

# The Australian Longitudinal Study on Women's Health

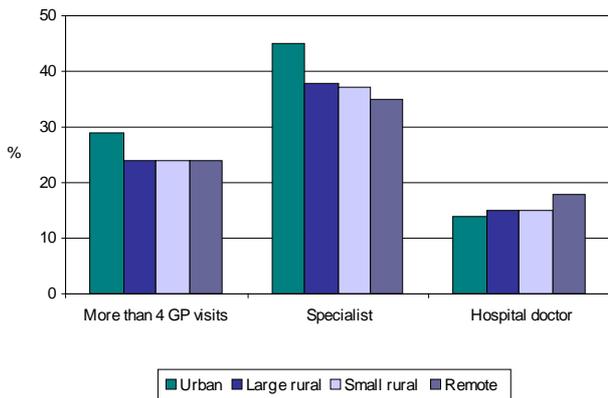


## Chronic Disease and Health Services in Australia

### 1 WOMEN IN RURAL AREAS HAVE MULTIPLE PROBLEMS OBTAINING HEALTH CARE SERVICES

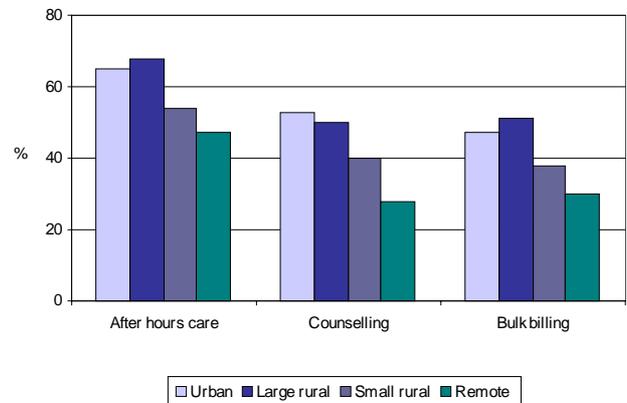
Women who live in rural and remote areas of Australia are less likely than urban women to visit GPs frequently or to see specialists (Figure 1). In remote areas, however, hospitals provide a high proportion of primary health care.

Figure 1. Use of health services by Mid-aged women in urban and country areas



Access to after hours care, women's health/family planning services, counselling services, or the hours GPs are available are all significant problems for women in small rural centres and remote areas, compared with women in larger centres (Figure 2).

Figure 2. Access to services: percentage of Mid-aged women who rate their access as 'excellent' or 'very good'.



*"I live in a small, rural community; access to a doctor is a problem ... (There is) ... a part-time female doctor who works when I work. Waiting times are horrendous ... I avoid going to the doctor because of the wait and the confidentiality problem ... I know the receptionists and they speak loudly in front of the other patients ..."*



Access to doctors who bulk bill is lower for country women, their out-of-pocket costs are higher, and the differences are increasing.

The Australian Longitudinal Study on Women's Health will be able to monitor changes in these indicators in response to major policy initiatives to improve health services for people in rural and outer metropolitan areas.

Further information is available in the technical report *Chronic Disease and Health Services in Australia*



## 2 WOMEN WITH CHRONIC CONDITIONS HAVE GOOD ACCESS TO HEALTH CARE SERVICES

Among conditions in the National Health Priority areas, musculoskeletal disorders are most frequently reported by women in this study (Figures 3 and 4). Asthma and mental health problems are reported by 10%-30% of women. Other major conditions, including diabetes, cancer and heart disease, are less common (except in Older women).

