

# The Australian Longitudinal Study on Women's Health

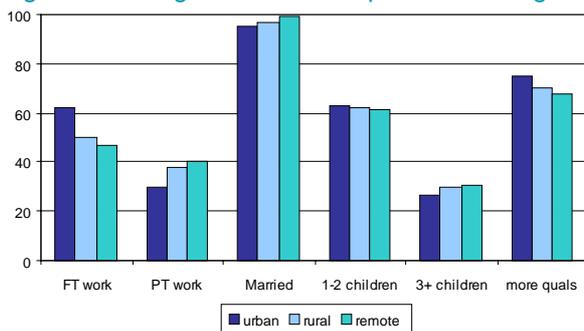


## Health in Rural and Remote Areas of Australia

### 1 HOW ARE THE LIVES OF WOMEN IN RURAL AND REMOTE AREAS DIFFERENT FROM THOSE OF OTHER AUSTRALIAN WOMEN?

**Younger** rural women's aspirations and life experiences are very different from those of their city cousins (see Figures 1 and 2). Rural women marry younger and have more children, at an earlier age, than urban women. They are also less likely to have completed high school or have post-secondary qualifications.

Figure 1. Younger Women's Aspirations for Age 35



Rural women of all ages are more likely to do unpaid work in the family business or farm. Lack of qualifications and experience, combined with a depressed rural job market, restrict their options for paid work.

*"... now so many of us are widowed and no longer...drive cars, are finding it very difficult living in the country. My town like so many other small towns is without public transport."*

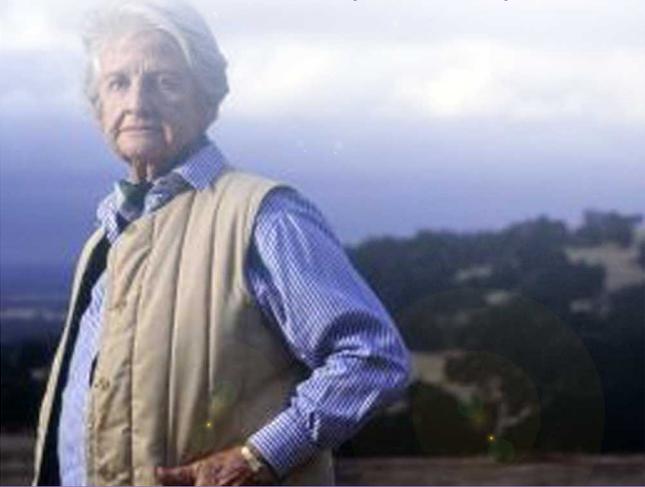
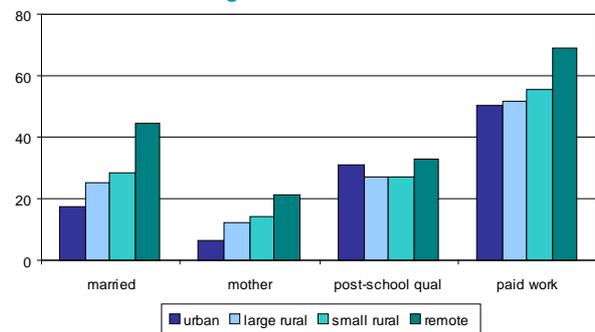


Figure 2. Motherhood, Education and Relationships: Younger Women in 2000



Given their earlier marriage and motherhood, Younger rural women also need more GP, obstetric and gynaecological services, yet there is a shortage of these services in rural areas.

**Mid-age** rural women are likely to be providing care for ageing relatives as well as caring for their grandchildren. Approximately 20% of Mid-age women in all geographic areas provide family care to frail, ill or disabled family members, but 46% of Mid-age women in rural and remote areas provide childcare, compared with 36% in urban areas. Caregivers are more likely to spend some time out of the paid workforce, and it is not surprising that Mid-age rural and remote women have more difficulty in managing on their income than women in urban areas.

**Older women** both give and receive care, but there is a lack of nursing homes, respite care and hospices in rural areas. Older rural women have particular needs, for example health care and transportation, which require particular consideration in policy and planning.

