not asked; bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	Visited hospital doctor			Admitted to hospital		
	O	M	Y	O	M	Y
All women	18	15	23	28	-	19
Arthritis	<b>21</b>	-	-	<b>32</b>	-	-
Osteoporosis	<b>22</b>	<b>26</b>	-	<b>36</b>	-	-
Stiff & painful joints	<b>24</b>	<b>23</b>	-	<b>36</b>	-	-
Back pain	<b>25</b>	<b>23</b>	<b>28</b>	<b>36</b>	-	<b>24</b>
Asthma	<b>24</b>	<b>20</b>	<b>27</b>	<b>36</b>	-	<b>21</b>
Low mental health score	<b>30</b>	<b>24</b>	<b>28</b>	<b>41</b>	-	<b>22</b>
Depression	<b>32</b>	<b>23</b>	<b>33</b>	<b>40</b>	-	<b>25</b>
Anxiety	<b>29</b>	<b>22</b>	<b>34</b>	<b>41</b>	-	<b>24</b>
Heart disease	<b>28</b>	<b>32</b>	33	<b>42</b>	-	24
Cancer	<b>24</b>	<b>28</b>	<b>42</b>	<b>41</b>	-	<b>36</b>
Diabetes	<b>24</b>	<b>23</b>	<b>34</b>	<b>36</b>	-	<b>32</b>

*Table A8. Access to medical specialists and hospitals: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	Medical specialists			Hospital		
	O	M	Y	O	M	Y
Total	60	58	44	63	65	54
Area of residence						
Urban	<b>67</b>	<b>71</b>	<b>51</b>	64	<b>69</b>	<b>56</b>
Large rural	<b>64</b>	<b>63</b>	<b>42</b>	65	<b>69</b>	<b>54</b>
Small rural	<b>53</b>	<b>48</b>	<b>33</b>	62	<b>62</b>	<b>54</b>
Remote	<b>35</b>	<b>31</b>	<b>15</b>	59	<b>55</b>	<b>43</b>
Socio-economic status						
High (Y - university)	<b>63</b>	<b>63</b>	<b>51</b>	<b>66</b>	<b>70</b>	<b>59</b>
Medium (Y - trade/diploma)	<b>62</b>	<b>57</b>	<b>41</b>	<b>64</b>	<b>65</b>	<b>53</b>
(Y - year 12)			<b>40</b>			<b>52</b>
Low (Y - yr 10 or less)	<b>53</b>	<b>53</b>	<b>33</b>	<b>58</b>	<b>60</b>	<b>49</b>
Language spoken at home						
English	<b>61</b>	<b>58</b>	44	<b>63</b>	<b>65</b>	55
Other	<b>47</b>	<b>47</b>	41	<b>49</b>	<b>50</b>	48
Marital status						
Married, de facto	61	58	<b>42</b>	<b>65</b>	<b>66</b>	55
Single, separated, divorced	60	57	<b>45</b>	<b>60</b>	<b>61</b>	53
Widowed	59			<b>61</b>		

*Table A9. Access to after hours care and GPs who bulk bill: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	After-hours care			GP who bulk bills		
	O	M	Y	O	M	Y
Total	44	60	32	70	43	48
Area of residence						
Urban	<b>46</b>	<b>65</b>	<b>33</b>	<b>78</b>	<b>47</b>	<b>58</b>
Large rural	<b>49</b>	<b>68</b>	<b>37</b>	<b>67</b>	<b>51</b>	<b>36</b>
Small rural	<b>41</b>	<b>54</b>	<b>29</b>	<b>63</b>	<b>38</b>	<b>32</b>
Remote	<b>42</b>	<b>47</b>	<b>22</b>	<b>60</b>	<b>30</b>	<b>26</b>
Socio-economic status						
High (Y - university)	43	<b>63</b>	<b>35</b>	<b>69</b>	<b>46</b>	<b>51</b>
Medium (Y - trade/diploma)	46	<b>60</b>	<b>31</b>	<b>72</b>	<b>44</b>	<b>45</b>
(Y - year 12)			<b>31</b>			<b>46</b>
Low (Y - yr 10 or less)	41	<b>53</b>	<b>28</b>	<b>67</b>	<b>39</b>	<b>45</b>
Language spoken at home						
English	<b>44</b>	<b>60</b>	<b>33</b>	<b>70</b>	<b>43</b>	<b>47</b>
Other	<b>31</b>	<b>47</b>	<b>25</b>	<b>63</b>	<b>35</b>	<b>54</b>
Marital status						
Married, de facto	45	60	32	70	43	<b>45</b>
Single, separated, divorced	46	58	33	70	41	<b>50</b>
Widowed	42			69		

