# Health in Rural and Remote Areas of Australia

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

Report prepared for the

Rural Health and Palliative Care Branch
of the
Australian Commonwealth Department of Health and Ageing

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Acknowledgements

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# Take Home Messages

1. There are few differences in physical health among women living in different parts of Australia.

2. The prevalence of overweight and obesity is increasing over time in all age groups of Australian women, but Younger and Mid-age women in rural and remote areas are more likely to be overweight or obese than urban women of the same age. This is of concern in regard to a higher incidence of diabetes particularly in remote areas.

3. Rates of smoking are higher among women in rural and remote areas in all age groups.

4. Rates of moderate to high risk alcohol consumption are higher among Younger than Mid-age women, but are highest for women in remote areas in both age groups. Levels of unsafe drinking are very low among Older women, regardless of area of residence.

5. There are lifestyle issues specific to each age cohort of rural women which have implications for their health and well-being:
   - Younger rural women marry earlier, have their children at an earlier age, and want larger families. They are thus more likely to require access to GP and specialist obstetric and gynaecological services. Marriage and motherhood are also associated with weight gain and decline in physical activity.
   - Mid-age rural women are more likely than urban women to provide care to ageing relatives as well as providing childcare for their grandchildren. Mid-age caregivers have poorer health and are also more likely to spend time out of the paid workforce, thus prejudicing their economic wellbeing.
   - Older rural women both give and receive care, but there is a lack of nursing homes, respite care and hospices in rural areas. Older women who move from rural to more urban areas experience better access to health services, but a decline in social support.

6. Women in large rural areas rated their access to after hours care better than women in urban areas. Women in large rural areas and urban areas were more satisfied with their access to a hospital than women in small rural and remote areas. However, satisfaction with access to medical specialists declined with distance from an urban centre.

7. Mammographic screening is a success story, with approximately 80 per cent of Mid-age women in all areas having had a mammogram in the previous two years.

8. Frequency of use of GPs did not vary across areas of residence. However, choice of GP, access to a female GP, and cost of last GP visit were rated less positively according to distance from an urban centre.

9. Experiences of abuse were higher among women in rural and remote areas. Barriers perceived by women seeking help for emotional distress in rural and remote areas included difficulties in accessing a GP, a lack of confidentiality in small towns, the difficulty of obtaining specialist mental health care services, and poor access to counselling services.

# Overview

## *The rural context*

For the last thirty years, Australia's rural communities have been experiencing profound economic and social changes. Rural production is no longer as important to Australia as it was thirty years ago: '…it is just another industry struggling to survive in a world of globalised production relations' (Lawrence & Gray, 2000: 48). As farm populations and incomes and the incomes of those who service the agricultural industries diminish, people are moving away to larger centres in search of education or employment. Because it is the young people who move away, the proportion of older people in the rural population is increasing at a rate faster than other parts of Australia, introducing particular emphases to health service provision (Sternberg et al., 1997).

Population decline is predominantly a small town phenomenon, with around 92 per cent of declining communities having a resident population of less than 5000. Rural growth is commonly occurring around metropolitan commuter belts and in coastal and scenic regions (Tonts, 2000). Kilpatrick and Bell point to similarities between Australia and the United States in terms of the 'gaps' between urban and rural areas where there is 'higher unemployment, higher suicide rates, lower standards of health care, education and telecommunication services, and lower life expectancy' (2000: 4).

In Australia, almost one third of the population lives outside the major metropolitan centres, in areas which are serviced by less than one quarter of general practitioners (DHFS, 1996), health service use and related behaviours among rural people tend to be influenced by distance and availability of services (Elliot-Schmidt & Strong, 1997). Health-selective migration has been implicated as one of the mechanisms by which socio-spatial disadvantage is created and maintained, and there is a growing literature on the links between chronic ill health, social disadvantage and place (Larson et al., 2002).

The welfare of Australian rural communities is likely to be dependent on support provided from the community itself (Teather, 1998), and there is an increasing body of research documenting the multiple roles of rural women and the (undervalued) contribution these women make to their families, communities and the economy (Alston, 1998). Dempsey has shown how the dominant male culture and men's greater economic power in small Australian towns serves to disadvantage women (1992). National data indicate that the median gross weekly income of rural women in 1996 was $A198. This compares with $A352 for rural men and $A226 for urban women (Office of the Status of Women, 1999).

There are important health policy implications associated with the socio-cultural context and demographic changes described above, and they are particularly relevant to women, who are greater users of the health care system, both as patients and carers, than are men. However a distinction must be made between apparent levels of *satisfaction* with health services, and *responsiveness*_in relation to delivery of services which takes account of expectations.

Considerable effort has been made at a policy level focusing on strengthening the provision of rural health services, notably in relation to primary care. The attraction and retention of more GPs in rural areas has been the particular target of many policy initiatives. As the data presented in this report indicate, there have also been some markedly successful programs implemented, such as with mammography screening.

These are valuable directions that should be maintained, but there are also continuing concerns in relation to women's access to specialist medical services. In particular, given the earlier motherhood of young rural women, obstetric and paediatric specialists are needed. Other issues include access to counselling services and to female general practitioners. At issue also are the greater rates of violence against women in rural and remote areas, increasing levels of overweight in women outside urban areas, with implications for the prevalence of diabetes particularly in remote areas, the relative paucity of nursing homes and respite care services, and the higher incidence of gynaecological surgery.

While there are important health issues specific to Indigenous Australian women, data on these issues are beyond the scope of this report. Indigenous women are, however, represented in the three cohorts in the Australian Longitudinal Study on Women's Health.

## *Background to this report*

This report arose from a series of discussions between members of the Australian Longitudinal Study on Women's Health (ALSWH) research team and members of the Rural Health and Palliative Care Branch of the Commonwealth Department of Health and Ageing. These discussions resulted in the development of a series 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 What is the 'big picture' in regard to the health of rural women? This included aspects such as:
   - the frequencies of the top ten health conditions, symptoms and health behaviours identified by rural and remote women in all three age cohorts
   - the incidence of Pap tests and of mammography screening
   - rural/urban differences in help-seeking for depression, violence, and other significant conditions
   - comparison of views of available treatment options

2 Are there any particular issues of concern to women which are expressed in their qualitative comments?

This technical report begins with a brief description of ALSWH. It then sketches 'the big picture', drawing on a range of indicators and data on health behaviours and generational lifestyle issues. The next two sections of the report discuss the most common conditions and procedures reported by women in rural and remote areas, and their perceptions and usage of health services. In the final section, studies of rural women's experiences of seeking help for violence and psychological distress are reviewed.

In recruiting participants for ALSWH, women in rural and remote areas were deliberately oversampled to ensure adequate representation. The locational categories used in this report were those recommended by the Rural Health and Palliative Care Branch of DoHA. Comparisons are shown between women in Capital Cities and Other Urban areas (RRMA categories 1 & 2), Large Rural Centres (RRMA category 3), Small Rural Centres and Other Rural Areas (RRMA categories 4 & 5) and Remote Centres and Other Remote Areas (RRMA categories 6 & 7). Definitions of these categories are shown in Table 1.

*Table 1. Rural, Remote and Metropolitan Areas (RRMA) Classification, and terms used in this report*

| RRMA | Classification | Term Used |
|---|---|---|
| 1 | Capital city: State and Territory capital city statistical divisions | Urban |
| 2 | Other metropolitan centres: one or more statistical subdivisions that have an urban centre with a population of 100,000 or more | |
| 3 | Large rural centre: statistical local areas where most of the population resides in urban centres with a population of 25,000 or more | Large Rural |
| 4 | Small rural centre: statistical local areas in rural zones containing urban centres with populations between 10,000 and 24,999 | Small Rural |
| 5 | Other rural area: all remaining statistical local areas in the rural zone | |
| 6 | Remote centre: statistical local areas in the remote zone containing populations of 5,000 or more | Remote |
| 7 | Other remote area: all remaining statistical local areas in the remote zone | |

*Source: Department of Primary Industries and Energy, and Department of Human Services and Health (1994)*

Unless otherwise specified, the data used in this report are derived from the most recent ALSWH surveys. The numbers of respondents who completed the most recent surveys are shown in Table 2.

*Table 2: Respondents by RRMA and age cohort*

| | Urban RRMA 1 & 2 | Large Rural RRMA 3 | Small rural RRMA 4 & 5 | Remote RRMA 6 & 7 | Not stated |
|---|---|---|---|---|---|
| Younger Survey 2 Aged 22-27 (2000) | 5647 (58%) | 943 (10%) | 2334 (24%) | 388 (4%) | 373 (4%) |
| Mid-age Survey 3 Aged 50-55 (2001) | 4185 (37%) | 1515 (14%) | 4746 (42%) | 585 (5%) | 171 (2%) |
| Older Survey 2 Aged 73-78 (1999) | 4233 (41%) | 1259 (12%) | 4473 (43%) | 237 (2%) | 219 (2%) |

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.

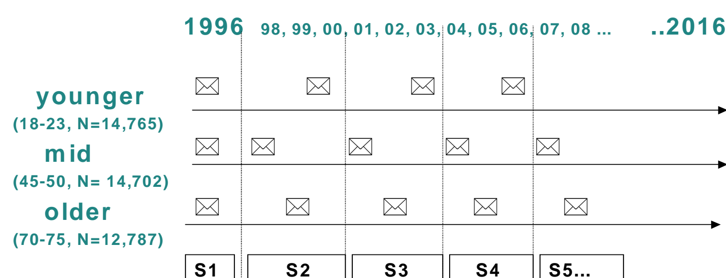
## What is the Australian Longitudinal Study on Women's Health?

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, selected on a random basis with deliberate over-sampling of women in rural and remote areas. It provides an evidence base 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 life spans.

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 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 was 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 in 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 employment and 31% part-time. While 91% were mothers, only 58% had children under 16 living with them. Middle age is a time of relative demographic stability, so the picture was relatively similar by Survey 3, with 78% married, 37% in full-time work and 23% in part-time work, although the number 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)
- Sociodemographic factors (location, education, employment, family composition)
- Life stages and key events (such as childbirth, divorce, widowhood).