Further information is available in the technical report *Health in Rural and Remote Areas of Australia*

women's  
health  
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[www.newcastle.edu.au/centre/wha](http://www.newcastle.edu.au/centre/wha)

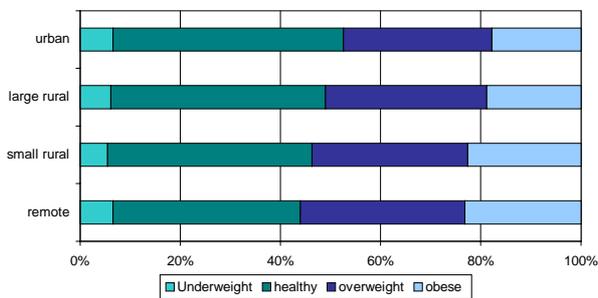
## 2 THE BIG PICTURE: THE HEALTH OF WOMEN IN RURAL AND REMOTE AREAS

In terms of physical health and quality of life, the project finds surprisingly few differences between women living in different parts of Australia. Women in rural and remote areas have slightly higher scores for mental health-related quality of life, but these group differences are small and of little significance.

However, there are some risk factors for the health of women living outside urban areas.

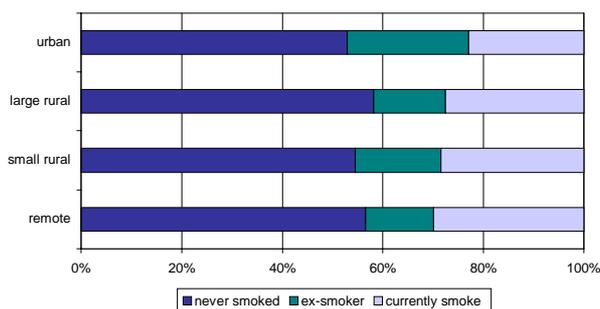
**Overweight** is more common in rural and remote areas (see Figure 3). This is reflected in higher rates of diagnosed diabetes, particularly in remote areas. 5% of Mid-age women and 9% of Older women in remote areas, compared with 3% of urban Mid-aged women and 7% of urban Older women, have been diagnosed with diabetes. Hypertension is also notably higher in rural and remote areas – 22% of remote-dwelling Mid-age women, versus 16% of urban Mid-age women.

Figure 3. Weight Categories of Mid-age Women



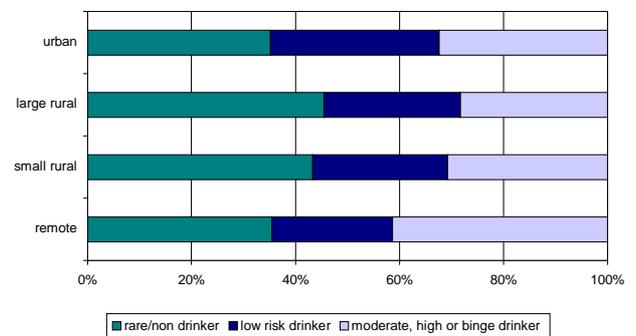
**Smoking:** There are both age cohort and area of residence trends in smoking. While Older women are least likely to smoke in all areas, rates of smoking are higher in rural areas for each age group (see Figure 4).

Figure 4. Smoking: Younger Women

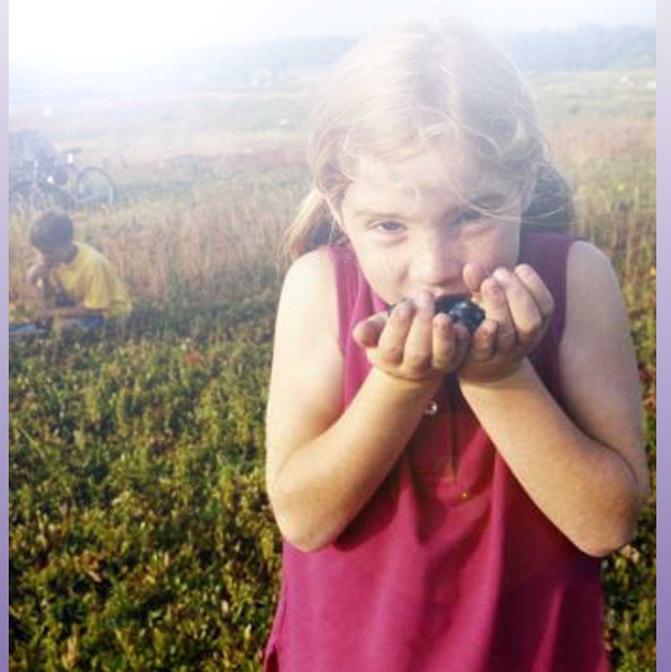


**Alcohol:** In each age group, problematic drinking is highest among women in remote areas (see Figure 5). This is the case both for moderate- to high-risk drinking (more than 14 standard drinks a week) and for bingeing (more than 5 standard drinks on any one occasion). Younger women have the highest levels of problematic drinking in all areas. Levels of unsafe alcohol consumption are very low among Older women, regardless of area of residence.

