

Gender, generation and geography: findings from the Australian Longitudinal Study on Women's Health on the health and well-being of women at different lifestages

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ABSTRACT

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. Women in three age groups (aged 18–23 years, 45–50 years and 70–75 years in 1996) were randomly selected from the Medicare database with deliberate oversampling of women in rural and remote areas to ensure adequate representation. 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 women's life span.

This paper begins with a brief description of ALSWH. It then sketches 'the big picture', drawing on a range of indicators and data on health, health behaviours, health service use and generational lifestyle issues among women in different geographical locations. This analysis has confirmed that there are indeed important spatial differences in women's opportunities for health and well-being. Although there are few differences in physical health among women living in different parts of Australia, we found that the life-course pattern of women in remote and rural areas is closer to traditional patterns for women, even though most are, or will be, in employment. But their situations involve access to opportunities and services inferior to those of their urban counterparts. Important health policy implications are associated with this socio-cultural context and they are particularly relevant because women are greater users of the health care system, both as patients and carers, than are men.

These patterns of spatial inequality in Australia cannot be adequately understood unless account is taken of the gender factor. This is likely to become increasingly salient if women's earnings continue to contribute an ever larger share to family income. This would be likely to exacerbate the differences between women but also disrupts the more traditional relationships between women and men as well. While there have been some important and successful health policy initiatives in recent times, such as mammography screening, there is an urgent need to integrate a thoroughly gendered approach, not only into all analyses of spatial inequality, but also in the analysis of the distribution of and access to services.

INTRODUCTION

For the last thirty years, Australia's rural communities have been experiencing profound economic and social changes, resulting in significant population shifts. Many young people are moving away and the proportion of older people in the rural population is therefore increasing at a rate faster than other parts of Australia, introducing particular emphases to health service provision. This paper draws on findings from the Australian Longitudinal Study on Women's

Health (ALSWH), a 20 year study of the health of 40 000 Australian women in three age cohorts, to raise life stage issues associated with the general health and well-being of women in rural and remote areas.

The welfare of Australian rural communities is likely to be dependent on support provided from the community itself ¹, and the multiple roles of rural women and the (undervalued) contribution these women make to their families, communities and the economy, have been well documented ². Dempsey has shown how the dominant male culture and men’s greater economic power in small Australian towns serves to disadvantage women³. National data indicate that the median gross weekly income of rural women in 1996, when ALSWH began, was A\$198. This compares with A\$352 for rural men and A\$226 for urban women⁴.

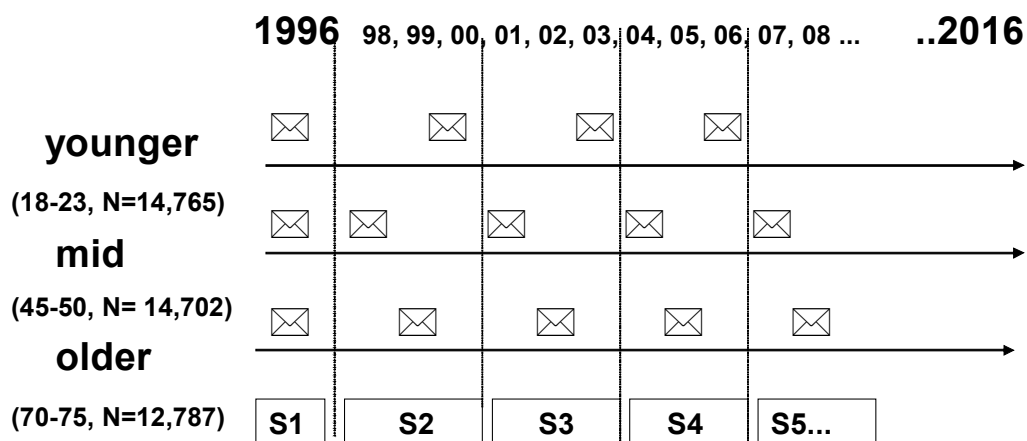
There are important health policy implications associated with the socio-cultural context and demographic changes described above, and they are particularly relevant to women, who are greater users of the health care system, both as patients and carers, than are men. While there are important health issues specific to Indigenous Australian women, data on these issues are beyond the scope of this paper. Indigenous women are, however, represented in the three cohorts in the Australian Longitudinal Study on Women’s Health.