*Table A10. Access to a female GP and rating of hours a GP is available: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked*

	Female GP			Hours GP is available		
	O	M	Y	O	M	Y
Total	-	48	44	52	43	33
Area of residence						
Urban	-	<b>60</b>	<b>50</b>	<b>57</b>	<b>49</b>	<b>36</b>
Large rural	-	<b>52</b>	<b>43</b>	<b>55</b>	<b>47</b>	<b>31</b>
Small rural	-	<b>40</b>	<b>33</b>	<b>48</b>	<b>38</b>	<b>30</b>
Remote	-	<b>26</b>	<b>25</b>	<b>35</b>	<b>30</b>	<b>20</b>
Socio-economic status						
High (Y - university)	-	<b>52</b>	<b>48</b>	50	43	34
Medium (Y - trade/diploma)	-	<b>48</b>	<b>42</b>	54	43	32
(Y - year 12)			<b>41</b>			32
Low (Y - yr 10 or less)	-	<b>45</b>	<b>41</b>	52	43	34
Language spoken at home						
English	-	48	44	<b>52</b>	43	<b>33</b>
Other	-	43	43	<b>45</b>	39	<b>28</b>
Marital status						
Married, de facto	-	<b>47</b>	43	53	43	33
Single, separated, divorced	-	<b>52</b>	45	50	43	33
Widowed	-			52		

Table A11. Number of GPs to chose from and ease of seeing the GP of choice: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference)

	Number of GPs to choose from			Ease of seeing GP of choice		
	O	M	Y	O	M	Y
Total	54	50	43	63	48	36
Area of residence						
Urban	<b>60</b>	<b>59</b>	<b>46</b>	<b>70</b>	<b>56</b>	<b>38</b>
Large rural	<b>58</b>	<b>57</b>	<b>49</b>	<b>67</b>	<b>54</b>	<b>40</b>
Small rural	<b>49</b>	<b>44</b>	<b>38</b>	<b>56</b>	<b>42</b>	<b>32</b>
Remote	<b>30</b>	<b>27</b>	<b>20</b>	<b>45</b>	<b>31</b>	<b>24</b>
Socio-economic status						
High (Y - university)	55	<b>53</b>	44	<b>65</b>	50	<b>34</b>
Medium (Y - trade/diploma)	55	<b>50</b>	43	<b>64</b>	48	<b>37</b>
(Y - year 12)			42			<b>36</b>
Low (Y - yr 10 or less)	52	<b>48</b>	43	<b>60</b>	48	<b>42</b>
Language spoken at home						
English	<b>55</b>	51	<b>43</b>	<b>63</b>	49	36
Other	<b>44</b>	45	<b>37</b>	<b>51</b>	46	35
Marital status						
Married, de facto	55	50	44	64	48	37
Single, separated, divorced	53	52	42	64	48	35
Widowed	53			62		

Table A12. Ease of obtaining a Pap test and access to a counselling service: percentage of women in demographic groups who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked

	Ease of obtaining Pap test			Counselling service		
	O	M	Y	O	M	Y
Total	-	75	63	-	45	38
Area of residence						
Urban	-	<b>80</b>	<b>66</b>	-	<b>53</b>	<b>41</b>
Large rural	-	<b>82</b>	<b>64</b>	-	<b>50</b>	<b>39</b>
Small rural	-	<b>71</b>	<b>60</b>	-	<b>40</b>	<b>35</b>
Remote	-	<b>58</b>	<b>51</b>	-	<b>28</b>	<b>24</b>
Socio-economic status						
High (Y - university)	-	<b>78</b>	66	-	47	39
Medium (Y - trade/diploma)	-	<b>76</b>	62	-	44	39
(Y - year 12)			63			37
Low (Y - yr 10 or less)	-	<b>71</b>	60	-	44	39
Language spoken at home						
English	-	<b>75</b>	<b>64</b>	-	45	39
Other	-	<b>68</b>	<b>55</b>	-	40	32
Marital status						
Married, de facto	-	75	65	-	45	38
Single, separated, divorced	-	74	62	-	46	38
Widowed	-			-		