Figure 5. Percentage of Younger women in each category of reported alcohol consumption, by area of residence (Survey 2).



*“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... We also do a lot of entertaining ... the country lifestyle.”*

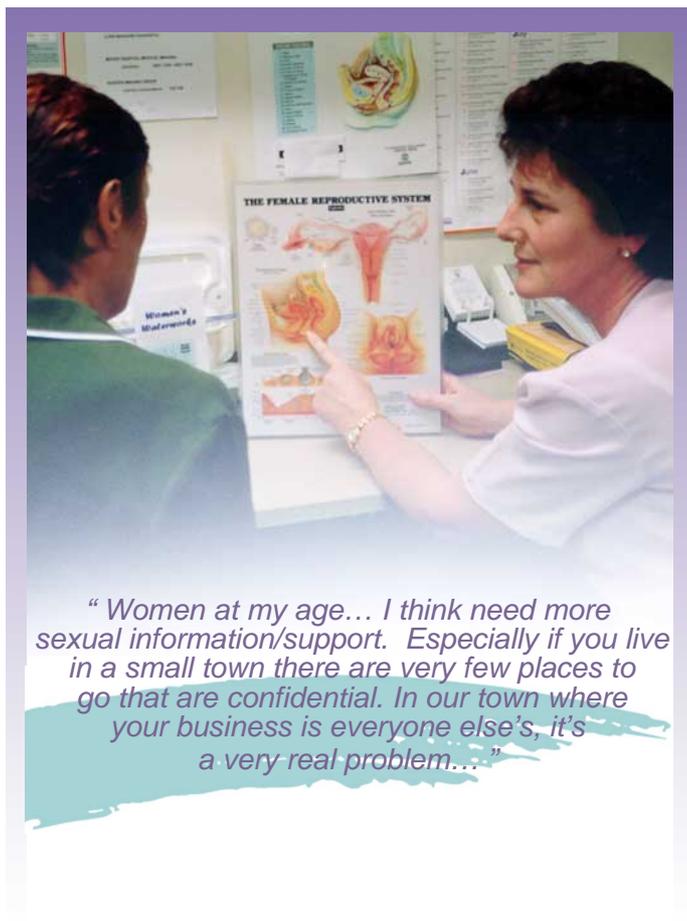
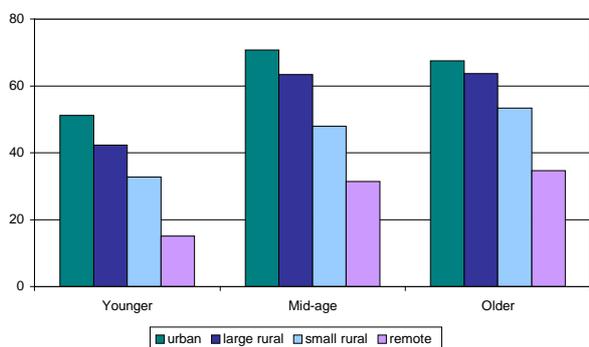


### 3. HOW DO RURAL WOMEN RATE THEIR ACCESS TO HEALTH SERVICES?

#### Access to health services

Women in rural areas have poorer access to health services than women in the cities, and the Younger women report the poorest access. Figure 6 shows the results for access to medical specialists. Essentially the same results are found for access to GPs, hospitals, counsellors, women’s health centres, and all other health services.

Figure 6. Access to Medical Specialists: Percent Rating “Excellent/Very Good”



#### Satisfaction with health services

Satisfaction with health services also varies by area of residence, with women in rural areas being less satisfied with access to after-hours care, greater waiting times, choice of GPs, availability of female GPs, and other aspects of health service provision (see Figure 7 and 8). Younger women are consistently less satisfied than Mid-age and Older women. Younger rural women also report concerns about confidentiality which are not found among the urban women.

#### The “gratitude factor”

Despite lower levels of satisfaction among the Younger women, it is unlikely that they actually have worse access than Mid-age or Older women. Reports of satisfaction are subjective ratings. Younger women may have higher expectations and a greater willingness to criticise than obtains among the Older cohort. Older women may be accustomed to relatively poor access to health care and thus express gratitude for services that Younger women take for granted.

Figure 7. Access to After Hours Care: Percent Rating “Excellent/Very Good”

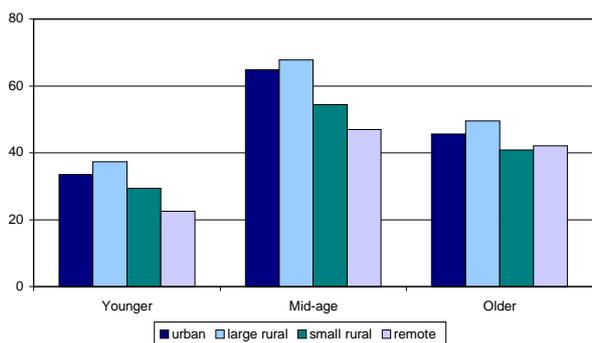
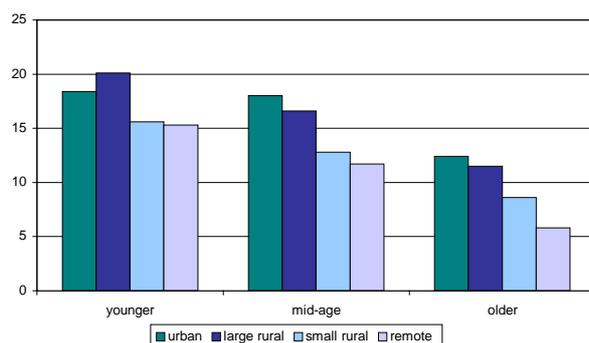


Figure 8. Access to Hospital : Percent Rating “Excellent/Very Good”



## 4 WHAT DO WOMEN SAY ABOUT GENERAL PRACTITIONER SERVICES IN RURAL AND REMOTE AREAS?

### Use of GP services

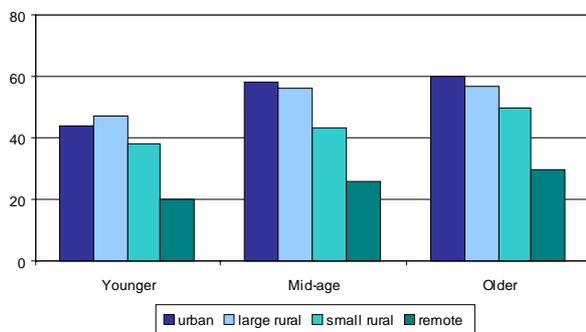
The percentage of women who had visited a GP at all, and the percentage who were “high” users (more than 4-6 visits in the past year), did not vary across areas of residence.

Overall, about 70% of Younger women, 90% of Mid-age women, and 98% of Older women had visited a GP at least once, while about one quarter of Younger and Mid-age women and one third of Older women were “high” users.

### Choice of GP

Choice of GP is rated less positively in rural and remote areas by women in all age groups, and Younger women’s satisfaction with this aspect of health services is lower than that of Mid-age and Older women (see Figure 9).

Figure 9. Choice of GP: Percent Reporting “Excellent/Very Good” Choice



An issue that is especially relevant to health care in rural areas is that of trust. There is often a sensitivity when the practitioner or receptionist is known socially, particularly for Younger women.

### Continuity of care

Continuity of care results in cost savings and better patient outcomes. Mid-age rural women are more likely than Younger rural women to report “always” seeing the same GP. Two thirds of Younger women in remote areas don’t see the same GP every time. In contrast, Mid-age rural and remote-dwelling women are more likely to have established a relationship with one GP.



*“ 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 X 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.”*

### Cost of GP visits

Rural and remote women are much more likely to incur out-of-pocket costs for their most recent GP visit. This applies even to the Older age group, the majority of whom are pensioners. Among Mid-age women in 1998, the median out of pocket cost per consultation ranged from \$2.11 in capital cities to \$6.48 in remote areas.

Younger women expressed the most dissatisfaction with the cost of their last visit and their awareness of the possibilities of “doctor shopping” is revealed in the comment above, from a Younger respondent.

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.

