

What Women's Health Australia can tell us about women's well-being in the bush

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ABSTRACT

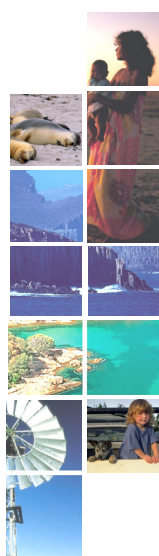
Women's Health Australia (WHA) is a large-scale longitudinal project funded by the Commonwealth Department of Health and Ageing to provide a population-wide evidence base for the development of appropriate policy and practice in women's health. It consists of a 20-year longitudinal survey of the health of Australia's women, with a strong emphasis on the needs of women in rural and remote areas. The survey began in 1996 and the research team are currently collecting our third wave of data from women across Australia.

The project involves three cohorts of women, randomly selected from the Medicare database, to represent young (aged 18–23 in 1996), mid-age (45–50), and older women (70–75). Over-sampling of women in rural and remote areas allows an examination of geographical variations in health and in access to health care. More than 41,000 women responded to mailed baseline surveys in 1996, and over 50% have also agreed to linkage with their Medicare data. Women participating in the survey complete a "main" survey every three years, addressing aspects of their physical and mental health, use of health services, health-related behaviour, sociodemographics, time use, and major life events. They may also be invited to participate in smaller targeted substudies that address particular diseases such as diabetes or life experiences such as partner violence.

This paper provides an overview of the project, and then goes on to present descriptive data on measures of mental health and coping in all three age cohorts. A consistent pattern emerges, showing that older women have the best mental health and younger women the worst, but that rural women have equivalent levels of mental health to city women. This effect is despite evidence that rural women have poorer access to a range of services than their city counterparts. The older rural women report high levels of neighbourhood satisfaction and access to social and practical support, but the mid-age and younger rural women do not appear to have these community advantages over urban women. The data suggest that strategies to support and maintain a sense of community in rural areas are essential to the continued maintenance of good emotional health among women in the bush.

INTRODUCTION

The Australian Longitudinal Study on Women's Health (also known as Women's Health Australia) is a longitudinal project, funded by the Commonwealth Department of Health and Ageing, that collects data from over 40,000 women across Australia in order to provide an evidence base for the development and evaluation of health service policy and practice in Australia (Lee, 2001a). Aspects of Women's Health



Australia have been presented at previous National Rural Health Conferences (e.g. Lee, 2001b) but, because of its breadth of scope and the ongoing nature of the work, each update is able to provide a significantly different perspective on the health of rural Australian women. This paper serves as the introduction to a symposium on aspects of the project: the focus for this year is on middle-aged women in rural areas, and in particular on mental health and well-being, and on access to support services when practical and emotional help is needed.

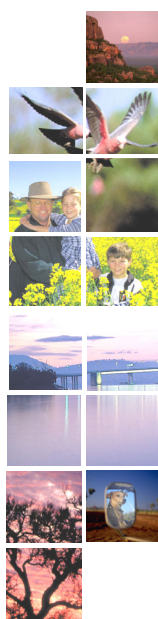
OVERVIEW

Women's Health Australia has been described in detail elsewhere (Brown et al., 1998; Lee, 2001a). The main project involves mailed surveys to collect self-report data on health and related variables from three cohorts of Australian women, who were aged 18-23 years ("young"), 45-50 years ("mid-age") and 70-75 years ("older") when the project began in 1996. Over 40,000 women were recruited from the Australian population, with the Health Insurance Commission's Medicare name-and-address as the sampling frame. Recruitment was random within those age groups, except that there was over-sampling of women living in rural and remote areas. This was done so that sufficient women would be recruited from outside the major urban areas to allow a comprehensive analysis of rural women's needs, and to allow comparisons between rural and urban women.

The aim of the project is to conduct a series of interlocking data analyses and produce a series of integrative reports in order to develop an understanding of structural and societal factors that affect the health and well-being of women. The overall goal is to inform government health policy in the twenty-first century, and the emphasis on rural health is apparent in the analyses conducted and the information requested to date from various Sections of the Department of Health and Ageing (Lee, 2001a).

The project is designed to run for twenty years, so that the "younger" cohort can be tracked through early and middle adulthood, the "mid-age" cohort through menopause, later middle age, and early old age, and the "older" cohort through their seventies, eighties and beyond. The age groups were selected in order to be able to collect baseline data and then follow women through life stages which are argued to be critical to women's health and well-being. The younger age group was selected in order to obtain a group who, generally, were in the early stages of transition from adolescence to adulthood, so that they could be tracked longitudinally as they moved into the work force, entered adult relationships, and became mothers. The mid-age group was selected in order that the majority of this group would be pre-menopausal, and thus menopausal transitions could be examined longitudinally. The early 70s were selected for the oldest group, in order to recruit a cohort of women who – although definitely older Australians – included a large number who were still active, involved members of the community. These women will be tracked in order to obtain information on predictors of continuing well-being in older adult life, and conversely to examine the effects of ill health on older women's quality of life and ability to live independently.