*Table A13. Access to women’s health/family planning services: percentage of women who rated their access as “excellent” or “very good” (Survey 2) – bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked*

	Women’s health/ Family planning		
	O	M	Y
Total	-	45	38
Area of residence			
Urban	-	<b>54</b>	<b>41</b>
Large rural	-	<b>58</b>	<b>44</b>
Small rural	-	<b>37</b>	<b>32</b>
Remote	-	<b>29</b>	<b>23</b>
Socio-economic status			
High (Y - university)	-	47	39
Medium (Y - trade/diploma)	-	45	38
(Y - year 12)			38
Low (Y - yr 10 or less)	-	43	38
Language spoken at home			
English	-	45	38
Other	-	43	35
Marital status			
Married, de facto	-	45	39
Single, separated, divorced	-	47	38
Widowed	-		

*Table A14. Access to medical specialists and hospitals: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked*

	Medical specialists			Hospital		
	O	M	Y	O	M	Y
All women	60	58	44	63	65	54
Arthritis	<b>58</b>	-	-	62	-	-
Osteoporosis	60	56	-	61	62	-
Stiff & painful joints	<b>56</b>	<b>51</b>	-	61	<b>59</b>	-
Back pain	<b>56</b>	<b>53</b>	<b>37</b>	61	<b>60</b>	51
Asthma	60	56	42	64	63	54
Low mental health score	<b>50</b>	<b>47</b>	<b>36</b>	58	<b>54</b>	<b>45</b>
Depression	57	<b>54</b>	41	62	<b>61</b>	<b>50</b>
Anxiety	57	55	43	64	<b>60</b>	52
Heart disease	60	55	48	65	63	45
Cancer	63	58	42	67	64	50
Diabetes	60	55	39	64	60	49

Table A15. Access to after hours care and a GP who bulk bills: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked

	After hours care			GP who bulk bills		
	O	M	Y	O	M	Y
All women	44	60	32	70	43	48
Arthritis	42	-	-	70	-	-
Osteoporosis	<b>40</b>	56	-	70	42	-
Stiff & painful joints	41	<b>53</b>	-	70	<b>37</b>	-
Back pain	42	<b>54</b>	30	71	<b>37</b>	46
Asthma	45	59	32	72	42	48
Low mental health score	<b>37</b>	<b>48</b>	<b>26</b>	68	<b>32</b>	<b>45</b>
Depression	40	<b>56</b>	30	72	<b>39</b>	50
Anxiety	41	<b>55</b>	32	71	<b>38</b>	51
Heart disease	45	57	32	70	39	51
Cancer	46	59	33	74	40	50
Diabetes	44	55	28	70	44	42

Table A16. Access to a female GP and rating of hours a GP is available: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked

	Female GP			Hours GP available		
	O	M	Y	O	M	Y
All women	-	48	44	52	42	33
Arthritis	-	-	-	51	-	-
Osteoporosis	-	48	-	50	43	-
Stiff & painful joints	-	<b>45</b>	-	51	<b>39</b>	-
Back pain	-	<b>45</b>	42	50	<b>39</b>	31
Asthma	-	49	44	54	42	33
Low mental health score	-	<b>41</b>	<b>40</b>	<b>47</b>	<b>35</b>	<b>27</b>
Depression	-	48	44	52	41	32
Anxiety	-	48	47	51	42	34
Heart disease	-	46	39	54	37	26
Cancer	-	48	40	53	40	33
Diabetes	-	45	41	52	43	29

*Table A17. Number of GPs to choose from and ease of seeing a GP of choice: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	Number of GP to choose from			Ease of seeing GP of choice		
	O	M	Y	O	M	Y
All women	54	50	43	63	48	36
Arthritis	54	-	-	61	-	-
Osteoporosis	52	48	-	61	47	-
Stiff & painful joints	53	<b>46</b>	-	61	46	-
Back pain	53	<b>47</b>	42	61	46	33
Asthma	58	50	43	63	49	36
Low mental health score	55	<b>41</b>	<b>37</b>	<b>56</b>	<b>40</b>	<b>30</b>
Depression	52	50	43	59	46	34
Anxiety	50	50	47	64	47	37
Heart disease	54	45	43	62	47	36
Cancer	55	48	38	64	49	37
Diabetes	54	49	43	63	52	38