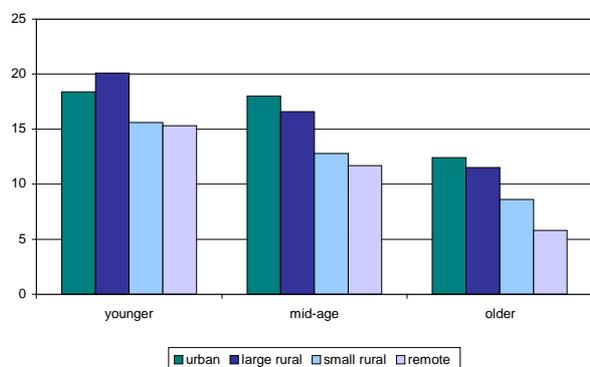
## 5 ARE THERE GEOGRAPHICAL DIFFERENCES IN COMMON HEALTH CONDITIONS?

**Among Older women**, as for the Mid-age women, arthritis and hypertension were the most commonly reported diagnoses in all geographical areas. Hypertension was more prevalent among women in remote areas, while arthritis was slightly less common.

Skin surgery – mainly for skin cancers - was the most common procedure experienced by Older women in all areas (about 30%), but was markedly more frequent among remote area women (almost 40%). In contrast, endoscopy was the second most common procedure (20%), but was far less frequent among Older remote area women (less than 12%). Women in small rural and remote areas were more likely not to have undergone any surgical procedure in the previous three years.

**Among Mid-age women** there were few differences in common health conditions by area, with arthritis and hypertension again most common in all areas. However, Type 2 diabetes was more prevalent among women in remote areas. Women in remote areas also reported the highest rates of hypertension, the lowest rates of osteoporosis, and were less likely to report low iron levels. All of these may be associated with increased rates of obesity (and reduced underweight) in remote areas.

Figure 10. Percent Reporting They 'Always' Prefer To See a Female GP



**Among Younger women** there were few differences in common conditions or procedures. The exceptions were those related to pregnancy, such as hospitalisations.

Younger rural women's intentions to have larger families mean that services in rural areas require an emphasis on obstetrics and gynaecological services.

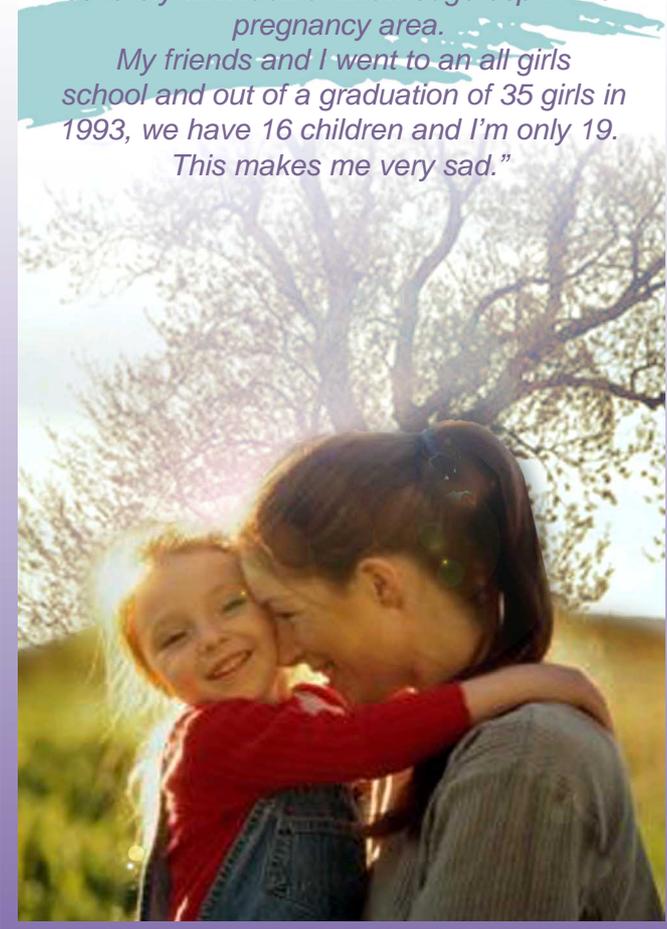
Rates of diagnosed mental health conditions among Younger women are lower in rural areas, with the exception of postnatal depression, again a function of higher rates of childbirth outside urban areas.

Younger ALSWH women living with a partner, particularly those with children, are more likely to report low levels of physical activity and be overweight. As this is a more common lifestyle for younger rural and remote women than for urban women, this represents a further disadvantage for their health.

Figure 10 shows that Younger women in all areas were most likely to prefer to see a female GP. Limited access to female practitioners may affect health outcomes if Younger 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 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."*



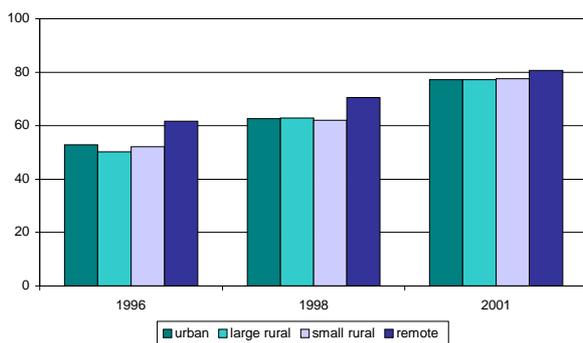
## 6 ACCESS TO SCREENING

### Mammography

Figure 11 shows that a very high proportion of remote-area Mid-age women report having had a mammogram. Turning 50 is the strongest predictor of uptake of mammography. The number of women over 50 who are not screened is small, and these women are generally low users of health services, or conversely are women with many severe health problems for whom one extra test may be a major burden.

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

Figure 11. Rates of Mammography in Previous 2 Years - Mid-age Women



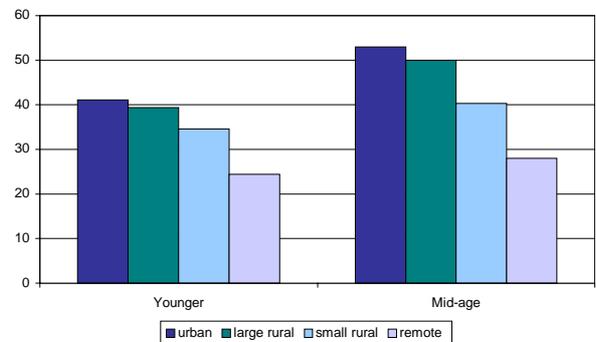
### Pap Screening

The majority of women in the Younger and Mid-age cohorts report having had adequate Pap screening (screened in previous two years), regardless of area of residence. But country women are less likely to be happy with their access to Pap screening (see Figure 12), and many have to travel long distances to find a practitioner with whom they feel comfortable.

### Preference for a woman doctor

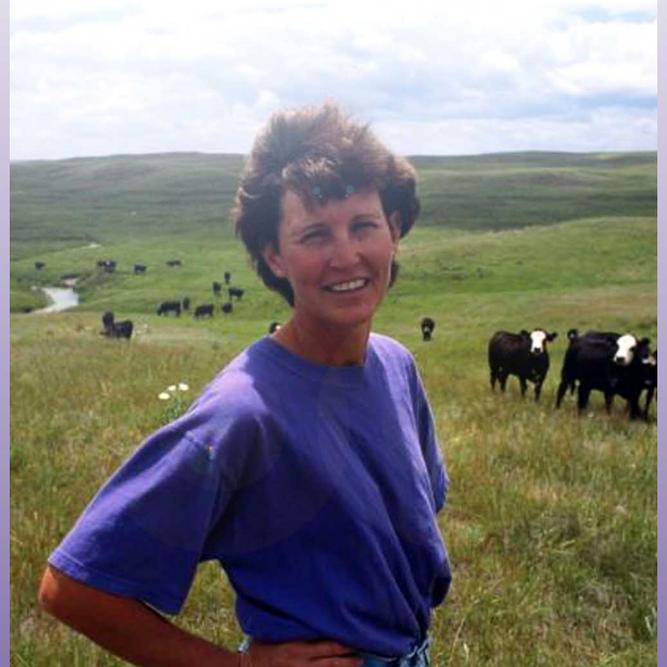
Many women prefer to see a female GP for a Pap test, but there are fewer women doctors in rural areas.

Figure 12. Younger and Mid-age Women Reporting "Excellent/Very Good" Access to Pap Screening



Younger women in rural areas may find it particularly difficult to find a GP with whom they are likely to feel comfortable.