Figure 3. Older women: prevalence of selected chronic conditions

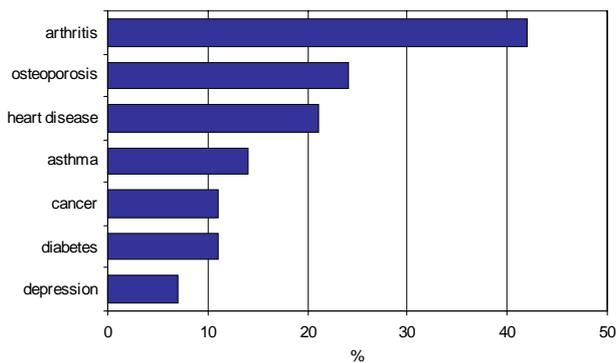
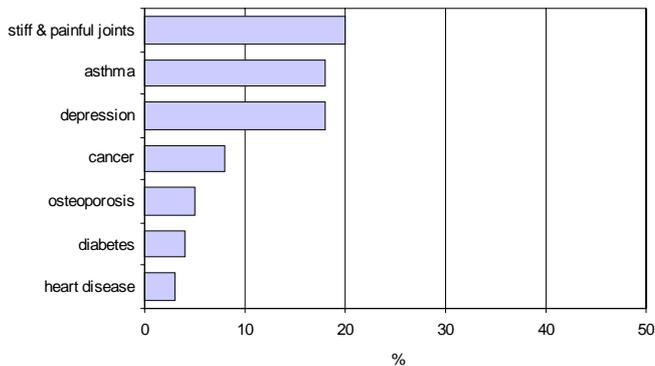


Figure 4. Mid-aged women: prevalence of selected chronic conditions

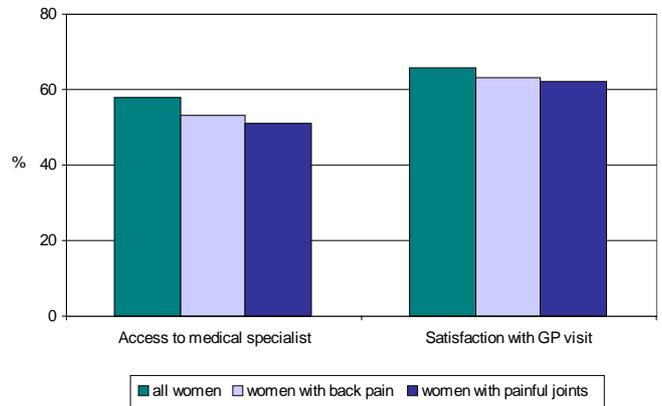


### Musculoskeletal conditions

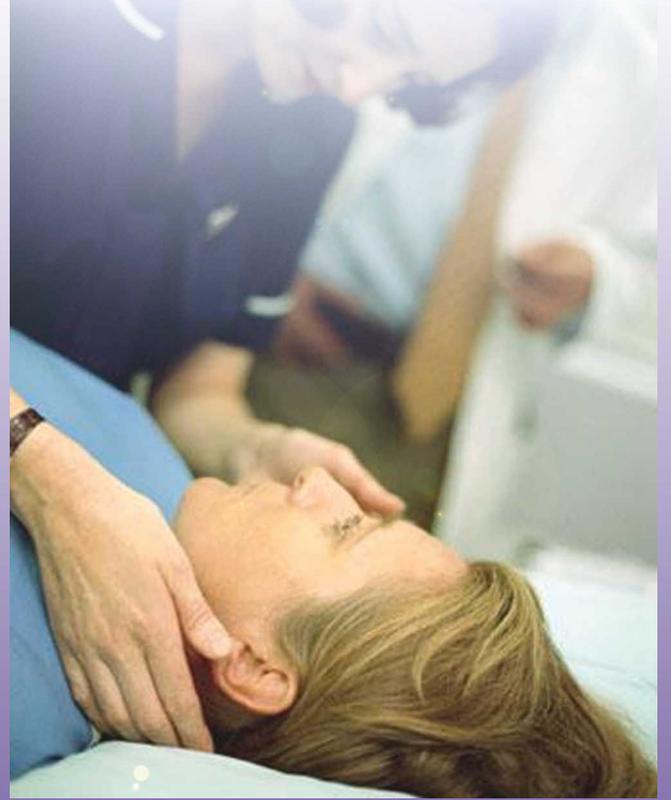
Women with these conditions are high users of the health services. Those with arthritis or osteoporosis diagnosed by a doctor have similar levels of satisfaction with services to other women of their age.

Women with symptoms such as stiff and painful joints or back pain have lower levels of satisfaction with all aspects of care (Figure 5). This may reflect disappointment with treatment and outcomes for their conditions.

