Women's Health Tasmania

Talking to Women in Rural and Remote Tasmania 2019

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Contents

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Women's Health Tasmania

Women's Health Tasmania (WHT) is a health promotion charity funded by the Tasmanian Department of Health. It is guided by the World Health Organisation's definition of health – "Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity"[i].

WHT provides a range of health promotion activities in different locations, and health services from its centre in North Hobart. It also provides evidence-based policy advice on issues that impact on women. While it is a universal service, it has a concern for women vulnerable to poor health

WHT's vision is for Tasmanian women to be informed, supported and active decision-makers in their own health and well-being. As a result, WHT has also been a key advocate on issues such as a woman's right to make informed choices about her health. Our leadership has been evident in a wide range of health policy, in social justice and gender equity. WHT consistently advocates on behalf of women with both State and Commonwealth governments, on a range of legislation and policies impacting on women's health. In recent years, WHT has broadened its service delivery component by undertaking outreach activities and offering a state-wide information telephone line and using social media. It currently provides services to women from 74 different postcode areas.

WHT is part of a national network of women's health services.

Background

This report gathers together information from meetings Women's Health Tasmania held in May – June 2019.

As the health of women is dependent on a range of social factors, including the physical, economic and political environment in which they live and work, we adopted a social determinant approach to our discussions – asking about what was working to keep women well and active in their communities, and what was making it hard for women to be well and active. And then we listened as women talked about social cohesion, volunteering, transport and income inadequacy.

Listening to women in rural and remote areas is important as living in a rural area is a risk factor for poor health. Tasmania has a small but dispersed population with 36% living outside Launceston and Hobart.[ii] The health experiences of people in these areas are different to those of people in the cities. Generally, they have poorer access to health services and experience more socio-economic disadvantage. Health can also be affected by social factors such as poor transport and unemployment, and these are also significant issues in rural communities. While Tasmanians generally are positive about their health system, our online survey revealed that women living outside the cities are less satisfied than their urban counterparts.

Who did we talk to?

We talked to 48 women from 9 different postcodes at meetings in Rosebery, Burnie, Geeveston and St Helens.

The women who attended the consultations ranged in age from 20 to 92 but the majority (87%) were aged 40 – 80. The women had a broad range of lived experiences: 17% of them were Aboriginal, 31% of them identified as having a disability, 42% of them had been diagnosed as experiencing a mental illness at some point in their lives, and while all of the women spoke English at home, 25% of them were born in other countries, including non-English speaking European and Asian countries.

Most of the women were living on low incomes; 71% of them had Commonwealth Concession cards (Health Care Cards or Pensioner Concession Card).

This report also includes data from an online survey of women's health needs conducted in June 2019. 161 women who responded to that survey lived outside Hobart and Launceston (35% of the total respondents). The survey received 462 responses from 70 postcodes around Tasmania and attracted responses from a broad demographic (see our report on the survey responses).

How did we find them?

To reach women for these consultations we partnered with Neighbourhood Houses in each community. The consultations were advertised through the Neighbourhood House networks, on local media and through WHT's own social media.

The survey was initially distributed through WHT's social media, but it was also picked up and distributed by other community service organisations, including Neighbourhood Houses, and by local media.

What did we hear?

What is working well?

Communities, community services, friendship and social capital

Women told us that mutual support, friendship, volunteering and the networks of relationships in rural and remote areas all play an important role in sustaining their health and wellbeing. With these strengths, efforts to address poor health and community disadvantage which use the communities' own characteristics and opportunities are particularly important.

Women reported that they get good support from Child and Family Centres and Neighbourhood Houses where they had access to these. Their stories suggested that community service workers generally appear to operate as informal gateways to health services, providing health information, supporting the development of health literacy, and facilitating access to health services.

Health promotion

Women told us that they highly valued low impact, accessible, affordable or free exercise opportunities, although these tended to be confined to regional centres. The importance of affordability to enable access meant that often these programs had to be subsidised by grants, delivered as pilots, or innovations – so they appeared and disappeared in local areas.