As well as the main surveys, participants are invited to participate in sub-studies which address specific issues or target specific groups. For example, a sample of Mid-age women with low levels of mental well-being participated in a telephone survey focusing on coping and help-seeking, while 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. 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.

The maintenance of these cohorts 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 brief reports have been prepared on the basis of 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 brief 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 or visit the website http://www.newcastle.edu.au/centre/wha

# The Big Picture: The Health, Welfare and Lifestyle of Women in Rural and Remote Areas

## *Indices of women's health*

### Self-reported health status: SF36

There is little difference in the physical health-related quality of life of women in different areas of residence. Women in rural and remote areas seem to have slightly higher scores for mental health-related quality of life, but these group differences are small and of little significance.

Tables 3 and 4 below present physical and mental health component summary scores (PCS and MCS) from the SF-36, for all three cohorts at the time of the most recent available survey. The scores have been standardised for age, and thus cannot be compared across age groups.

*Table 3. Mean physical health (PCS) scores by age cohort and area of residence: Most recent survey*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 50.2 | 49.2 | 49.1 | 50.5 |
| Mid-Age Survey 3 | 48.6 | 48.5 | 48.0 | 48.0 |
| Older Survey 2 | 49.3 | 49.4 | 49.3 | 49.3 |

*Table 4. Mean mental health (MCS) scores by age cohort and area of residence: Most recent survey*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 49.9 | 50.8 | 51.6 | 51.2 |
| Mid-Age Survey 3 | 51.2 | 51.2 | 51.8 | 52.3 |
| Older Survey 2 | 51.3 | 51.0 | 51.7 | 52.5 |

### Healthy weight

Overweight is an increasing concern for all Australians, as it is an important risk factor for major disease targets, including diabetes and heart disease, as well as contributing significantly to reduced quality of life. With a Body Mass Index (BMI) in the range of 20 to 25 defined as a healthy weight range, Figure 2 shows that most Younger women are within this range, but Figures 3 and 4 demonstrate that about half of Mid-age and Older Australian women are overweight or obese. Comparisons with Survey 1 data indicate that the prevalence of overweight and obesity is increasing slightly over time in all three age groups.

Younger and Mid-age women in urban areas are leaner than others; this issue is reflected in the finding that that the incidence of non-insulin dependent diabetes is higher in ALSWH mid-age women in remote areas.

*Figure 2. Body Mass Index category by area of residence: Younger cohort, Survey 2.*

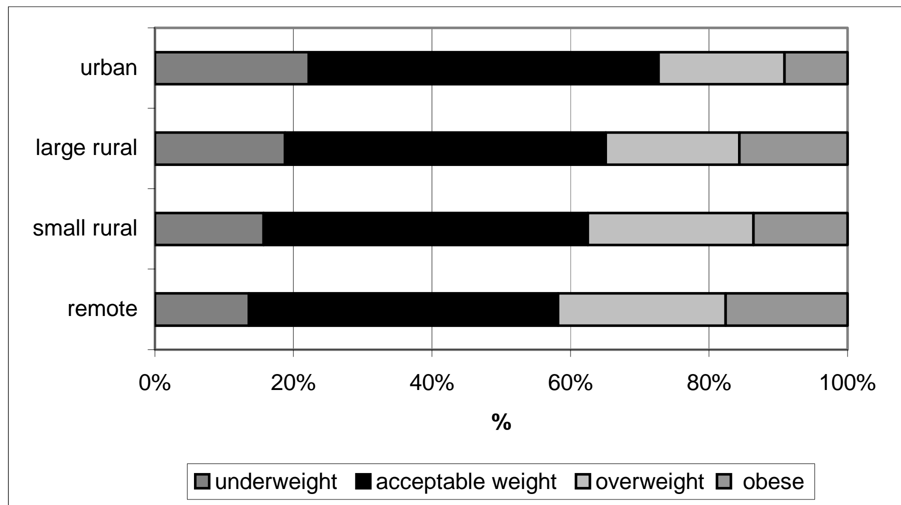
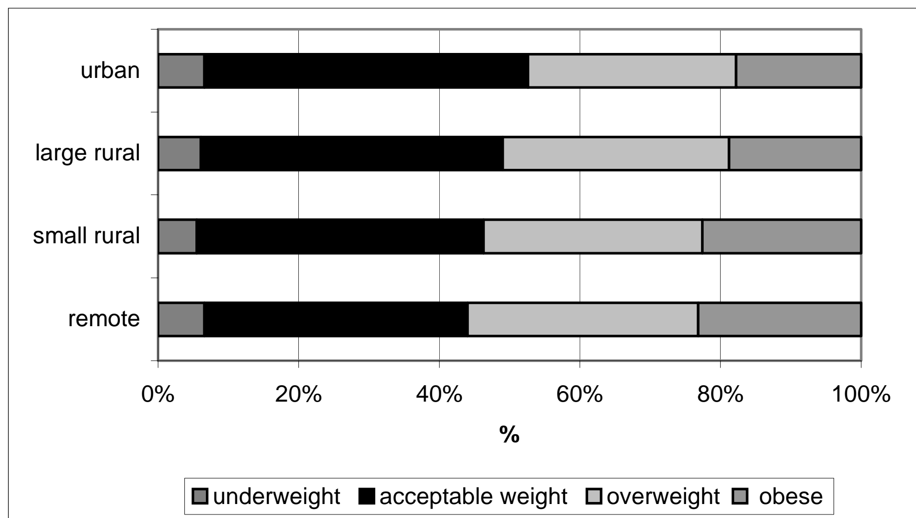
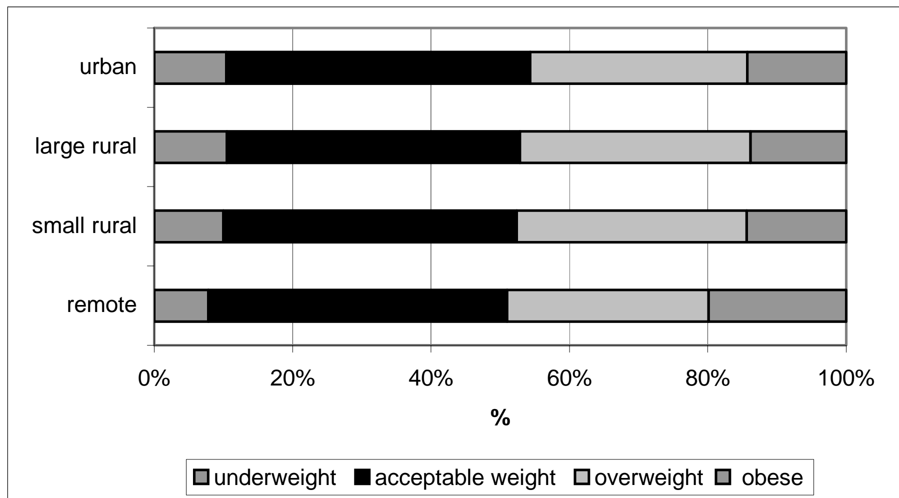



*Figure 3. Body Mass Index category by area of residence: Mid-age cohort, Survey 2.*




Note: Percentages for all figures shown in this report are given in the Appendix.

*Figure 4. Body Mass Index category by area of residence: Older cohort, Survey 2.*




## Smoking

Figures 5 to 7 show that there are both age cohort and area of residence trends in smoking. While older women are least likely to smoke in all areas, rates of smoking are higher in more rural areas for each age group.

*Figure 5. Cigarette smoking by area of residence: Younger cohort, Survey 2.*

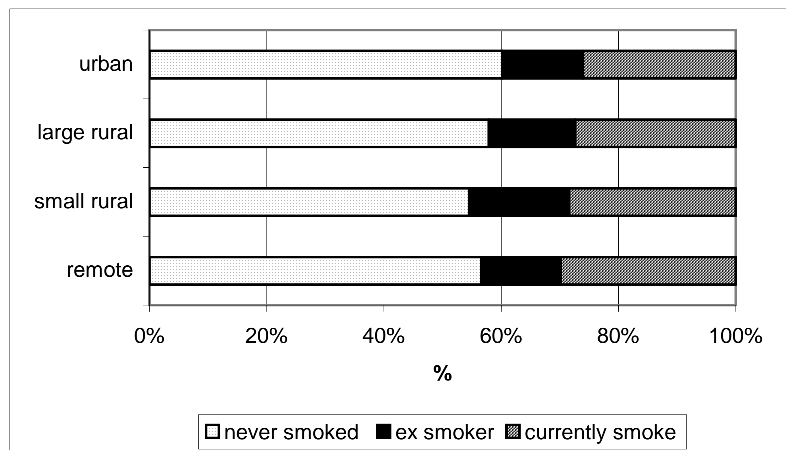


*Figure 6. Cigarette smoking category by area of residence: Mid-age cohort, Survey 2.*

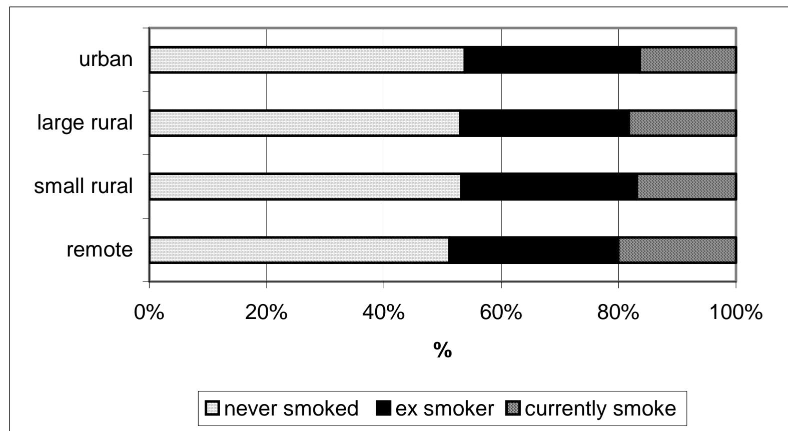
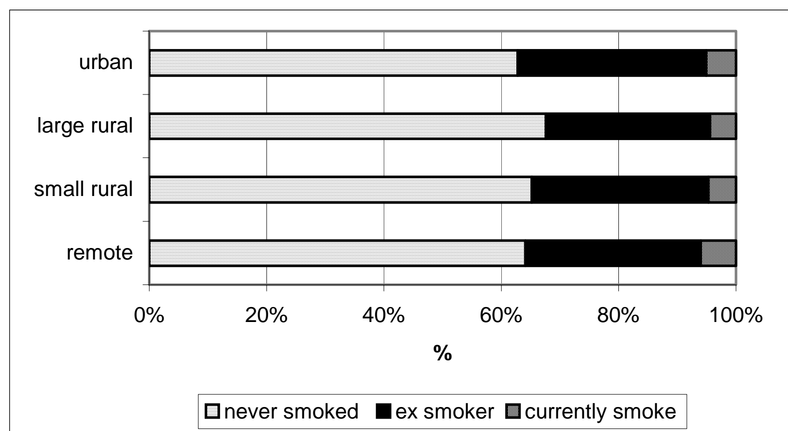



*Figure 7. Cigarette smoking category by area of residence: Older cohort, Survey 2.*



## Alcohol Use

Figures 8 and 9 show that there are both age cohort and area of residence trends in alcohol use: rates of moderate- to high-risk drinking (more than 14 standard drinks a week) or bingeing (more than 5 standard drinks on any one occasion) are higher among the Younger than the Mid-age women, and in each age group are highest for women in remote areas. Data for Older women are not presented, as levels of unsafe alcohol consumption are very low among these women, regardless of area of residence.