Figure 5. Mid-aged women's satisfaction with aspects of health services



*“Chronic back pain – upper back is getting worse. Short of surgery, the only help I can get is anti-inflammatories and panadeine. ... I don't go the doctor very often – they don't seem to be able to do anything.”*

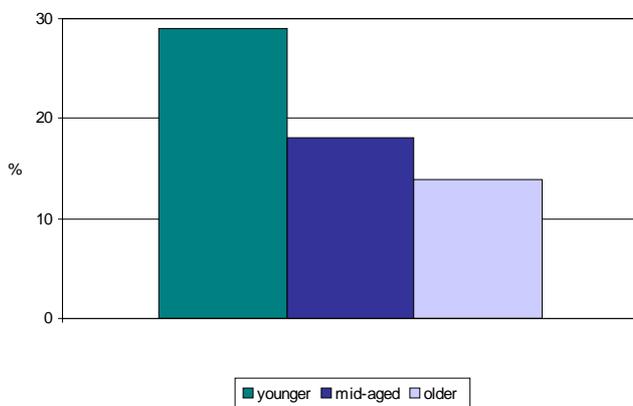


## Asthma

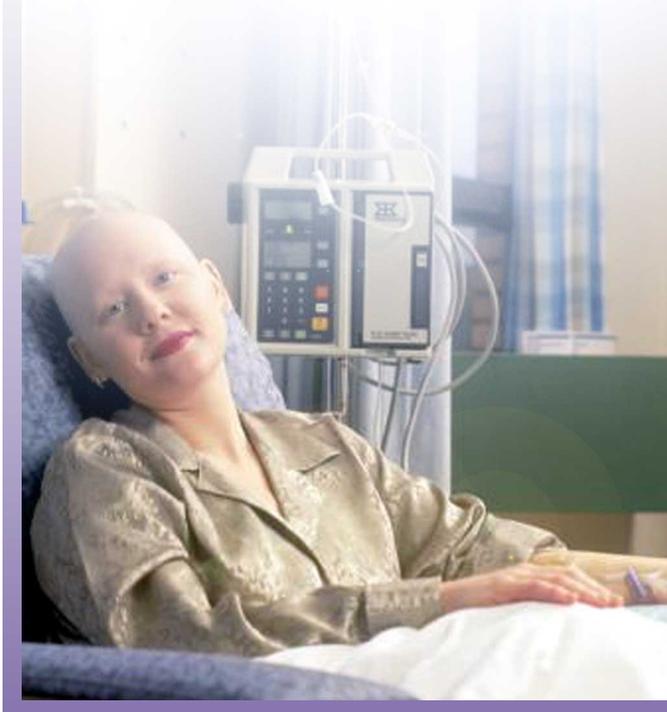
The prevalence of asthma is much higher in younger women than Mid-aged or Older women (Figure 6).

Women with asthma are relatively high users of the health services. They rate their access to services highly and report high levels of satisfaction with their doctors

Figure 6. Prevalence of asthma among women in different age groups



*“Cancer is not the terrible thing that most people consider it to be...the care I’ve received has been excellent, so I’m not the slightest bit concerned about how I’ll be looked after when I come to the end of the line.”*

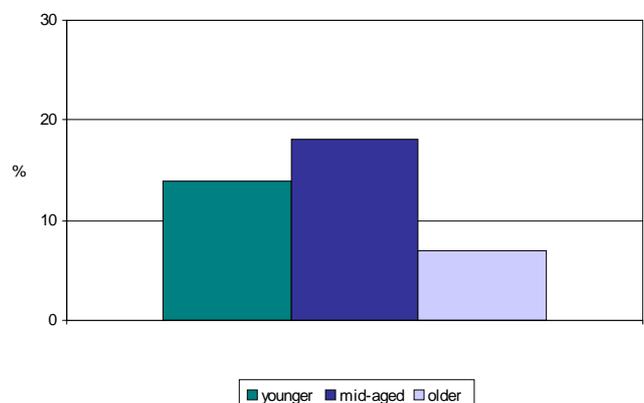


## Mental health

Mid-aged and Younger women report higher prevalence of depression and anxiety and have lower mental health scores than Older women (see Figure 7).

Women with poor mental health are high users of the health services but rate their access to and satisfaction with these services lower than women with good mental health. Women’s perceptions of limitations of the health system for helping with their problems, and their preferences for managing mental health issues, are outlined in the companion brochure on findings of the Study on mental health.