*Table A18. Ease of obtaining Pap test and access to counselling services: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked*

	Ease of obtaining Pap test			Counselling service		
	O	M	Y	O	M	Y
All women	-	75	63	-	45	38
Arthritis	-	-	-	-	-	-
Osteoporosis	-	71	-	-	42	-
Stiff & painful joints	-	<b>71</b>	-	-	<b>41</b>	-
Back pain	-	<b>71</b>	61	-	<b>41</b>	36
Asthma	-	74	64	-	43	39
Low mental health score	-	<b>65</b>	<b>56</b>	-	<b>36</b>	35
Depression	-	<b>71</b>	62	-	43	40
Anxiety	-	<b>71</b>	64	-	44	42
Heart disease	-	68	61	-	46	34
Cancer	-	74	65	-	42	36
Diabetes	-	<b>66</b>	59	-	45	38

Table A19. Access to women’s health/family planning services: percentage of women with chronic conditions who rated their access as “excellent” or “very good” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked

	Women’s health/family planning		
	O	M	Y
All women	-	45	38
Arthritis	-	-	-
Osteoporosis	-	40	-
Stiff & painful joints	-	<b>40</b>	-
Back pain	-	<b>41</b>	37
Asthma	-	43	37
Low mental health score	-	<b>36</b>	<b>32</b>
Depression	-	42	37
Anxiety	-	43	40
Heart disease	-	46	39
Cancer	-	45	31
Diabetes	-	43	37

Table A20. Satisfaction with location of surgery and waiting time: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked

	Surgery location			Waiting time		
	O	M	Y	O	M	Y
Total	71	71	71	49	39	32
Area of residence						
Urban	<b>70</b>	<b>70</b>	<b>75</b>	50	40	<b>34</b>
Large rural	<b>69</b>	<b>71</b>	<b>65</b>	48	41	<b>31</b>
Small rural	<b>74</b>	<b>73</b>	<b>69</b>	48	39	<b>30</b>
Remote	<b>72</b>	<b>71</b>	<b>60</b>	50	39	<b>26</b>
Socio-economic status						
High (Y - university)	<b>73</b>	72	-	<b>51</b>	40	-
Medium (Y - trade/diploma)	<b>72</b>	72	-	<b>50</b>	39	-
(Y - year 12)			-			-
Low (Y - yr 10 or less)	<b>69</b>	70	-	<b>46</b>	39	-
Language spoken at home						
English	<b>72</b>	<b>72</b>	<b>72</b>	<b>50</b>	<b>40</b>	33
Other	<b>59</b>	<b>60</b>	<b>64</b>	<b>35</b>	<b>29</b>	30
Marital status						
Married, de facto	72	72	<b>73</b>	49	40	30
Single, separated, divorced	71	71	<b>68</b>	50	39	33
Widowed	70	-	-	49		-

*Table A21. Satisfaction with the personal manner of the doctor and the doctor’s explanation: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked*

	Personal manner of doctor			Doctor’s explanation		
	O	M	Y	O	M	Y
Total	87	78	68	79	71	59
Area of residence						
Urban	87	78	67	81	73	59
Large rural	86	79	70	78	72	61
Small rural	86	78	68	79	71	60
Remote	84	75	63	76	69	58
Socio-economic status						
High (Y - university)	<b>89</b>	79	-	<b>82</b>	72	-
Medium (Y - trade/diploma)	<b>88</b>	78	-	<b>80</b>	71	-
(Y - year 12)			-			-
Low (Y - yr 10 or less)	<b>84</b>	78	-	<b>76</b>	71	-
Language spoken at home						
English	<b>88</b>	<b>79</b>	<b>68</b>	<b>80</b>	<b>72</b>	<b>60</b>
Other	<b>76</b>	<b>68</b>	<b>53</b>	<b>68</b>	<b>64</b>	<b>54</b>
Marital status						
Married, de facto	87	<b>79</b>	68	80	72	60
Single, separated, divorced	87	<b>76</b>	68	80	70	59
Widowed	86	-	-	79	-	-