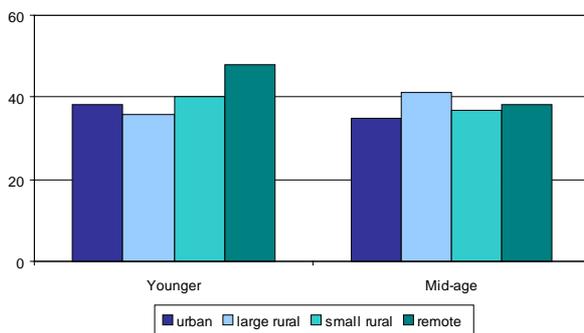
*"... lack of knowledge of female problems such as Pap smears etc. Most of us know nothing about the checks we're supposed to be having, and are too scared to ask the family doctor because in our [rural] area, the male doctors lecture the girls about going on the pill because he is old-fashioned - but the result is pregnancy"*



## 7 “Everybody knows everyone else’s business”: RURAL WOMEN’S EXPERIENCES OF PSYCHOLOGICAL DISTRESS AND ABUSE

Women living in rural and remote areas have particular needs in regard to mental health issues. Concerns about confidentiality and conflicting relationships are stronger in rural areas. Rural women are more likely than urban women to have experienced an abusive relationship (see Figure 13), and are also more likely to experience economic difficulties which may limit their ability to seek help.

Figure 13: Experiences of Abuse



Access to counselling services is better in urban and large rural centres, and poorer in remote areas. Only 24% of remote-dwelling younger women are positive about their access to counselling services, compared with 41% of younger urban women. As for other aspects of health care, Younger women are less positive in their perceptions than Mid-age women irrespective of area of residence.

In interviews with rural women who had experienced emotional distress, most commented on encounters with their GP, drawing attention to the lack of GPs in rural and remote areas, the long waiting times, and concerns when professional and social relationships are combined.

Lack of transport and having to travel long distances to visit a GP were problems for some women. Additional comments were made about the difficulty of obtaining mental health services.

Barriers encountered by women seeking help for abuse in rural and remote areas included:

- Social and physical isolation
- Transport difficulties
- Unreliable or unavailable telephone services
- Limited financial resources
- Prevalence of firearms
- Limited availability of legal services, such as police, legal aid, advocacy support
- Lack of specialist domestic violence services
- Social stigma

Many rural women feel unable to seek help for psychological distress because of a lack of confidentiality and privacy.

Factors inhibiting women in rural and remote areas from leaving an abusive situation include:

- Fear of the abuser
- Financial dependence, particularly on income from a family property or business
- Perceived need to move away from local community and existing support networks
- Lack of transport
- Worry about housing
- Fear about future employment

*“...some services such as specialist psychiatric care come to a town only once per month.”*

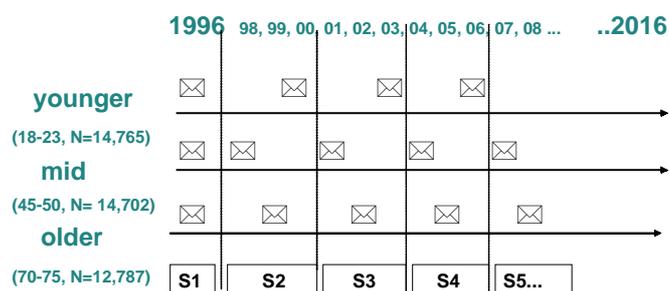


## 8 Background: What is the Australian Longitudinal Study on Women's Health?

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. It provides information to assist the Commonwealth Department of Health and Ageing – and other Commonwealth and State Departments - to develop policies which are appropriate to Australian women of all ages.

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. The study is designed to run for 20 years, with each age cohort surveyed every three years.

Figure 14. Timeline for ALSWH Surveys



The groups were selected in order to follow women through life stages which are critical to their health and well-being. When the study began, the Younger age group was in transition from adolescence to adulthood. They can be tracked as they move into the work force, enter adult relationships, and become mothers. At Survey 1, most 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 married or in 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 the social and personal changes of that life stage as well as menopause. At Survey 1, 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 stability, so the picture was similar at 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, to recruit older women who are still healthy and active. The focus is 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% are pensioners, though 35% have superannuation or other income.

The study 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 life. It assesses:

- Physical and emotional health (including health-related quality of life, 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 (education, employment, family composition)
- Life stages and key events (such as childbirth, divorce, widowhood).

Participants are also invited to consent to linkage of survey responses with unit records from the Medicare database, which provides information about type of service, characteristics of the provider, and out-of-pocket costs for Medicare-eligible services.

The information in this report was compiled by Penny Warner Smith, Christina Lee and the ALSWH team

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