Figure 7. Prevalence of doctor diagnosed depression among women in different age groups



## Cancer, heart disease and diabetes

These chronic conditions are less prevalent than musculoskeletal conditions, asthma or poor mental health (see Figures 3 and 4), although hypertension and heart disease are common among Older women. While women with these particular conditions are high users of services, their levels of use are similar to those of women with other more common chronic conditions. They rate their access and satisfaction with the health system highly and report good continuity of care – that is, they are always likely to go to the same place and always see the same doctor.

### 3 WOMEN WITH LOWER SOCIOECONOMIC STATUS ARE HIGH USERS OF HEALTH SERVICES BUT RATE THEIR ACCESS POORLY

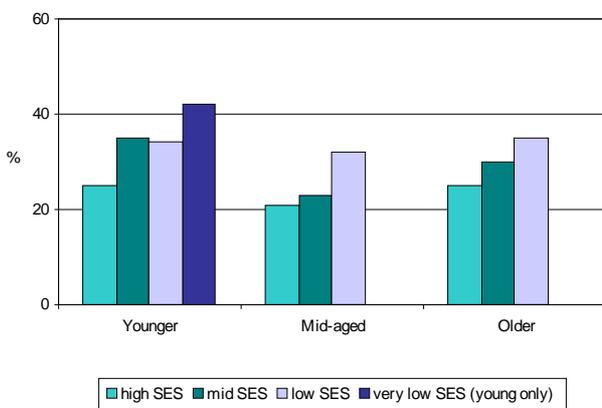
Women's socio-economic status (SES) is assessed from their level of education and their occupational classification.

Women with lower SES are more likely than other women to be high users of GP services (Figure 8). They are also more likely to be admitted to hospital, but they are less likely to visit specialists.

Mid-aged women with low SES are more likely to be bulk billed than women with higher SES. For older women, bulk billing is much more common and there is little SES differential, while for Younger women the pattern is unclear as bulk billing is affected by many other factors.

As lower SES is often associated with living in rural and outer urban areas, initiatives to improve services in these locations may also reduce SES differentials.

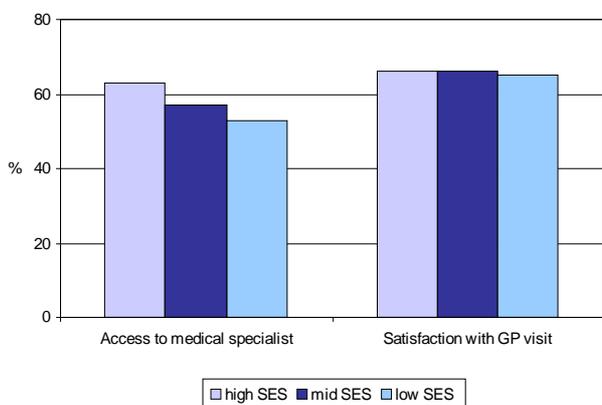
Figure 8. High use of GP services



*“At A, we have no resident Doctor. We have a weekly visit from a GP who comes from a town some 60 miles away - a very unsatisfactory situation indeed. B is our nearest larger town, which provides very good medical service but is so difficult for older members of the community who don't have their own transport and for parents of young children who often become suddenly ill. Health services for rural women are very unsatisfactory.”*

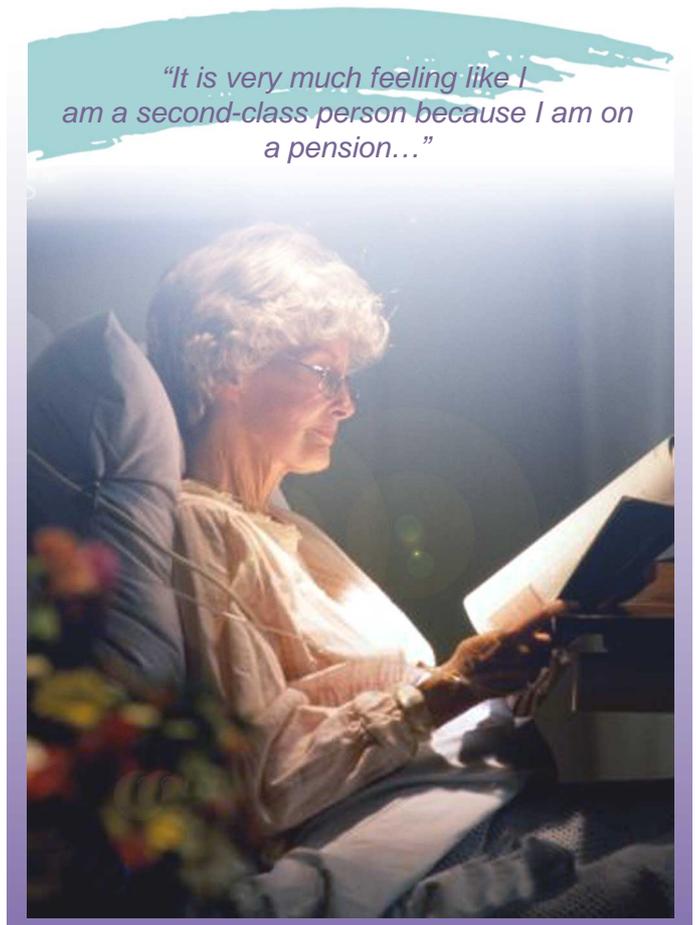
Access to health services tends to be rated lower by women with low SES. However, their satisfaction with GP visits is generally similar to more advantaged women (Figure 9).