*Table A22. Satisfaction with the doctor’s interest in her feelings and the opportunity to ask questions: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked*

	Doctor’s interest in your feelings			Opportunity to ask questions		
	O	M	Y	O	M	Y
Total	78	67	55	79	72	62
Area of residence						
Urban	78	68	54	81	73	61
Large rural	77	67	57	78	73	63
Small rural	78	67	55	78	71	63
Remote	77	66	52	78	69	59
Socio-economic status						
High (Y - university)	<b>80</b>	66	-	<b>82</b>	73	-
Medium (Y - trade/diploma)	<b>79</b>	67	-	<b>80</b>	72	-
(Y - year 12)			-			-
Low (Y - yr 10 or less)	<b>74</b>	68	-	<b>76</b>	71	-
Language spoken at home						
English	<b>79</b>	<b>68</b>	<b>55</b>	<b>81</b>	<b>72</b>	<b>62</b>
Other	<b>65</b>	<b>60</b>	<b>50</b>	<b>67</b>	<b>64</b>	<b>57</b>
Marital status						
Married, de facto	78	68	56	80	72	63
Single, separated, divorced	78	66	54	81	70	62
Widowed	77	-	-	79	-	-

*Table A23. Satisfaction with the time spent with the doctor and the visit overall: percentage of women in demographic groups who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked*

	Time spent with doctor			Visit overall		
	O	M	Y	O	M	Y
Total	72	65	50	77	66	56
Area of residence						
Urban	72	66	50	79	<b>68</b>	57
Large rural	69	64	50	76	<b>65</b>	58
Small rural	72	64	50	76	<b>64</b>	55
Remote	72	63	48	74	<b>64</b>	51
Socio-economic status						
High (Y - university)	<b>75</b>	66	-	<b>80</b>	66	-
Medium (Y - trade/diploma)	<b>72</b>	65	-	<b>78</b>	66	-
(Y - year 12)			-			-
Low (Y - yr 10 or less)	<b>68</b>	64	-	<b>74</b>	65	-
Language spoken at home						
English	<b>73</b>	<b>65</b>	<b>51</b>	<b>79</b>	<b>66</b>	<b>57</b>
Other	<b>56</b>	<b>55</b>	<b>45</b>	<b>61</b>	<b>56</b>	<b>52</b>
Marital status						
Married, de facto	72	<b>65</b>	52	78	66	56
Single, separated, divorced	72	<b>62</b>	50	78	65	56
Widowed	71	-	-	77	-	-

*Table A24. Satisfaction with the location of the surgery and the waiting time: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked*

	Surgery location			Waiting time		
	O	M	Y	O	M	Y
All women	71	71	71	49	39	32
Arthritis	-	-	-	-	-	-
Osteoporosis	<b>67</b>	67	-	<b>43</b>	36	-
Stiff & painful joints	<b>65</b>	<b>67</b>	-	<b>44</b>	<b>35</b>	-
Back pain	<b>65</b>	<b>68</b>	<b>68</b>	<b>43</b>	<b>37</b>	30
Asthma	70	70	70	46	38	32
Low mental health score	<b>57</b>	<b>64</b>	<b>65</b>	<b>40</b>	<b>33</b>	<b>27</b>
Depression	-	-	-	-	-	-
Anxiety	-	-	-	-	-	-
Heart disease	<b>67</b>	65	68	<b>45</b>	38	35
Cancer	72	67	<b>62</b>	48	40	28
Diabetes	<b>67</b>	<b>64</b>	67	46	34	37

*Table A25. Satisfaction with the personal manner of the doctor and the doctor’s explanation: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked*

	Personal manner of doctor			Doctor’s explanation		
	O	M	Y	O	M	Y
All women	87	78	68	79	71	59
Arthritis	-	-	-	-	-	-
Osteoporosis	86	79	-	77	72	-
Stiff & painful joints	<b>85</b>	76	-	<b>75</b>	<b>67</b>	-
Back pain	<b>85</b>	77	66	<b>75</b>	<b>68</b>	57
Asthma	88	78	68	80	71	60
Low mental health score	<b>77</b>	<b>70</b>	<b>62</b>	<b>65</b>	<b>63</b>	<b>51</b>
Depression	-	-	-	-	-	-
Anxiety	-	-	-	-	-	-
Heart disease	86	77	70	78	69	63
Cancer	88	78	61	80	71	51
Diabetes	85	77	62	78	72	55

*Table A26. Satisfaction with the doctor’s interest in her feelings and the opportunity to ask questions: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked*

	Doctor’s interest in your feelings			Opportunity to ask questions		
	O	M	Y	O	M	Y
All women	78	67	55	79	72	62
Arthritis	-	-	-	-	-	-
Osteoporosis	76	70	-	78	72	-
Stiff & painful joints	<b>74</b>	<b>64</b>	-	<b>76</b>	<b>68</b>	-
Back pain	<b>75</b>	<b>64</b>	52	<b>76</b>	<b>68</b>	60
Asthma	79	68	55	80	72	62
Low mental health score	<b>65</b>	<b>59</b>	<b>48</b>	<b>67</b>	<b>62</b>	<b>54</b>
Depression	-	-	-	-	-	-
Anxiety	-	-	-	-	-	-
Heart disease	78	67	64	79	69	68
Cancer	78	68	53	79	72	58
Diabetes	75	69	54	78	71	57

*Table A27. Satisfaction with the time spent with the doctor and the visit overall: percentage of women with chronic conditions who rated this aspect of their most recent GP visit as “excellent” or “very good” (Survey 1); bold indicates a significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-” indicates question not asked*

	Time spent with doctor			Visit overall		
	O	M	Y	O	M	Y
All women	72	65	50	77	66	56
Arthritis	-	-	-	-	-	-
Osteoporosis	70	64	-	76	67	-
Stiff & painful joints	<b>67</b>	<b>61</b>	-	<b>73</b>	<b>62</b>	-
Back pain	<b>68</b>	<b>62</b>	47	<b>72</b>	<b>63</b>	49
Asthma	73	65	50	79	66	55
Low mental health score	<b>59</b>	<b>55</b>	<b>43</b>	<b>64</b>	<b>56</b>	<b>47</b>
Depression	-	-	-	-	-	-
Anxiety	-	-	-	-	-	-
Heart disease	71	65	57	<b>75</b>	64	57
Cancer	71	63	46	77	66	49
Diabetes	69	65	52	77	68	53

*Table A28. Cost and satisfaction with cost of most recent GP visit: percentage of women who reported no cost, rated the cost “excellent”, “very good” or “good” (high satisfaction), or rated the cost “fair” or “poor” (low satisfaction) (Survey 2)*

	Older			Mid-aged			Younger		
	No	High	Low	No	High	Low	No	High	Low
Total	69	22	9	35	23	42	43	35	22
Area of residence									
Urban	<b>79</b>	<b>16</b>	<b>5</b>	<b>48</b>	<b>20</b>	<b>33</b>	<b>54</b>	<b>30</b>	<b>16</b>
Large rural	<b>61</b>	<b>27</b>	<b>12</b>	<b>28</b>	<b>24</b>	<b>48</b>	<b>28</b>	<b>42</b>	<b>30</b>
Small rural	<b>62</b>	<b>26</b>	<b>12</b>	<b>27</b>	<b>25</b>	<b>48</b>	<b>25</b>	<b>44</b>	<b>31</b>
Remote	<b>73</b>	<b>17</b>	<b>10</b>	<b>28</b>	<b>25</b>	<b>47</b>	<b>28</b>	<b>37</b>	<b>36</b>
Socio-economic status									
High (Y - univ)	68	23	10	<b>31</b>	<b>22</b>	<b>47</b>	<b>45</b>	<b>34</b>	<b>21</b>
Medium (Y - trade/dip)	71	20	9	<b>33</b>	<b>24</b>	<b>43</b>	<b>40</b>	<b>38</b>	<b>23</b>
(Y - year 12)							<b>44</b>	<b>34</b>	<b>23</b>
Low (Y - $\leq$ yr 10)	68	22	9	<b>40</b>	<b>23</b>	<b>38</b>	<b>43</b>	<b>35</b>	<b>22</b>
Language spoken at home									
English	69	22	9	<b>34</b>	<b>23</b>	<b>43</b>	<b>42</b>	<b>36</b>	<b>23</b>
Other	73	17	10	<b>49</b>	<b>20</b>	<b>31</b>	<b>59</b>	<b>26</b>	<b>16</b>
Marital status									
Married, de facto	<b>65</b>	<b>24</b>	<b>11</b>	<b>32</b>	<b>24</b>	<b>44</b>	<b>39</b>	<b>36</b>	<b>25</b>
Single, sep, divorced	<b>70</b>	<b>20</b>	<b>9</b>	<b>48</b>	<b>19</b>	<b>33</b>	<b>46</b>	<b>34</b>	<b>19</b>
Widowed	<b>74</b>	<b>18</b>	<b>7</b>						

*Table A29. Cost and satisfaction with cost of most recent GP visit: percentage of women with chronic conditions who reported no cost, rated the cost “excellent”, “very good” or “good” (high satisfaction), or rated the cost “fair” or “poor” (low satisfaction) (Survey 2) ; bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked*

	Older			Mid-aged			Younger		
	No	High	Low	No	High	Low	No	High	Low
Total	69	22	9	35	23	42	43	35	22
Arthritis	<b>71</b>	<b>20</b>	<b>9</b>	-	-	-	-	-	-
Osteoporosis	72	18	10	<b>42</b>	<b>24</b>	<b>34</b>	-	-	-
Stiff & painful joints	71	18	10	<b>39</b>	<b>19</b>	<b>42</b>	-	-	-
Back pain	<b>72</b>	<b>18</b>	<b>10</b>	<b>38</b>	<b>20</b>	<b>42</b>	42	24	26
Asthma	70	19	11	<b>38</b>	<b>19</b>	<b>43</b>	44	34	23
Low mental health score	71	19	10	<b>39</b>	<b>19</b>	<b>42</b>	<b>47</b>	<b>30</b>	<b>23</b>
Depression	<b>75</b>	<b>15</b>	<b>10</b>	<b>39</b>	<b>20</b>	<b>41</b>	<b>50</b>	<b>31</b>	<b>19</b>
Anxiety	73	16	11	<b>38</b>	<b>21</b>	<b>41</b>	<b>52</b>	<b>30</b>	<b>18</b>
Heart disease	70	20	10	38	20	43	43	27	30
Cancer	72	21	9	39	22	40	45	36	19
Diabetes	72	21	7	<b>43</b>	<b>20</b>	<b>37</b>	44	30	26

*Table A30. Continuity of care: percentage of women in demographic groups who reported “always” (Survey 2); bold indicates significant differences within a demographic group ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked.*

	Go to same place			See same GP		
	O	M	Y	O	M	Y
Total	-	73	47	-	48	29
Area of residence						
Urban	-	<b>69</b>	<b>40</b>	-	<b>47</b>	<b>26</b>
Large rural	-	<b>78</b>	<b>61</b>	-	<b>55</b>	<b>37</b>
Small rural	-	<b>76</b>	<b>61</b>	-	<b>47</b>	<b>34</b>
Remote	-	<b>70</b>	<b>46</b>	-	<b>42</b>	<b>27</b>
Socio-economic status						
High (Y - university)	-	<b>69</b>	<b>38</b>	-	<b>42</b>	<b>21</b>
Medium (Y - trade/diploma)	-	<b>74</b>	<b>54</b>	-	<b>47</b>	<b>33</b>
(Y - year 12)			<b>51</b>			<b>32</b>
Low (Y - yr 10 or less)	-	<b>77</b>	<b>60</b>	-	<b>53</b>	<b>39</b>
Language spoken at home						
English	-	<b>73</b>	48	-	<b>47</b>	29
Other	-	<b>67</b>	44	-	<b>57</b>	32
Marital status						
Married, de facto	-	<b>74</b>	<b>52</b>	-	48	<b>33</b>
Single, separated, divorced	-	<b>69</b>	<b>43</b>	-	48	<b>26</b>
Widowed	-			-		

Table A31. Continuity of care: percentage of women with chronic conditions who reported “always” (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference), “-“ indicates question not asked.

	Go to same place			See same GP		
	O	M	Y	O	M	Y
All women	-	73	47	-	47	29
Arthritis	-	-	-	-	-	-
Osteoporosis	-	76	-	-	53	-
Stiff & painful joints	-	75	-	-	<b>51</b>	-
Back pain	-	75	47	-	<b>51</b>	29
Asthma	-	73	49	-	<b>44</b>	30
Low mental health score	-	71	45	-	50	29
Depression	-	73	46	-	48	30
Anxiety	-	70	44	-	47	30
Heart disease	-	78	52	-	<b>55</b>	36
Cancer	-	76	55	-	<b>53</b>	32
Diabetes	-	79	50	-	54	35

Table A32. Preference for a female doctor: percentage of women in demographic groups who reported preference “always” (Alw), “for certain things” (Cert) or “no” or “don’t care” (No) (Survey 2); bold indicates significant differences between demographic groups ( $p < 0.005$  and  $\geq 3$  percentage points difference)

	Older			Mid-aged			Younger		
	Alw	Cert	No	Alw	Cert	No	Alw	Cert	No
Total	12	22	66	15	27	58	18	43	39
Area of residence									
Urban	12	22	65	<b>18</b>	<b>28</b>	<b>54</b>	<b>18</b>	<b>48</b>	<b>34</b>
Large rural	12	20	68	<b>17</b>	<b>23</b>	<b>60</b>	<b>20</b>	<b>35</b>	<b>45</b>
Small rural	9	21	70	<b>13</b>	<b>26</b>	<b>61</b>	<b>16</b>	<b>37</b>	<b>48</b>
Remote	6	25	70	<b>12</b>	<b>30</b>	<b>59</b>	<b>15</b>	<b>44</b>	<b>40</b>
Socio-economic status									
High (Y - univ)	10	23	67	<b>17</b>	<b>28</b>	<b>55</b>	<b>20</b>	<b>47</b>	<b>33</b>
Medium (Y - trade/dip)	11	21	68	<b>14</b>	<b>26</b>	<b>60</b>	<b>18</b>	<b>43</b>	<b>39</b>
Low (Y - $\leq$ yr 10)	10	21	69	<b>15</b>	<b>26</b>	<b>59</b>	<b>13</b>	<b>36</b>	<b>50</b>
Language spoken at home									
English	10	21	69	<b>15</b>	<b>26</b>	<b>59</b>	<b>18</b>	<b>43</b>	<b>40</b>
Other	15	30	55	<b>18</b>	<b>38</b>	<b>45</b>	<b>18</b>	<b>53</b>	<b>29</b>
Marital status									
Married, de facto	10	23	67	<b>15</b>	<b>27</b>	<b>59</b>	17	40	43
Single, sep, divorced	13	23	64	<b>18</b>	<b>25</b>	<b>57</b>	18	46	35
Widowed	11	20	69						

*Table A33. Preference for a female doctor: percentage of women with chronic conditions who reported preference “always” (Alw), “for certain things” (Cert) or “no” or “don’t care” (No) (Survey 2); bold indicates significant difference from women without this condition ( $p < 0.005$  and  $\geq 3$  percentage points difference)*

	Older			Mid-aged			Younger		
	Alw	Cert	No	Alw	Cert	No	Alw	Cert	No
All women	12	22	66	15	27	58	18	45	37
Arthritis	11	22	68	-	-	-	-	-	-
Osteoporosis	11	23	65	15	28	56	-	-	-
Stiff & painful joints	11	23	66	15	26	59	-	-	-
Back pain	11	23	66	15	27	58	19	42	39
Asthma	11	22	68	14	27	59	17	43	40
Low mental health score	<b>15</b>	<b>22</b>	<b>63</b>	<b>17</b>	<b>28</b>	<b>55</b>	20	43	37
Depression	<b>16</b>	<b>21</b>	<b>62</b>	17	27	56	21	38	40
Anxiety	<b>13</b>	<b>23</b>	<b>64</b>	17	28	54	22	39	39
Heart disease	10	21	69	15	22	63	22	36	42
Cancer	9	21	70	<b>13</b>	<b>23</b>	<b>64</b>	16	38	46
Diabetes	13	18	69	16	22	62	20	32	48