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 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. 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 span⁵.

Women in three age groups were randomly selected from the national health insurance system (Medicare) database, with deliberate oversampling of women in rural and remote areas to ensure adequate representation. Each age cohort is surveyed once every three years. Figure 1 shows the timeline for surveys, beginning with Survey 1 of all three cohorts in 1996.

Figure 1 Timeline for main ALSWH surveys



The final question in each survey asks ‘Have we forgotten anything? Is there anything else you would like to tell us?’ The rich store of qualitative responses provide depth and explanatory power for aspects of the quantitative data. Further fleshing out of specific issues occurs through targeted sub-studies.

YOUNGER WOMEN’S LIVES AND ASPIRATIONS

Women in the younger cohort of the study were asked about their aspirations for lifestyle at the age of 35. At Survey 1, irrespective of where they lived, most of the women saw a combination of motherhood and paid work to be desirable. However, the survey data show that in many respects younger rural and remote women had more ‘traditional’ aspirations than their urban counterparts.

Table 1 shows differences in the actual experiences of younger women according to location, at three time points.

Table 1 Relationships, motherhood, educational qualifications, and employment status of younger women: Surveys 1, 2 and 3

	Urban			Large rural			Small rural			Remote		
	S1	S2	S3	S1	S2	S3	S1	S2	S3	S1	S2	S3
Married or in a relationship	17.6	41.7	57.6	25.1	49.6	63.5	28.4	55.7	66.1	44.5	61.8	71.2
Mother	6.6	13.3	23.1	12.2	26.6	39.5	14.4	33.6	46.1	21.1	34.3	47.9
Post-school qualification	30.7	70.8	77.0	26.9	59.5	63.5	26.8	52.2	56.2	32.9	57.5	57.2
In paid employment	50.3	70.5	82.6	51.5	60.7	74.4	55.3	55.8	69.9	68.8	65.3	68.5

Figures are percentages

Younger rural women are much more likely to have their children early and to hold fewer post-school qualifications. A key issue for policy is that early motherhood and lower socio-economic status are likely to go together. While most young Australian women 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 have 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 are more likely to have two or more children, feel a need to find work outside the home in order to help maintain the household, have had more experience of unemployment, and are simultaneously more likely than urban women to be involved in unpaid work in a family business or farm (Table 2).

Table 2 Differences in economic factors, younger women, Survey 3

	Urban	Large rural	Small rural	Remote
	S3			
Two or more children	9.5	18.9	23.5	26.2
Working in family business without pay	15.9	18.3	21.3	29.2
Ever unemployed 6 or more months	3.3	6.2	6.5	6.7

Figures are percentages

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. ALSWH data have shown associations between employment and well-being, although the pattern of hours worked differs according to life stage⁶.

Younger ALSWH women living with a partner, particularly those with children, are 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 represents a further disadvantage for their health. Given their earlier marriage and motherhood, younger rural women are also more likely to require access to general practice (GP) and obstetric and gynaecological services, yet they report poorer access to most health services. In regard to continuity of care, women's choice is limited by the number of local GPs 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 outcomes⁷. Almost three quarters of ALSWH Younger women in remote areas don't see the same GP, which may indicate the rapid turnover of remote-area GPs or their use of visiting doctor services.