Figure 9. Percentage of Mid-aged women who rate GP access and satisfaction as 'excellent' or 'very good'



*“It is very much feeling like I am a second-class person because I am on a pension...”*

Women with low SES report greater continuity of GP care than other women - they are more likely to go to the same place and see the same doctor.



## 4 OLDER WOMEN ARE MORE SATISFIED WITH HEALTH SERVICES

Satisfaction with health services is subjective. The World Health Organization is promoting alternative, more objective measures of 'responsiveness'.

### Satisfaction vs. Responsiveness

*Satisfaction* is subjective and depends on characteristics of the patient. It is affected by:

- Expectations
- Past experiences
- 'Gratitude' factor

*Responsiveness* is an objective measure of the actual experience, and depends on characteristics of the health care system. It is affected by:

- Quality of facilities
- Prompt attention
- Respect/dignity
- Confidentiality

Younger women are less satisfied with services than Mid-aged or Older women (Figures 10 and 11). These age differences may not indicate that the services received by Younger women are objectively poorer, but rather that their expectations are higher.

*"I frequently attend different G.P.s as I haven't found one that I feel comfortable with."*

- Young woman

*"I changed to a woman doctor a year ago. Before I went to a male GP and received no satisfaction when I developed symptoms of menopause which were making my life miserable. After one visit to a female GP, I have no further problems."*

- Mid age woman



*"The only reason I need help at the moment is through having a socket and ball hip replacement. I am improving all the time and hope in the future to get back to doing everything for myself. I would just like to say that the help and care given to me at the X base hospital from the time I was told I needed my operation to the time I was discharged was marvellous. The staff right from orderlies through to sisters and doctors couldn't have been more helpful and caring."*

- Older woman

Figure 10. Satisfaction with aspects of visiting a GP (% rating 'excellent' or 'very good').

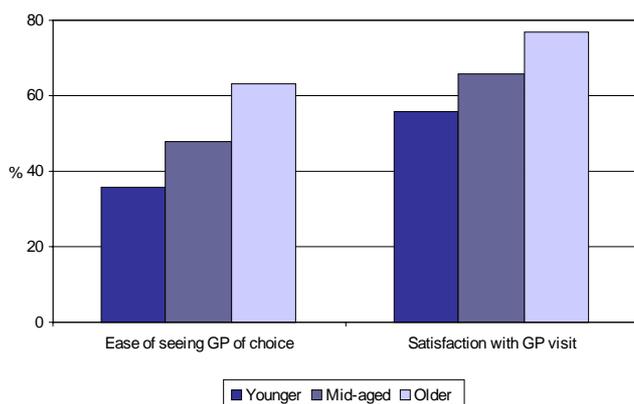
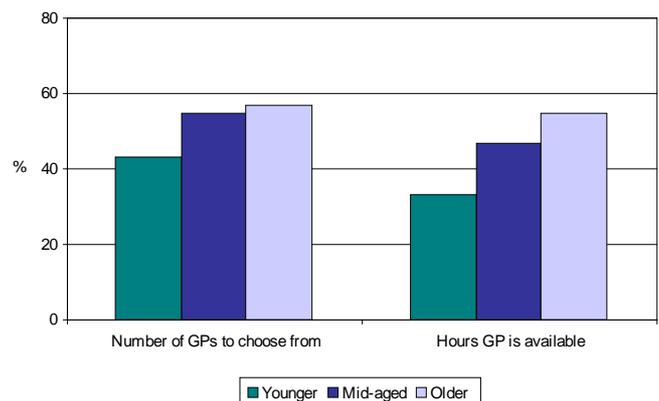


Figure 11. Satisfaction with GP availability (% rates 'excellent' or 'very good').