*Figure 8. Percentage of Younger women in each category of reported alcohol consumption, by area of residence: Survey 2.*

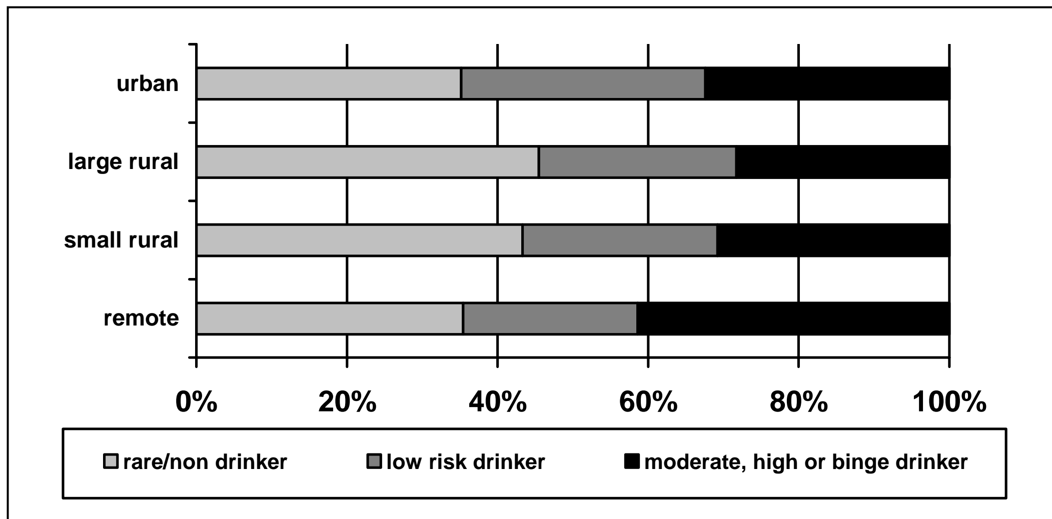
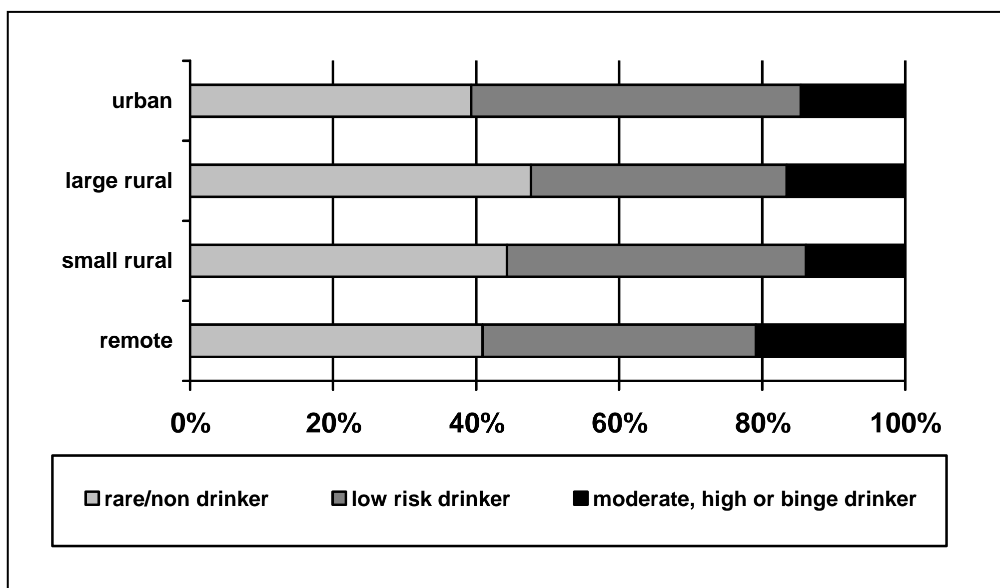



*Figure 9. Percentage of Mid-age women in each category of reported alcohol consumption, by area of residence: Survey 2*



## *Lifecourse issues for rural women*

### Younger women's lives and aspirations

Young rural women's life experiences and aspirations are very different from those of their city cousins. ALSWH data show that Younger rural women are more likely to be married or in a long term relationship than Younger urban women, are more likely to have children, and are less likely to have completed high school or have post-secondary educational qualifications. Many young women living in the city have put off having children, initially while they obtained further qualifications and then further deferring motherhood as they moved into the paid workforce.

Table 5 shows differences in the experiences of Younger women according to location, at two time points. At Survey 1 in 1996, being in a long-term relationship was far more common among Young rural women than those in urban areas. At Survey 2 in 2001, many more of all Younger women were married or in a de facto relationship, but there were still clear differences according to area. Almost 60 per cent of the urban women were still single, whereas a majority of the rural and remote women were in a relationship.

*Table 5. Relationships, motherhood, educational qualifications, and employment status of Younger women: Surveys 1 and 2.*

| | Urban | | Large rural | | Small rural | | Remote | |
|---|---|---|---|---|---|---|---|---|
| | S1 | S2 | S1 | S2 | S1 | S2 | S1 | S2 |
| Married or in a relationship | 17.6 | 41.7 | 25.1 | 49.6 | 28.4 | 55.7 | 44.5 | 61.8 |
| Mother | 6.6 | 13.3 | 12.2 | 26.6 | 14.4 | 33.6 | 21.1 | 34.3 |
| Post-school qualification | 30.7 | 70.8 | 26.9 | 59.5 | 26.8 | 52.2 | 32.9 | 57.5 |
| In paid employment | 50.3 | 70.5 | 51.5 | 60.7 | 55.3 | 55.8 | 68.8 | 65.3 |

*Figures are percentages*

At Survey 1, Younger rural women were more than twice as likely as young women in the city to have a child or children, and more than 20% of the remote-area women had one or more children. By Survey 2, there were many more mothers among the urban women but they were still less likely than rural women to have begun families.

Although most of the Younger cohort aspired to a combination of paid work and motherhood, young women in rural and remote areas had fewer years of formal education than women in the metropolitan areas: at Survey 1, the percentage of Younger women who had completed high school was 58% in urban areas, compared to 50% in rural areas, and 45% in remote areas. At Survey 2, the urban women were more likely to have acquired post-school qualifications. Almost half of Younger urban ALSWH women had a university degree, compared to only about one quarter to a third of rural and remote women.

The Younger women were asked about their aspirations for lifestyle at the age of 35: at Survey 1, irrespective of where they lived, most wanted to be in paid work, to be in a permanent relationship, and to be mothers by the time they were 35, indicating that most young Australian women see a combination of motherhood and paid work to be desirable. However, in many respects Younger rural and remote women had slightly more traditional

aspirations than Younger urban women. They were more interested in part-time than full-time work, they wanted to have larger families, and they were less interested in further qualifications.

ALSWH data on the paid and unpaid work status of Mid-age women suggests that, given current social arrangements and attitudes, the nature of the Younger rural women's education and aspirations is likely to have implications for their longer term socio-economic status and, in turn, for their health and well-being.

While it is not clear that the Younger cohort will necessarily parallel the Mid-age women in their lives and well-being, it is interesting to note that – among the Mid-age women - those with 35 to 40 hours' paid work per week have the highest PCS scores, while those in 16 to 24 hours' paid work per week have the highest MCS scores.

A key issue for policy is that early motherhood and lower socio-economic status are likely to go together. While most young Australian women still aspire to forming a relationship and having children, it also appears that the experience of motherhood – and particularly the age at which young women have their children – is related to broader patterns of social inequality and to the disadvantage of young rural women. Of particular concern is the fact that there appears to be an increasing polarisation between better educated young women who are choosing to defer motherhood, and young women who are less well qualified and are having their children at a younger age. ALSWH data show that this polarisation has a strong geographic aspect to it.

There are particular problems for young rural women who, as they establish their families, are likely to be under financial pressure. They feel a need to find work outside the home in order to help maintain the household, and are simultaneously more likely than urban women to be involved in unpaid work in a family business or farm. Lack of qualifications and experience, combined with a depressed rural job market, mean that their options are likely to lie in the casualised, poorly paid and insecure sectors of the secondary labour market.

Given their earlier marriage and motherhood, Younger rural women are also more likely to require access to GP and obstetric and gynaecological services, yet the shortage of general practitioners and specialist services in rural areas has been well documented. Younger ALSWH women living with a partner, particularly those with children, were more likely than others to report low levels of physical activity and to be overweight or obese. As this is a more common lifestyle for Younger rural and remote women than for urban women, this represented a further disadvantage for their health.

### Mid-age women's time use in rural and remote areas

ALSWH data show that Mid-age women in all geographical areas provide care for someone who is elderly, frail or disabled, however Mid-age rural and remote women are more likely also to be providing childcare for their own grandchildren or for someone else's children. They may therefore be characterised as the "sandwich" generation of women who are caring for both the older and the younger generation.