Each woman is invited to complete a "main" survey every three years. These are comprehensive and wide-ranging, addressing issues including physical health and symptoms; emotional well-being; health service use, access and satisfaction;



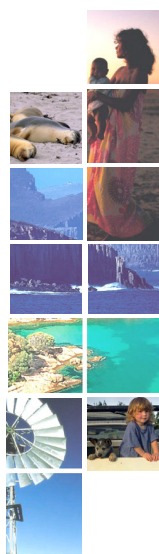
demographic and family variables; health behaviours including smoking, diet, alcohol and physical activity; time use including time spent in paid and unpaid work, family responsibilities and leisure; major life events that may impact on health and well-being. At the end of each questionnaire, women are also invited to write about any additional issues which they feel have affected their health and well-being. As well as these “main” surveys, women are invited to participate in smaller targeted substudies, such as the ones presented in the other papers in this symposium. In each case, information from the main surveys was used to select women with specific characteristics and to follow up on these particular issues in more depth.

In addition, participants are also invited to consent to linkage of their survey responses with unit records from the Medicare database of the Health Insurance Commission. Approximately 26,000 women have given consent to record linkage. Medicare data do not feature in the present symposium, but they are used to examine service use, rates of bulk billing, out-of-pocket costs, and other aspects of health service provision, in different regions of Australia, and to relate these variables to women’s self-rated well-being and satisfaction with health care.

RURAL WOMEN'S HEALTH

Rural and remote areas were defined according to the Rural Remote and Metropolitan Areas (RRMA) classification (Departments of Primary Industries and Energy and Human Services and Health, 1994). In the analyses presented in this paper, women’s area of residence was categorised by their postcode as Urban (Capital City and Other Metropolitan RRMA codes); Large Rural Centres; Small Rural Centres; and Other Rural and Remote Areas (Other Rural, Remote Centres and Other Remote RRMA codes). However, we also have ARIA (Accessibility and Remoteness Index for Australia) codes for the participants’ addresses and are able to make use of extensive information on the accessibility and remoteness of addresses throughout Australia.

The focus of this symposium is the middle-aged cohort – aged 45 to 50 when first surveyed in 1996, 47 to 52 when surveyed again in 1998, and 50 to 55 when most recently surveyed, in 2001. The rest of this paper presents some descriptive information on the lives of these middle-aged women, with an emphasis on their family and personal circumstances, on their emotional well-being, and on their perceptions of the emotional and practical support available to them. Middle-aged women are frequently described as the lynchpins of families (and thus of family businesses and of social networks more generally). Women often take a heavy load of unpaid work, supporting their husbands in family businesses or farms, while at the same time raising children and caring for elderly family members. At the same time, it is increasingly necessary for financial reasons (as well as for the personal and social benefits) that middle-aged women have paid employment. When family members need help, it is very often middle-aged women who are called upon to provide support. Women frequently internalise an “ethic of care” (Shaw, 1994), a sense that it is their responsibility to put other family members’ needs before their own, and a sense that taking time to care for themselves or asking for support from others is not legitimate. When the economic climate is difficult, as is the case in rural Australia, and when services are less accessible than in urban areas, it may be particularly difficult for these women to gain access to help and support when they need it. Thus, the



symposium focuses on rural women's experiences with help-seeking, with emotional distress, and with finding time and space for themselves.

Data from Survey 2 of the mid-age women show that the lives of rural women are different from those of city women: Table 1 shows that the more rural the location, the more likely the respondents are to be married (and less likely to be divorced or never-married). Rurality is also associated with lower rates of full-time and part-time paid work and higher rates of home duties and of unpaid work in the family business or property. While rural and urban women do not differ in family caregiving responsibilities for frail or disabled family members, rural women are more likely to be providing childcare, usually to small grandchildren while their sons and daughters work. Sources of overall household income also differ, with households in more rural areas more likely to rely on income from a business, farm or partnership and less likely to rely on salaries. Thus, economic and family life tend to be more interdependent for rural women.

Table 1 Family and lifestyle characteristics of Australian women aged 47–52, by area of residence

	Capital city/ other metro (n=4527) %	Large rural centres (n=1677) %	Small rural centres (n=1728) %	Other rural/ remote (n=4214) %
Marital status				
Married/de facto	78.2	79.4	83.6	86.0
Widowed	2.3	2.6	2.5	1.8
Divorced/sep	14.6	14.3	10.6	7.2
Never married	4.3	3.5	2.2	2.6
Employment				
Full-time paid	44.2	40.7	36.3	33.2
Part-time paid	20.1	20.7	20.3	19.3
Unpaid (eg family business)	2.4	3.4	4.5	9.0
Home duties	28.7	30.4	34.4	34.7
Other	4.1	4.4	3.7	3.1
Ever provide childcare	36.4	41.2	42.2	46.1
Ever provide family caregiving	36.2	35.8	34.8	34.5
Sources of income				
Salary/wages	77.2	73.8	68.2	64.7
Business/farm	24.2	27.5	31.4	41.2
Investments	7.6	7.6	7.2	7.1
Government pensions/ allowances	12.3	17.0	17.8	16.6

Source: Women's Health Australia Mid-Age Survey 2, 1998

The extent to which access to health services differs between rural and urban areas is well documented, and previous research from Women's Health Australia has demonstrated the extent to which rurality is associated with lower perceived access to a range of health services, lower rates of use of health services, and greater out-of-pocket costs for services (Young, Dobson & Byles, 2000, 2001). The Survey 2 data for the mid-age cohort conform to this general pattern of findings, with women in more rural locations being more likely to give a rating of "fair" or "poor" (rather than good, very good or excellent) for their access to the GP of their choice; a female GP; after-hours or flexible GP service; medical care in an emergency; counselling services; or any other aspect of health service.

When asked about the degree of social support that they experienced, it is interesting to observe that there is little difference in the degree of perceived social support across areas of residence. Table 2 shows few differences across areas defined by rurality for aspects of practical support (e.g. "someone to help with the daily chores if you are sick"), advice and information (e.g. "someone to give you good advice in a crisis"), and emotional support (e.g. "someone to hug you").

Table 2 Availability of social support, rated by Australian women aged 47–52, by area of residence

	Capital city/ other metro (n=4527) %	Large rural centres (n=1677) %	Small rural centres (n=1728) %	Other rural/ remote (n=4214) %
Practical support: someone to				
Take you to the doctor	76.1	76.1	78.4	77.9
Prepare meals if you're unable	62.2	64.3	66.0	64.5
Help with chores if you are ill	60.0	59.3	62.7	59.3
Help you if confined to bed	59.1	58.4	61.4	57.7
Advice, information: someone to				
Listen when you need to talk	70.9	70.8	69.8	67.7
Confide in	68.8	67.8	68.4	66.5
Give good advice in a crisis	65.1	64.5	65.0	62.3
Share private worries	62.9	62.8	63.8	63.1
Give suggestions on dealing with a personal problem	62.7	63.4	63.5	62.5
Emotional support: someone to				
Love you	73.4	74.4	76.2	75.8
Have a good time with	72.7	72.0	72.0	72.9
Hug you	70.6	70.8	72.4	71.9
Relax with	68.7	67.4	67.4	68.0

Source: Women's Health Australia Mid-Age Survey 2, 1998. (figures are percentages who state that they receive this type of support most or all of the time).

Ratings of physical and emotional health also show very little difference across areas of residence. The SF-36 (Ware & Sherbourne, 1994) provides a general measure of both physical and emotional well-being, with eight separate subscales which are sensitive to minor differences in well-being and functioning; Figure 1 shows clearly that there are few differences across areas of residence in the four physical-related subscales, while there is a small trend towards slightly higher scores in rural areas in the four mental-related subscales.

When one turns to more clinical measures of mental health, there would appear to be a clear rural advantage. The more rural the area, the lower the prevalence of a diagnosis of clinical depression or anxiety (although the patterns for other psychiatric diagnoses are less clear-cut); women in rural areas are also less likely to be taking prescription medications for sleeping difficulty, for depression, or for "nerves" (see Table 3). This pattern may be due to veridically better levels of mental health in rural areas, or perhaps to different patterns of diagnosing of, and prescribing for, mental distress in rural areas by comparison with the city.

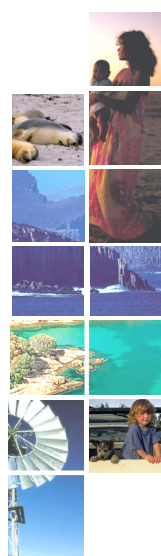
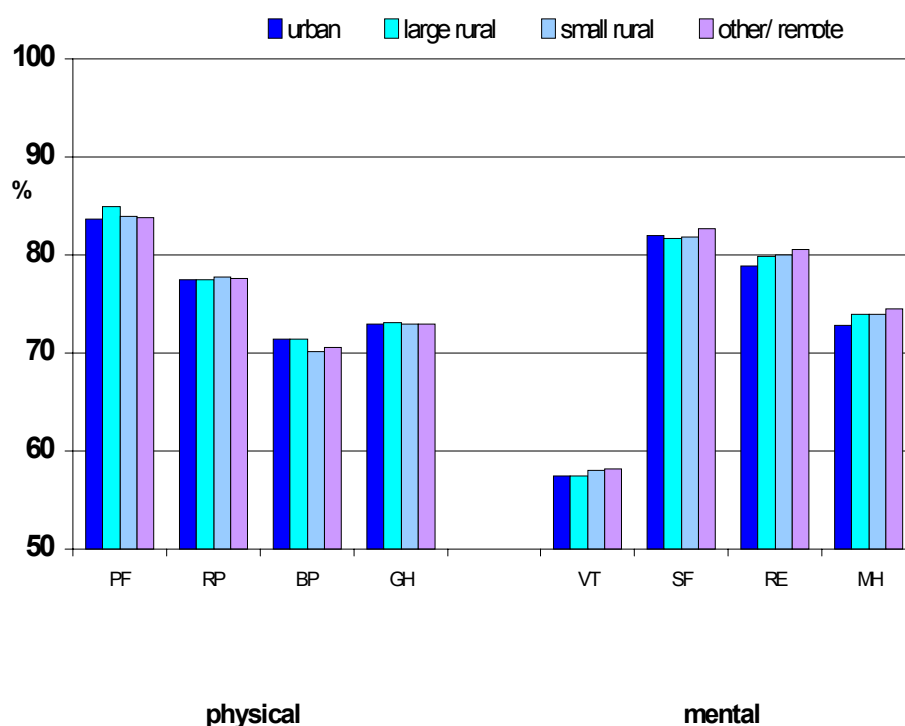


Figure 1 Subscales of the SF-36 for Australian women aged 47–52, by area of residence



Source: Women’s Health Australia Mid-Age Survey 2, 1998.

NB The four “physical” subscales are: PF physical functioning; RP role-physical; BP bodily pain; GH general health. The four “mental” subscales are: VT vitality; SF social functioning; RE role-emotional; MH mental health. In all cases, a higher score indicates better functioning. Differences across areas do not reach statistical significance.

Table 3 Indicators of clinical psychological distress reported by Australian women aged 47–52, by area of residence

	Capital city/ other metro (n=4527) %	Large rural centres (n=1677) %	Small rural centres (n=1728) %	Other rural/ remote (n=4214) %
Ever diagnosed by a doctor with				
Depression	18.4	18.5	17.4	16.6
Anxiety	15.0	14.7	14.2	12.5
Other psychiatric disorder	1.5	2.1	1.4	1.2
Currently on medication for				
Sleeping difficulty	9.5	8.3	8.0	7.8
Depression	6.5	7.2	6.8	6.1
“Nerves”	5.0	5.1	5.0	4.2

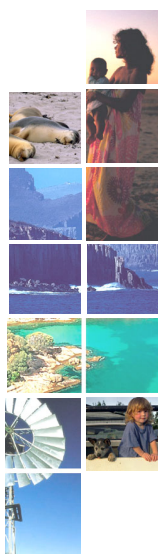
Source: Women’s Health Australia Mid-Age Survey 2, 1998.

RURAL WOMEN: RESILIENCE AND COPING

The broad-brush data from the main surveys of Women’s Health Australia suggest that women in rural areas are in good physical health, and have rather better emotional health than city women. However, the reduced access to health services is a concern for the ongoing well-being of rural women. This is particularly an issue for

emotional problems and for problems arising from relationship and family difficulties. Rural women are more likely than urban women to be working without pay or caring for a household, and a significantly greater proportion of them rely on income from a family business or farm. This may mean that family problems or emotional distress will have financial and well as personal repercussions. Marital breakdown and separation, for example, may be distressingly complicated by economic dependence, or by joint ownership of the property or business that supports the entire family (Alston, 1997).

The three papers which make up the rest of this symposium use detailed substudies to explore these issues in more depth. Women whose main survey data indicated specific family circumstances or emotional distress were surveyed in depth to explore differences between urban and rural women in their experiences of family distress and family life, their access to appropriate and confidential services, and their beliefs about what is needed to maintain their health and well-being. Women's access to, and use of, leisure time was explored to assess how rural women cope with conflicting demands. Rural women play a large role in the maintenance of rural communities and families, as well as having health service needs in their own right. This symposium illustrates some difficulties faced by rural women, and some strategies that they use to manage their well-being and that of their families and communities.



RECOMMENDATION

The emotional well-being of rural women is essential to the continuation of rural life in Australia. This paper recommends that investigation by Women's Health Australia into factors influencing rural women's ability to cope should continue to be funded.

ACKNOWLEDGMENT

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PRESENTER

Christina Lee is Manager of the Australian Longitudinal Study on Women's Health and Director of the Research Centre for Gender and Health, University of Newcastle. She has a PhD in psychology and her research interests focus particularly on the relationships between women's physical and emotional well-being in the context of their personal lives.