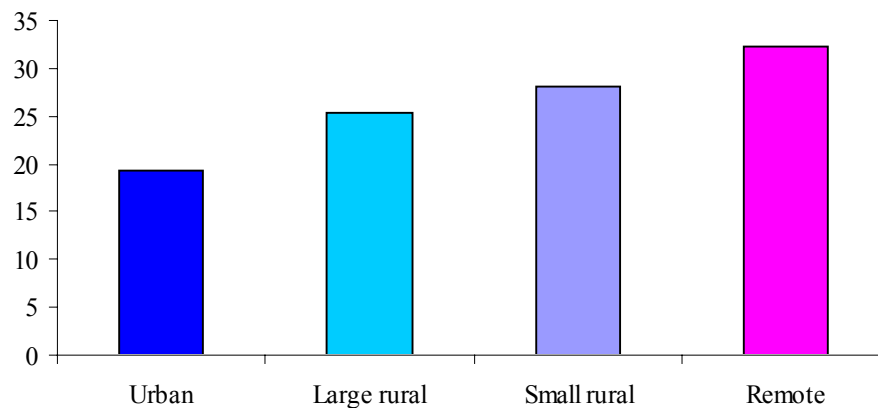
There are fewer women doctors in rural areas and 25 per cent of male GPs in rural areas are aged over 55⁸. Thus, younger women in rural areas may find it particularly difficult to find a GP who is *either* female *or* close to their own age, and with whom they may be more likely to feel comfortable. Anne Young's paper in this symposium discusses rural women's concerns about poorer levels of access to health services, particularly to GPs.

Although our data do not reveal differences in the physical health of younger women living in different areas, as measured by SF-36 scores, rural hospitalisations and rates of post-natal depression are higher, reflecting earlier motherhood. However, terminations are as commonly reported by younger, rural women as by younger, urban woman, averaging 10% in all areas at Survey 2.

MID-AGE WOMEN: TIME USE AND FAMILY RELATIONSHIPS

There is a growing body of research documenting the multiple roles of rural women and the contribution these women make to their families, communities and the economy². The responsibilities associated with volunteerism involve sustaining important social services for the betterment of the community like 'helping out at the local primary school, caring for the elderly'⁹, as well as preparing for men's service clubs' dinner meetings, farm sales and community events¹. Figure 3 shows the unpaid contribution of ALSWH Mid-age women in voluntary work.

Figure 3 Unpaid voluntary work, mid-age women, Survey 3



At Survey 2 in 1998, about 30% of mid-age women in all geographical areas were providing some degree of care for someone who was elderly, frail or disabled. However, 40% of mid-age, rural and remote women were also providing childcare for their own grandchildren or for someone else's children. The 'sandwiching' of this generation of women, who are caring for both the older and the younger generation, is emphasised for women in country areas by the earlier marriage and motherhood of rural women, the disproportionate ageing of the rural population, and the lack of services such as nursing homes and childcare centres in rural and remote areas. The evidence of women's multiple roles represents another facet of the complex issues involved in the spatial inequalities in contemporary Australia.

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. As the following quote indicates, one mid-age respondent had significant worries about the effects of her caring responsibilities on other aspects of her life.

I often find the stress/lack of sleep affects my diabetes and this in turn occasionally affects the level of my work as an RN and I feel that I am not functioning to my full capacity, and could maybe at some time lose my job. It is not mistakes in my work just the fact that I am working much slower than others at times and I lose confidence in myself.

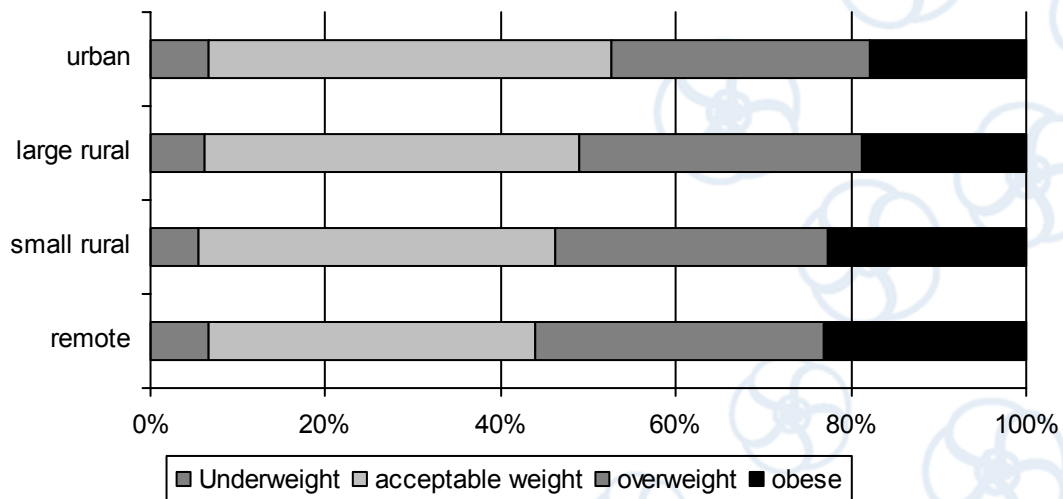
As the ALSWH study shows, women who provide care are more likely to have time out of the labour force, thus further disadvantaging the economic position of rural and remote women. While incomes are lower in rural areas, the analyses discussed in Anne Young's paper in this symposium show a striking gradient in financial and non-financial barriers to health care associated with area of residence.

A success story for the health of mid-age rural women is the extent of mammographic screening, something that clearly demonstrates the potential effectiveness of well-conceived government sponsored programs. The number of women over 50 who are not screened is small, though 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.

Weight is an increasing concern for all, as being overweight is an important risk factor for major disease targets, including diabetes and heart disease, as well as contributing significantly to reduced quality of life⁵. ALSWH longitudinal data indicate that the proportion of women who are overweight or obese is increasing slightly over time in all three age groups. At the time of the first survey, about half of mid-age and older Australian women were overweight or

obese and rural women were heavier than women in the cities (see Figure 4). This issue is reflected in the finding that the incidence of non-insulin dependent diabetes is higher in ALSWH mid-age women in remote areas, another aspect of spatial inequality that requires further attention.

Figure 4 Body mass index (BMI) of mid-age women, Survey 2



Two ALSWH sub-studies of mid-age women have focused on the ways in which rurality affects women’s choices, experiences of help-seeking, and use of the health system in regard to their mental health and well-being^{10,11}. 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, 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”.

The distinctiveness of rural women’s experiences is also reflected in many rural women feeling 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”. Rural women also identified explicit or implicit pressure from significant others such as family, in-laws and spouse to keep problems within the family.

In her paper in this symposium, Deborah Loxton analyses the challenges and difficulties for rural women with children after the breakdown of a relationship.

OLDER WOMEN IN RURAL AND REMOTE AREAS: ISSUES OF CARING AND BEING CARED FOR

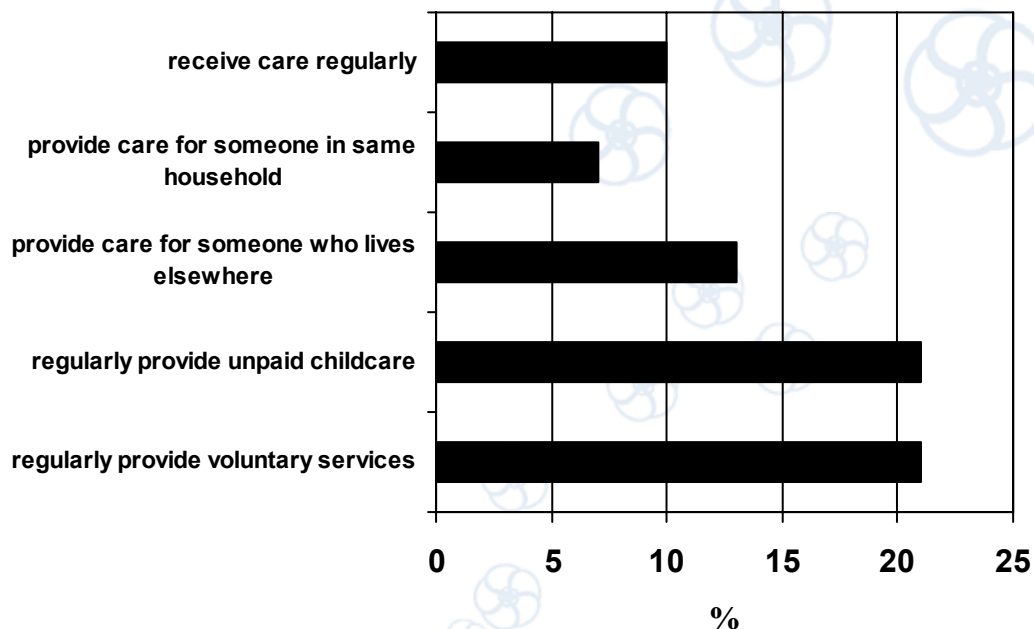
The proportion of older people in the rural population is increasing at a rate faster than in other parts of Australia. This movement is producing particular health service needs as well as accentuating spatial segregation based on age and socio-economic opportunity. As one older respondent pointed out, people in her generation are ‘a tough, resilient group’, but they are nevertheless finding the going tough 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 [was] 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?