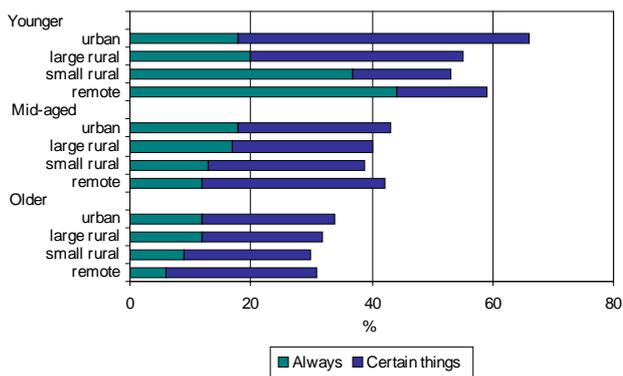
## 5 YOUNG WOMEN, AND WOMEN WHO DO NOT SPEAK ENGLISH AT HOME, PREFER FEMALE DOCTORS

In the ALSWH, women are asked if they prefer to see a female GP. The response options are: “yes, always”, “yes, but only for certain things”, “no” or “don’t care”.

Younger women, especially those with the highest level of education, have strong preferences for female GPs. Older women have the least preference (Figure 12).

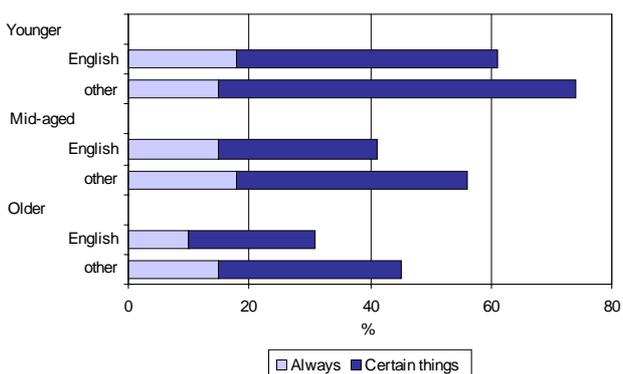
Preference for female GPs is strongest in urban areas. Women in remote areas also indicated a preference for female GPs at least for certain things. The data reflect an unmet need for female GPs in remote areas where access to female doctors is lowest.

Figure 12. Preference for a female GP by age group and area



Women who do not speak English at home have stronger preferences for a female GP than English speaking women (Figure 13). This is true for all three age groups and the preference is most pronounced “for certain things” probably reflecting cultural issues.

Figure 13. Preference for a female GP by age group and language spoken at home



This may be due to these women’s difficulty in navigating the health care system. Women who speak a language other than English at home also have smaller social networks and family members may live overseas, making it harder for these women to seek informal advice and support.

*“I live in a small rural town...no female doctors... I feel that I cannot go to the doctor here because it would be embarrassing as he is male.”*



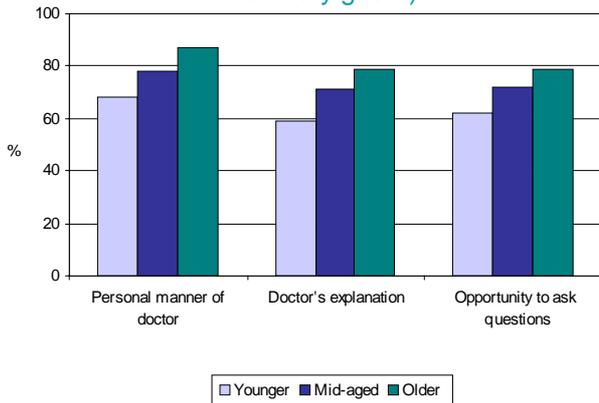
*“I relied on the children to interpret... when the children moved from home I suffered loneliness...my husband and I have been riddled with one sickness after another.”*



## 6 WOMEN IN DIFFERENT AGE GROUPS HAVE DIFFERENT EXPECTATIONS

Women report high levels of satisfaction for personal aspects of their most recent GP visit, particularly Older women (Figure 14). However, satisfaction with waiting time and time with the GP is much lower (Figure 15).

Figure 14. Satisfaction with personal aspects of the most recent GP visit (% of women rating these as "excellent" or "very good")

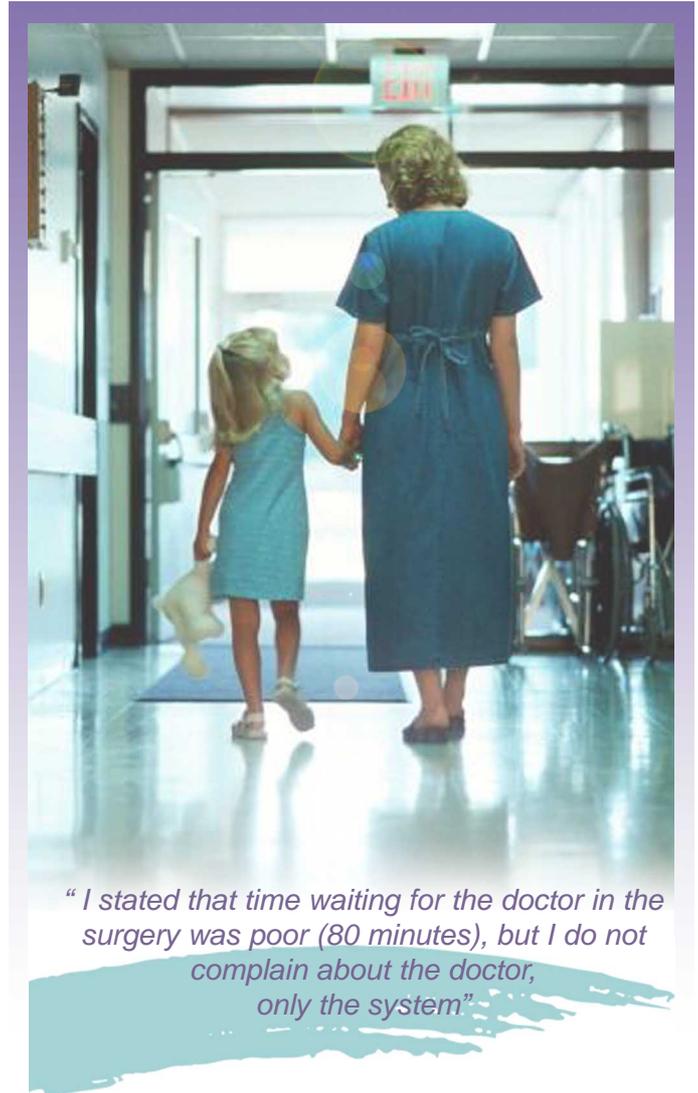


Again Younger women are more less satisfied than Mid-aged and Older women with all aspects of their contact with the health care system.

Figure 15. Satisfaction with aspects of the most recent GP visit (percentage of women rating these as "excellent" or "very good")



While it is possible that some of these aspects of GP services may be objectively different for women in different age groups, differences in expectation are also likely to affect how they rate GPs. Older women may recall times in the past when medical care was limited and much more difficult to access, while Younger women have grown up to regard excellent health services as a right.

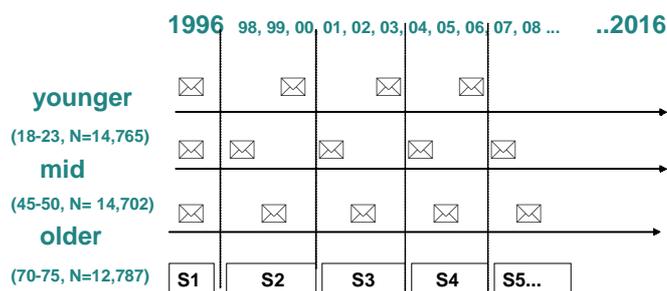


## 7 Background: What is the Australian Longitudinal Study on Women's Health?

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 (see Figure 8).

Figure 16. 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  
**Annette Dobson and the ALSWH team**

*If citing this report: Summary report from the Australian Longitudinal Study on Women's Health, conducted by researchers at the Universities of Newcastle and Queensland and funded by the Commonwealth Department of Health and Ageing*

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