Improving Access and Equity in Rural and Remote Australia - Provision of Women's Health Medical Services by Female GPs in Remote and Rural Areas

Priscilla (Vall) Whittle, Libby Williams

6th National Rural Health Conference
Canberra, Australian Capital Territory, 4-7 March 2001
Improving access and equity in rural and remote Australia — provision of women’s health medical services by female GPs in remote and rural areas

Priscilla (Vall) Whittle, Libby Williams

PART 1 — LIBBY WILLIAMS, CONSUMER

For the past 13 years I lived at Lambina Station, a remote 3535 km² cattle station in the far north of South Australia, with my husband Mark and our three young children. Our property is situated 1200 kms north of Adelaide and 450 kms south of Alice Springs. My husband and I own and manage the cattle station as part of a large family partnership. We run 4000 head of Poll Hereford cattle and we usually employ three stockmen and a sometimes a governess.

Because of our isolation all our foodstuffs are ordered by Facsimile and are then transported by truck to the nearest town of Marla, 75 kms west of our property. I then have to drive the 150 km round trip on very rough dirt roads to collect all our supplies and any other freight each fortnight, weather permitting. At times the roads are impassable due to the rain and it is then that we rely on our well-stocked pantries to get us through. Our mail, which includes the children’s correspondence lessons, arrives once a week by plane from Alice Springs. The Port Augusta School of the Air muster, called “Get Together”, is an annual event where the children actually get to see their class teacher and classmates. This involves a 900 km trip south, and takes us about 10 hours. Various health appointments including the children’s annual school dental visit, Christmas shopping and various business appointments are dealt with on such a trip as they are few and far between.

The Royal Flying Doctor Service (RFDS), Port Augusta base is responsible for our Primary and emergency health care needs. We also have access to the Marla health clinic, which is staffed by remote area nurses. The RFDS provides our primary health care by means of a monthly station clinic flight and provides essential emergency retrieval services as the need may arise.

Managing a large cattle station involves employing a number of staff and cooking for the “mob”, together with bringing up and teaching your children, attending to all the business needs such as book-keeping and wages, and involvement on many school and rural committees. Life for a woman on a pastoral property is more than a full time job. Many city people ask often ask me, “What do you do all day, you must get so bored?” I usually just laugh as words cannot describe to them the intrigue and wonder that life in the bush brings. I often wonder what excitements tomorrow will bring.

It is probably the isolation from the extended network of family and friends together with the lack of respite from household management and childcare which gives bush
women the feeling that they are on the go 24 hours a day, 7 days a week. There are no handy cafes around the corner to pop into for a café latte and a chat. The reality is that bush women learn to be self reliant and resourceful and manage each crisis as it occurs but it is reassuring to know that the RFDS provides the safety net for women and their families in the bush.

When I was pregnant with each of my children, all my antenatal care was carried out at 4-weekly intervals when the RFDS from Port Augusta would fly into our station and conduct a clinic either on the plane or in the shade of the wing of the aircraft. I had to leave my home at about 37 weeks gestation for confinement at either Port Augusta Hospital or the Queen Victoria Hospital in Adelaide. This means an en masse relocation for myself and the children to stay with a tolerant relative or friend for the wait. My husband would ensure that I was safely “down south” and then return to the station until closer to the expected date of delivery. But, as with our last child, nature has a way of messing up the best laid plans and our son arrived a week early, with his Dad finally meeting him when he was three days old.

Both myself and the babies’ post natal care was carried out at the once per month RFDS clinic, with the flight nurses performing the babies’ weights and checks, immunisations as well as maternal health checks.

At Marla, the clinic provided access to remote area nurse and opportunity to access wider range of health services, such as the annual female doctor’s visit that was provided by the RFDS. This choice of service was only provided when the RFDS was able to retain the services of a female doctor willing to fly out to the remote areas and when the aircraft were not occupied for some other purpose. Therefore, the women’s health program was far from a regular thing but rather a bonus service that was provided when the RFDS could manage it.

For remote and isolated women such as myself to access women’s health and a female doctor, the RFDS provided an annual clinic flight to various remote areas over the course of a couple of days. This “whistle stop” tour of the outback by a female doctor was most inadequate, as the remote women had to drop everything for this limited opportunity to access a female doctor. Sometimes the clinics were at Marla late in the afternoon, not a good time for women with young families nor station women who have other issues such as distance to travel to even get to town. The 2–3-hour time constraints of these clinics meant that consultation time was too short, limiting the remote women’s quality access to this service.

As a bush woman and health consumer living in a remote area, and convenor of the Consumer Network Group of the RFDS Central Section since 1994, the issue of equity of access to quality women’s health services has always been a high priority of mine.

The previous practice of the RFDS, where visits by female doctor were highly infrequent, not well publicised, inadequate consultation time, often inappropriate venue, such as on aircraft with lack of privacy and at the mercy of the elements, seem to be now alleviated by the new service provision.

An improved level of funding and a genuine desire by federal government and the RFDS to champion the cause of women’s health has enabled female doctors’ access to
women in the bush. These regular RFDS flights to rural and remote areas has now all but eliminated the problem of bush women putting off their health needs and waiting months to access a female doctor on their next visit to a large town or city. At last bush women are enjoying the same access to women’s health services that their city cousins have enjoyed for years.

PART 2 — DR PRISCILLA WHITTLE, PROVIDER OF THE RURAL WOMEN’S GP SERVICE

The Office of the Status of Women and the CWA surveyed women in rural Australia in 1988 and discovered that almost two thirds of women indicated that health and medical services “were among their priorities for increased Government action in rural areas”. This paper looks at the lives and health status of women in rural and remote Australia, and reports on a Government funded program that is improving health care access for rural women.

So who are we thinking of, when we say “rural women”?

It would be a mistake to assume that all women experience life in the country in the same way…. (they) are a diverse group with a range of backgrounds and experience.

There is an overall assumption that living in the country has certain health benefits, such as clean air, fresher food, better housing, less stress and a sense of community and support. This is not untrue. However, recent statistics have clearly demonstrated that people in rural and remote Australia have poorer health than city people in several health categories.

People living in the “bush” have higher mortality rates and consequently lower life expectancy. It is important to note that Indigenous Australians suffer a higher burden of illness and die at a younger age than non-Indigenous Australians, and this is true for almost every disease or condition for which information is available.

With particular reference to women’s life expectancy: Females in capital cities expect to live half a year longer than those in rural zones, but 4 years longer than in remote areas.

Women’s health

Women have unique health issues which are often magnified when they live in rural and remote locations. Research suggests that rural women have greater family and community responsibilities than urban women. They usually come from larger families, begin their own families earlier, have more children and play key roles in family and community. They often care for ill and disabled relatives without the support of agencies available in cities, and with less access to respite care. The stresses imposed by this may cause poorer health, and women in these roles have identified mental health care as a high priority.

Domestic violence is a serious problem for women in rural communities. Statistics on interpersonal violence reveal that women from remote zones have 7–25 times higher rates of hospitalisation due to violence than women from elsewhere. They are often
reluctant to involve the police if they suffer from domestic violence, for several reasons. Often they know the police socially, and may be embarrassed about their situation becoming known to others. It is more difficult to gather the resources needed to leave a violent situation and live independently in remote areas.

Cervical cancer is the eighth most common cancer in Australian women. The benefits of participating in screening programs have been well established; 90% of invasive cervical cancer could be prevented if all eligible women were screened at 3-yearly intervals. However, research conducted in 1998 discovered that rural women may be more likely than their urban counterparts to be screened initially, but less likely to repeat screening in two years.

Women from remote areas have higher death rates from cervical cancer than all other areas, with Indigenous women’s death rates being eight times higher, presumably reflecting the lower rate of screening.

Services
A reality of living in rural and remote areas of Australia is that there are fewer health care services. In 1996 there were almost twice as many practitioners providing health services in “capital cities” per head of population, compared with “other remote areas”.

The cost of transport is a further barrier to services, and while various types of government assistance do help, the allowances fall short of the true cost of taking time off work and associated social costs. Privacy is another issue for women in small towns, where they may have a social or working relationship with their doctor. For some women this makes discussion of personal or intimate matters difficult. Women in rural areas often have a limited choice of doctor, and in a small town, the alternative may be a long drive away. Many women prefer to attend a female doctor, but female practitioners make up less than a quarter of the rural GP work force.

Women patients often find women doctors easier to talk to and feel more comfortable and less embarrassed with them, particularly in discussing personal matters.

The program
In an effort to improve the equity of health services for women in rural and remote Australia, the Commonwealth Government set up a program called the “Rural Women’s GP Service”.

The aim is to “improve access to primary and secondary health services for women in rural Australia”. Female GPs would attend rural communities as the need requires and deliver a range of services.

The Contract to deliver this program was signed in May 2000, between the National Office of the Royal Flying Doctors Service and the Commonwealth Department of Health and Aged Care. The service would cover all states and the Northern Territory and the rollout would involve consultation and negotiation between the community, the local GP and local health providers and agencies, and the female GP to deliver the service.
The Royal Flying Doctor Service has been providing health services to people living, working and travelling in the Australian outback for over 70 years. It operates from twenty bases Australia wide. This history and experience as a key provider of health services to rural Australia made the Royal Flying Doctor Service a sound base upon which to launch this innovative women’s health program.

The program so far

The rollout of this service began soon after the contract was signed. A few months later 97 clinics had been conducted by female GPs in 50 locations throughout Australia. The frequency of these clinics ranges from monthly to quarterly, with the success of the program indicated by the following stories:

At Tennant Creek four clinics per year were planned, but demand was so great after the second clinic that the community requested the service monthly. There have been three clinics since, with each fully booked two clinics in advance.

At Cummins, on the Eyre Peninsula in South Australia, clinics were planned quarterly, but now operate every 4–6 weeks, with women travelling up to 150 kms to attend.

At Yorketown in South Australia there is a waiting list of up to 22 patients for 6–8 weekly clinics.

I work at Coober Pedy in the far north of South Australia, and there clinics were planned for every 8 weeks. They are operating monthly with clinics planned until December and a waiting list of 20–30 women. The GPs in the town have reported no change in their work load, and suggest that we have tapped into an area of unmet need.

Clinics are held in GP practices, Aboriginal Health Centres or Community Health Centres. I use the latter in Coober Pedy and have the services of a women’s health nurse. I set aside one session (out of four) specifically for Indigenous women, although they are free to come at other times if they wish, and this seems to be working well.

I would like to finish with a quote from a rural woman responding to a survey looking into the health of mid-age rural woman in 1995.

The drought and low commodity prices are causing very detrimental health and financial problems and in lots of ways the women are shouldering the burden. We still feel living in the country is the healthiest place to live but at the moment it is presenting big problems (Brown et al 1997, p. 261–266).

REFERENCES


Caleidin, C. and Bentley, B. A Partnership Approach to Gender and Health: Building Strategic Alliances for Sustainable Change. 5th National Rural Health Conference; 1999; 241–246.


McLennan, W. and Madden, R. The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples. ABS, 1997.