Some women had access to periodic mobile service delivery or diagnostic services, oral health services or outreach allied health services and spoke very highly of these. For example, The Bone Bus, mobile breast cancer services and the Vitamin D bus were all commended. Some of these services only go to regional centres and women in more remote parts of the start must drive long distances to reach them.

Where women could get reliable internet access and they also had digital literacy skills, the support available through online forums and from health information websites was commented on positively.

Primary health care

GPs played a critical role in supporting women's health and wellbeing when women had access to a GP, had the chance to build a relationship with that person over time, and particularly where they felt the doctor took the time to listen to them. They said that in areas with few services and resources, GPs are a critical source of health and service information.

Women hoped for access to female GPs or a doctor who specialised in women's health.

Practical assistance

The Patient Transport Access Scheme provides important support to address the financial cost of travel for rural and remote women. Acknowledging the limitations of the support available, women who had been able to utilise this scheme pointed to it as a valuable help to access health services.

Community transport was also highly valued but in high demand. Community transport is low cost, but participants pointed out that this is not the same as being affordable.

What isn't working well?

Continuity of GP care and GP availability

Some rural areas rely heavily on locum GPs. Women talked at length about the importance of having the same person providing general practitioner

> ***"You're at an increasing disadvantage the farther you are from Hobart and the less money you have."***

services over time; building trust and an understanding of their health. Many women reported not being able to get an appointment with a GP in less than 2-3 weeks – a significant issue in areas with no 24-hour medical services, and which are a long way from ambulance base services.

It is clear from our discussion that women felt there is a great need for local and consistent GP services in rural communities.

Health literacy

In order to make decisions and manage their health and health care women need to be able to access information, understand it and use it. In our discussions women told us they had great difficulty in getting access to information. They had difficulty getting

- understandable written health information
- information about mobile service visits
- information about community support services
- Information about community events

The majority said they relied on their GPs to tell and interpret things for them, but they had difficulty getting GP appointments.

Understanding information so it can be used to inform decision making was also an issue. On the West Coast the need for locally based health workers who could deal with people face to face, help them find and understand information and find and access services, was strongly identified.

Access to online services

Some women participating in the forums did not have access to computers or smartphones and said they did not have any digital literacy skills. This was particularly common in our discussions on the West Coast, where only one in three of the women in the group had computer access or the skills to use the public computers in the Neighbourhood House.

The unreliability of the internet in rural areas – particularly in Rosebery – was a significant barrier to finding health information online. The move to online booking systems for some GP practices was causing issues for some women.

Preventative health care

Participants identified several initiatives that had worked well in their communities, particularly physical activity initiatives, that had stopped 'when the funding ran out'. These included locally run low impact exercise opportunities. This had an impact on older people in their communities who needed subsidised or free activities in accessible venues and people with chronic conditions. (Physical inactivity is a risk factor for several chronic conditions including type 2 diabetes, cardiovascular disease, some cancers and mental health disorders.)

Lack of specialist services

The lack of services in rural areas has serious consequences. The inability of women outside Hobart to access low cost terminations of pregnancy was a significant issue for survey respondents living outside the urban centres.

The absence of services to support rural people living with serious illness was also identified in our discussions.[1] It was understood that lack of access to diagnostic services, to speciality care, or to specific treatment had potentially serious consequences for people in their communities.

Women also discussed the lack of access to allied health services, which play a key role in chronic disease management. Many allied health services in rural Tasmania are provided from central clinics to reduce travel time for the clinicians. However, transport is required for people to be able to access these clinics.

Participants also told us about the experiences of family members with terminal illness needing palliative care who were transferred out of small

[1] Serious illness includes those medical conditions which are serious and complex, that carry a degree of impairment or disability and have a need for comprehensive care management.

communities to a larger centre. This caused significant stress for them and their families.

Across the board, women participating in the focus groups talked about the lack of coordination between health services and the barriers and hurdles to accessing needed services. The difficulties in getting specialist appointments at times when they could get community or public transport to attend them was repeatedly noted.