Women who provide care are more likely to have time out of the labour force, thus further disadvantaging the economic position of rural and remote women. ALSWH data also show that Mid-age carers have poorer health. This association does not apply to Older carers, who are likely to be provided with professional health care for their family members if they are in poor health themselves.

While health policies have tended to ignore access to leisure activities, analysis of ALSWH data has demonstrated that only about 35% of Mid-age women are being happy with the time

they have available for active leisure activities (Brown & Brown, 1999). The data also indicated that satisfaction with leisure is associated with both PCS and MCS. Patterns of leisure activity are strongly differentiated by gender and regional differences, as well as those of age, class and ethnicity.

A small ALSWH substudy explored the leisure and wellbeing of Mid-age rural women in a small country town in the late 1990's, focusing on issues which have been identified as being significant for women in isolated areas. These include poor job opportunities, a lack of public transport and other facilities, community designs that isolate women in their homes, family mobility, and the politics of being "different" in a small community.

The culture of the small Australian town has traditionally privileged men's leisure preferences and experiences. It is apparent that the leisure choices of respondents in rural and remote areas are undertaken within a framework of constraints which are both explicit, such as time in paid/unpaid work, restricted discretionary income and access to facilities and programs, and implicit, such as cultural expectations of appropriate behaviour for one's age and gender. Nevertheless, ALSWH substudy data also demonstrate mid age women's capacity to resist gendered constraints. Rural respondents struggle to undertake the journey to a concert in a distant city, they create leisure 'spaces' for themselves to sit in the sun and admire the view, and they take their radio with them to 'keep in touch'. One part of the picture that emerged showed strong, mutually enhancing relationships in a rural context in which work and leisure were often blurred.

> *Our typical weekend is pretty hectic. My husband looks after 12 properties in this area. He spends a lot of time going around the district visiting the properties. I often go with him… that's work, but it's also leisure because I'm spending time with him. We also do a lot of entertaining… the country lifestyle*

However, there are constraints associated with the leisure of women in rural communities, and the impact of economic restructuring, isolation, conservative gender expectations, and family fragmentation cannot be underestimated. Life stage is also relevant to the pressures women feel as partners, mothers and carers.

## Older women in rural and remote areas: Issues of caring and being cared for

The proportion of older people in the rural population is increasing at a rate faster than in other parts of Australia. This is occurring because young people are moving away to larger centres in search of education or employment, and produces particular health service needs. As one Older respondent pointed out, people in her generation are "a tough, resilient group", but they are nevertheless finding the going hard in rural areas:

> *'Reading back through my own answers I appear to be doing very well for my age and so will many others in my age group 70-74. We are mostly a tough, resilient group, having lived through the depression years in our childhood, World War 11 (with its worries and limitations), and our battles to make homes, work hard and raise families over the years. Many of us married ex-service men whose health was not always good. Now so many of us are widowed and no longer, or do not drive cars, are finding it very difficult living in the country. My town like so many other small towns are without public transport. If it wasn't for my Legacy man and his caring wife I would be in trouble. I am also lucky in that we have a shire community car which takes us to specialists, dentists etc. Veteran Affairs pays for my trips. Our hospital recently closed its doors to in-patients. The one ambulance is overworked, one elderly lady left on the footpath in pain for ages. Two of the three banks recently*

*closed, the remaining one has restricted hours. Modern medicine is wonderful in prolonging our lives, but we still have battles with which to contend. Is anyone listening?'*

Increasingly, the welfare of Australian rural communities is dependent on support provided from the community itself, and particularly the contributions of women of all ages. An analysis of the effects of family caregiving on well-being among the older cohort found that 10% (N=1,235) identified themselves as caregivers for frail, ill or disabled family members. The data failed to demonstrate any differences in physical health between Older caregivers and others, but they were much more likely to have low levels of emotional well-being and to feel stressed, rushed and pressured. Qualitative analysis supported the value of the concept of the "ethic of care" in understanding the social and individual forces which propel vulnerable older women into providing family care despite its demonstratively negative effects on their well-being.

*'Social activities are somewhat limited as I care for my very frail 82 year old husband who in spite of having a pacemaker has poor circulation, and severe arthritis as a result of wartime parachuting accidents. I don't like to be out leaving him alone in the morning particularly. I could of course call in family members 24km away, or respite carers for anything important, but am quite happy living quietly'*

*'Respite care should be more available- I find among my friends what help it means to them to have a break from...(ill)... spouses. We also need more nursing homes with caring staff and hospices'.*

The 'view from inside' is provided by an Older rural woman who needed care but had no family support.

*'I also believe we should have half way houses respite care for single in-patients to be looked after, after having weakening illnesses. Less money wasted and being spent on Olympic Games would make me more content, as it is very traumatic to feel abandoned like I did when I had a stroke 3 and a half years ago, and went home and became depressed through weakness and aloneness'*

The study provides opportunity to understand health and related factors associated with these life events and transitions. For example, moving house was one of the top ten life events reported in Survey 1. Many women wrote about how they had had to move because they could not afford to stay in their own homes or because maintenance had become problematic, or to move from rural to more urban areas to be closer to family and services.

Between Survey 1 and Survey 2, 3% of the older women in the study had moved from rural or remote areas to urban areas. Women in remote areas were most likely to move, with 11% of the 72 women living in these areas having moved at follow up. There was a significant trend for Older women who moved to have more symptoms at Survey 2 than women who remained in their original homes. Also, contrary to women in other areas who recorded significant increases in Mental Health SF-36 subscale scores between Survey 1 and Survey 2, women who moved had no significant increase in these scores. Women who moved to more urban areas had higher perceived access to health care, but had lower reported use of community services than women in rural or remote areas. The women who moved also had the lowest neighbourhood satisfaction scores and a greater negative change in social support scores than women who remained in their original area of residence classification. These data suggest that women who move from rural to more urban areas are a vulnerable and potentially disadvantaged group of older women, who require particular consideration in policy and planning.

# Rural Women's Use and Perceptions of Health Services

## *Access to health services*

### After hours care

General practitioners are required to provide after-hours care for their patients as a condition of their vocational registration, but the manner in which after-hours care is provided in Australia varies greatly according to area. In urban areas, after-hours services are commonly provided via an after-hours service covering a defined area. Patients may also choose to access a 'walk-in' 24 hour medical centre, or to attend a hospital emergency department. In rural areas, GPs are more likely to provide their own after-hours care which may include staffing the local hospital on a cooperative rostered basis. In regard to after-hours medical care, women in large rural areas appear to be better served than those in urban areas, presumably due to access to community hospitals (see Table 6). Women in remote areas are least likely to rate their access as excellent or very good.

*Table 6. Percentage reporting "excellent" or "very good" access to after hours medical care, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 33.5 | 37.3 | 29.4 | 22.5 |
| Mid-age Survey 2 | 64.8 | 67.8 | 54.4 | 47.0 |
| Older Survey 2 | 45.6 | 49.5 | 40.9 | 42.1 |

Despite lower levels of satisfaction among the Younger women, it is unlikely that they actually have worse access than Mid-age or Older women. It is worth noting that reports of satisfaction are subjective ratings and will be influenced by the expectations and attitudes of the individual, in contrast to measures of "responsiveness" which aim to incorporate more objective indicators of availability and appropriateness of service. Thus, the lower satisfaction of the Younger cohort need not reflect service which is in any objective sense less adequate, but may be influenced by higher expectations and a greater willingness to criticise than obtains among the Older cohort.

### Medical specialists

Access to medical specialists is an issue of concern to rural Australians, and Table 7 shows that there is a marked gradient in perceived access to medical specialists between urban and remote areas. Younger women from all areas reported significantly poorer satisfaction with access than the Mid-age or Older women.

*Table 7. Percentage reporting "excellent" or "very good" access to medical specialists, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 51.2 | 42.3 | 32.7 | 15.1 |
| Mid-age Survey 2 | 70.7 | 63.4 | 47.9 | 31.4 |
| Older Survey 2 | 67.5 | 63.7 | 53.4 | 34.7 |

## Hospitals

In regard to access to a hospital, the disparity between areas is characterised by generally more positive perceptions of access in urban and large rural centres than in small rural centres and remote areas (see Table 8). The gradient noted in access to specialists is not seen with hospitals, presumably because many rural hospitals are serviced by GPs and staffed by experienced nurses. Although there is an age disparity, it is not as great as differences in satisfaction with access to medical specialists.

*Table 8. Percentage reporting "excellent" or "very good" access to hospital, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 55.7 | 54.1 | 53.7 | 42.6 |
| Mid-age Survey 2 | 68.8 | 68.7 | 61.5 | 55.3 |
| Older Survey 2 | 63.9 | 64.7 | 61.8 | 59.1 |

## Counselling services

Perceived access to counselling services appears to be better in urban and large rural centres, and poorer in remote areas (see Table 9), but Younger women are less positive in their perceptions than Mid-age women irrespective of area of residence (this question was not asked of the Older women).

*Table 9. Percentage reporting "excellent" or "very good" access to counselling services, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 41.1 | 39.4 | 34.6 | 24.4 |
| Mid-age Survey 2 | 53.0 | 50.0 | 40.3 | 28.0 |

## Pap screening

The proportion of women in the Younger and Mid-age cohorts who report having actually had adequate Pap screening (screened in previous two years) does not differ significantly by area of residence, but it is notable that perceptions of access to Pap testing do. Table 10 shows that women in remote areas are less likely to regard their access positively, while again ratings of access are more positive for Mid-age than for Younger women (Older women were not asked this question).

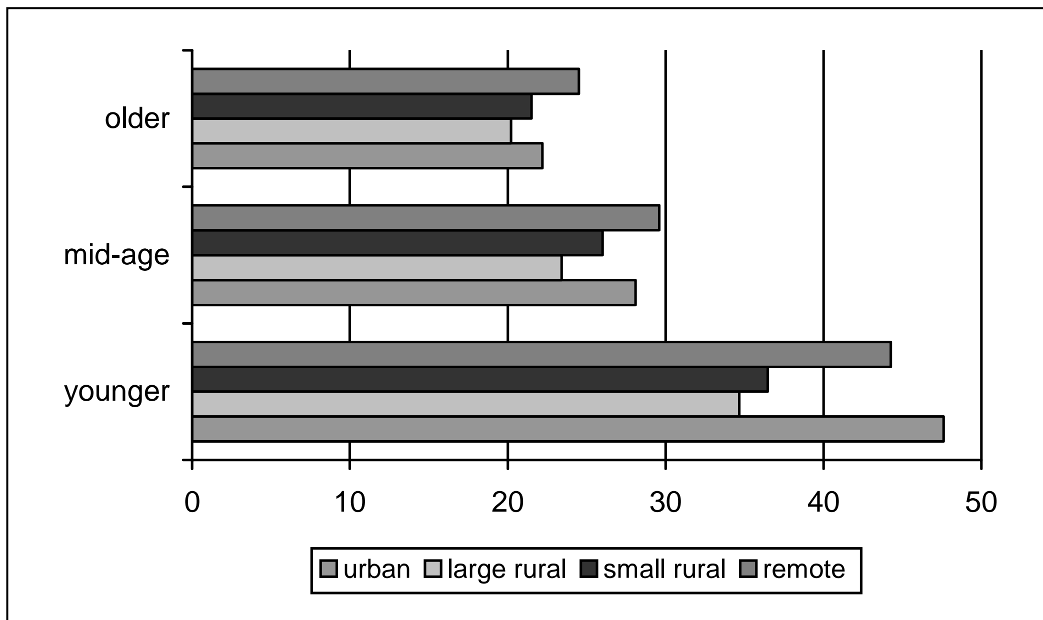
*Table 10. Percentage reporting "excellent" or "very good" access to Pap tests, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 66.1 | 64.4 | 59.6 | 50.6 |
| Mid-age Survey 2 | 79.8 | 82.2 | 70.6 | 58.1 |

Many women prefer to see a female GP for a Pap test, but there are fewer women doctors in rural areas and 25 per cent of male GPs in rural areas are aged over 55. Thus, Younger women in rural areas may find it particularly difficult to find a GP who is *either* female *or* close to their own age, and with whom they may be more likely to feel comfortable.

Younger women are significantly more likely than Mid-age or Older women to prefer to see a female GP "for certain things" (Figure 10).

***Figure 10. Preference for seeing a woman doctor "for certain things" (%)***

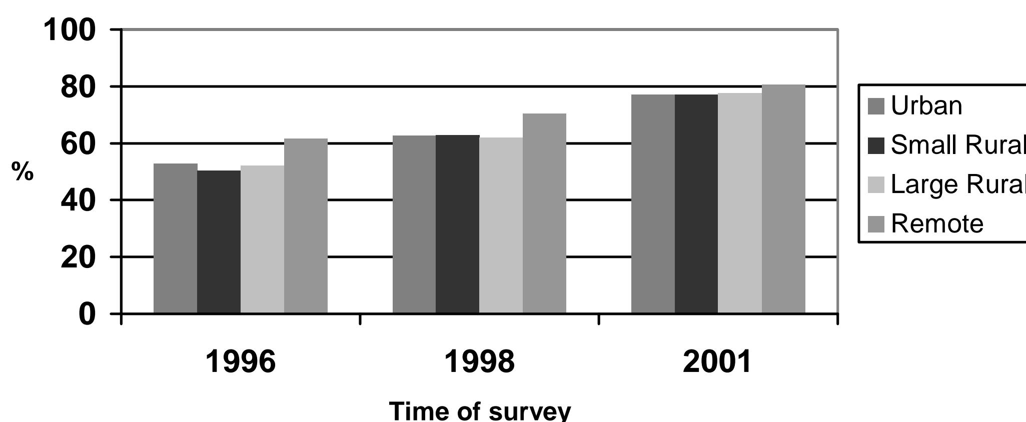



## Mammography

Data from the Mid-age women indicate that a very high proportion of remote-area Mid-age women reported having had a mammogram. Figure 11 shows that rates of mammography increased in all areas of residence, from Survey 1 (1996), through Survey 2 (1998), to Survey 3 (2001). The strongest association with new uptake of mammography was turning 50, an age at which Commonwealth initiatives promote first screening. The number of women over 50 who are not screened is small, and these women are generally characterised by low levels of health service use or conversely by high numbers of major diagnoses, obesity, and other severe health problems.

These data reflect the success of strategies to promote mammographic screening in remote areas of Australia.

*Figure 11. Percentage of Mid-age women reporting mammographic screening in previous two years, by area of residence: Surveys 1, 2 and 3.*




## General Practitioner Services

The following section focuses on issues related to GP services, including cost of last visit to a GP, continuity of care, and availability of and preferences for female practitioners. The poorer levels of access for rural women are well demonstrated, and the difference is summed up in this comment from a Younger participant:

> *My answers… are influenced by the fact that home is both in Brisbane and where my parents live… I go to the same in each town, but I go to two different clinics… In Brisbane I use the uni health service, which means no waiting time, bulk billing, and plenty of female doctors. These three things are not available in the more rural area where my parents live.*

### Use of GP services

The percentage of women who had visited a GP at all, and the percentage who were "high" users (more than 4 visits in the past year for Younger women; more than 6 visits per year for Mid-age and Older women) did not vary across areas of residence. Overall, 71% of Younger women, 92% of Mid-age women, and 98% of Older women had visited a GP at least once, while 24% of Younger women, 27% of Mid-age women, and 32% of Older women were "high" users.

### 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).

Overall, Mid-age women were most likely, and Older women least likely, to have incurred some out-of-pocket cost for their most recent GP visit. Table 11 shows that rural and remote

women are much more likely to incur a cost, even those in the older age group, the majority of whom are pensioners.

*Table 11. Percentage reporting no out-of-pocket cost for their last GP visit, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 54.1 | 27.5 | 25.2 | 27.7 |
| Mid-age Survey 2 | 47.6 | 28.3 | 26.8 | 28.2 |
| Older Survey 2 | 79.3 | 61.4 | 61.8 | 72.9 |

Of those women who did have to pay, between a quarter and a third rated the cost as "excellent" or "very good". Table 12, showing percentages of those women who incurred a costs, shows that the more rural the location, the less likely the woman was to be satisfied with the cost of her most recent visit. In all areas, young women expressed the most dissatisfaction with the cost of their last visit.

*Table 12. Percentage of women paying for their last GP visit, who were satisfied with the cost, by age cohort and area of residence: Survey 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 27.0 | 22.3 | 23.1 | 22.0 |
| Mid-age Survey 2 | 37.3 | 33.1 | 34.9 | 35.0 |
| Older Survey 2 | 34.0 | 31.0 | 29.4 | 24.6 |

*Women with no out-of-pocket cost are excluded from this table*

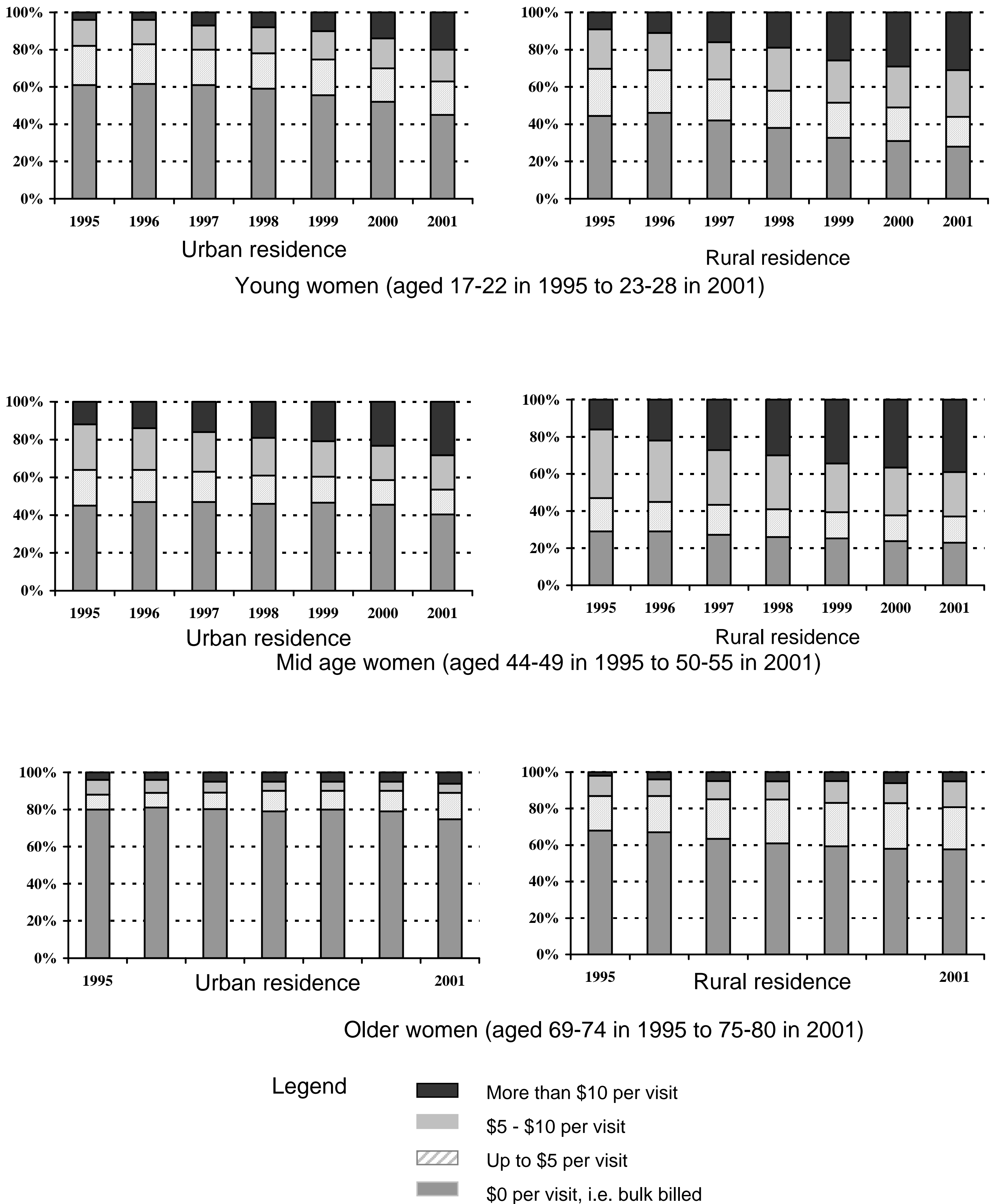
These data have been explored in an ALSWH study to assess geographical equity in the availability, accessibility and out of pocket costs of GP services for women in Australia (Young *et al,* 2000, 2002). The analyses showed a striking gradient in financial and non-financial barriers to health care associated with area of residence. Older women were more likely to have no out of pocket costs for their GP consultations but in all age groups, the proportion was lower in rural areas than in urban areas.

Figure 12 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. Among mid aged women, the median out of pocket cost per consultation ranged from $2.11 in capital cities to $6.48 in remote 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.

Importantly for policy development, women who reported better access to care were also more likely to be satisfied with their most recent general practice consultation and less likely to be sceptical of the value of medical care (Young *et al*, 2001).

*Figure 12: Mean out-of-pocket cost per GP consultation per woman 1995-2001, by age group and area of residence.*



## Continuity of care

In regard to continuity of care, women's choice is limited by the number of GPs who are geographically available, as well as their preferences for, and expectations of, seeing a particular doctor. Continuity of care is well documented as resulting in cost savings and better patient outcomes (see, for example, Harris & Frith, 1996). ALSWH data demonstrate that Mid-age women are more likely than Younger women to report "always" seeing the same GP. As Table 13 shows, the patterns across areas of residence differ for these two age groups (Older women were not asked this question).

*Table 13. Percentage of women reporting that they "always" go to the same GP, by age cohort and area of residence: Survey 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 26.0 | 36.7 | 33.5 | 27.0 |
| Mid-age Survey 2 | 46.7 | 55.4 | 46.9 | 42.0 |

The fact that almost three quarters of Younger women in urban areas don't see the same doctor may indicate their usage of large walk-in clinics; conversely, that the same proportion of Younger women in remote areas don't see the same GP may indicate the rapid turnover of remote-area GPs or their use of visiting doctor services. This contrasts with Mid-age women, who are more likely to have established a relationship with a particular GP.

## Choice of GP

The distribution of general practitioners in Australia is a major factor in the results shown in Table 14, which shows the extent to which women perceive that they have a choice of GP. Choice of GP is rated less positively in rural and remote areas by women in all age groups; again, Younger women's satisfaction with this aspect of health services is lower than that of Mid-age and Older women.

*Table 14. Percentage reporting "excellent" or "very good" choice of GPs, by age cohort and area of residence: Survey 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 46.1 | 48.8 | 37.9 | 19.7 |
| Mid-age Survey 2 | 58.9 | 57.5 | 44.1 | 26.5 |
| Older Survey 2 | 60.1 | 58.2 | 49.1 | 30.0 |

An issue which is especially relevant to health care in rural areas is that of trust. Country people may be sensitive to newcomers who may be perceived not to understand the rural context, and there is often also sensitivity about privacy and confidentiality when the practitioner or receptionist is known socially, particularly for younger women. This was apparent in the comments which participants added in response to the open-ended question at the end of the ALSWH questionnaire.

> *Women at my age, 19, I think need more sexual information/support. Especially if you live in a small town there are very few places to go that are confidential. In our town where your business is everyone else's, it's a very real problem.*

For this reason, among others, the lack of choice of GP in rural areas disadvantages women. Another reason is the preference among many women for a female doctor, and the fact that women GPs are underrepresented in the rural medical workforce. The ratio of male to female

general practitioners is 1.9:1 in urban areas, 2.1:1 in large rural centres; 3.1:1 in small rural centres, and 2.3:1 in remote areas (DoHAC, 2000).

## Preference for a female GP

Questions about preferences for female GPs in each ALSWH Survey allowed women to indicate a preference "always" or "for certain things." Table 15 shows the percentage of women responding that they "always" prefer to see a female GP.

*Table 15. Percentage reporting they "always" prefer to see a female GP, by age cohort and area of residence: Surveys 1 and 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Younger Survey 1 | 20.4 | 21.8 | 16.9 | 19.3 |
| Younger Survey 2 | 18.4 | 20.1 | 15.6 | 15.3 |
| Mid-age Survey 1 | 17.1 | 16.3 | 12.9 | 12.0 |
| Mid-Age Survey 3 | 18.0 | 16.6 | 12.8 | 11.7 |
| Older Survey 1 | 11.4 | 10.1 | 7.5 | 6.7 |
| Older Survey 2 | 12.4 | 11.5 | 8.6 | 5.8 |

Younger women are significantly more likely than Mid-age or Older women to prefer to see a female GP for all services. It is notable that female GPs are on average seven years younger than male GPs, and that 25 per cent of male GPs in rural areas are aged over 55, compared to approximately nine per cent of female GPs (DoHAC, 2000). Thus, Younger women in rural areas may find it particularly difficult to find a GP who is *either* female *or* close to their own age, and with whom they may thus be more likely to feel comfortable. Paralleling the administrative data on male and female GPs, the figures in Table 16 show that women in more rural areas are less likely than those in urban areas to perceive their access to female GPs as excellent or very good.

*Table 16. Percentage reporting "excellent" or "very good" access to a female GP, by age cohort and area of residence: Survey 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 50.5 | 42.8 | 32.6 | 24.7 |
| Mid-age Survey 2 | 60.4 | 51.8 | 39.8 | 25.7 |

It has been argued that it is the 'culture of practice' exhibited by female doctors which young women find attractive, rather than the actual gender of the practitioner. Female GPs tend to provide longer consultations, greater frequency of patient consultations, greater number of problems treated per visit, and more counselling, than male GPs. Women are more likely than men to see GPs for psychosocial problems, and female GPs treat more of such presentations. Specifically, it has been found that women doctors are better at dealing with issues of domestic violence (Bryson and Warner-Smith, 1998). One ALSWH respondent articulated this situation.

> *No services for abused kids, badly need more services. Need more female doctors for women's health.*

The findings suggest that restricted access to female practitioners may affect health outcomes if young rural women are reluctant to seek medical services provided by male doctors practising in traditional modes.

> *'... I think the youth of today are struggling severely with lack of knowledge esp in the pregnancy area. My friends and I went to an all girls Catholic school and out of a graduation of 35 girls in 1993, we have 16 children and I'm only 19. This makes me very sad. Also lack of knowledge of female problems such as Pap smears etc. Most of us know nothing about the checks we're supposed to be having, & are too scared to ask the family doctor because in our area out west, the male doctors lecture the girls (about) going on the pill because he is old-fashioned - but the result is pregnancy'*

## The 'gratitude factor'

It is worth noting that reports of satisfaction are subjective ratings. Despite lower levels of satisfaction among the Younger women in regard to most aspects of health services, it is unlikely that they actually have worse access than Mid-age or Older women, but they may have higher expectations and a greater willingness to criticise than obtains among their mother's and grandmother's generations.

# Common Health Conditions, Procedures and Symptoms: Women in Rural and Remote Areas

This section presents data from the most recent surveys for each cohort. The "top ten" conditions, procedures and symptoms reported by women in rural and remote areas are described. Information about help-seeking for particular conditions and women's satisfaction for the help they received is also shown. In all cases, the data are derived from pre-specified lists of diagnoses and symptoms.

## *Younger Cohort*

### Top ten medical diagnoses

Table 17 shows the ten most commonly reported diagnoses in the Younger cohort (Survey 2, 2000), according to area of residence. Urinary tract infections and low iron levels were the most frequently reported conditions, but were less common among women in the more remote areas than those in urban areas. Younger women living in remote areas were more likely than women in urban and rural areas to experience hypertension during pregnancy, largely as a result of high rates of pregnancy in these areas.

*Table 17. Percentage of Younger cohort reporting major diagnoses, by area of residence: Survey 2*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Urinary Tract Infection | 23.7 | 24.2 | 20.2 | 20.3 |
| Low Iron | 19.6 | 19.1 | 18.4 | 17.4 |
| Asthma | 11.1 | 12.8 | 10.8 | 10.4 |
| "Other" major illness | 3.7 | 3.7 | 3.9 | 3.4 |
| Genital Warts | 3.6 | 4.3 | 2.9 | 1.8 |
| Endometriosis | 3.2 | 3.5 | 2.7 | 3.1 |
| Hypertension (not during pregnancy) | 2.5 | 2.7 | 3.3 | 2.1 |
| Hypertension (during pregnancy) | 2.4 | 4.8 | 5.8 | 6.0 |
| Genital Herpes | 1.8 | 2.0 | 1.2 | 2.9 |
| Chronic Fatigue Syndrome | 1.7 | 2.0 | 1.7 | 1.0 |

The data shown earlier, of high rates of obesity among Younger rural women, suggest that Younger women from rural areas will have an increased risk of developing diabetes as they age.

Type 2 diabetes is the eighth most common condition for the Mid-age cohort and the sixth most common condition for women in the Older cohort. Of the Mid-age and Older cohorts, women living in remote areas reported higher rate of diabetes than women living in urban areas.

## Mental health diagnoses

Table 18 summarizes the reported rates of three diagnosed mental health conditions among the Younger cohort, according to area of residence. Rates of diagnosed mental health problems are higher in urban than in rural areas, with the exception of postnatal depression; this is again a function of higher rates of childbirth among rural and remote-living Younger women.

*Table 18. Percentage of Younger cohort reporting diagnosed mental health conditions, by area of residence: Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Depression (not postnatal) | 12.2 | 12.6 | 10.3 | 9.6 |
| Anxiety | 5.6 | 3.8 | 3.7 | 1.6 |
| Postnatal Depression | 1.5 | 3.8 | 3.9 | 2.9 |

## Gynaecological and hospital procedures

Reflecting the earlier age of motherhood in non-urban areas, Younger women outside urban areas had higher rates of pregnancy-related hospitalizations; however, rates of hospitalization for other reasons did not differ by area of residence. Termination of pregnancy also occurs at an equal rate regardless of area of residence (see Table 19) but ALSWH data do not provide information as to where this procedure is carried out.

*Table 19. Percentage of Younger cohort reporting terminations and hospitalizations, by area of residence: Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Terminations (abortions) | 11.7 | 10.0 | 11.4 | 10.8 |
| Hospitalizations for problems during pregnancy | 2.1 | 4.7 | 5.1 | 4.8 |
| Hospitalizations for normal childbirth | 4.6 | 8.5 | 11.1 | 11.5 |
| Hospitalizations for all other reasons | 10.1 | 9.5 | 10.9 | 11.8 |

## Top ten symptoms

The extent to which Younger women reported experiencing each of a list of specified symptoms was also assessed at Survey 2. While these symptoms may not be associated with diagnosed disease, they do contribute to reduced quality of life and have been shown to be associated with absenteeism from work, as well as reductions in sufferers' ability to carry out their paid and unpaid responsibilities. Table 20 shows the percentage of Younger women reporting each of the ten most common symptoms "often" (other response categories were "rarely", "sometimes", and "never").

*Table 20. Percentage of Younger cohort reporting symptoms "often", by area of residence: Survey 2*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Allergies | 21.8 | 21.9 | 18.8 | 16.5 |
| Headache/migraines | 19.5 | 21.3 | 20.5 | 22.2 |
| Severe Tiredness | 16.0 | 18.7 | 16.9 | 13.1 |
| Premenstrual Tension | 14.6 | 11.9 | 10.7 | 7.0 |
| Back Pain | 13.2 | 13.9 | 15.8 | 13.7 |
| Severe Period Pain | 11.2 | 9.7 | 10.4 | 9.3 |
| Skin Problems | 11.2 | 10.8 | 9.4 | 10.1 |
| Difficulty Sleeping | 9.8 | 11.8 | 10.7 | 8.5 |
| Irregular Periods | 8.8 | 7.7 | 8.5 | 8.0 |
| Depression | 6.6 | 7.8 | 6.4 | 6.7 |

Allergies, headaches and migraines, severe tiredness and back pain were the most frequently reported symptoms for Younger women. Younger women in urban areas were less likely to report headaches/migraines 'often' than women from remote areas, whereas Younger urban women were more likely to report they 'often' experienced tiredness than women from remote areas.

## *Mid-age Cohort*

### Top ten medical diagnoses

Table 21 shows the ten most commonly reported diagnoses in the Mid-age cohort (Survey 3, 2001), according to area of residence. Arthritis and hypertension were the most frequently reported conditions, reported by around 20 per cent. Women from remote areas reported the highest rate of hypertension and the lowest rate of osteoporosis.

Type 2 diabetes shows a higher reported incidence among women in remote areas, where it was the sixth most common condition.

Mid-age women from remote areas were less likely to report a diagnosis of low levels of iron than urban women, and this may be related to dietary differences, but may also reflect under-reporting. The contribution of diet requires further investigation through ALSWH data.

*Table 21. Percentage of Mid-age cohort reporting major diagnoses, by area of residence: Survey 3*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Arthritis | 22.1 | 22.9 | 23.5 | 22.5 |
| Hypertension | 16.0 | 18.1 | 19.6 | 21.5 |
| Asthma | 10.1 | 12.0 | 9.5 | 10.2 |
| Low Iron level | 9.9 | 7.9 | 8.3 | 6.4 |
| Bronchitis | 4.8 | 5.2 | 4.7 | 4.7 |
| Osteoporosis | 4.2 | 2.9 | 2.8 | 2.4 |
| Other major illness | 3.7 | 3.6 | 3.9 | 2.6 |
| Non-insulin dependent (type 2) diabetes | 2.8 | 2.6 | 2.8 | 4.7 |
| Heart Disease | 1.8 | 2.1 | 2.0 | 1.9 |
| Chronic Fatigue Syndrome | 1.3 | 1.3 | 1.1 | 1.2 |

## Mental health diagnoses

Table 22 summarizes the reported rates of three diagnosed mental health conditions among the Mid-age cohort, according to area of residence. Rates of diagnosed mental health problems are higher in urban than in remote areas.

*Table 22. Percentage of Mid-age cohort reporting diagnosed mental health conditions, by area of residence: Survey 3*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Depression | 11.6 | 12.6 | 11.0 | 8.8 |
| Anxiety | 6.8 | 8.4 | 6.2 | 4.7 |
| Other Psychiatric disorder | 0.7 | 0.8 | 0.5 | 0.5 |

## Top ten procedures

Table 23 summarizes the reported rates of the most common surgical procedures among the Mid-age cohort, according to area of residence. Gastroscopy – a procedure used to screen for a range of gastrointestinal conditions – is by far the most commonly reported procedure, followed by breast biopsy and hysterectomy. Mid-aged women from remote areas have the lowest rates of gastroscopy, endometrial ablation, and mastectomy, but otherwise there are few differences across areas of residence.

*Table 23. Percentage of Mid-age cohort reporting surgical procedures, by area of residence: Survey 3*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Gastroscopy | 12.7 | 12.4 | 12.1 | 10.0 |
| Breast Biopsy | 4.9 | 3.5 | 4.4 | 4.0 |
| Hysterectomy | 4.5 | 4.3 | 4.1 | 3.8 |
| Prolapse Repair (vagina, bladder or bowel) | 2.4 | 2.1 | 2.6 | 2.4 |
| Cholecystectomy | 1.9 | 2.6 | 1.9 | 1.6 |
| Both ovaries removed | 1.8 | 2.2 | 2.0 | 1.5 |
| Lumpectomy | 1.8 | 1.7 | 1.9 | 1.8 |
| Cosmetic surgery | 1.7 | 1.1 | 1.2 | 1.3 |
| Endometrial ablation | 1.6 | 1.7 | 1.7 | 0.7 |
| Mastectomy | 0.6 | 0.7 | 0.4 | 0.2 |

### Top ten symptoms

The extent to which Mid-age women reported experiencing symptoms was also assessed at Survey 3. Table 24 shows the percentage of Mid-age women reporting each of the ten most common symptoms "often". Hot flushes and stiff or painful joints were the most common symptoms reported by Mid-age women. There were few differences in reports of symptoms according to area of residence.

*Table 24. Percentage of Mid-age cohort reporting symptoms "often", by area of residence: Survey 3*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Hot Flushes | 18.1 | 16.6 | 19.8 | 20.8 |
| Stiff/painful joints | 17.1 | 18.1 | 18.3 | 18.4 |
| Difficulty sleeping | 16.3 | 16.8 | 17.7 | 14.5 |
| Back pain | 15.6 | 16.2 | 17.2 | 16.7 |
| Allergies | 14.1 | 14.8 | 13.9 | 16.1 |
| Night sweats | 12.3 | 11.8 | 14.4 | 15.5 |
| Severe tiredness | 11.6 | 11.6 | 10.6 | 9.0 |
| Headache/ migraines | 11.5 | 9.5 | 11.5 | 10.5 |
| Eyesight problems | 11.4 | 12.0 | 11.6 | 11.7 |
| Irregular periods | 8.4 | 7.2 | 7.7 | 6.5 |

## *Older Cohort*

### Top ten medical diagnoses

Table 25 shows the ten most commonly reported diagnoses in the Older cohort (Survey 2, 1999), according to area of residence. As for the Mid-age women, arthritis and hypertension were the most commonly reported diagnoses in all areas of residence. However, hypertension was more prevalent among women in remote areas, while arthritis was slightly less common. Women in remote areas also had a slightly higher rate of heart disease and diabetes than those in the other areas, but lower rates of osteoporosis and iron deficiency.

*Table 25. Percentage of Older cohort reporting major diagnoses, by area of residence: Survey 2*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Arthritis | 42.9 | 41.2 | 41.0 | 38.4 |
| Hypertension | 33.6 | 33.9 | 33.6 | 40.1 |
| Heart disease | 13.1 | 13.3 | 13.5 | 15.1 |
| Osteoporosis | 13.5 | 13.0 | 11.6 | 10.0 |
| Asthma | 7.7 | 9.0 | 8.0 | 8.6 |
| Diabetes | 6.8 | 6.8 | 7.9 | 9.0 |
| Bronchitis/emphysema | 6.9 | 6.7 | 5.5 | 6.9 |
| Low iron | 4.6 | 5.4 | 4.3 | 3.4 |
| Stroke | 2.9 | 3.3 | 2.4 | 3.4 |
| Thrombosis | 1.4 | 1.5 | 1.8 | 1.3 |

## Mental health diagnoses

Table 26 summarizes the reported rates of three diagnosed mental health conditions among the Older cohort, according to area of residence. Rates of diagnosed mental health problems are higher in urban than in rural areas. It should be noted that rates of dementia are likely to be underestimates, as women with these diagnoses are less likely to participate in ALSWH than are other Older women.

*Table 26. Percentage of Older cohort reporting diagnosed mental health conditions, by area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Depression | 7.5 | 6.1 | 5.9 | 7.3 |
| Anxiety | 6.2 | 5.5 | 5.1 | 5.2 |
| Alzheimers/dementia | 0.7 | 0.3 | 0.4 | 0.9 |

## Top ten procedures

Table 27 summarizes the reported rates of the most common surgical procedures among the Older cohort, according to area of residence. Skin surgery – mainly for skin cancers – and endoscopy - a procedure used to screen for a range of gastrointestinal conditions – are by far the most commonly reported procedures, followed by eye surgery. Skin surgery was the most common experience for all groups, but was markedly more frequent among remote area women. In contrast, endoscopy was the second most common procedure, but was far less frequent among older remote area women. About 30 per cent of the Older women had not undergone any of the listed procedures, but the proportion was lowest in large rural areas (29%) and urban (31%) areas, and highest among older women in small rural (33%) and remote (36%) areas.

*Table 27. Percentage of Older cohort reporting surgical procedures, by area of residence: Survey 3*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Skin surgery | 31.1 | 30.0 | 31.2 | 38.8 |
| Endoscopy | 21.2 | 21.0 | 19.8 | 11.8 |
| Eye surgery | 19.3 | 21.6 | 19.1 | 15.1 |
| Arthroscopy | 6.2 | 6.7 | 6.1 | 7.2 |
| Prolapse repair (vagina, bladder or bowel) | 4.4 | 5.45 | 4.7 | 3.3 |
| Heart surgery | 4.3 | 3.6 | 3.5 | 3.3 |
| Hip surgery | 3.4 | 2.3 | 3.6 | 1.3 |
| Cholecystectomy | 3.2 | 2.1 | 3.0 | 4.0 |
| Hysterectomy | 1.7 | 2.7 | 2.0 | 0.1 |
| Removal of both ovaries | 0.7 | 0.7 | 0.6 | 0.7 |

# Rural Women's Experiences of Seeking Help for Psychological Distress and Abuse[1]

This section of the report focuses on the ways in which rurality impacts on women's choices, experiences of help-seeking, and use of the health system in regard to their mental health and well-being. It draws specifically on two ALSWH studies of Mid-age women: the first examined experiences of help-seeking for psychological distress and mental health services in rural areas (Outram, 2003). The second reported on women's experiences of help-seeking whilst living in and/ or leaving an abusive relationship in rural and remote regions of Australia (Loxton et al., 2003). They demonstrate the inter-relationships of sociocultural and economic factors and women's health, and that effective health policies and programs need to take account of the social context and social policy gaps and/or initiatives.

Mental health, abuse, and help-seeking have to be seen in the context of broader social and demographic factors, as well as women's expectations of professional help. In interviews with rural women who had experienced emotional distress, it was notable that the majority of women commented on their encounters with their GP, drawing attention to the lack of GPs in rural and remote areas, long waiting times, and closed books. The lack of transport services and having to travel long distances to visit a GP, which could be two or more hours each way, was a problem for some women. Additional comments were made about the difficulty of obtaining specialty mental health care services, for example, *"…some services such as specialist psychiatric care come to a town only once per month".*

Many rural women felt constrained from seeking help for psychological distress due to the lack of confidentiality and privacy in small towns where *"everyone knows everyone else's business".* Some women preferred talking to their GP about psychological problems rather than use services being offered through community health centres, where those services existed. Lack of confidentiality remains one a major health-service-related concern among women in rural communities. Concerns about the lack of privacy and confidentiality also affect the help-seeking of health and welfare workers and those with a high community profile in rural areas.

Rural women also identified explicit or implicit pressure from significant others such as family, in-laws and spouse to keep problems within the family. Beliefs and attitudes such as *"no-one can understand unless they have been there themselves"; "I don't believe in therapy"; "people will think badly of me"* were expressed by women in regard to seeking help. For some women privacy meant talking to no-one, others would talk only to their family, or sometimes friends. Rural women's concerns about GP services included the difficulty of changing their GP if they were unhappy with the interaction, low expectations of care, and busy GPs lacking the time to spend on emotional health concerns.

Women in rural areas who live in abusive relationships face particular problems. Table 28 outlines the percentage of women in Younger and Mid-age cohorts, by area of residence, who reported having experienced any form of physical, mental, emotional or sexual abuse or violence, whether as a child, in an adult relationship, or at any other time.

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[1] Parts of this section are from Outram, S (2001). *An Exploration Of Psychological Distress In Midlife Australian Women*. Unpublished Doctoral Thesis, University of Newcastle.
Parts are from Loxton, D et al (2003). *Women's Experiences of Domestic Abuse in Rural and Remote Australia.* Paper presented at National Rural Health Conference, Hobart, February 2003.

*Table 28. Percentage reporting experience of abuse, by age cohort and area of residence: Survey 2.*

| | Urban | Large rural | Small rural | Remote |
|---|---|---|---|---|
| Younger Survey 2 | 38.6 | 37.4 | 39.7 | 46.6 |
| Mid-age Survey 2 | 36.2 | 40.9 | 36.8 | 37.7 |

Barriers which were specifically identified in an interview survey (conducted by Deb Loxton as part of ongoing PhD research) as making it difficult for women living in rural and remote areas to seek help included the following:

- social and physical isolation
- transport difficulties
- unreliable or unavailable telephone services
- limited financial resources
- the prevalence of firearms in the country
- limited availability of legal services, such as police, legal aid and advocacy support
- a lack of specialist domestic violence services (long term counselling, refuge accommodation)
- social stigma

Even when services were available, the stigma related to having relationship problems often prohibited women from using counselling services, and prevented women from changing their domestic situation. Women reported concerns about disclosing abuse to health, welfare and police employees who were personal or family friends. They were also inhibited by a perception that domestic abuse must involve physical violence. Many women talked to their family doctor; they were more likely to disclose abuse when they had a good rapport with their doctor, but high staff turnover made it difficult for some women to form a trusting relationship with their GP. Limited availability of GPs meant that choosing a particular doctor was not always possible.

Other factors that inhibited women from disclosing abuse included previous responses of health workers and legal services, such as not being believed, being told that there was nothing that could be done, and a general unwillingness of police to become involved in 'domestic disturbances'. There was also a belief that they would be judged as being to blame, in combination with feelings of shame, not knowing who to talk to, and a fear that they would not be believed.

Some women spoke of being reluctant to leave abusive relationships because they were financially dependent, and this was particularly problematic when the family depended on income from a property or business. Some believed that they would feel safe only if they moved away from their local communities, entailing leaving behind the social support networks that they did have. Lack of transport and fears about future employment prospects were also issues for some women.

Many women spent years planning or wanting to leave their relationships. Barriers to leaving included fear of the abuser, not wanting to leave their familiar surroundings, a lack of financial and social support, transport difficulties, and fears over housing and future employment prospects. Gaining support, usually from family members, allowed many women to overcome these obstacles. Asking for support in order to leave was usually prompted by a severe incident of physical abuse, the realization that things were never going to get better, or the negative impact of the abusive relationship on their children.

In the short term, leaving an abusive relationship was found to involve moving house, leaving the local community, finding work, replacing possessions that were left behind, financial hardship, and loss of friendships. In the longer term, the outcomes of leaving an abusive relationship were more positive. Most of the women in the study had paid employment and felt settled in their new housing. While some were still experiencing financial difficulties, most were not. All felt that they had built successful social support networks, although this may have taken a considerable length of time (up to five years). All of the women in this study said that they did not regret leaving their abusive partner. While urban women report a similar trajectory, there are additional barriers of distance, economic circumstances, and local culture which make it more difficult for rural women.

Women living in rural and remote areas have particular concerns in regard to mental health issues, are more likely than urban women to have experienced an abusive relationship, and are also more likely to experience economic difficulties. ALSWH reinforces the need for supportive policy and a social environment that enables women to make choices that sustain their health and well-being.

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# APPENDIX

Tables showing data used for figures in the text.

*Figure 2 Body Mass Index category by area of residence: Younger cohort, Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Underweight | 22.2 | 18.8 | 15.7 | 13.6 |
| Acceptable weight | 50.2 | 46.3 | 46.8 | 44.6 |
| Overweight | 18.2 | 23.9 | 23.9 | 24.2 |
| Obese | 9.1 | 15.6 | 13.6 | 17.6 |

*Figure 3. Body Mass Index category by area of residence: Mid-age cohort, Survey 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Underweight | 6.6 | 6.1 | 5.5 | 6.6 |
| Acceptable weight | 46.0 | 42.9 | 40.8 | 37.4 |
| Overweight | 29.6 | 32.2 | 31.1 | 32.8 |
| Obese | 17.8 | 18.8 | 22.6 | 23.2 |

*Figure 4. Body Mass Index category by area of residence: Older cohort, Survey 2.*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Underweight | 10.4 | 10.5 | 10.0 | 7.8 |
| Acceptable weight | 43.9 | 42.3 | 42.4 | 43.2 |
| Overweight | 31.4 | 33.3 | 33.2 | 29.1 |
| obese | 14.3 | 13.8 | 14.4 | 19.9 |

*Figure 5. Cigarette smoking by area of residence: Younger cohort, Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Never smoked | 60.2 | 57.9 | 54.5 | 56.6 |
| Ex-smoker | 27.4 | 14.2 | 17.1 | 13.5 |
| Currently smoke | 26.1 | 27.4 | 28.4 | 29.9 |

*Figure 6. Cigarette smoking by area of residence: Mid-age cohort, Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Never smoked | 53.8 | 53 | 53.2 | 51.2 |
| Ex-smoker | 29.8 | 28.8 | 29.9 | 28.7 |
| Currently smoke | 16.4 | 18.2 | 16.9 | 20.1 |

*Figure 7. Cigarette smoking by area of residence: Older cohort, Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Never smoked | 62.8 | 67.6 | 65.2 | 64.1 |
| Ex-smoker | 32.1 | 28.0 | 30.1 | 29.9 |
| Currently smoke | 5.1 | 4.4 | 4.7 | 6.0 |

*Figure 8. Percentage of Younger women in each category of reported alcohol consumption, by area of residence: Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Rare/non drinker | 35.2 | 45.5 | 43.3 | 35.8 |
| Low risk drinker | 32.4 | 26.2 | 25.9 | 23.4 |
| Moderate, high or binge drinker | 32.4 | 28.3 | 30.8 | 41.8 |

*Figure 9. Percentage of Mid-age women in each category of reported alcohol consumption, by area of residence: Survey 2*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Rare/non drinker | 39.3 | 42.9 | 44.3 | 40.9 |
| Low risk drinker | 46.1 | 32.2 | 41.8 | 38.2 |
| Moderate, high or binge drinker | 14.6 | 14.9 | 13.9 | 20.9 |

*Figure 10. Percentage of women who preferred to see a female GP "for certain things"*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| Younger | 47.6 | 34.66 | 36.47 | 44.27 |
| Mid-age | 28.1 | 23.4 | 26.0 | 29.6 |
| Older | 2.2 | 20.2 | 21.5 | 24.5 |

*Figure 11. Percentage of Mid-age women reporting mammographic screening in previous two years, by area of residence: Surveys 1, 2 and 3*

| | Urban | Large Rural | Small Rural | Remote |
|---|---|---|---|---|
| 1996 | 52.9 | 50.3 | 52.2 | 61.7 |
| 1998 | 62.7 | 62.9 | 62.1 | 70.5 |
| 2001 | 77.2 | 77.2 | 77.6 | 80.7 |