As Teather has noted, increasingly the welfare of Australian rural communities is dependent on support provided from within the community itself, and particularly the contributions of women of all ages¹. An analysis of the effects of family care-giving on well-being among the older cohort found that 10% (N=1235) of all women in this age group also identified themselves as care-givers for frail, ill or disabled family members (Figure 5).

Figure 5 Receipt and provision of practical care, older women, Survey 2



The data failed to demonstrate any differences in physical health between older caregivers and others, but caregivers 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 ... 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.

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... it is very traumatic to feel abandoned like I did when I had a stroke three and a half years ago, and went home and became depressed through weakness and aloneness.

The ALSWH not only provides opportunities to understand health issues but also factors associated with various life events and transitions. For example, moving house was one of the ten, life events most often reported by Older women 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 to be closer to family and services, or because maintenance had become problematic. One older rural woman very much wanted to remain in her own home but was too worried about the dangers of bush fires, as she had no one to clear the roof gutters for her.

The implications of moving house are discussed further in Julie Byles' paper in this symposium.

CONCLUSION AND POLICY IMPLICATIONS

This analysis of issues of health and well-being, making comparisons between women in urban and remote and rural areas, has confirmed that there are indeed important spatial differences in women's opportunities for health and well-being.

We found that women in remote and rural areas tend to have their children at an earlier age than urban women, to have more children and to have and aspire to fewer educational qualifications. This life-course pattern is closer to traditional patterns for women, even though most are, or will be, in employment. But their situations involve access to opportunities inferior to those of their urban counterparts as well as inferior access to services, including child care, other family carer support and health services. Important health policy implications are associated with this socio-cultural context and they are particularly relevant because women are greater users of the health care system, both as patients and carers, than are men. There are continuing concerns in relation to rural 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 greater rates of violence against women in rural and remote areas, increasing levels of overweight, with implications for the prevalence of diabetes particularly in remote areas, and the relative paucity of nursing homes and respite care services.

These patterns of spatial inequality in Australia cannot be adequately understood unless account is taken of the gender factor. This is likely to become increasingly salient if women's earnings continue to contribute an ever larger share to family income. This would be likely to exacerbate the differences between women but also disrupts the more traditional relationships between women and men as well. Yet economic analysts give scant attention to this. What is needed is more systematic attention to life-course trajectories in all socio-economic analysis relating to both men's and women's circumstances.

RECOMMENDATION

Considerable effort has been made at a policy level to focus on strengthening the provision of rural health services, notably in relation to primary care. While such valuable initiatives should be maintained, there is an urgent need to integrate a thoroughly gendered approach which

pays attention to life-course trajectories, not only into all analyses of spatial inequality, but also in the socio-economic analysis of the distribution of and access to services.

ACKNOWLEDGMENTS

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PRESENTER

Penny Warner-Smith is the Project Manager for the Australian Longitudinal Study on Women's Health (Women's Health Australia) and Deputy Director of the Research Centre for Gender and Health. As a sociologist, Penny is particularly interested in issues concerning employment and women's health. She presently has Australian Research Council funding for three projects that she is carrying out with colleagues: one is an investigation of work-life tensions among dual-earner parents in Australia; one is on women's expectations and experiences of retirement; and a third is a study of regional variations in teenage pregnancy.