Support for women as mothers

It was identified that there is a lack of support for mothers with young children in some rural areas with consequences for the mental health of young mothers. Child Health and Parenting Service and playgroups are valued but women's access to local maternity services, childcare services, Child and Family Centres, respite services, family support services, child and adolescent mental health services and youth services is severely constrained.

We were told how an inability to access childcare impacts on women's ability to exercise or attend health appointments.

It was repeatedly said that women have little time or resources to look after their health. Many women told us that they carry the bulk of the responsibility of parenting with little support and few breaks, as well as working and caring for other family members. Women repeatedly reported physical and emotional fatigue.

Mental health support

Women reported high levels of mental ill health in their communities, particularly identifying grief, loneliness, anxiety and depression. There was also much discussion of the impact of stigma on the mental health of individuals, particularly the stigma associated with socio-economic disadvantage and social exclusion.

Women wanted initiatives to help support good mental health and their suggestions included initiatives to promote positive mental health and prevented mental health problems, early intervention when problems developed, better access to mental health services, and action to address the stigma experienced by particular groups of people.

Nutrition

The difficulties in accessing affordable fresh food was particularly raised by women in the Huon Valley, on the West and East Coasts, areas in which the consumption of fruit and vegetables is at particularly poor levels,[iii] well above the general poor and declining levels across the state.[iv]

Although more women than men meet the fruit and vegetable eating guidelines, women are often the gatekeepers of the family's diet so their difficulties accessing fruit and vegetables raises concerns for their households, including children.

Insufficient healthy food is responsible for several chronic conditions and diseases, including obesity, heart disease, diabetes and some cancers.

Transport

In the consultations a lack of money and poor access to transport were repeatedly cited as a barrier to accessing health services, transport, employment, digital services and physical activity opportunities.

Access to emergency services

For those women living substantial distances from emergency departments also discussed the potentially significant consequences of emergencies and the additional stress this places on parents of infants and young children. Analysis has found that people in the areas of Central Highlands, Derwent Valley, Geeveston/Dover, Triabunna/Bicheno and Forestier/Tasman are more than 50 kilometres from the nearest emergency department and that the nearest emergency departments they are nearest to are located within rural facilities, staffed by generalist providers.[v]

What hasn't begun but needs to start?

There were clear priorities for specific interventions and activities in the local area to help rural people

Women told us that more is needed in regional and remote areas to help people prevent and manage chronic ill health, including mental health problems. They wanted access to GPs, more time to talk to them in appointments, and greater continuity of care with their GPs.

Women said they wanted community and health services to understand the whole of their lives, and develop approaches to providing services that reflect this and the importance of social connection and engagement as part of a health service model

Women also said that improving the health of women in rural and remote areas also requires a 'gender focus' on service delivery. For example, the said that attention needs to be given to ensure flexible appointment times are available to cater for childcare needs and working women, that services a 'child friendly' and that health promotion activities build child care into their models.

Appendix: Current challenges for women in rural and remote Tasmania

Socio economic disadvantage

In general, rural communities tend to experience higher levels of socio-economic disadvantage. The communities consulted in this consultation process tended to have had older populations, higher rates of unemployment, lower levels of educational attainment, and less ownership of cars than the Tasmanian average. The median household weekly income was also lower than the Tasmanian median, ranging from 68% of the Tasmanian median income to 90%.[vi] Their disadvantage is relatively high from a national perspective

too. On the SEIFA index of disadvantage[2] all four communities are in the top 10 or 20% of disadvantaged Australian suburbs.

Some indications that socio-economic disadvantage is increasing among Tasmanians is reflected in the growth in numbers reporting increased financial hardship and food insecurity.[vii] It is worth noting that income support payments such as Newstart Allowance have not been increased in real terms in decades, and that women are most affected by penalties in welfare to work programs which suspend income payments[viii].

These social determinants of health are associated with several indicators of lower health and wellbeing status including self-assessed health status, oral health and high body mass index (which is associated with a risk of cardiovascular disease, type 2 diabetes, some cancers and other chronic conditions).

There is also a socio-economic gradient of understanding health information, with people who are most disadvantaged reporting the greatest difficulty in understanding.[ix] And there is a significant association between socio-economic disadvantage and poor oral health. Tasmanians in the North West region have the highest proportion of fair or poor oral health (self-assessed) and a significantly higher proportion of complete tooth loss than other parts of Tasmania.[x]

Access to primary health care

Tasmania has a higher rate of GPs per population than the rest of Australia. However, this is not the case in rural and remote Tasmania, as the GPs are concentrated in Hobart and Launceston.

Difficulties in accessing GPs means that people delay getting medical advice for minor symptoms and wait until their symptoms become more severe.

Access to specialist/allied health services

Access to specialists in Tasmania is heavily constrained. Currently non-urgent patients are waiting long periods - up to three years to see a Gastroenterologist for example, and even urgent patients are facing unacceptable waits – over a year to see a neurosurgeon.[xi]

[2] The SEIFA index of disadvantage is an Australian Bureau of Statistics tool which ranks areas of Australia according to their relative disadvantage. These include: low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. A lower score on the index indicates a higher level of disadvantage. St Helens, Rosebery and Burnie are all in the first decile of disadvantage, Geeveston is in the second decile.

Access to allied health providers is also limited. The Tasmanian Allied Health workforce is lower than the Australian norm per 100,000 population, and is in fact the lowest or second lowest of all Australian territories across a range of disciplines including audiology, dietetics, occupational therapy, physiotherapy and psychology.[xii]

The lack of access to health services means that rural and remote areas in Tasmania have a higher rate of potentially avoidable hospitalisations.

Chronic disease

More than half of Australians have at least two chronic health conditions (eg arthritis, asthma, backpain, cancer, cardiovascular disease, diabetes chronic obstructive pulmonary disease and mental health).[xiii] The latest Population Health Survey found that the prevalence of most chronic diseases in Tasmania has increased significantly over recent years, with the largest increase being for depression/anxiety.[xiv] High levels of psychological distress are more common for women than men and for Aboriginal people than the population as a whole.[xv]

Australians living in very remote locations have poor access to mental health services. Country people risk exacerbated mental illness because there aren't enough early intervention and prevention services. This means that early diagnosis, treatment and ongoing management of mental health conditions is less likely. Distance, cost and a reluctance to seek help all also contribute to poorer mental health outcomes in rural areas. The result of this is an increased likelihood of hospitalisation and sometimes, self-harm.[xvi]

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[i] Constitution of the World Health Organisation, April 1948 https://www.who.int/about/who-we-are/constitution

[ii] World Population Review http://worldpopulationreview.com/territories/tasmania-population/

[iii] Primary Health Tasmania Break O'Day and West Coast community health profiles, https://www.primaryhealthtas.com.au/resources/community-health-profiles/

[iv] Department of Health, *Report on the Tasmanian Population Health Survey 2016,* March 2017, Hobart, https://www.dhhs.tas.gov.au/publichealth/epidemiology/tasmanian_population_health_survey_2016

[v] KP Health *Provision of Primary Health Care Service Strategic Study,* Royal Flying Doctor Service, 2015 https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/194936/Royal_Flying_Doctors_Service_-_Attachment_1.pdf

[vi] Primary Health Tasmania, *ibid*

[vii] Department of Health, *ibid*

[viii] The Senate Community Affairs References Committee, *ParentsNext, including its trial and subsequent broader rollout,* https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024267/toc_pdf/ParentsNext,includingitstrialandsubsequentbroaderrollout.pdf;fileType=application%2Fpdf

[ix] Department of Health, *ibid,* p. 51

[x] Department of Health, *ibid,* p. 62

[xi] Tasmanian Health Service, Outpatient Clinics, *Estimated Outpatient Appointment Waiting Times,* http://outpatients.tas.gov.au/clinicians/wait_times

[xii] Constitution of the World Health Organisation, April 1948 https://www.who.int/about/who-we-are/constitution

[xiii] Australian Institute of Health and Welfare, *Chronic disease* https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview

[xiv] Department of Health, *ibid*

[xv] Department of Health, *ibid*

[xvi] Mental Health in Rural and Remote Australia National Rural Health Alliance Fact Sheet, December 2017, http://ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf