ACT women's health matters!

ACT Women's views about their health; their health needs; their access to services, supports, and information; and the barriers to maintaining their health

Emma Hoban

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Thanks to those women who participated in the health and wellbeing information survey and who gave their time to contribute their insights, experiences and opinions to this research. We hope that through documenting your views and experiences, local ACT responses can be improved so that women's health and wellbeing needs are better understood and will be better met in the future.

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About Women's Centre for Health Matters Inc.

The Women's Centre for Health Matters Inc. (WCHM) is a community based organisation which works in the ACT and surrounding region to improve women's health and wellbeing. WCHM believes that the environment and life circumstances which each woman experiences affects her health outcomes. WCHM focuses on areas of possible disadvantage and uses research, community development and health promotion to provide information and skills that empower women to enhance their own health and wellbeing. WCHM undertakes research and advocacy to influence systems change with the aim to improve women's health and wellbeing outcomes. WCHM is funded by ACT Health.

The findings and discussion presented in this report are those of WCHM, and not necessarily those of the ACT Health Directorate.

About the Author

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Introduction

Over the last few years there has been much discussion about health care responses in the ACT, at the same time as the health care environment in the ACT has continued to change:

- The ACT population is projected to increase from 402,549 persons in 2017 to 470,839 persons in 2027, representing a 17% growth in the population over this period.[1]
- The 2016 ABS census data shows that females make up 51% of the ACT population.[2]
- The percentage of Canberrans aged over 65 years is set to double from the 2015 level of 12% of total population to 22% in 2062.[3]
- With an ageing population, disability levels are likely to increase in the ACT and increases in life expectancy will also result in increases in the number of people with age-related chronic conditions (with women making up the majority of that older population).
- Almost 2/3 of adults in the ACT are overweight or obese, and one in 4 adults are obese.[4]
- 1 in 5 people in the ACT reported receiving a mental health disorder diagnosis in the preceding 12 months, with more females (22%) reporting receiving a mental health diagnosis compared with males (13%).[5]
- Women's mental health needs are significantly different from those of men - certain mental illnesses are more prevalent in women, they use mental health services more frequently than men, and they want a broader range of treatment options than are currently available.[6]
- Women are also 1.6 times as likely as men to suffer coexisting mental and physical illness.[7]
- This is at a time when bulk billing for General Practitioner (GP) visits in the ACT has decreased to 56% in the ACT in the 2015-16 financial year, compared to 84% across Australia.[8] *Note that the proportion of patients fully bulk billed (and with no out of pocket costs) is much lower.*

At the ACT level a range of reforms have been underway in relation to health and the service system:

- The Minister for Health's title was expanded to include 'Wellbeing', and a Minister for Mental Health was introduced in the ACT.

[1] ACT Government Treasury, *ACT Projections: projections of the resident population, ACT by age and sex*, Canberra, 2017, retrieved on the 26th of February 2018; https://apps.treasury.act.gov.au/demography/projections/act
[2] Australian Bureau of Statistics, *General Community Profile*, Canberra, (Catalogue number 2001.0) 2016.
[3] ACT Government, *ACT Budget 2016-2017 for Canberra, Older people*, Canberra, 2015, retrieved on the 26th of February 2018; https://apps.treasury.act.gov.au/budget/budget-2016-2017/budget-booklets/social-inclusion/older-people
[4] ACT Health, *Healthy Canberra, Australian Capital Territory Chief Health Officer's Report*, Canberra, 2016.
[5] Ibid.
[6] M, Duggan, *Investing in Women's Mental Health. Strengthening the foundations for women, families and the Australian economy.* Australian Health Policy Collaboration Issues paper No. 2016-02. Australian Health Policy Collaboration, Melbourne, 2016.
[7] Ibid.
[8] Australian Government Productivity Commission, Report on Government Services 2017, Canberra, 2017, retrieved on the 26th of February 2018; https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/primary-and-community-health, Table 10A.33

- ACT Health released a draft *Territory-wide Health Services Framework 2017-2027* which sets out the overarching principles for integrating patient-centred care to improve the health of Canberrans, and it is intended to guide the development and redesign of health care services across the Territory over the next decade.[9]
- In the 2017-18 ACT Budget, the ACT Government committed to developing a *Preventative Health Strategy,* which will align with the Framework.
- In the Budget there was also a commitment to establish a new *Office of Mental Health* to ensure that ACT's mental health services are well coordinated and deliver what the community needs.
- A regional mental health plan will also be developed in collaboration with ACT's primary health network, Capital Health Network, to enhance the coordination of mental health and suicide prevention planning and improve the efficiency, effectiveness and integration of services.
- Three new nurse-led walk-in centres (WiCs) will be introduced in the Gungahlin and Weston Creek regions to give people in these areas fast, free care access to healthcare for less serious conditions and one-off treatment for minor illnesses and injuries.
- A new University of Canberra Hospital: Specialist Centre for Rehabilitation, Recovery and Research will open in July 2018 as Canberra's first, purpose-built rehabilitation hospital.

The *ACT Women's Plan 2016-26* recognises that "health issues, and manifestations of health issues, are impacted by gender" and that:

"A gender lens must therefore be applied to health care services in the ACT to differentiate between requirements for health related matters for males, females and those of diverse gender identities, and to ensure that affordable and accessible gender and culturally-sensitive health services are provided across the ACT."[10]

Supporting the Women's Plan, health and wellbeing is one of the priority areas for action in the *First Action Plan from 2017-19*, which has as a key action for Physical and Mental Health that "Information and Services are tailored to the needs of women and girls from diverse backgrounds". [11]

We know that the best health outcomes for women will be achieved if health responses are tailored to meet the local needs and priorities of different groups. But nationally and locally most studies and policies relating to health access, barriers and needs have focussed on the broader population, or on specific disease areas or parts of the health system. Very few have included local ACT data, and even fewer have focussed on the needs of women, gendered

[9] ACT Health, 'Draft ACT Health territory-wide health services framework, 2017-2027', Canberra 2017, retrieved on the 16th of October 2017: https://www.health.act.gov.au/sites/default/files//Territory%20Wide%20Health%20Services%20Framework%20%28TWHSF%29-18Sept17-with%20draft.pdf

[10] The Legislative Assembly for the Australian Capital Territory, *The ACT Women's Plan 2016-26*, Canberra, 2016, *retrieved on the 26th of February 2018;* http://www.communityservices.act.gov.au/__data/assets/pdf_file/0019/1108306/ACT-Womens-Plan_Report_2016_2026.pdf

[11] The Legislative Assembly for the Australian Capital Territory, *The ACT Women's Plan 2016-26 First Action Plan*, Canberra, 2016, *retrieved on the 26th of February 2018;* https://www.communityservices.act.gov.au/__data/assets/pdf_file/0020/1040375/ACT-WOMENS-PLAN-2016-26-FIRST-ACTION-PLAN-2017-19-WEB.pdf

evidence about the impacts on women's health or emerging health needs and barriers for women in accessing health services and supports.

It is therefore important to know about the experiences of women using and accessing health services and supports, so that ACT health and wellbeing policies, community initiatives and other service responses can respond well to their needs. Understanding how ACT women use services and knowing about their health issues at different stages can help to inform the provision of better health responses in the ACT, and better access for women to appropriate health information provision.

The WCHM conducted a survey in March 2008 about the health and wellbeing issues for women in the ACT, which included the barriers for them in acting on their health and wellbeing issues.[12] And in 2010, WCHM released a report on the findings of a survey conducted in August and September of 2009 about women's views about health and wellbeing information in the ACT. This report also covered the identified barriers for women to accessing health and wellbeing information and to accessing GPs.[13]

So that WCHM could provide more updated information to inform the current consultations and changes in the ACT, WCHM conducted a consultation survey to explore ACT women's main health issues, what health services they accessed and their experiences of those, the barriers that inhibited their ability to address their health issues, and their preferred methods of seeking access to health and wellbeing information. The forums further explored their unmet health needs and the barriers to healthy behaviours.

The following report summarises the results of the consultation and provides the findings and narratives of the 601 ACT women who responded to the survey, and who completed all the survey questions.

This report is comprised of several parts. The first part describes the methodology used, and is followed by a brief review of the literature about women's health needs, their use of health services and information, their barriers and other relevant themes from similar national and international research.

We then present the survey findings, including the demographic characteristics of the survey respondents, and the responses for each of the main sections of the survey: women's understanding of what good health means; their self-rated health; barriers to addressing their health issues; health service use and information seeking; and their experiences.

The discussion section explores the major themes from the consultation and looks more closely at the health issues, barriers and experiences facing women in the ACT, and their preferences.

The conclusion outlines the overall key findings from the feedback from both the survey and focus group respondents.

[12] Women's Centre for Health Matters, *Health and Wellbeing Issues for Women in the Australian Capital Territory*, Canberra, 2008.
[13] A Carnovale and E Carr, *It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, Canberra, 2010.

It is WCHM's hope that this report will improve understanding of the needs of women in the ACT, in order to facilitate better health and wellbeing policy, services and information provision that is responsive to their needs, and to identify opportunities to improve local responses.

Executive Summary

The ACT is experiencing a shortage of GPs, a lack of bulk billing by GPs and specialists, demand in the hospital system, and increased requests to explore opportunities in the roles of pharmacists and nurse practitioners at the same time as it is conducting reform in the local acute and community-based healthcare systems. The changing external environment and the increasing complexity of health issues that women are facing poses challenges in relation to ACT women and their access to health services and supports to manage and maintain their health and wellbeing, as well as in accessing trustworthy, reliable health and wellbeing information.

ACT women comprise the majority of the ACT population who are 15 years and over at 51%.[14] Women live longer so are more likely than men to live with disability and chronic conditions.[15] [16] Women are also more likely to have unique health concerns and issues that relate to their gender and their life roles which will impact on their conditions.[17] [18] This means they will use health services and medicines more frequently, and over a longer period of time, increasing the demand on the health system and expenditure on health care costs. [19] [20]

Women are also often the main family decision makers for health issues and the main family carers, so their access to appropriate health and wellbeing services, supports and information is crucial. They need to be able to make informed choices about their own and their family's health, and access relevant services and support.[21]

Because ACT residents generally have higher weekly earnings than the national average, those who don't can experience issues that can impact negatively on their health service access and equity including costs, location and transportation barriers.

Therefore, the views from ACT women are important to know about so that the ACT health care system can respond to issues such as the availability of GPs, specialists, community health services and acute care, and the role of support groups; the appropriateness, affordability and accessibility of the responses; and the integration of these different responses. This information is important for those aiming to improve the ACT's health responses, and for those working in or influencing future changes to the health system.

Currently ACT Health provides services for a catchment of approximately 400,000 people in the ACT and a further 200,000 people from the surrounding Southern NSW area. [22] The health care environment in the ACT will continue to change over the coming years and will face

[14] Australian Bureau of Statistics, *General Community Profile*, Canberra, (Catalogue number 2001.0) 2016.
[15] Australian Institute of Health and Welfare, Australia's Health 2012, Australia's health series no.13. Cat. No AUS156. Canberra, 2012.
[16] Australian Institute of Health and Welfare, Australia's health 2016, Australia's health series no. 15. Cat. no. AUS 199. Canberra, 2016.
[17] NSW Ministry of Health, *NSW health framework for women's health 2013,* North Sydney, 2013.
[18] Department of Health and Ageing, *National women's health policy 2010*, Canberra, 2010.
[19] NSW Ministry of Health, *NSW health framework for women's health 2013,* North Sydney, 2013.
[20] Department of Health and Ageing, *National women's health policy 2010*, Canberra, 2010.
[21] M Murphy, B Murphy, & D Kanost, *Access to Women's Health Information: A Literature Review of Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 8.
[22] ACT Health, 'Draft ACT Health territory-wide health services framework, 2017-2027', Canberra 2017, retrieved on the 16th of October 2017: https://www.health.act.gov.au/sites/default/files//Territory%20Wide%20Health%20Services%20Framework%20%28TWHSF%29-18Sept17-with%20draft.pdf

challenges in relation to the delivery of health services. These challenges include:

- An ageing population;
- The increased incidence of chronic disease;
- Difficulty in filling gaps in some areas of the health workforce;
- Increasing demand for health services;
- New health technologies;
- Increasing costs and demand in the acute system; and
- How to provide integrated and coordinated care in a range of settings.[23]

The aim of the ACT's health system is to prevent illness and disease so that people remain as healthy as possible for as long as possible, as well as providing timely treatment and support for illness and health problems. WCHM knows that good quality health information and care leads to better health outcomes, and that barriers to accessing health services or information may impact on those outcomes.

Primary and community health services are often the first point of contact with the health system and aim to promote health and prevent illness, and manage illness and injury in the community, by providing access to that is:

- Timely, affordable and accessible;
- Appropriate and responsive to meet the needs of individuals throughout their lifespan and communities; and
- Well co-ordinated to ensure continuity of care.[24]

Unfortunately, there is scant research or data identifying ACT women's health needs and preferences in relation to their health issues, their understanding of health and wellbeing; their use of health services and information to support their health and wellbeing; the barriers that may impact on them accessing appropriate services and support; and the gaps they may experience in the ACT.

It is for this reason that in 2016 the WCHM conducted a consultation to explore women's experiences.

This report explores the views of ACT women in accessing health and wellbeing services, supports and information. Women's views and personal stories were sought through a variety of media — a survey (601 responses), several focus groups and the primary data was supplemented by a literature review.

The findings of this report are consistent with previous research undertaken by WCHM in 2010 which demonstrated that women's access to health and wellbeing services and supports can be affected by their social and economic circumstances - the social determinants of health. In

[23] ACT Health, 'Draft ACT Health territory-wide health services framework, 2017-2027', Canberra 2017, retrieved on the 16th of October 2017: https://www.health.act.gov.au/sites/default/files//Territory%20Wide%20Health%20Services%20Framework%20%28TWHSF%29-18Sept17-with%20draft.pdf

[24] Australian Government Productivity Commission, Report on Government Services 2017, Canberra, 2017, retrieved on the 26th of February 2018; https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/primary-and-community-health.

2010, ACT women said they wanted information to be "*available, affordable, accessible and appropriate".* [25]

This has not changed, and this report's findings demonstrate that women's barriers still include availability, affordability, accessibility and appropriateness when accessing health services, supports and information — including for preventive health. These are part of the social determinants of women's lives that can lead to health inequalities.

Women wanted affordable and accessible ways to access appropriate health care, which did not need to be through a GP given the costs, waiting times and demand, and they supported the provision of timely assistance and referrals through other options. These included WiCs, pharmacists and non-specialist community services who could provide advice and support in prevention and screening, early intervention and assistance with self-management.

The development of these options and using the facilities and infrastructure already available in the WiCs and community health centre for other organisations to provide outreach, could also assist by providing immediate access to more affordable health services which do not require GP or specialist skills.

The mental health needs of women and the differences to those of men need to also be considered given the more frequent use of mental health services than men, and the need fora broader range of treatment options than are currently available.

The draft *Territory-wide Health Services Framework 2017-2027* "sets out the overarching principles for integrating patient-centred care to improve the health of Canberrans", and "will guide the development and redesign of health care services across the Territory over the next decade". The Framework describes the expectation for a person's experience through the health system to include "timely access to effective and appropriate care across a range of health care settings (prevention in the community, care in the hospital and the management of care back in the community) to make it easier for patients to navigate the services they need." [26]

WCHM hopes that this feedback from ACT women will provide an up to date understanding about the differences in their health status, health issues, experiences of health and wellbeing, health service use and barriers, and health information seeking.

We hope that this will contribute to the implementation of the Framework and to other improvements to health programs and policies in the ACT, so that they can adapt to women's needs and lead to improvements that enable women to use the ACT health care system more effectively to improve their overall health and wellbeing.

[25] A Carnovale and E Carr, *It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 47.
[26] ACT Health, 'Draft ACT Health territory-wide health services framework, 2017-2027', Canberra 2017, retrieved on the 16th of October 2017: https://www.health.act.gov.au/sites/default/files//Territory%20Wide%20Health%20Services%20Framework%20%28TWHSF%29-18Sept17-with%20draft.pdf

Recommendations

1. WCHM work with ACT Health to explore ways to develop alternative access points for women to access more affordable and accessible options for appropriate health care which are accessible, affordable, appropriate and provide timely provision of health supports.

2. WCHM to advocate with ACT Government about the need to continue to explore, pilot and evaluate new community based care that is complementary to GP practices and emergency departments in hospitals, and which meets women's physical and mental health needs.

3. WCHM to advocate and work with the new ACT Office for Mental Health to ensure a focus on the mental health needs of women and that recognises the differences to those of men, the more frequent use by women of mental health services, the need for a broader range of treatment options than are currently available, and the need to ensure that future mental health service provision account for women's roles as workers, mothers and carers.

4. WCHM to work with the Capital Health Network to explore opportunities for working together to inform more affordable and accessible options for physical and mental health services and support that are applicable to women's needs.

5. WCHM to work with ACT Health to consider the issues raised by women about the need for better integrated navigation about health information for women in the ACT, and to build on the success of recent local integrated ACT websites - Having a Baby In Canberra (www.havingababyinCanberra.org.au) and BPD (www.borderlineintheACT.org.au) websites.

Methodology

The research design involved a survey and focus groups.

An initial online survey was conducted by WCHM from May to July 2016, to consult ACT women about their health, their health service utilisation, their health needs and their barriers to service access, and to seek their opinions and personal stories. The online survey was available via a link on the WCHM website and was distributed throughout email networks and personal contacts.

To attract participation in the online survey, information was distributed through WCHM's email and Facebook networks (both WCHM's Facebook page and paid Facebook advertising); other community organisations and service providers, ABC 666 Radio with Genevieve Jacobs; flyers and community newsletters, and the Community Development Network (CDNET).

As with all surveys conducted to date by WCHM, we used a non-probability convenience sample. This means that the survey was widely promoted and all women were welcome to participate. As a result, the numbers of women in our sample does not reflect the population of women in the ACT as a whole, and it is therefore not representative. Rather, the findings laid out in this report provide an indication of the issues that exist for women in the ACT, as well as recommendations for actions that could be taken to address these.

The survey sought to answer the following research questions:

- How do women understand and manage their health needs?
- Which health services are being utilised and whether there are barriers to that need?
- What are women's preferred methods of seeking health information and are there barriers to information seeking?

Respondents qualifying for the survey were women aged 16 and over and living or working in the ACT or Queanbeyan. A total of 601 valid surveys were collected.

Thematic analysis was then undertaken using NVivo to analyse both quantitative and qualitative survey data.

The survey was followed by two focus groups to explore some of the key issues identified in the analysis of survey responses. Participants for the focus groups were recruited through individuals, peak community sector networks or community organisations working with the specific groups of women, and a flyer was also sent out through existing networks.

While the survey received 828 responses, the report focuses on analysing the findings from the 601 completed survey responses, and the views expressed in the focus groups.

Limitations and strengths

This qualitative study does not aim to be representative of all ACT women's views, but rather to capture themes from a sample of ACT women.

Literature Review

OBJECTIVES

The objectives of the literature review were to explore the recent available research on:

- women's understanding of health and wellbeing, and their self-rated status of physical mental health;
- the top health and wellbeing issues for women, and their experiences of managing these;
- women's use and experiences of particular health and wellbeing services and supports and information sources (such as GPs, specialists, pharmacists, allied health professionals, the internet, telephone helplines, paper based publications, mass media and family and friends).
- how women access and use health and wellbeing services, supports and health information, including which services and what barriers were experienced to that access;
- who women access health and wellbeing services, supports and health information for.

Women's understanding of what good health means

The World Health Organisation (WHO) has a simple definition of health - "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity". [27]

The meaning of health, and good health, means different things to different women. For example, women may identify themselves as healthy if they don't have disease or disability, and those with a disease or disability may define themselves as in good health if they are managing their condition and it does not impact badly on their life. On the other hand, women with minor illness may describe themselves as having poor health if they feel their health should be better.

There are also a range of other factors in women's lives that can influence their health, and their experiences of health, both throughout their life and at different points in their life. These include age and genetics which are beyond the control of an individual. But health is also impacted by other factors such as income, caring responsibilities, health service accessibility and location, cultural or age appropriateness, living conditions, the availability of support networks, employment and working conditions, etc.

The health of most people will change due to ageing, the conditions they may develop, and changes in their knowledge or attitudes about health, but they also may change because of impacts from changes in circumstances such as employment, housing, and family circumstances.

And while physical health is important to good health, a person's mental health is equally as important, and a person's physical health can influence their mental state.

Self assessed health status

A person's health status is their overall level of health, and can be measured through self-assessed health status - a commonly used measure of health status. Self-rated health (SRH) (also known as self-assessed health or self-perceived health) refers to a single-item health measure in which individuals rate the current status of their own health on a four- or five-point scale. While this may seem a superficial way of determining health status, self-rated health has been shown to be an unusually strong predictor of mortality.[28]

The legitimacy of self-rated health seems to be increasing over time, perhaps due to increased access to health-related information, and patients seeking more information from their physicians than they did in the past.[29] Research has found that those who seek information give more realistic reports of self-rated health, which may mean that more exposure to health information improves the self-prediction of health status.[30] Research has also shown that

[27] World Health Organisation, From Alma Ata to the year 2000. Reflections at the midpoint, WHO, Geneva, 1988.
[28] J Schnittker & V Bacak, 'The Increasing Predictive Validity of Self-Rated Health', *PLoS ONE*, vol. 9, no. 1, 2014, pp. e84933.
[29] Ibid.
[30] Ibid.

individuals who have had contact with the health care system provide more valid reports of self-rated health than those with no contact.[31]

Self-rated physical health has been found to be a predictor for mortality, morbidity, and increased health service utilisation.[32] [33] [34] [35] However, few studies specifically explore women and self-rated health.

In 2006, just over half of women aged 18 years and over (58%) in Australia considered their health status to be excellent or very good. The percentage of women who rated their health as poor or fair increased with age, while those who considered their health to be excellent or very good peaked at ages 25 to 34 years and then declined with increasing age.[36]

In the 2008 survey of 180 women by WCHM on health and wellbeing issues for women in the ACT, more than 80% of women reported good health or better (very good or excellent).[37]

In 2011, results from the *ACT General Health Survey* showed that 84% of young people rate their health as 'excellent', 'very good' or good'', whereas young males (86%) rated themselves higher than young females (81%). [38]

Older people's perception of their own health has also been seen as a good predictor of their mental and physical condition and of mortality. [39] According to the 2011–2012 ACT General Health Survey, three-quarters (76%) of older persons in the ACT considered their health to be excellent, very good or good.[40]

In 2014–15, 57% of women in the ACT (aged 15+) rated their health as excellent or very good.[41] The proportion of women rating their health as excellent or very good varied by age-group: 67% of women aged 25–34 rated their health as excellent, compared with 36% of women aged 75 years and over.

Nationally in the *2016 Jean Hailes Women's Health Survey* of 3,236 women, when women were asked how they would rate their overall health, over 70% of women self-reported their health as 'good' to 'very good'.[42]

And more recently, in the *2017 Jean Hailes Women's Health Survey*, over 92% of women described their overall health as 'excellent', 'very good' or 'good'.[43]

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[31] J Schnittker & V Bacak, 'The Increasing Predictive Validity of Self-Rated Health', *PLOS ONE*, vol. 9, no. 1, 2014, pp. e84933.
[32] M Jylha, 'What is self-rated health and why does it predict mortality? Towards a unified conceptual model', *Social Science and Medicine*, no.69, 2009, pp. 307-316.
[33] M Bopp, J Braun, F Gutzwiller & D Faeh, 'Health risk or resource? Gradual and independent association between self-rated health and mortality persists over 30 years', *PLoS One*, vol. 7, issue 2, 2012, pp. 1-10.
[34] J Sundquist & S Johansson, 'Self-reported poor health and low educational level predictors for mortality: a population based follow up study of 39 156 people in Sweden', *Journal of Epidemiology and Community Health*, vol. 51, 1997, pp.35-40.
[35] P M Smith, R H Glazier & L M Sibley, 'The predictors of self-rated health and the relationship between self-rated health and health service needs are similar across socioeconomic groups in Canada', *Journal of Clinical Epidemiology*, vol. 63, 2010, pp. 412-421.
[36] Australian Bureau of Statistics, *General Social Survey*, Cat No. 4159.0. ABS, Canberra, 2006.
[37] Women's Centre for Health Matters, *Health and Wellbeing Issues for Women in the Australian Capital Territory*, Canberra, 2008.
[38] Epidemiology Branch, ACT Health, *Health Status of Young People in the ACT*, ACT Government, Canberra, 2011.
[39] Australian Bureau of Statistics, *Health status: Health of older people. Australian Social Trends*. Canberra, cat.no.4102.0, 1999
[40] ACT Health. *Health and Wellbeing of Older Persons in the Australian Capital Territory. Health Series*. Canberra, Australia: ACT Health, 2016.
[41] Australian Bureau of Statistics, *National Health Survey: First results 2014–15*, ABS cat. no. 4364.0.55.001. Canberra, 2015
[42] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia* survey, Melbourne, 2016, pp. 16, retrieved on the 26th of February 2018; https://jeanhailes.org.au/survey2017/report_2017.pdf
[43] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia* survey, Melbourne, 2017, retrieved on the 26th of February 2018; https://jeanhailes.org.au/survey2017/report_2017.pdf

Women's top health issues

In the 2008 survey by WCHM on health and wellbeing issues for women in the ACT the major physical and wellbeing issues reported were musculoskeletal and nervous system conditions, eating and weight issues, and cardiac and circulatory problems. [44]

The *Australian National Women's Health Policy 2010* identified the major challenges associated with death and burden of disease for women from 2010-30 as:

- Prevention of chronic disease and control of risk factors;
- Mental health and wellbeing;
- Sexual and reproductive health; and
- Healthy ageing.[45]

In 2015 Jean Hailes for Women's Health conducted a large national survey to understand the health information needs and behaviours of women living in Australia.[46] It surveyed 2,798 women of all ages, cultures and backgrounds, and found that the top health issues for Australian women were:

- Healthy living (weight management, physical activity, ageing, fatigue and diet);
- Mental and emotional health (mental health, depression, anxiety, stress, dementia, memory);
- Female specific cancers (breast cancer, skin cancer, ovarian cancer); and
- Cardiovascular health (heart health, hypertension, stroke, cholesterol).[47]

The 2016 Jean Hailes for Women's Health Survey found that the top five top health issues identified by women were:

- weight management (23%), specifically weight gain;
- cancer (17%) such as breast cancer, ovarian cancer and skin cancer;
- mental and emotional health, particularly anxiety and depression (15%);
- menopause (9%); and
- chronic pain (8%).[48]

And *the 2017 Jean Hailes for Women's Health Survey* found that the top 5 health conditions that all women were most concerned about were:

[44] Women's Centre for Health Matters, *Health and Wellbeing Issues for Women in the Australian Capital Territory*, Canberra, 2008, pp. 4.
[45] Commonwealth of Australia Department of Health and Ageing, *National Women's Health Policy 2010*, Canberra, 2010.
[46] Jean Hailes for Women's Health, *What do women need to know? Women's health information needs in Australia* survey 2015, pp. 19.
[47] Ibid.
[48] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia* survey 2016, pp. 10.

- Menopause (21%);
- Cardiovascular (heart) disease (16%);
- Breast cancer (11%);
- Bowel health (11%); and
- Painful sex (8%).[49]

However, when age was taken into consideration, 18-50 year-olds had significantly different health concerns - breast cancer; bowel health; fertility, endometriosis and period pain.

Chronic conditions

Chronic conditions have become an increasing concern in the Australian healthcare context. Defined by the Australian Institute of Health and Welfare (AIHW) as "a group of diseases that tend to be long lasting and have persistent effects," chronic conditions were the leading cause of death, disability and illness in 2011, accounting for 90% of all deaths in Australia.[50]

The AIHW report, *Australia's Health 2016*, identified that cancer, cardiovascular disease, mental and substance use disorders, musculoskeletal disorders, and injuries contributed the most burden in Australia in 2011.[51] Together, they accounted for around two-thirds of the disease burden (69% of males and 62% of females). The share of burden between males and females also varied by disease group. Males experienced almost three-quarters (72%) of the burden from injury and a greater share of the burden from cardiovascular (59%), endocrine and infant and congenital diseases (57% each), and from cancer (56%). Females experienced a greater share of the burden from blood and metabolic disorders (59%), neurological conditions (58%) and musculoskeletal conditions (55%).

In line with this, chronic conditions were identified by Australian women in the *2015 Jean Hailes Women's Health Survey* with cardiovascular conditions and cancer within their top health concerns.[52] The 2016 survey by Jean Hailes for Women's Health found that cancer, mental and emotional health, and chronic pain were among the top 5 issues identified by women.[53] And the 2017 Survey identified cancer, and mental health in the top 5 health issues for women.[54]

In a recent report by WCHM about younger ACT women (18-50 years old) with chronic conditions a large proportion of the 161 women reported having mental health conditions

[49] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia* survey 2017, pp. 25.
[50] Australian Institute of Health and Welfare, *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178, Canberra, 2014.
[51] Australian Institute of Health and Welfare. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra, 2016.
[52] Jean Hailes for Women's Health, *What do women need to know? Women's health information needs in Australia survey* 2015, Melbourne, 2015, pp. 3.
[53] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia survey, Melbourne* 2016, pp. 10.
[54] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia survey, Melbourne, 2017*, pp. 25.

(40%), auto-immune diseases (39%), musculoskeletal conditions (39%) and endocrine disorders (29%).[55]

Research shows that Australian women are more likely than men to experience coexisting mental and physical illness, and are 1.6 times more likely than men to experience multimorbidities. People with chronic conditions are also two to three times more likely than the general population to experience a mental health condition.[56]

Mental illness is also seen to contribute to the development of physical conditions. A link has been found between depression and heart disease, the leading cause of premature death for women, with people with mental illness aged between 25 and 44 six times more likely to experience cardiovascular mortality than the general population.[57]

WCHM found that younger ACT women who had more than one chronic disease were more likely to have a multi-morbid mental health condition (57%), and those with four diseases or more had the largest percentage of mental health multi-morbidity (65%).[58]

Ongoing, persistent pain is a key characteristic of many chronic conditions and has been seen to significantly impact the ability of individuals to live productive lives. Women report more pain related conditions than men with research showing women experience greater pain sensitivity.[59] Evidence also suggests women are less likely to have their pain taken seriously and instead "their request for diagnosis and treatment are ignored, disregarded and rejected."[60] [61] As symptoms more commonly experienced by women, such as pain or anxiety, are invisible, women are often accused of faking or exaggerating symptoms, inhibiting their ability to access accurate, quality treatment.[62] In a healthcare context, women must prove they are as sick as a man to receive the same level of treatment.[63] Many studies have demonstrated women experiencing chronic pain conditions report negative experiences with health professionals.

In WCHM's 2018 research, close to half of the younger women surveyed mentioned pain as a symptom of their chronic condition.[64]

Mental health

Mental illness is a widespread and significant public health issue in the ACT, and throughout Australia. It is a chronic disease in itself, and people who report receiving a mental health

[55] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease,* WCHM, Canberra, 2018.
[56] Australian Health Policy Collaboration, *Joining up Physical and Mental Health: The case for a new approach in policies and services,* Victoria, pp. 2, retrieved on the 9th of August 2017; https://www.vu.edu.au/sites/default/files/AHPC/pdfs/opinion-piece-joining-up-physical-mental-health.pdf
[57] Ibid, pp. 3
[58] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease,* WCHM, Canberra, 2018.
[59] D E Hoffmann & A J Tarzian, 'The girl who cried pain: A bias against women in the treatment of pain', *Journal of Law, Medicine & Ethics,* vol. 29, 2001, 13-27.
[60] E E Johansson et al., '"I've been crying my way" -qualitative analysis of a group of female patients' consultation experiences', *Family Practice*, vol.13, no. 6, 1996, pp. 498-503.
[61] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, WHCM, Canberra, 2018.
[62] D E Hoffmann & A J Tarzian, 'The girl who cried pain: A bias against women in the treatment of pain', *Journal of Law, Medicine & Ethics,* vol. 29, 2001, 13-27.
[63] B Healy, 'The Yentl Syndrome', *The New England Journal of Medicine*, vol. 325, 1991, pp. 274.
[64] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease*, WHCM, Canberra, 2018.

diagnosis were more likely to report several risky behaviours that could contribute to other chronic diseases as well.[65]

Women's mental health needs are significantly different from those of men and require different responses.[66] Evidence shows that certain mental illnesses are more prevalent in women, that women use mental health services more frequently than men, and that women would like a broader range of treatment options than are available currently.

Literature demonstrates that Australian women are more likely than male counterparts to experience mental health conditions such as:

- Anxiety disorders (18%)
- Affective disorders such as depression (7%)
- Eating disorders (15% of young women reported experiencing an eating disorder at some point in their life and it is the third most common chronic disease for this sub group of the population.)
- Deliberate self-harm – females report higher rates of hospitalisations due to self-harm across age groups.[67]

Women face a greater likelihood of experiencing mental illness comorbidities with depression and anxiety being the most common illnesses to coexist.[68]

According to a report to the Council of Australian Governments in 2013,[69] women were more likely to report significantly higher levels of high/very high psychological distress than men, and a significantly higher proportion of women than men reported high/very high levels of psychological distress in all age groups between 24 and 74 years. The proportion of women who reported high/very high psychological distress levels was generally consistent across all jurisdictions, with 11.0% in the ACT compared to the highest of 13.6% in Queensland.

Women with mental disorders were also more likely than men to use GP mental health services, and there were some significant differences in the mental health services used by men and women. [70]

Seventeen per cent of adults surveyed for the *ACT General Health Survey* reported having been diagnosed with a mental health disorder in the preceding 12 months, and more females (22%) reported receiving a mental health diagnosis compared with males (13%).[71]

Psychological distress has been shown to decrease with age in research published from the *Australian Longitudinal Study on Women's Health*.[72] Literature has also linked positive outlooks of health in older adults to a difference in health expectations and understandings of

[65] ACT Health, *Healthy Canberra, Australian Capital Territory Chief Health Officer's Report*, Canberra, 2016.
[66] M Duggan, *Investing in Women's Mental Health. Strengthening the foundations for women, families and the Australian economy*. Australian Health Policy Collaboration Issues Paper No. 2016-02. Australian Health Policy Collaboration, Melbourne, 2016
[67] M Duggan, *Investing in Women's Mental Health. Strengthening the foundations for women, families and the Australian economy*. Australian Health Policy Collaboration Issues Paper No. 2016-02. Australian Health Policy Collaboration, Melbourne, 2016
[68] World Health Organisation, *Mental Health Action Plan 2013-2020,* Geneva, 2013, pp. 3.
[69] COAG Reform Council 2013, *Tracking equity: Comparing outcomes for women and girls across Australia*, COAG Reform Council, Sydney.
[70] Ibid.
[71] ACT Health, *Healthy Canberra, Australian Capital Territory Chief Health Officer's Report*, Canberra, 2016.
[72] Women's Health Australia, *Australian Longitudinal Study on Women's Health: Annual Report 2016*, Newcastle, retrieved on the 12th of July 2017; https://www.alswh.org.au/images/content/pdf/annual_reports/2016AnnualReport.pdf

health.[73] This is particularly true for mental health with evidence demonstrating that older cohorts tend to have different perceptions of mental health caused by changing cultural, social and educational factors.[74]

In the 2008 survey by WCHM on health and wellbeing issues for women in the ACT the major mental health and wellbeing issues reported were depression, stress and anxiety.[75]

Findings from the *2015 Jean Hailes Women's Health Survey* found that mental health was the third biggest health concern for Australian women; [76] and the 2016 Survey found that mental and emotional health was the top issue identified by women[77].

Forty per cent of the women respondents in WCHM's 2018 research on chronic conditions in younger ACT women reported having a mental health condition, and of those 86% reported that they also had a physical health condition. [78]

In Australia, mental health conditions are the leading cause of non-fatal illness for women with 43% (3.5 million) experiencing a mental health condition at some point in their lives. The Australian Longitudinal Study on Women's Health predicts the number of women aged 20-90 who experience psychological distress will increase from 1.2 million to 1.7 million from 2015 to 2035.[79]

Some researchers have associated the increased prevalence of mental illness with an improved ability of health professionals to recognise and diagnose issues of mental health, with the definition of mental illness broadening and treatment options increasing as the field of mental health becomes better understood.[80] But the decline in the mental health of women has also been attributed to the erosion of social connection and civic engagement, interpersonal trust and financial security.[81]

Recent research on the experience of women has linked improved mood and positivity as women transition from midlife to late life and having more time for themselves as they transition from full time work and family responsibilities reduce as children grow up.[82]

Weight, diet and fitness

Findings from the *Jean Hailes Women's Health Survey* in 2015 showed that healthy living was the largest concern for Australian women, including issues of weight, diet and physical

[73] J D Frence, K Sargent-Cox and M A Luszcz,' Correlates of Subjective Health Across the Aging Lifespan: Understanding Self-Rated Health in the Oldest Old', *Journal of Health and Ageing, vol.* 24, no. 8, 2012, pp.1462.
[74] E L Idler, 'Age Differences in Self Assessments of Health: Age Changes, Cohort Differences, or Survivorship', *Journal of Gerontology, vol.* 48, no. 6, 1993, pp. 291.
[75] Women's Centre for Health Matters, *Health and Wellbeing Issues for Women in the Australian Capital Territory*, Canberra, 2008, pp. 4.
[76] Jean Hailes for Women's Health, *What do women need to know? Women's health information needs in Australia survey, Melbourne, 2015, pp.* 9.
[77] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia survey, Melbourne, 2016, pp.* 10.
[78] A Hutchison, *"I don't have the spoons for that…" The views and experiences of younger ACT women (aged 18 to 50 years) about accessing supports and services for chronic disease,* WCHM, Canberra, 2018.
[79] G Mishra, et al, *Future health service use and cost: Insights from the Australian Longitudinal Study on Women's Health*, Newcastle, 2016, pp. 1, retrieved on the 8th of June 2017, http://www.alswh.org.au/images/content/pdf/major_reports/Major%20Report%20K_final_20160914.pdf.
[80] H Hafner, "Are Mental Disorders Increasing over Time, *Psychopathology*, vol. 18, no. 2, 1985, pp. 70.
[81] C M Herbst, 'Paradoxical' decline? Another look at the relative reduction in female happiness', *Journal of Economic Psychology,* vol. 32, no. 5, 2011, pp. 774.
[82] K E Campbell, L Dennerstein, M Tracey and C E Szoeke. 'The trajectory of negative mood and depressive symptoms over two decades', *Maturitas,* vol. 95, 2017, pp. 38.

activity.[83] *The Jean Hailes Women's Health Survey of 2016* identified the top health concern for women as weight management (specifically weight gain). [84]

Fifty six percent of women in the ACT were reported as overweight or obese.[85] In 2011 it was reported that only 65% of women aged 18-24 years old and 49% of 25+ year old's were participating in the recommended physical activity amount.[86]

A study conducted in 2011 with primarily female participants concluded that weight self-stigma influenced by BMI contributed to experiential avoidance and impacted negatively on measures of health rated quality of life.[87]

Weight stigma in society and the media places pressure on women to maintain an ideal body type, and contributes to negative thinking and body dissatisfaction. In the 2017 *Australian Longitudinal Study on Women's Health*, 25% of women with a normal BMI were dissatisfied with their body shape or weight, and two thirds of women who identified as overweight or obese were unhappy with their weight.[88]

This stigma may have implications for the mental and physical health of Australian women. A five-year longitudinal study conducted on adolescents found that both males and females were more likely to engage in unhealthy weight control behaviours, dieting, binge eating, low levels of physical activity and low fruit and vegetable intake if they had low body satisfaction.[89]

Another study conducted in depth interviews with young women and found they faced considerable scrutiny around issues of weight issues and appearance.[90] Women's distorted perception of their own body and cultural expectations were determined to be negative factors influencing wellbeing and lifestyle change. Researchers concluded that a more relaxed focus on issues of weight and appearance was needed to be effective when addressing weight and lifestyle change in young women.[91]

Weight also has implications in healthcare settings, as there is some evidence to suggest that overweight people avoid preventative care. A study of 498 overweight and obese women in America indicated that 68% reported delaying seeking health care because of their weight and 83% reported that their weight was a barrier to receiving appropriate health care.[92] Causes of delays in treatment seeking included mistreatment by health professionals resulting from

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[83] Jean Hailes for Women's Health., *What do women need to know? Women's health information needs in Australia survey,* Melbourne, 2015, pp. 9.
[84] Jean Hailes for Women's Health., *Understanding health information needs and health behaviours of women in Australia survey,* Melbourne, 2016, pp. 10.
[85] D White, ACT has among the highest rates of obese or overweight adults of city areas, Canberra Times, Canberra, 2017, retrieved on the 1st of march 2018; http://www.canberratimes.com.au/act-news/act-has-among-the-highest-rates-of-obese-or-overweight-adults-of-city-areas-20171123-gzrjna.html
[86] ACT Health, Health status of young people in the ACT, Canberra, 2011, retrieved on the 23rd of November 2017; http://stats.health.act.gov.au/sites/default/files/Health%20Series%20No%2053%20-%20Health%20status%20of%20young%20people_in_the_ACT.PDF
[87] J Lillis, M E Levin and S C Hayes, 'Exploring the relationship between body mass index and health-rated quality of life: A pilot study of the impact of weight self-stigma and experiential avoidance.' *Journal of Health Psychology,* vol. 16, no. 5, 2011, pp. 724.
[88] R Lauche, D Sbbritt, T Ostermann, N R Fuller, J Adams & H Cramer. 'Associations between yoga/meditation use, body satisfaction, and weight management mentions: Results of a national cross-sectional survey of 8009 Australian women. *Nutrition,* vol. 34, 2017, pp. 58.
[89] D Neumark-Szatain, S J Paxton, P J Hannan, J Haines and M Story, 'Does Body Satisfaction? Five-year Longitudinal Associations between Body Satisfaction and Health Behaviours in Adolescent Females and Males', *Journal of Adolescent Health*, vol. 39, no. 2, 2006, pp. 244.
[90] A Sand, N Emaus, O Lian 'Overweight and obesity in young adult women: A matter of health or appearance? The Troms? Study: Fit futures', *International Journal of Qualitative Studies on Health and Well-Being,* vol. 10, 2015, pp. 10.
[91] Ibid.
[92] N K Amy, A Aalborg, P Lyons, L Keranen, 'Barriers to routine gynaecological cancer screening for White and African-American obese women' *International Journal of Obesity*, vol. 30, no. 1, 2006, pp. 147–155.

negative and disrespectful attitudes and behaviours; and embarrassment resulting from experiences of being weighed, and receiving unsolicited advice on weight.[93]

Barriers to addressing health issues

Access to health care, particularly primary health care such as GPs and other health care providers, is extremely important to good health for women, especially in relation to prevention, early detection and treatment of illness, as well as management of chronic conditions. Timely access to appropriate health care can also decrease burden on other parts of the health system and potentially prevent hospitalisations.

The 2008 survey of 180 women by WCHM on health and wellbeing issues for women in the ACT found that women in the ACT experienced a number of barriers to acting on their health and wellbeing issues.[94] These included: affordability of treatment; long waiting lists for appointments; difficulties with transport; not having enough time to take action; not knowing where to get help; and not seeing the issue as a health priority.[95] Women felt that their interactions with health practitioners would improve if the practitioners improved their communication skills, increased their use of accredited interpreters, provided greater access to relevant health information, improved scheduling and waiting times and improved access to bulk billing.[96]

In 2009, the Health Care Consumers Association of the ACT ran an online survey - *GP Snapshot 2009*- which identified that cost was the major barrier to primary health care, which related to the low rate of bulk-billing by ACT GPs, and the subsequent high out of pocket costs. Other barriers included:

- Long waiting times to get an appointment and delays of up to one hour after the allotted time to see the GP;
- Limited public transport to many primary health care services, coordination and timing of public transport and the time taken to travel to the GP by public transport; and
- That standard (ten-minute) GP consultations were not long enough to deal with. [97]

A 2010 *It goes with the Territory* report produced by WCHM identified that many women felt rushed during a consultation and unable to request the information they needed from GPs.[98] Some women reported limiting their consultation time to prevent "taking up too much of their doctor's time when other patients were waiting to be seen".[99]

The *ACT General Health Survey 2010* found that overall, 21.1% of people believed there were inadequacies in the health services in their local area, and the most common difficulties in accessing services were waiting times to see a GP (14%), obtaining access to specialist

[93] R M Puhl and C A Heuer, 'Obesity Stigma: Important Considerations for Public', American Journal of Public Health, vol. 100, no. 6, 2010, pp. 1019-1028.
[94] Women's Centre for Health Matters, *Health and Wellbeing Issues for Women in the Australian Capital Territory*, Canberra, 2008, pp. 4.
[95] Ibid., pp. 5.
[96] Ibid., pp. 5.
[97] Health Care Consumers Association of the ACT, *Submission to GP Task Force,* Canberra, 2009.
[98] A Carnovale and E Carr*, It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 47.
[99] C Wathen & R Harris, "'I Try to Take Care of It Myself.' How Rural Women Search for Health Information." *Qualitative Health Research*, vol. 17, no. 5, 2007, pp. 639–651.

services (3.2%), cost of healthcare services (2.8%) and shortages of GPs in the area (2.3%). In terms of barriers to health care use, 21% of respondents reported delaying using a health service because they couldn't afford it, and 6.7% reported that they were unable to get to the health service. [100]

In 2015, a large national survey conducted by Jean Hailes for Women's Health surveyed 3,325 women of all ages, cultures and backgrounds, and found that Australian women face many barriers to accessing health information and services, with the biggest barriers identified as time, motivation and cost. Other prohibitive factors included self-esteem, insufficient knowledge of health promoting practices, inadequate specific relevant information, unsupportive partners, and a lack of childcare.[101]

The *Australian Bureau of Statistics (ABS) Patient Experience Survey* which collects data on access and barriers to a range of health care services in the previous 12 months, found that in 2015-16 for females aged 15 and over:

- Over 1 in 5 (21%) waited longer than they felt acceptable to get an appointment with a GP;
- Over 1 in 20 (5%) delayed seeing, or did not see, a GP when needed due to cost reasons at least once in the past 12 months; and
- Almost 1 in 10 (9%) delayed getting, or did not get prescribed medication, due to cost.[102]

The survey also found that:

- One in twelve people (8%) who needed to see a medical specialist delayed or did not go because of the cost;
- One in five (19%) people who needed to see a dental professional delayed or did not go because of the cost;
- 19% of people who saw a GP waited longer than they felt acceptable to get an appointment with a GP; and
- Around one in four (23%) people who saw a medical specialist waited longer than they felt acceptable to get an appointment.[103]

The most recent Report on Government Health Services in 2017 identified that:

- GP numbers in the ACT were the lowest of all states and territories, recording 73 per 100,000 people;
- Sixty per cent of ACT patients waiting to have an urgent appointment, waited longer than four hours for a GP compared to the national average which was only 36%;Bulk-billing rates in the ACT were 60%, and below the nation's 85% average;
- Eight per cent of people deferring visits to GPs due to financial barriers; and

[100] *Australian Capital Territory Chief Health Officer's Report 2010*. Australian Capital Territory, Canberra, 2010.
[101] Jean Hailes for Women's Health., *What do women need to know? Women's health information needs in Australia* survey, Melbourne, 2015, pp. 19.
[102] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.
[103] Ibid.

- Patients in the ACT were less satisfied with their GPs with 90% of people believing that their doctor always or often listened to them carefully (the second lowest figure among states and territories). [104]

Affordability

Affordability of healthcare services is a barrier for a significantly higher proportion of women than men, and women are more likely than men to find cost a barrier when accessing GP services.[105]

Women deferred access to a range of health services because of cost, at a significantly higher rate than men—including dentists (24%), prescriptions (11%), specialists (11%) and GPs (9%).

The ACT has the lowest rates of bulk billing in Australia. The proportion of health professionals who bulk bill in the ACT was reported to be 60% compared to 85% in the rest of Australia, with children under 16 and older people being the main ones who were bulk billed.[106]

In 2009-10 families in the ACT also spent an average $554 per household on specialist and consultant specialist consultations. This was the highest in the country with the Australia-wide average being $325 and Tasmanians only spending an average of $125 per household.[107] This reflects the fact that the ACT has the highest median fees for specialist services.[108]

The 2010 '*It goes with the Territory'* report produced by WCHM identified that one of the biggest barriers inhibiting ACT women from accessing information from primary care services such as GPs was affordability. Forty per cent of participants identified that the high cost of seeing a GP was a barrier to accessing a GP and 20% noted that not being able to find a GP who bulk billed limited their access.[109]

Statistics from 2015-16 show that in Canberra 8% of people had deferred going to see a GP in the previous 12 months because of financial constraints, compared to the national average of 4%. And 8% of ACT residents also delayed filling a prescription because of cost and 16% delayed a visit to the dentist.[110]

Waiting times and lack of appointments

In 2010, 52% (n=316) of ACT women responding to a WCHM consultation survey identified that the most significant barrier to accessing GPs was difficulties getting in to see a GP due to

[104] Australian Government Productivity Commission, Report on Government Services 2017, Canberra, 2017, retrieved on the 26th of February 2018; https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/primary-and-community-health,
[105] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.
[106] Australian Government Productivity Commission, Report on Government Services 2017, Canberra, 2017, retrieved on the 26th of February 2018; https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/primary-and-community-health,
[107] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.
[108] G L Freed & A R Allen, 'Variation in outpatient consultant physician fees in Australia by speciality and state and territory', *MJA*, *vol.* 206, no. 4, 2017, pp. 178.
[109] A Carnovale and E Carr*, It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 47.
[110] Australian Government Productivity Commission, Report on Government Services 2017, Canberra, 2017, retrieved on the 26th of February 2018; https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/primary-and-community-health

waiting times. For the women respondents who reported that they did not see a GP, 40% identified not being able to find a GP taking new patients as a key barrier.[111]

Sixty per cent of ACT patients waiting to have an urgent appointment, waited longer than four hours for a GP compared to the national average which was only 36%.[112]

Time poverty and time Constraints

Insufficient time due to work and caring responsibilities is the most common reason provided by women for not seeking information to maintain or improve their health and wellbeing.[113]

The literature shows that women's lack of time impacts upon their health and wellbeing. Many women lack sufficient time to make their health and wellbeing a priority, and lack the choice to organise their time differently because of work and caring responsibilities.[114]

Time constraints often mean that health information is delivered as a one-way factual transfer from health professionals to clients., rather than a two-way dialogue. Helping women to develop their health literacy by increasing consultation time to ensure they can access, understand, and use quality health information, is a better long-term approach.[115]

Lack of continuity of care

Continuity of care is important, and is often used to describe the personal relationship between a patient and their GP. If a GP has a good previous knowledge of the patient it makes the disclosure of issues easier.

Mental healthcare literature emphasises coordination of services and the stability of patient-provider relationships over time. Unlike primary care, the relationship is typically established with a team rather than a single provider. Care provided by different professionals is coordinated through a common purpose and plan.[116]

Continuity of care is also important across the health system to manage chronic conditions and patients with a health care plan which is used by all health care providers have been shown to have better health outcomes.[117]

The integration of services and coordination are often used to describe continuity, but continuity is about the individual and how they experience the integration of services and coordination. In addition. Continuity includes "informational continuity" (Information links care from one provider to another and from one health issue to another); "management continuity" (where health issues require management from several providers and need to be delivered in

[111] Australian Government Productivity Commission, Report on Government Services 2017, Canberra, 2017, retrieved on the 26th of February 2018; https://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/primary-and-community-health
[112] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.
[113] E Kontos, G Bennett & K Viswanath, 'Barriers and Facilitators to Home Computer and Internet Use Among Urban Novice Computer Users of Low Socioeconomic Position' *Journal of Medical Internet Research*, vol. 9, no. 4, 2007, pp. e31.
[114] Ibid.
[115] R Adams et al. 'Health literacy: A new concept for general practice?' *Australian Family Physician*, vol. 38, no. 3, 2009, pp.144–147.
[116] R Tessler, G Willis & G D Gubman, 'Defining and measuring continuity of care. Journal of *Psychsocial Rehabilitation,* vol. 10, 1986, pp. 27-38.
[117] R Raivio et al, 'Decreasing trends in patient satisfaction, accessibility and continuity of care in Finnish primary health care - a 14-year follow-up questionnaire study', *BMC Family Practice*, vol. 15, no. 98, 2014, pp. 1-7.

a complementary and timely manner); and "relational continuity" (links past and current care but as well as future care). [118]

The experience of continuity by patients should be that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future. For providers, the experience of continuity should be that they have sufficient knowledge and information about a patient to support them and that they know other providers will act on this.[119]

An Australian national public consultation process revealed that patients often experience: a fragmented system, with providers and services working in isolation from each other rather than as a team; and uncoordinated care.[120]

The *ABS Patient Experience Survey 2016-17* found that one in six people (17%) saw three or more health professionals for the same condition. Among those who saw three or more health professionals for the same condition, 12% reported that there were issues caused by a lack of communication between the health professionals. [121]

Accessibility

Accessibility of health care services is important to meeting individual health care needs. 'Access' can be defined as the opportunity to identify health care needs, to seek health care, to reach, obtain or use health care services, and to have the need for services fulfilled. [122]

Improving access is more than targeting specific groups and managing affordability and workforce availability – it is about patient ability to access health care services, and overcoming other barriers to access.

Levesque et al identified a framework of accessibility which included: approachability; acceptability; availability and accommodation; affordability; and appropriateness. They also identified five abilities of populations to interact with accessibility to generate access: ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage.[123]

Facilitating access to appropriate health care is complex. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. But gaining access also depends on financial, organisational and social or cultural barriers that can limit the utilisation of services. Access is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply.[124]

[118] J L Haggerty et al. 'Continuity of care: a multidisciplinary review', *British Medical Journal*, vol. 327 no. 22, 2003, pp 1219-1221.
[119] Ibid.
[120] Primary Health Care Advisory Group, *Final Report Better Outcomes for People with Chronic and Complex Health Conditions,* Department of Health, Canberra, 2016, pp. 11.
[121] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.
[122] J F Levesque, M F Harris, G Russell G, 'Patient-centred access to health care: conceptualising access at the interface of health systems and populations', *International Journal of Equity Health*, vol. 12, no. 18, 2013, pp. 1-9.
[123] Ibid.
[124] Ibid.

Transport

Transport is an access issue in the ACT, with coordination and timing of public transport to primary health care services difficult, especially if there are additional difficulties such as limited mobility, or travelling with children, especially sick children. The time taken to travel to the GP, especially by public transport, can be both lengthy and difficult, in particular at night or at weekends. This is accentuated where the travel involves a sick child.[125]

Treatment by health professionals

The way a patient is treated by a health professional is an important aspect of their satisfaction with their care.

A 1996 report by Dorothy Broom '*There should be more!*' found that 50% of women had concerns about their most recent health consultation. They felt health professionals had not been thorough, informative or sympathetic.[126]

The WCHM 2010 *It goes with the Territory!* report identified that younger women reported feeling misunderstood and having their health issues disregarded and marginalised by health professionals. Research participants also noted a medically orientated system focus that lacked holistic personalised care.[127]

In the *2016-17 Patient Experiences survey*, all respondents who had seen a GP were asked for their perceptions on how they were treated by the GPs.[128] Of those who saw a GP in the last 12 months, 75% reported that the GP always listened carefully to them, 81% reported that they always showed them respect and 76% reported that they always spent enough time with them. Males were more likely than females to report that the GP always listened carefully to them (77% compared with 73%), always showed them respect (82% compared with 80%), and always spent enough time with them (78% compared with 75%).

Health promotion messages

There has been a shift in recent policy direction towards prevention and early intervention, and messages from health professionals and the health system about the importance of individual health behaviour to avoid chronic diseases through managing health risks. This focus on individual responsibility to act on and avoid health risks implies that individuals are able to control their actions.

For example, the 2007 Foresight Report on obesity identified that simple solutions such as targeting obese individuals with messages about eating less and moving more is only a small part of the solution. Obesity has to be seen as a result of an interrelationship of factors (e.g.

[125] Health Care Consumers Association of the ACT, *Submission to GP Task Force,* Canberra, *2009.*
[126] D H Broom, *There should be more! Women's use of community health centres*, National Centre for Epidemiology and Population Health, Australian National University, Canberra, 1996, pp. 17.
[127] A Carnovale and E Carr*, It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 47.
[128] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.

power relationships, poverty, employment). If responses are too narrow, focusing on individual lifestyle, the outcome will be failure.[129]

Walls et al shows that social marketing campaigns that focus on addressing obesity by telling people to lose weight are unsuccessful. Walls et al goes on to propose that campaigns should focus on improvement of health behaviours such as physical activity and healthy eating.[130] The Marmot review working committee discussed government responses to obesity as 'lifestyle drift'. 'Lifestyle drift' is the emphasis that public health policies and programs put on individual behaviour, such as diet and exercise, while ignoring what is actually causing these behaviours.[131] Marmot and Allen write in their paper *Social Determinants of Health Equity* that we need a social determinants approach to tackle obesity, where governments focus on the building health equities rather than focus on individuals. [132]

A review by Deborah Lupton from the University of Canberra showed that people have the knowledge of what to do when it comes to weight management but have not been able to make necessary changes to their behaviour. Researchers in the field of sociological qualitative research have found that there are many reasons why people have not made healthy changes in response to health campaigns focussed on "anti-obesity" and using "obesity epidemic" messaging. Identified barriers to weight management include lack of money and time and prioritising emotional wellbeing. Often public health campaigns do not take into consideration a person's life reality and therefore people become resistant to the messaging, they are also often disengage due to constant changing opinions of health professionals and expert advice.[133]

While an individual's health and health behaviours are influenced by knowledge and "willpower", women's actions can also be impacted by their roles and the social determinants of their life. In a study of midlife women's views of health and health behaviour women described how their awareness of health and health behaviours, as well as their ability to engage in such behaviours, changed over the life course, and while they had a history of healthy eating and exercise, their perceptions of health and healthy behaviour at midlife contradicted that history.[134] Often women felt guilt that they were not doing enough for their own health. They were constantly reminded that "health is fragile and at risk" by media, friends and family and that there were consequences of not putting enough work in. [135]

A review of literature about the factors that prevent older women with chronic conditions from engaging in healthy lifestyle activities found personal barriers such as "feeling what I do

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[129] K McPherson, T Marsh & M Brown, *Foresight. Tackling obesity: future choices – Modelling future trends in obesity & their impact on health*, Government Office for Science, UK, 2007, retrieved on the 13th of December 2017 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287943/07-1469x-tackling-obesities-future-choices-summary.pdf
[130] H L Walls et al, 'Public health campaigns and obesity – a critique', BMC Public Health, 2011, vol. 11, no. 136, pp. 1-7.
[131] D J Hunter et al., *Learning Lessons from the Past: Shaping a Different Future,* Marmot Review Working Committee 3 Cross-cutting sub-group report, UK, 2009, retrieved on the 2nd of March 2018; http://www.instituteofhealthequity.org/resources-reports/the-marmot-review-working-committee-3-report/the-marmot-review-working-committee-3-report.pdf
[132] M Marmot & J J Allen, 'Social Determinants of health equity', *American Journal of Public Health*, vol. 104, no. 4, pp. 517-519.
[133] D Lupton, '"How do you measure up?" Assumptions about "obesity" and health-related behaviors and beliefs in two Australian "obesity" prevention campaigns' *Fat Studies*, vol. 3, no. 1, 2014, pp. 32-44.
[134] K Smith-DiJulio & C Windsor & D Anderson, 'The Shaping of Midlife Women's Views of Health and Health Behaviors,' *Qualitative Health Research,* vol. 20, no. 7, 2010, pp. 966-76
[135] K Smith-DiJulio & C Windsor & D Anderson, 'The Shaping of Midlife Women's Views of Health and Health Behaviors,' *Qualitative Health Research,* vol. 20, no. 7, 2010, pp. 966-76

doesn't help" and "embarrassed about appearance" were ranked highly. The research went on to point out that financial hardship and poor support from family and friends were reported to reduce older women's ability to carry out healthy lifestyle activities. In addition, older women also listed barriers such as poor weather conditions, infrastructure and lack of transportation. Other women needed more support from health professionals to manage health behaviours.[136]

Australian research on positive body image and health found that women in their 60s appear more accepting of health and bodily changes.[137] Researchers found that these women have a more "positive view of their well-being" than 50 year old women. Even with this very small age gap of 10 years, their research shows women are different across different ages and therefore lifestyle programs need to target age groups differently. The research showed that women in their 50s were "physically able" although needed support with age related changes to their health and body. Counter to that women in their 60s were more accepting of changes but may need "great physical assistance." They also suggested that "since most women preferred making dietary changes to exercising more, perhaps lifestyle modification programs need to start with dietary changes and encourage women to be more active as a second stage".[138]

What health services do ACT women use?

Women's access to and satisfaction with health care services and information allows them to maintain their health and wellbeing.

In WCHM's 2008 report, the most consulted professional on physical health, mental health, and general health and wellbeing were GPs (86% of respondents); dentists (52%); specialists (49%); and alternative therapies professionals (30%).[139]

In WCHM's 2010 consultation with ACT women[140], 83% of respondents reported that they were most likely to obtain health and wellbeing information from their GP. This was followed closely by the internet for 58% of respondents; pharmacists for 34%; family members and friends for 26%; allied health professionals for 20%, paper based publications for 18%; alternative therapists for 18%; and telephone helplines for 12%.

In Australia, women are more frequent users of the health system, and annual Medicare statistics for 2016 show that 9 in 10 females reported visiting a GP in the previous 12 months. [141] And women are more likely than men to see a GP (88% compared with 76%).[142]

Allied health practitioners work with individual patients/consumers, treating (and sometimes diagnosing) a wide range of health conditions, particularly chronic illnesses. An analysis of

[136] A M McGuire, D J Anderson & P Fulbrook*, 'Perceived barriers to healthy lifestyle activities in midlife and older Australian women with type 2 diabetes', Collegian*, vol. 21, no. 4, 2014, pp. 301 – 310.
[137] R L Anderson, D J Anderson & C P Hurst, 'Modeling factos that influence exercise and dietary change among midlife Australian women: results from the healthy aging of women study', *Maturitas*, vol. 67, no. 2, 2010, pp. 151-8.
[138] R L Anderson, D J Anderson & C P Hurst, 'Modeling factos that influence exercise and dietary change among midlife Australian women: results from the healthy aging of women study', *Maturitas*, vol. 67, no. 2, 2010, pp. 151-8.
[139] Women's Centre for Health Matters, *Health and Wellbeing Issues for Women in the Australian Capital Territory*, Canberra, 2008, pp. 4.
[140] A Carnovale and E Carr*, It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010.
[141] Australian Bureau of Statistics, *Health Service Usage and Health Related Actions, Australia, 2014–15.* ABS cat. no. 4364.0.55.002. Canberra, 2017.
[142] Australian Bureau of Statistics, *Patient Experiences in Australia: Summary of findings, 2015–16*. ABS cat. no. 4839.0. Canberra, 2016.

2007–2008 National Health Survey data revealed that 24% of people had visited a physiotherapist, chiropractor, podiatrist, or dietitian the previous year. Women were more likely than men to access these AHPs, particularly in older age-groups; the difference was primarily accounted for by podiatrist services.[143]

Women also access a range of other medical services more than men:

- Thirty six per cent of people saw a medical specialist in the previous 12 months, and women were more likely than men to see a medical specialist (40% compared with 33%);
- Forty eight per cent of people saw a dental professional in the previous 12 months, and women were more likely than males to see a dental professional (52% compared with 44%);
- Eight per cent of people saw an after hours GP service in the previous 12 months, and women were more likely than men (9.7% compared to 6.3%); and
- Fourteen per cent of people had visited an Emergency Department for their own health in the previous 12 months, with women more likely than men (15% compared with 13%).[144]

The ACT has experienced GP shortages, which impacts on access to services. While there have been a range of strategies developed to attract more GPs to the ACT,[145] different models of care have been developed in response to this shortage, including the introduction of a nurse-led primary care Walk-in Centre in the ACT in May 2010. The intent of the nurse-led primary care ACT Walk-in Centre was to complement, not replace, other primary care services,[146] and was modelled on the WiC in the UK which had been the subject of a national evaluation. [147]

With respect to the UK, Salisbury et al found that WiCs for many patients are an additional, rather than alternative, service and convenience was a key factor in their decision to attend a walk-in centre.[148]

The main reasons that respondents in the ACT used the original WiC rather than going elsewhere was because it was quicker than getting an appointment with their GP (59%) and/or they perceived they would encounter a shorter wait than going to the Emergency Department (39%). Other reasons included convenient opening hours (39%); cheaper than getting an

[143] M M Foster, 'Does Enhanced Primary Care enhance primary care? Policy-induced dilemmas for allied health professionals', *MJA*, vol. 188, no. 1, 2008, pp. 29-32.
[144] Ibid.
[145] J Thistlethwaite et al. *Attracting health professionals into primary health care: Strategies for recruitment*, Australian Primary Health Care Research Institute, Canberra, 2007.
[146] ACT Health, *Walk-in Centres in the Australian Capital Territory*, ACT Health, Canberra, 2008.
[147] C Salisbury et al. *The National Evaluation of NHS Walk-in Centres Final Report*, University of Bristol, Bristol, 2002.
[148] C Salisbury et al. 'Questionnaire survey of users of NHS walk-in centres: observational study', *British Journal of General Practice,* vol. 52, 2002, pp. 554-560.

appointment at the GP (32%); and convenient location (31%). Ten per cent cited their reason as they didn't have a GP.[149]

In the UK, most people attending WiCs attended very soon after their problem began, few had already consulted another health professional, most were given only advice and information, and few were referred to another health agency. A significant minority of those consulting in a walk-in centre intended to make an appointment with their doctor following the consultation. Most visitors to WiCs claimed that they would otherwise have attended a general practice or accident and emergency department and there is little evidence from this survey that WiCs were duplicating care already provided elsewhere. WiC users appear very satisfied with all aspects of the care they received. Compared with general practice they predominately saw nurses rather than doctors, and had shorter waiting times and longer consultations. These are all factors which have been associated with satisfaction in other settings.[150] [151] [152]

The literature also suggested that the WiCs were important in meeting local community needs particularly at times when other services were not accessible, with data showing that the activity of these centres was higher at evening and weekends than during office hours, which increased patients' accessibility to GPs at times when their own GP was not available.[153]

There is also a growing recognition of the need for responses which focus on educating and supporting patients to manage their own conditions as much as possible, rather than just clinical care.[154] [155] [156]

There is potential for local self help groups to play a role for women, especially given current health system constraints, and GPs having limited opportunity to provide all the information, support and skills management that patients require. Self-help groups can assist people to manage their chronic health issues, by giving support; imparting information; conveying a sense of belonging; communicating experiential knowledge; and teaching coping methods.[157]

By providing "increased emotional and social support, access to an expanded information base, a better understanding of their illness, and a greater sense of confidence and control", they can provide access to support and understanding that may not be available otherwise.[158] This can help an individual to feel more confident and hopeful about managing their health condition and lessen the isolation they might feel. [159] Information received may also encourage

[149] R Parker et al. *Independent evaluation of the nurse-led ACT Health Walk-in Centre*, Australian Primary Health Care Research Institute, Canberra, 2011, pp. 49.
[150] C Salisbury, 'Postal survey of patients' satisfaction with a general practice out of hours cooperative,' *British Medical Journal, vol. 314,* 1997, pp. 1594-1598.
[151] P Venning et al. 'Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care' *BMJ, vol. 320,* 2000, pp.1048-1053
[152] P Kinnersley et al. 'Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting 'same day' consultations in primary care', *British Medical Journal, vol. 320,* 2000, pp. 1043-1048.
[153] Arain et al, 'Patients' experience and satisfaction with GP led walk-in centres in the UK; a cross sectional study', *BMC Health Services Research*, vol.13, no. 142, 2013, pp. 142.
[154] J Epping-Jordan, et al, 'The challenge of chronic conditions: WHO responds, *British Medical Journal*, vol. *323*, 2001, pp. 947-8.
[155] National Public Health Partnership, *Preventing Chronic Disease: A Strategic Framework, Melbourne, 2001, retrieved on the 27th of February 2018; http://www.health.vic.gov.au/archive/archive2014/nphp/publications/strategies/chrondis-bgpaper.pdf.*
[156] J Whelan, 'WHO calls for countries to shift from acute to chronic care', *British Medical Journal*, vol. *324*, 2002, pp. 1237.
[157] L F Kurtz, *Self-Help and Support Groups: A Handbook for Practitioners.* Thousand Oaks: Sage, USA, 1997.
[158] Kay Coppa and Frances M. Boyle (2003), School of Population Health, The University of Queensland. *The role of self-help groups in chronic illness management: A qualitative study.* Australian Journal of Primary Health — Vol. 9, Nos. 2 & 3.
[159] T N Posner & S Momenzadeh, 'An association for people concerned with lymphoedema: the benefits of belonging' *International Journal of Self-Help and Self-Care*, vol. *1*, no. 4, 2000, pp. 341-9.

the better use of available services and community resources and offer practical solutions to problems.[160]

A study in south east Queensland found that people who contacted self help groups are likely to have higher levels of patient activation (knowledge, skills and confidence to manage their chronic condition) than found in the general community.[161]

Online

Many people may be reluctant to talk to their families or friends about their health concerns, and increasingly people are turning to online settings. Online forums can connect people who have shared interests and can be a valuable source of support, particularly for people who feel isolated due to illness or health conditions. Discussing symptoms and treatments, sharing anecdotal accounts or seeking advice and support from others can be important for women, and can encourage feelings of belonging and acceptance.

Who ACT women access services for

Women are more likely to take responsibility for the health of those around them including dependants and parents. With an ageing population and increasing life expectancies, this has implications for women and their interaction with the health system.

WCHM's 2010 consultation with ACT women found that 92% of respondents reported looking for health and wellbeing information for themselves; 53% for their partner, 48% for their children, 30% for their friend for their parents, 26% for their other family members, and 24% for another person in their community.[162]

The 2015 Jean Hailes Women's Health Survey found that women were the primary health information sources and seekers within families.[163]

Women are more likely to take responsibility for the health of dependants and parents with women making up 68% of primary carers and 56% of all carers.[164]

So it is important that women have access to flexible health services that enable them to fulfil their different roles.

Access to health information

People accessing health care look for information regarding all aspects of their health. They seek health information primarily to improve self-management of health and improve their knowledge and understanding. People's attitudes and behaviour are greatly influenced by gender and seeking health information is no different. Women are more active health

[160] R Kessler, K Mickelson & S Zhao, 'Patterns and correlates of self-help group membership in the United States', *Social Policy*, vol. *27*, no. 3, 1997, pp. 27-47.
[161] F M Boyle F.M, T N Posner, C B Del Mar, J Mclean, R A Bush. Self-help organisations: a qualitative study of successful collaboration with general practice''. *Australian Journal of Primary Health, vol 9*, 2003, pp. 75–79.
[162] A Carnovale and E Carr*, It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010.
[163] Jean Hailes for Women's Health, *What do women need to know? Women's health information needs in Australia* survey, Melbourne, 2015.
[164] Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings*, Cat No. 4430.0. ABS, Canberra, 2015.

information seekers then men and differences exist in the way they seek information such as the type of information sought and the differences in sources.[165] [166]

Women are the largest group of health and wellbeing information seekers, obtaining information not only for themselves but also for their partners, children, parents, extended family members, friends and other members of their communities.[167] Women access health and wellbeing information using a variety of sources for a multitude of reasons during their lifespan.[168] [169] They actively seek it using health websites, telephone helplines or health professionals and also passively absorb it from mass media or everyday discussions and interactions.[170]

While some individuals actively seek health information and care, others will live with pain, stress or ill health without seeking adequate information or services.[171] Not seeking out specific information to meet one's needs, relying on passively absorbed information or being a passive patient (less involved or interested in one's health decisions) results in less positive outcomes that can drastically affect a woman's present and future health and wellbeing.[172] [173]

Women experiencing "stigmatised" conditions or symptoms were more likely to search the Internet for health information. The Internet may be an acceptable resource that offers "anonymised" information or support to women and this has important implications for health service providers and public health policy.[174]

Internet usage data from a Canadian survey reported that 57% of people are searching for medical and health information. This was the third-most searched for topic after email and web browsing.[175] Health information was looked for by women more than men (76% versus 56%) and this was similar across age groups. The types of health information that was sought were information on; diseases, prevention and cures (81%), nutrition information (51%), prescription drug information (35%), physical activity (29%), and support group websites (13%).[176]

In an article from the Pew Research Centre, Fallows reported that "women are more likely than men to use the Internet to look for health and medical information and use websites to

[165] A Deeks, C Lombard, J Michelmore & H Teede, 'The effects of gender and age on health related behaviors', *BMC Public Health* 2009, vol. 9, 2009, pp. 213.
[166] V Tong, D K Raynor & P Astani, 'Gender differences in health and medicine information seeking behaviour – A review', Journal of Malta College of Pharmacy Practice, vol. 20, 2014, pp. 14- 16.
[167] A Carnovale and E Carr, *It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010.
[168] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 5-7 & 33-6.
[169] R Wyn & B Solis B, "Women's Health Issues Across the Lifespan", *Women's Health Issues*, vol. 11, no. 3, 2001, pp.148–159.
[170] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 28.
[171] M Mortimer, G Ahlberg, & the MUSIC-Norrtalje Study Group, 'To seek or not to seek? Care-seeking behaviour among people with low-back pain', *Scandinavian Journal of Public Health*, vol. 31, 2003, pp.194–203.
[172] R Brown et al, 'Responding to the active and passive patient: flexibility is the key,' *Health Expectations*, vol. 5, 2002, pp.236–245.
[173] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 7.
[174] I J Rowlands et al, *Seeking Health Information Online: Association with Young Australian Women's Physical, Mental, and Reproductive Health*, Centre for Longitudinal and Life Course Research, School of Public Health, University of Queensland, Brisbane, 2015.
[175] D Crowley, 'Where are we now? Contours of the internet in Canada [Information Deficit: Canadian Solutions 2001], Canadian Journal of Communication, vol. 27, no. 4, 2002, pp. 469-507.
[176] C Marton, *Understanding how women seek health information on the web*, Phd thesis, University of Toronto, 2011.

get support for health or personal problems."[177] [178] In addition, mid-aged women are more likely to use online health related websites compared to other age groups.[179] [180] [181] In other studies, gender has been shown to be one of the strongest and most consistent factors of using the Internet for health information".[182] [183]

International research shows that individuals with reported chronic conditions were more likely to search for health information on the Internet[184] and that self-rated 'good' health is also associated with online health information seeking.[185]

Having access to accurate information has frequently been identified as an important factor to promoting good health. It is a defining characteristic of many health frameworks and health promotion strategies including the *Ottawa Charter for Health Promotion*.[186].

In 2009 the WCHM conducted a study to explore the health information seeking practices and preferences of women in the ACT. They investigated ways women sought information, how they appraised it, and the barriers inhibiting access to information and services. Findings demonstrated that when it came to information seeking the four basic principles of "*available, affordable, accessible and appropriate"* underpinned the wants and needs of women who participated in the research.[187]

Findings from this research indicated that research participants primarily sought information from GPs with 83% of participants accessing a GP to obtain health and wellbeing information. The internet was the second most common method of information seeking with 58% of women utilising this method, then pharmacists 34%, friends and family 26%, and allied health professionals 20%. Interestingly though, when women were asked to specify where they accessed general wellbeing information the Internet was the most popular choice at 56% followed by friends and family members and GPs at 50%, then paper based publications 44%, pharmacist 31%, and mass media 24%.[188]

The survey also identified a number of barriers inhibiting women from accessing health services and information. This included cost, lack of awareness of services available, shortage of health services, limited numbers of female doctors, insufficient culturally appropriate and gender sensitive services, and inadequate availability of holistic care.[189]

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[177] C Marton, understanding how women seek health information on the web, phd thesis, university of Toronto 2011.
[178] D Fallows, *How women and men use the Internet*, Pew Research Center for People and the Press, Washington DC, 2005, retrieved 1st of March 2018; http://www.pewinternet.org/2005/12/28/how-women-and-men-use-the-internet/
[179] S Fox, *Health information online*. Pew Research Center for People and the Press, Washington DC, 2005, retrieved on the 28th of February, 2018; http://www.pewinternet.org/2005/05/17/health-information-online/
[180] Ibid.
[181] S Fox, & D Fallows*, Internet health resources*, Pew Research Center for People and the Press, Washington DC, 2003, retrieved on the 1st of March 2018; http://www.pewinternet.org/2003/07/16/internet-health-resources/
[182] C Marton, understanding how women seek health information on the web, phd thesis, university of Toronto 2011.
[183] R E Rice, 'Influences, usage and outcomes of internet health information searching: Multivariate results from the Pew surveys,' *International Journal of Medical Informatics*, vol. 5, no. 1, 2006, pp. 8–28.
[184] M K Bundorf et al, 'Who searches the Internet for health information?' *Health Services Res, vol 41,* 2006, pp. 819-36.
[185] H K Andreassen et al. 'European citizens' use of e-health services: a study of seven countries,' *BMC Public Health,* vol.7, no. 53, 2007, pp. 1-7.
[186] World Health Organization, 'The Ottawa Charter for Health Promotion', *First International Conference on Health Promotion,* 1986, retrieved on the 28th of June 2017; http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
[187] A Carnovale and E Carr*, It goes with the Territory! ACT Women's views about Health and Wellbeing Information*, WCHM, Canberra, 2010, pp. 51
[188] Ibid pp. 38.
[189] Ibid pp. 6.

The Jean Hailes 2015 What do women want to know? report also identified significant gaps in the information needs of women. Australian women reported their information needs were unmet when it came to recognising symptoms of heart disease, knowing the safety and effectiveness of natural therapies and supplements, understanding factors associated with memory and brain health, distinguishing ovarian cancer symptoms, observing bone health strategies, and knowing how to manage blood pressure. The internet, social media, and companies selling health products were acknowledged as the easiest methods of accessing health information, yet these sources were also recognised as the least trustworthy. Health professionals and independent health organisations were identified as the most trustworthy sources of health information.[190]

In the 2017, *Jean Hailes Women's Health Survey*, health professionals, independent health organisations, government health websites, and health information flyers at medical centres were perceived as the most trustworthy and reliable sources of health information obtained by women, while social media was perceived as the least reliable source for obtaining health information. Age and education significantly influenced the preferred method of accessing health information. Women who were younger or tertiary educated preferred to receive health information through online methods (e.g. health mobile applications, websites and social media) whilst non-online methods (e.g. health professionals, independent community health organisations and flyers) were preferred by women of older age groups, or by women who had not finished high school or were non-tertiary educated but finished high school.[191]

In 2002, Women's Health Victoria surveyed a community sample of 500 Victorian women about their health information seeking trends and preferences.[192] GPs were women's main source for seeking health information; with 96% having previously sought health information from their GPs.[193] GPs were also the preferred source for women of all age groups, although the strength of this trend correlated with increasing age.[194] As well as being an often used and preferred source, women also consider GPs to be the most trusted source of health information.[195]

Despite this, many women continue to seek more comprehensive information from other sources[196] because women feel rushed during their consultation and unable to ask additional questions, and women felt the information was not clear or thorough enough to satisfy their health information needs or develop understanding.[197]

[190] Jean Hailes for Women's Health., *What do women need to know? Women's health information needs in Australia survey 2015,* Melbourne, 2015, pp. 16.
[191] Jean Hailes for Women's Health., *What do women need to know? Women's health information needs in Australia survey 2017,* Melbourne, 2017, p. 21.
[192] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 12.
[193] Ibid.
[194] Ibid.
[195] J Pennbridge, R Moya & L Rodrigues, 'Questionnaire survey of California consumers' use and rating sources of health care information including the Internet,' *Western Journal of Medicine*, vol. 171, no. 5-6, 1999, pp.302–305.
[196] D Warner & J Procaccino 'Toward Wellness: Women Seeking Health Information, '*Journal of the American Society for Information Science and Technology*, vol. 55, no. 8, 2004, pp. 709–730.
[197] Ibid.

Information about general wellbeing and health behaviours was also considered to be missing from the GP and client interaction.[198] Barriers identified by women who seek health and wellbeing information from GPs include lack of time with the practitioner; the lack of depth and breadth of information provided; and a lack of information provided on specific issues such as sexual health.[199,200]

Women's Health Victoria found that women who use a GP as their primary source of health information would rely primarily on other sources if they could find good quality and reliable information.[201]

Use of the Internet

The internet is also increasingly being used as a source of health and wellbeing information, with young women consistently the most active in this regard.[202,203] Kummervold et al. surveyed a community sample of 14 956 individuals across seven countries, to investigate the trends of European health related internet use over an 18 month period. Of their sample, 46.8 per cent perceived the internet as an important source of health information, while the importance of other sources of health information stayed level or decreased.[204]

In addition to clinical health information and information to answer specific health queries, [205,206] women often use the internet to find personal stories from those with similar health issues and to connect with others in similar circumstances.[207]

In the United States, women are increasingly seeking online support networks to help fulfil their "need to be heard and respected when they looked for information about their health or on behalf of others". [208] This could partially result from women being unable to find adequate time to discuss health and wellbeing information during consultations with health professionals.[209]

But use of the internet for health and wellbeing information can be a problem if individuals do not have the experience or knowledge to identify reliable and credible information.[210,211] Many

[198] R Wyn, & B Solis, 'Women's Health Issues Across the Lifespan', *Women's Health Issues*, vol. 11, no. 3, 2001, pp.148–159.
[199] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 24.
[200] Ibid. pp. 26-27.
[201] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 24.
[202] P Kummervold et al, 'eHealth Trends in Europe 2005-2007: A Population-Based Survey', *Journal of Medical Internet Research*, vol. 10, no. 4, 2008, pp.e42.
[203] M Rahmqvist & A Bara, 'Patients retrieving additional information via the Internet: A trend analysis in a Swedish population, 2000-2005,' *Scandinavian Journal of Public Health*, vol. 35, no. 5, 2007, pp. 533–539.
[204] P Kummervold et al, 'eHealth Trends in Europe 2005-2007: A Population-Based Survey', *Journal of Medical Internet Research*, vol. 10, no. 4, 2008, pp.e42.
[205] Ibid.
[206] M Rahmqvist & A Bara, 'Patients retrieving additional information via the Internet: A trend analysis in a Swedish population, 2000-2005,' *Scandinavian Journal of Public Health*, vol. 35, no. 5, 2007, pp. 533–539.
[207] E Sillence et al, 'How do patients evaluate and make use of online health information?', *Social Science & Medicine*, vol. 64, no. 9, 2007, pp. 1853–1862.
[208] C Wathen & R Harris, "'I Try to Take Care of It Myself.' How Rural Women Search for Health Information.' *Qualitative Health Research*, vol. 17, no. 5, 2007, pp. 639–651.
[209] Ibid.
[210] E Kontos, G Bennett & K Viswanath, 'Barriers and Facilitators to Home Computer and Internet Use Among Urban Novice Computer Users of Low Socioeconomic Position', *Journal of Medical Internet Research*, vol. 9, no. 4, 2007, pp.e31.
[211] D Warner & J Procaccino, 'Women Seeking Health Information: Distinguishing the Web User', *Journal of Health Communication*, vol. 12, no. 8, 2007, pp. 787–814.

women access health information through common search engines and can be unaware that some sites promote particular political or religious views or sell products or services.[212]

Other sources of information

In Australia, telephone helplines are a minor source of health information compared to other sources.[213] General telephone helplines are useful sources of health and wellbeing information for individuals who need advice after hours.[214] Moreover women are the most frequent users of after hours helplines for primary care with many women seeking information for their children under 5 years old.[215]

Women often use informal networks of friends as health and wellbeing information sources. Women's Health Victoria found that young women in particular prefer informal networks for their health and wellbeing information, despite recognising that information from this source can be unreliable or outdated.[216] This may be because young women value obtaining information from easily accessible, informal and personal sources that they have a trusting relationship with, seeking advice from health professionals as a last resort.[217,218] This trend may also be because young women are concerned with confidentiality and are wary of information sources that will not respect this, even if the sources they use are of lesser quality.[219]

Increasingly, media is becoming a source of health and medical information, with larger numbers of consumers either hearing, seeing or reading about their medical conditions in the mainstream media; looking for more information about a condition after hearing about it in the media; or asking their doctor about a condition they had heard about in the media.[220]

The 2015 *Jean Hailes for Women's Health Survey* found that women easily found health information on the internet and social media, but they were concerned with the reliability and credibility of the sources.[221]

The results from *the 2016 Jean Hailes for Women's Health Survey* found that women were most likely to access health information from health professionals and internet searches and were least likely to access health information from social media and commercial organisations.

[212] Ibid.
[213] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 26.
[214] I St George & M Cullen, "The Healthline pilot: call centre triage in New Zealand", *New Zealand Medical Journal*, vol. 114, no. 1140, 2001, pp.429–430.
[215] R McKenzie, M Williamson & R Roberts, 'Who uses the 'after hours GP helpline'? A profile of users of an after-hours primary care helpline', *Australian Family Physician*, vol. 45, no. 5, 2016, pp. 313-318, retrieved on the 1st of March 2018; https://www.racgp.org.au/afp/2016/may/who-uses-the-%E2%80%98after-hours-gp-helpline%E2%80%99-a-profile-of-users-of-an-after-hours-primary-care-helpline/
[216] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp.13, 15, 17 & 24.
[217] J Belle Brown et al, "Women's decision-making about their health care: views over the life cycle," *Patient Education and Counselling*, vol. 48, 2002, pp. 225–231.
[218] C Wathen & R Harris, "'I Try to Take Care of It Myself.' How Rural Women Search for Health Information," *Qualitative Health Research*, vol. 17, no. 5, 2007, pp. 639–651.
[219] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 18.
[220] M B Hogue, E Doran & D A Henry, 'A Prompt to the Web: The Media and Health Information Seeking Behaviour', PLoS, vol. 7, no. 4, 2012, pp. 1-6.
[221] Jean Hailes for Women's Health, *What do women need to know? Women's health information needs in Australia* survey 2015, Melbourne, 2015, pp. 3.

And women reported that they were most likely to trust health information from health professionals and independent health organisations.[222]

Gaps in health and wellbeing information

Despite the numerous sources discussed above and the multitude of health and wellbeing information available, women continue to report being unable to access information on specific health issues and needs.[223]

Literature that deals with these questions argue that women want four things. Firstly, they want factual and comprehensive information on illness as well as general information on health and wellbeing. Secondly, personalised information relevant to their circumstances. Thirdly, the opportunity to discuss health and wellbeing issues with people of experience or knowledge to assist them in decision making. And finally, women want information about accessing health professionals and experts in specific fields.[224]

Health information is ineffective if it is not relevant to women's needs or if they are unaware of why it may be important to them personally. "Personally relevant health information is an important factor that can change individuals' perceptions of their health needs."[225] When women are more aware of their health and wellbeing needs and risks, efforts to promote preventative health care, such as screening, are more effective. Effective health promotion and illness prevention are important tools in reducing the burden of preventable illness for women and society as a whole.[226] Good quality health promotion and illness prevention information should highlight the short and long term benefits, be personally relevant and practical.[227]

Conclusion

Research discussed in this literature review highlights the primary ways that women access health services and health information, the health issues that they experience and the barriers that women face in accessing health and wellbeing services, supports and information. Given the importance of these issues in their potential to limit women's health and wellbeing and their ability to access services and to seek early support for preventable and chronic illness; including mental health, it is important to understand the ACT context and to address these in order to avoid the resulting costs to the health care system - and to optimise women's health and wellbeing.

[222] Jean Hailes for Women's Health, *Understanding health information needs and health behaviours of women in Australia* survey 2016, Melbourne, 2016, pp. 14.
[223] M Murphy, B Murphy & D Kanost, *Access to Women's Health Information: A Survey of Victorian Women as Information Seekers*, Women's Health Victoria, Melbourne, 2003, pp. 26.
[224] C Wathen & R Harris, "'I Try to Take Care of It Myself.' How Rural Women Search for Health Information." *Qualitative Health Research*, vol. 17, no. 5, 2007, pp. 639–651.
[225] R Parslow et al. "Use of medical services after participation in a community-based epidemiological health survey", *Social Psychiatry & Psychiatric Epidemiology*, vol. 39, no. 4, 2004, p. 311–317.
[226] Ibid.
[227] K Sullivan et al. 'Developing a stroke intervention program: What do people at risk of stroke want?' *Patient Education & Counselling*, vol. 70, no. 1, 2008, pp.126–134.

Findings

The demographics: The women who completed the survey questions

This section provides a breakdown of the demographic characteristics of the 601 ACT women respondents who completed the survey questions.

Age

Seven per cent (n=40) of respondents were 16-24 years; 26% (n=155) were 25-34 years; 22% (n=134) were 35-44 years; 20% (n=122) were 45-54 years; 15% (n=92) were 55-64; and 8% (n=50) were 65 years or older.

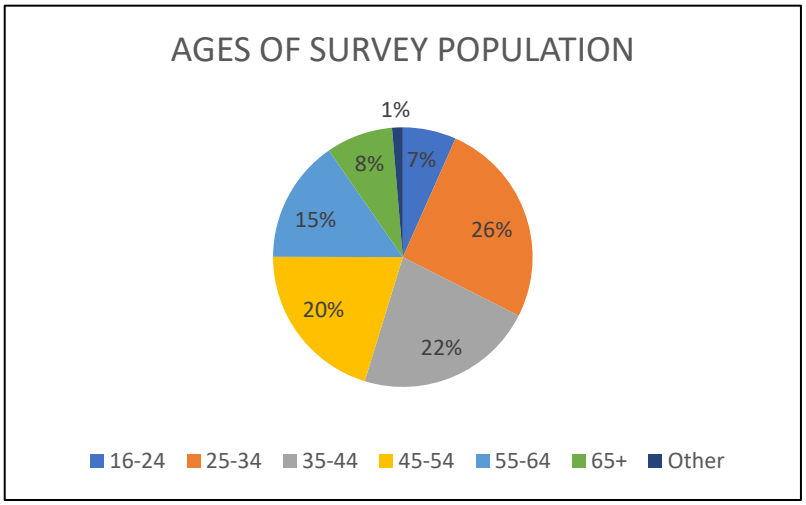

Figure 1: Age of survey population

Location

Nineteen per cent (n=116) were living in Belconnen; 17 % (n=103) of respondents were living in Tuggeranong; 11% (n=65) were living in Gungahlin; 18% (n=108) were living in Canberra's Inner North; 10% (n=59) were living in Weston Creek; 9% (n=56) were living in Woden Valley; 9% per cent (n=51) were living in Canberra's Inner South; and 2% per cent (n=14) were living in Queanbeyan, and 3% (n=15) were living in other surrounding rural NSW.

Women with a disability

Thirteen per cent (n=79) identified as a woman with a disability.

Of Aboriginal and Torres Strait Islander origin

Two per cent (n=12) identified as being of Aboriginal and Torres Strait Islander.

Speaks another language other than English

When asked if they spoke a language other than English at home, 7% (n=39) identified that they did, with 23 languages other than English identified.

Women's understanding of what good health means

When survey participants were asked to describe what good health meant to them, overall ACT women had balanced understandings of health and understood the multifaceted nature of good health and wellbeing.

> '*Healthy diet (allowing for chocolate when needed!), good amount of exercise and physical activity, positive frame of mind, allowing for calm and chill out times'*
>
> *'Being physically, emotionally and mentally healthy through having access to adequate nutrition, exercise, rest, recreation, social support and health care/services.'*
>
> *'Having energy Moving freely Feeling strong physically and emotionally Loving life Enjoying friendships and family time'*
>
> *'Eating nutritious meals, exercising regularly, sleeping well, managing stress and overall good physical condition'*
>
> *'feeling well both mentally and physically, being active, be aware of what you eat and drink, common sense and positive attitude'*
>
> *'Being mentally and physically fit - eating well, getting enough sleep and having a good work-life balance'*
>
> *'whole of person health - physical, mental, emotional, social wellbeing conducive to leading a full and productive life'*
>
> *'Eating well - high amounts of fruit and vegetables. Trying to keep consumption of packaged and sugary foods to a minimum (difficult because I love sweets). Exercising and being fit (running, hiking). Feeling content with life and being grateful for what we have.'*
>
> *'A healthy body, spirit and mind through fresh, unprocessed food, an active lifestyle, quality sleep, nourishing social networks and supports, positive thinking patterns, balanced hormones and a body free from disease/injury.'*
>
> *'Absence of illness, little or no need for medical or psychological support, good diet, exercise, fresh air & clean water…, friendship, healthy family relationships, love, laughter & good sleep.'*

The most common responses were a combination of physical and mental wellbeing.

> *'good physical and mental health'*
>
> *'Active mind and body'*
>
> *'Good health is both physical and mental. For me personally, the mental is most important at the moment.'*
>
> *'keeping mind and body active, being able to enjoy life'*

'A body that can move freely, a mind that can think clearly and internal contentment.'

'A strong body that stretches and moves with ease. A mind that is calm, content and resilient.'

'Good health means physically and mentally well to live my life.'

'feeling mentally and physically well and happy'

'Physically fit and mentally healthy.'

'Physical and mental health interact together in harmony.'

Many also included the idea of spiritual, social or emotional security within this.

'Wellbeing of body, mind and spirit'

'being physically, mentally and emotionally well'

'physical, mental, emotional, social wellbeing conducive to leading a full and productive life'

'balanced life with reasonable emotional, physical, spiritual, psychological health'

'Waking with an abundance of physical, emotional and spiritual energy ready for the day, and ending the day feeling ready for rest.'

'having the physical, psychological and emotional ability to fulfil my potential'

'Physical, mental and spiritual wellbeing that allows me to live a full and satisfying life.'

The second most common way that survey respondents defined health was in terms of the physical body and activity.

'Exercising and being fit (running, hiking).

'feeling fit and healthy'

'Being able to keep fit and active'

'Healthy BMI, regular exercise/activity'

'Enjoying good physical health, keeping fit, able to ride my bike, ski, swim'

A key component of health was also the concept of autonomy. The ability to do the things they wanted and needed independently was an important element of good health for many women.

'Being able to do the things I want do to (spend time with friends/family, travel, be spontaneous, go out) as well as the things I need to do (go to work, exercise, eat well).'

'I have the energy and motivation to do those things I want'

'Being able to physically do the things I want to do.'

'Being physically and mentally strong enough to look after myself, grow food, knit, play sport and be a contributing community member'

'being able to participate in things you want to do'

'The ability to do the things that are important to me, feeling good, having energy and strength to manage independently.'

'Having a body that performs in the ways I ask of it so that I can decide what I want to do, rather than having decisions made for me by pain or struggling organs.'

'Feeling well Being able to live comfortably and do the things I want to do.'

'Being fit and active and able to do the things that I need to in a day'

'Good health means being able to engage in life. To be able to run around, have kids and go to work (not be sick).'

'Vitality. Energy. Being able to achieve all that I want to.'

'Good health means that I can participate in the activities that I enjoy.'

'The ability to participate in life, doing the things I like to do ie physical exercise, education, taking care of family'

'The ability for my body to cope with all the work and play I would like to do!'

Some women defined good health as being the absence of illness, disease, pain, injury or ill health.

'To me, good health means being able to live my life without being prevented from doing so by ill health.'

'absence of disease and life inhibiting conditions.'

'Freedom from disease, freedom from pain, and freedom from emotional symptoms like depression and anxiety'

'Freedom from restricting pain. Freedom from fear of having a serious illness or disease.'

'No major illnesses or injuries'

'No pain or suffering'

'Freedom from chronic pain and disease'

'being able to function to the best of my ability without pain or incapacity'

'Not having any health complaints'

'Having energy, not fatigued, not sick or on constant medicine.'

‘Being able to participate in a 'normal' life, to be able to hold down a job, to not have to second guess every time you are asked out whether you will be able to go.’

‘Not having to reach for pain killers every day or ensuring you're stocked up with things you may need "just in case" Being able to go out and make plans without the fear of "what if" and the feeling of general well being physically and mentally.’

Others described good health as enabling them to fulfil their various roles.

‘Having good health enables me to carry out my normal duties as worker, mother and wife.’

‘Being healthy and happy and functioning as a community member and a member of a family. Able to contribute meaningfully to society.’

‘Being mentally and physically able to do the things I want and need - work, play with my child, pursue hobbies.’

‘Being able to work and do the things you enjoy doing and contributing to life.’

‘Good health for means being able to carry out my normal activities of housework and gardening, community involvement, tennis, travel, supporting others, free from pain and stress, nutritional diet/food, laughter, singing and entertainment, hope, love and joy through my Christian faith.’

‘Good health is feeling well enough to get up and go to work, go to the gym and socialise with my friends and be able to do those things without feeling like any of them are particularly difficult.’

‘Being able to do my everyday things, work, errands, hang out with mates etc. without my health affecting my levels of comfort, ability to perform or attendance.’

Other ways that women who participated in the research defined good health included:

- Having access to health care services

‘Accessibility to medical facilities and seen within a timely manner by qualified and respectful staff’

‘Good health meaning having a good level of physical, mental and emotional wellbeing. You can't have good health without access (that is also affordable) to relevant services for each.’

‘Feeling well, access to health care’

‘Good health is being physically active, knowing where and how to access health services (physical and mental) for when I'm not okay and taking the time to check in with myself to ensure my health is being looked after.’

'Physically and mentally well with the means to access services for treatment and support and advice to affect lifestyle factors which improve symptoms and health outcomes.'

'Access to medical services at an affordable price'

'Access to health services which cater to my needs'

'access to health services (GP, pharmacist, hospital) and support services as needed.'

'Being able to live my life to the fullest with my current medical issues getting in the way. Being able to access appropriate services.'

- social connection

  'social gatherings, safe community'

  'to enjoy, family, friends, community, ……caring for others'

  'Participation and connection.'

  'feeling energetic and connected with my world (family, work and community)'

- food and nutrition, and weight or appearance.

  'maintaining a healthy diet'

  'maintaining a healthy diet (with occasional treats)'

  'good diet home cooking'

  'Having a balanced diet, healthy weight and fitness.'

  'eating a balanced diet & keeping physically fit'

  'Fit, well and on top of maintaining healthy habits eg eating well.'

  'Eating healthily - fresh fruit and veg, meat. Limiting intake of packaged food. Exercising daily, drinking lots of water and minimal alcohol.'

  'Good health means that you eat right and do some sort of physical excise everyday (like walking 1-2 hours per day).'

  'Being healthy - exercise, good diet, regular health checks'

  'Eating healthy, exercising, and being in control of my reproductive health'

  'Being able to run, being thin, face clear of acne.'

Finding services in the ACT to help obtain and maintain good health

ACT women were asked if they were able to find services in Canberra that helped them to obtain and maintain good health.

Seventy five per cent (n=451) of respondents identified that they could find services and 11% (n=65) did not know or had not tried.

Participants who identified that they were unable to find services were asked to specify why. The responses demonstrated the complexity of ACT health system.

> *'The answer is yes and no. In relation to the no component, I'm currently seeing a dentist in Sydney after neglecting my dental hygiene for too long. I currently need 12 fillings and other dental attention. Finding an affordable dentist in Canberra has been too difficult. I'm using a dentist in Sydney after getting private health insurance purely because my dental situation was going to cost too much out of pocket. I have had good experiences with doctors, imaging etc in Canberra. I've been meaning to get to the Family Planning clinic for some time and have just been struggling with time. Ideally hours for sexual and repro health places need to extend to weekends and/or after hours. I've had no problems with the walk ins - great idea.'*

Respondents identified that they could find services in some areas but faced significant gaps in others.

> *'I have found a lot of services but nothing that meets my specific needs'.*
>
> *'mostly I can find services as I have worked in health for many years, unfortunately most services are expensive and have waiting lists.*

Twenty nine of the women who identified being unable to find services commented on the cost of ACT services.

> *'I can find them, but I can't afford the time off work to access them. If I take the time off work, then I cannot afford the money to pay for them.'*
>
> *'Too expensive, I'm a pensioner and haven't even found a bulk billing doctor for my son, let alone me, so I prioritise his needs'*
>
> *'I can't afford a doctor and the bulk billing places are too far away from where I live to be easily accessible. I also can't afford to join a gym.'*

Twenty women identified a lack of availability of services preventing them from accessing services, with many participants stating that they travel interstate to access services.

> *'Large gaps in specialists. Of specialists available, many have closed books, long waitlists or unable to dedicate sufficient time to existing patient list. Often travel to Melbourne or Sydney to access reliable services.'*

'I have had significant issues finding a Psychiatrist to treat my Attention Deficit Disorder. ….. I have had referrals to 3 psychologists which are able to Treat ADD, but are not taking new patients. I am now looking into people in Sydney that are able to treat ADD. This has implications for not being able to get my medication in Canberra which is a significant issue. I also have a number of existing conditions which make treatment more complex.'

'I was woefully cared for …. following my miscarriage and have found it difficult to access affordable psychology sessions as someone who has struggled with depression for years.'

'Services are only available during regular office hours. I need something that is available outside of office hours.'

Eleven identified the health systems' inability to provide holistic care as the reason they could not find services to maintain their health.

'I find most services are aimed at older people, or that they aren't as holistic as I need.'

'I have found it hard to find a GP who I trust to care for my whole health.'

Nine respondents who were unable to find services, identified that the treatment they had received from health professionals had impacted on their ability to find good services.

'I find doctors to be very dismissive and judgemental of women'

'Having chronic health conditions, I have felt very disappointed with the medical profession, with attitudes, lack of knowledge and scepticism. They hold the power and make you feel like a child.'

'I live in chronic pain, after moving here from QLD I find it very hard to find a GP who believes me, who believes that my pain is real and who will continue my pain management plan that was set up by my GP in QLD. I have been accused of being a junkie seeking pain medication or that my pain is in my head and not real.'

Self assessed health status

Survey participants were asked to rate their overall physical and mental health as either excellent, good, fair, poor, or very poor. In both categories, mental and physical health, participants were most likely to rate their health as either good or fair.

Physical health

Forty two per cent (n=251) of respondents rated their physical health as either fair, poor or very poor, compared to 48% (n=290) who rated their physical health as good.

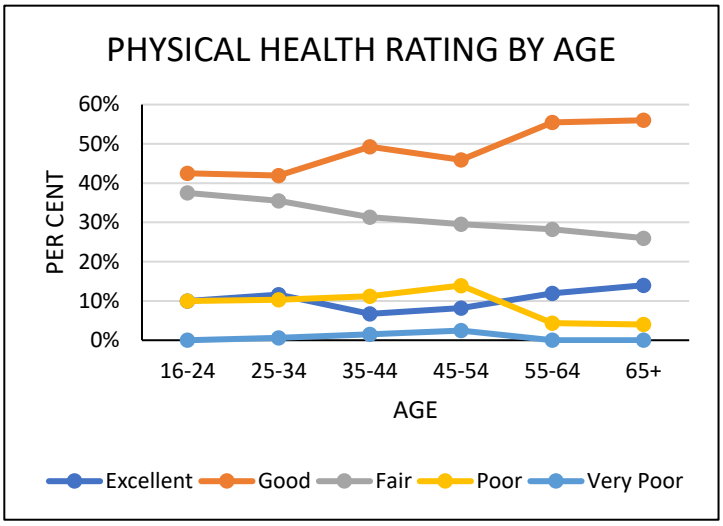

Figure 2: Physical health rating of participants by age.

Mental health

40% (n=237) of respondents rated their mental health as either fair, poor or very poor, compared to 283 who rated their physical health as good.

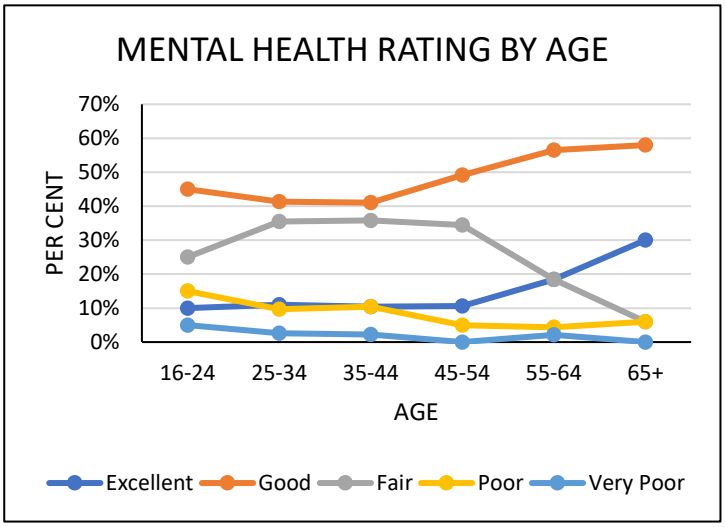

Figure 3: Mental health rating of participants by age.

Fair, poor and very poor mental and physical health

Twenty eight per cent (n=167) of respondents rated both their mental and physical health as either fair, poor or very poor.

Women's self-ratings of their health by age

Across all age groups research participants were most likely to rate their physical and mental health as either good or fair, except for the 65+ cohort. Participants in the 65+ age bracket were the most likely to rate both their physical and mental health as excellent or good.

- Twenty nine per cent (n=45) of the 25-34 age group rated both their mental and physical health as either fair, poor or very poor.
- Thirty one per cent (n=42) of the 35-44 age group rated both their mental and physical health as either fair, poor or very poor.
- Twenty six per cent (n=32) of the 45-54 age group rated both their mental and physical health as either fair, poor or very poor.

Who women accessed services for

Women who participated in the research were asked to identify who they had accessed services for in the last 12 months from a list of six options. They could choose as many categories as were applicable to them.

Women most accessed services for themselves. Ninety seven per cent (n=582) of participants had accessed services for themselves; 35% (n=213) had accessed services for their children; and 20% (n=119) for their partners. Those who selected “other” identified accessing services for friends, grandchildren, and clients.

The health services that ACT women accessed

Survey respondents were asked to identify which services they had accessed in the previous 12 months, from a list. They could identify as many items on the list as were appropriate to their personal experience.

In the preceding 12 months, the most accessed services were GPs with 94% of respondents (n=578), followed by 82% filling prescriptions (n=504) and 64% visiting a dentist (n=392).

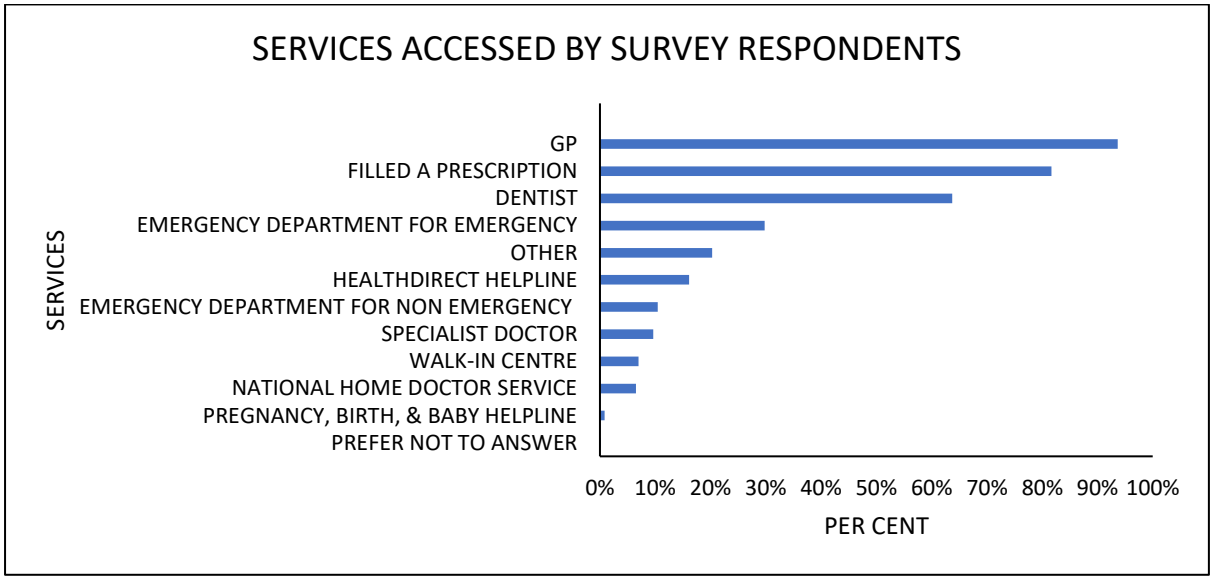

Figure 4: Percentage of services accessed by respondents.

The next highest service used was the Emergency Department (ED), with 30% (n=179) accessing it for emergencies it in the last 12 months, and 10% (n=63) accessing the ED for non emergencies.

When survey respondents chose “other”, they were asked to specify what services they had used outside of the ones described.

The most common type of service that women who chose “other” identified were allied health services with 39% (n=48) specifying some form of allied health service (including

physiotherapy, occupational therapy, dietitians, podiatrists or chiropractors), and 19% (n=13) identified that they had accessed a form of alternative therapy (such as acupuncture, naturopathy or massage). Eighteen per cent identified a mental health service such as psychologist or counselling.

The top three most utilised services (GP, filling a prescription, and dentist) remained consistent across all age groups as demonstrated in the table below.

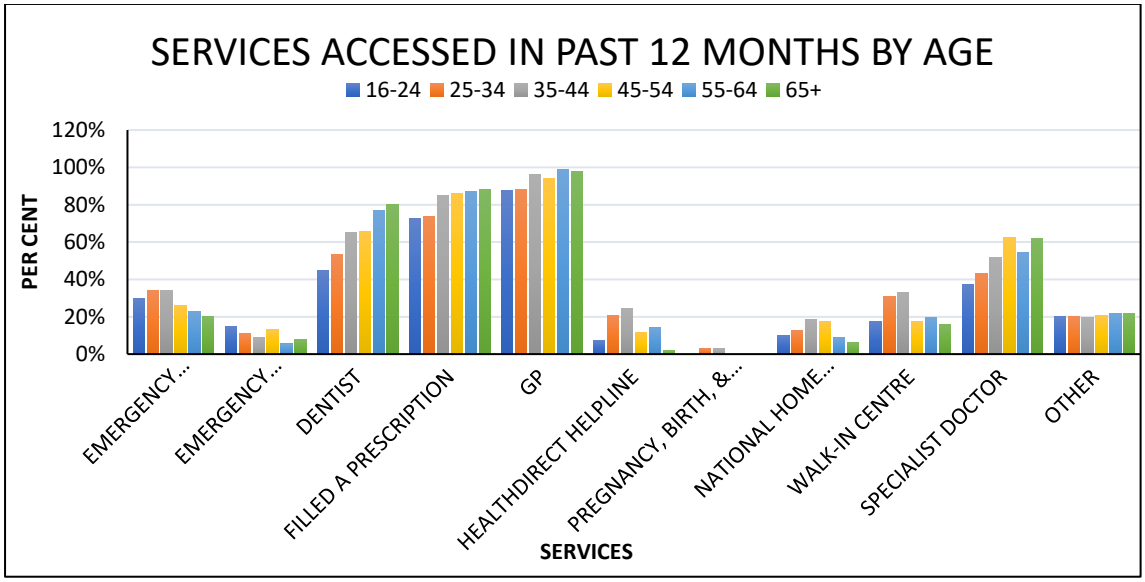

Figure 5: Services accessed in the past 12 months.

Survey respondents in older age groups were the most likely to access health services. This reflects the fact that 96% (n=48) of that age group identified having a chronic condition.

Survey participants in younger age groups were more likely to attend the emergency department and WiCs. Issues of affordability were often linked to utilisation of these services.

> *'it is cost and availability of services. If you want to access free services, waiting times are not ok- a matter of weeks. Private services are not much better for waiting times and also very expensive. Often the advice from services is to go to the ER- this is an inappropriate use of emergency as well as being an inappropriate tool for the problem faced by someone seeking immediate assistance- telling a suicidal person to come in in 3 weeks is unacceptable.'*

> *'Aside from the GPs at ANU, it can be very difficult to see a bulk billing doctor, and I did wait a fortnight to get paid in order to afford GP fees. ANU GPs often tell you that there is a two/three week waiting period and tell you to go to a nurse-led walk in clinic (which are excellent) but if you are very unwell (or injured), taking public transport can be quite difficult (especially if you have no idea where you are going). It would be great to see a Walk-in Centre in the inner-north to cater for the multitudes of students and just-out-of-home youth who tend to live there.'*

The use of WiCs correlated to the location of current WiCs in the ACT. Of the respondents who identified as having used a walk-in centre in the past 12 months, the majority were more likely to live in the areas where a walk-in centre existed. Twenty seven per cent of them (n=40) lived in Tuggeranong and 22% of them (n=32) in Belconnen where WiCs are currently located.

Sixteen per cent (n=96) of respondents identified using the Health Direct telephone helpline to obtain health information. Only one woman in the 65+ age group identified having used the telephone helpline in the previous 12 months.

The barriers or difficulties experienced when accessing health services

Survey respondents were asked if they had experienced barriers or difficulties when accessing health services. They were given a list of five options, could specify others if they chose, and could select as many items on the list as they deemed appropriate to them.

The main barrier identified by 50% of respondents (n=298) was affordability. Appointment availability (ability to get in to see a health professional of their preference at a convenient time) was the second highest barrier identified by 49% of respondents (n=295) and long wait times (the amount of time that a patient must wait, after making an appointment, to see a health professional) was identified by 42% (n=253).

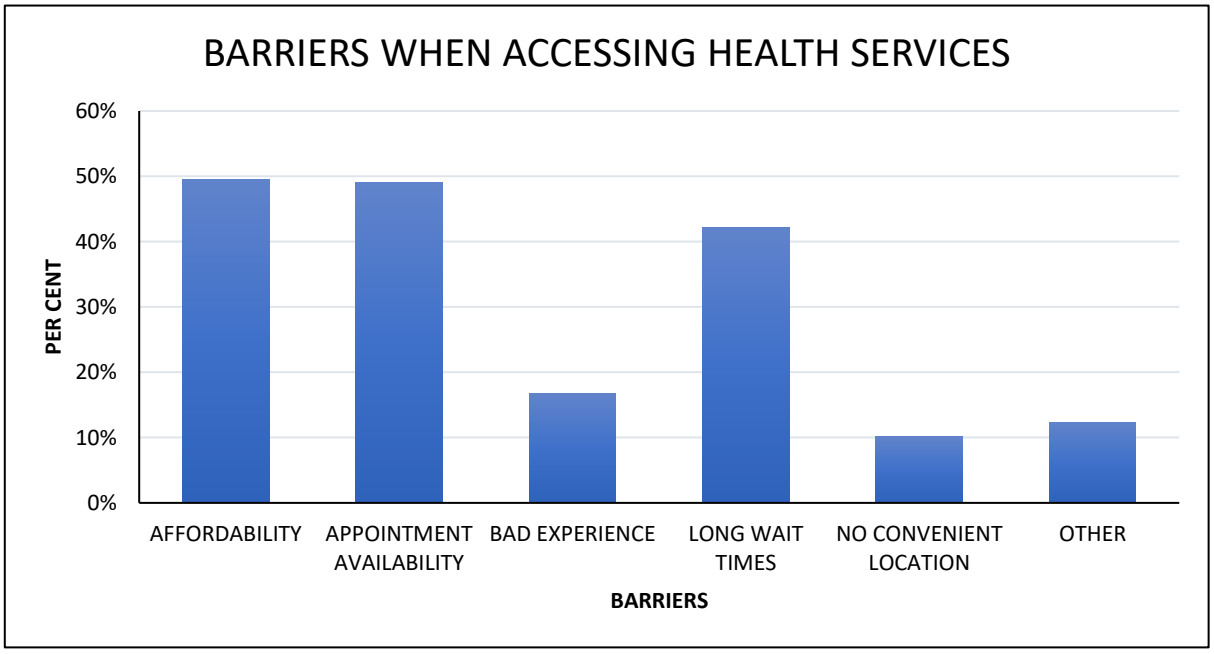

Figure 6: Percentage of barriers to accessing health services.

The issues identified by the 12% (n=74) of respondents who selected “other” were travel limitations, the inconvenient location of services, the availability of parking nearby, or the opening hours of the service.

‘No or limited disabled parking near services (meaning long walks etc.).’

'difficulty in getting to the place when it is open'

Seventeen per cent (n=101) of respondents also reported bad experience as barrier in their interaction with the health system, including difficulty establishing a rapport with GPs, feeling rushed in appointments, not being believed, or being misdiagnosed.

'It is hard to have conversations with a GP about broad health concerns in 15 mins'

The top three issues of affordability, appointment availability, and long wait times were consistent across all the age groups.

Older women who participated in the research identified long wait times as a more significant barrier with it being the top issue for the 55-64 age group and second for the 65+ age group. In the younger age groups, affordability and appointment availability were the top two barriers identified.

'The main difficulty is having to wait too long for appointments, e.g., 2-3 weeks to see GP except in dire emergencies.'

'It takes too long to see my asthma specialist when I'm having a bad spell.'

'While I can find the services, being an age pensioner I have been waiting over 5 months to see a specialist.'

Younger research participants were the most likely to report bad experience as a barrier to accessing health services with the proportion of participants who noted bad experience declining as age increased.

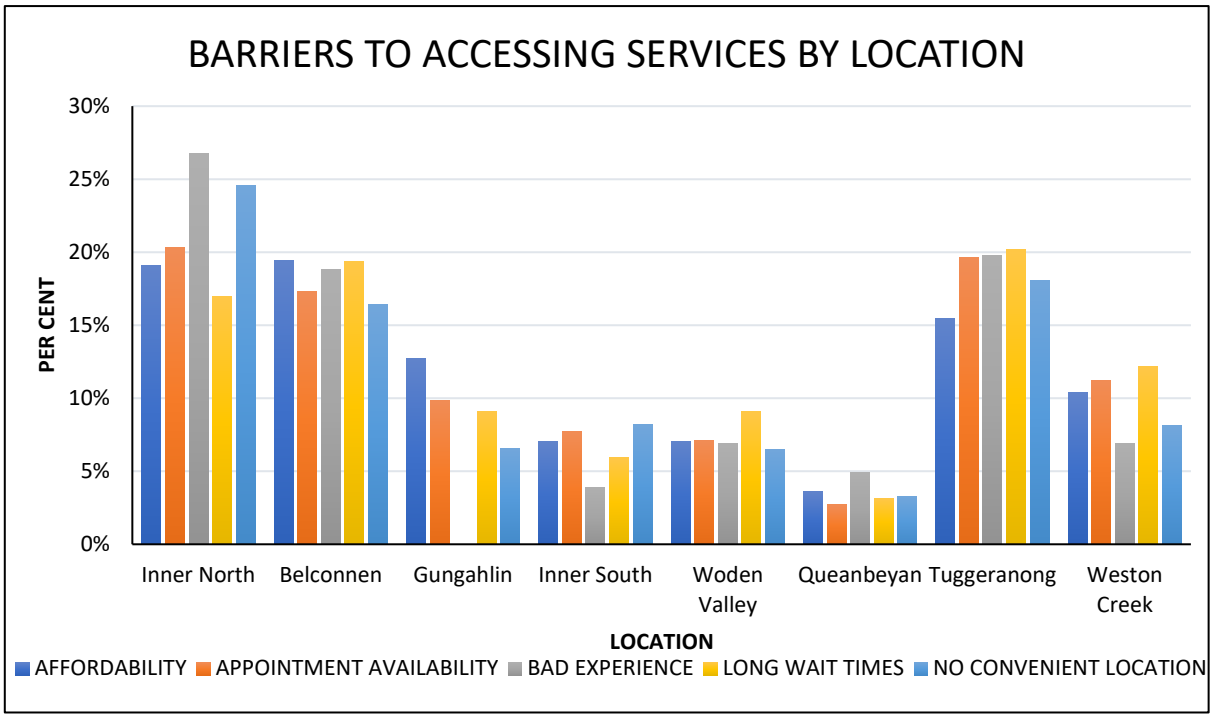

Figure 7. Barriers to accessing services by location.

In relation to affordability, Belconnen and Gungahlin respondents highlighted this as the main barrier, with 17% of Belconnen respondents and 10% of Gungahlin respondents.

Long wait times was the top issue identified by respondents from Woden Valley (9%), Tuggeranong (20%) and Weston Creek (11%).

A higher percentage of respondents from the inner north - 26% - identified having had a bad experience as a barrier to them accessing services. No respondents from Gungahlin recorded having a bad experience as a barrier.

Women's top health issues

Respondents were asked to identify their top three health issues. This question allowed women to manually enter the three health issues they were concerned about. As the survey did not specify a preference system, all issues were analysed together.

Over 300 issues were raised, and they were then grouped into the broad categories shown in the chart below.

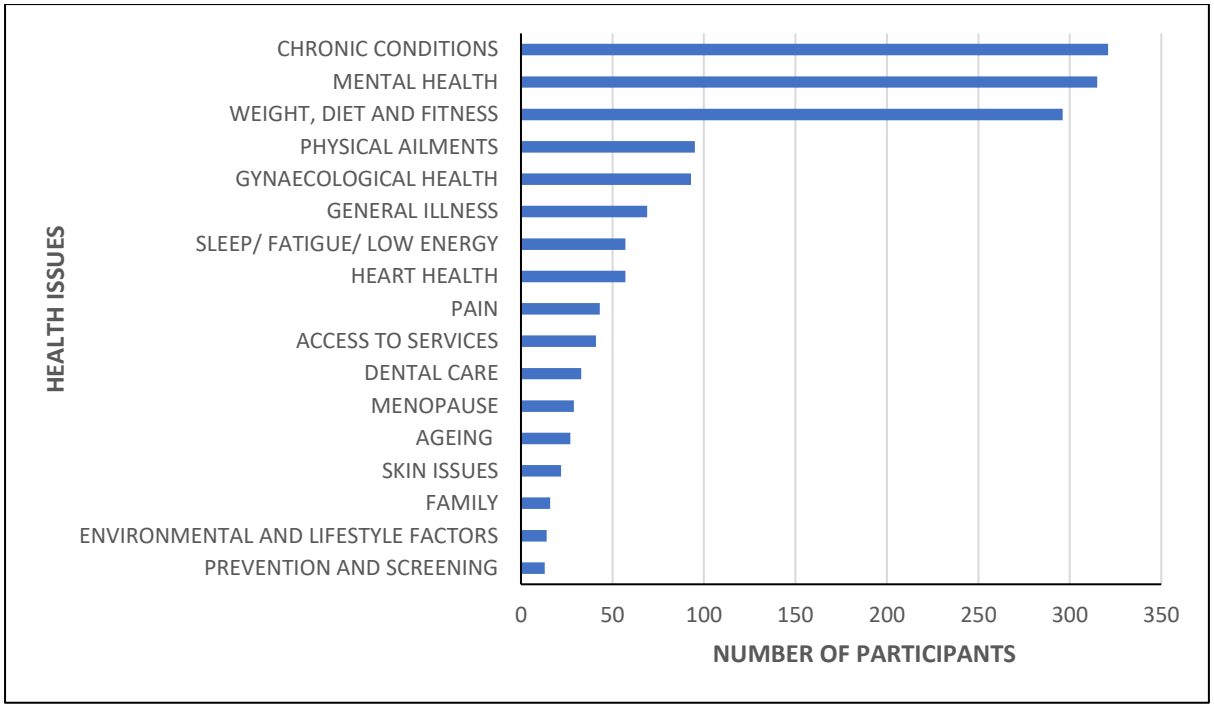

Figure 8. Distribution of the top health issues listed by respondents.

The top three health issues identified by 85% of the total survey respondents were chronic conditions, mental health, and weight/diet fitness. Of the 601 women who completed the survey only 15 % (n=93), of respondents did not identify one of these three issues within their top three.

Top 3 Health Issues self-identified by survey participants.

Main Categories	Number of Women	Percentage of Women
Chronic Conditions	321	53%
Mental Health	315	52%
Weight, Diet and Fitness	296	49%

Chronic conditions

Survey respondents identified 10 categories of chronic conditions as can be seen in the chart below.

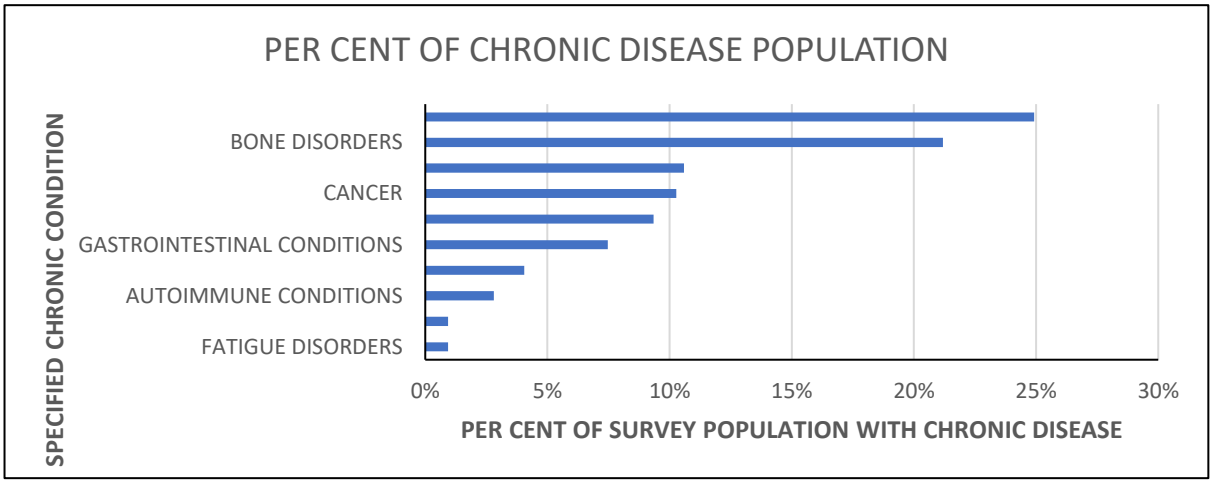

Figure 9. Distribution of the chronic conditions of respondents who self-identified a chronic condition as a top health issue.

The top three categories of chronic conditions reported by 321 survey respondents were endocrine disorders, bone disorders and chronic pain/ pain conditions.

Twenty five per cent (n=80) of respondents who identified as having a chronic disease specified a type of endocrine disorder (including diabetes, polycystic ovary syndrome (PCOS), endometriosis and hormonal conditions).

Bone disorders (such as arthritis and osteoporosis) were the second highest with 21% (n=68) and chronic pain/ pain conditions were the third highest at 11% (n=34).

Cancer was identified as a top health issue by 33 women and 30 women identified respiratory conditions.

Thirteen women identified three chronic conditions as their top health issues (excluding mental health conditions). When including mental health conditions as a chronic condition in this analysis, 24 women reported three chronic conditions.

Mental health

Eight mental health condition categories were identified by survey respondents as can be seen below in Figure 10.

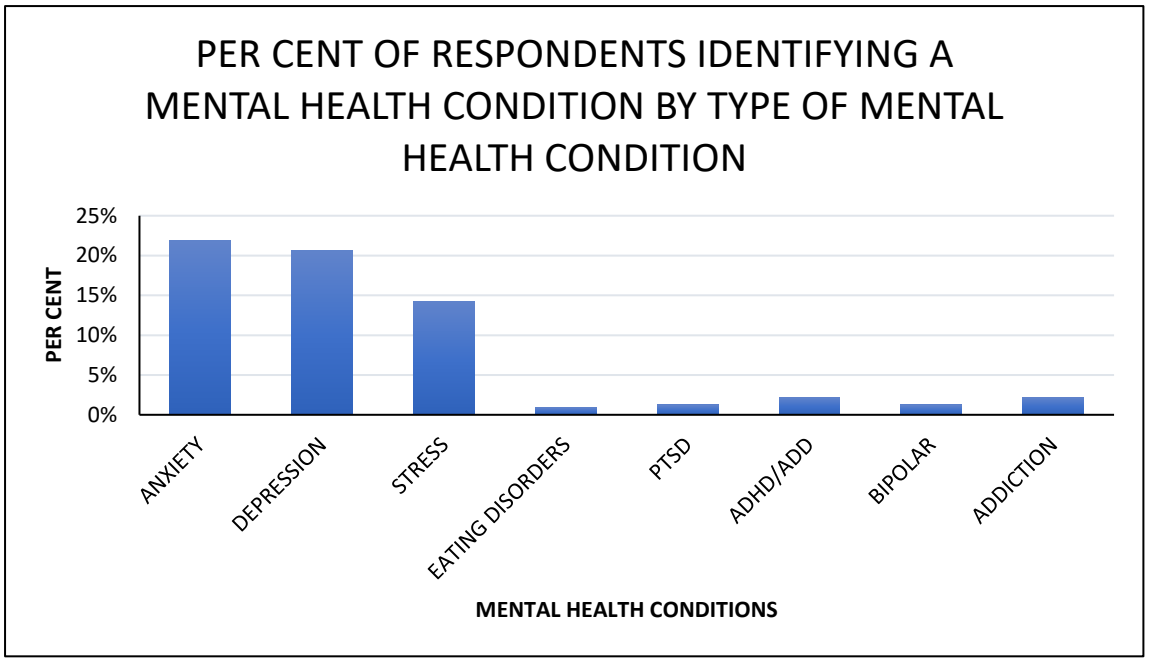

Figure 10. Distribution of the mental health conditions of respondents who self-identified a mental health condition as a top health issue.

The top three mental health illnesses/conditions reported by women who responded to the survey were anxiety, depression and stress.

Of the 315 respondents who identified a mental health condition in their top three health issues, 22% (n=69) identified anxiety, 21% (n=65) depression, and 14% (n=45) stress.

Two survey respondents identified some form of mental health illness or condition as all three of their top health issues.

Weight, diet and fitness

Of the 296 respondents who identified having weight, diet or fitness as a health issue, 53% (n=155) identified weight. This term included those who mentioned weight, losing weight, overweight, obesity, weight management, weight loss, weight gain, underweight, or weight in relation to a specific body area.

Twenty nine per cent (n= 86) identified fitness or physical activity as a health issue. This term included those who mentioned physical activity, exercise, lack of exercise, lack of physical activity, inactivity, strength, balance or flexibility.

Eighteen per cent (n=52) identified diet /eating habits. This term included those who mentioned diet, food, nutrition, healthy eating, unhealthy eating, sugar intake, food intolerance, vitamin deficiency, or food allergies.

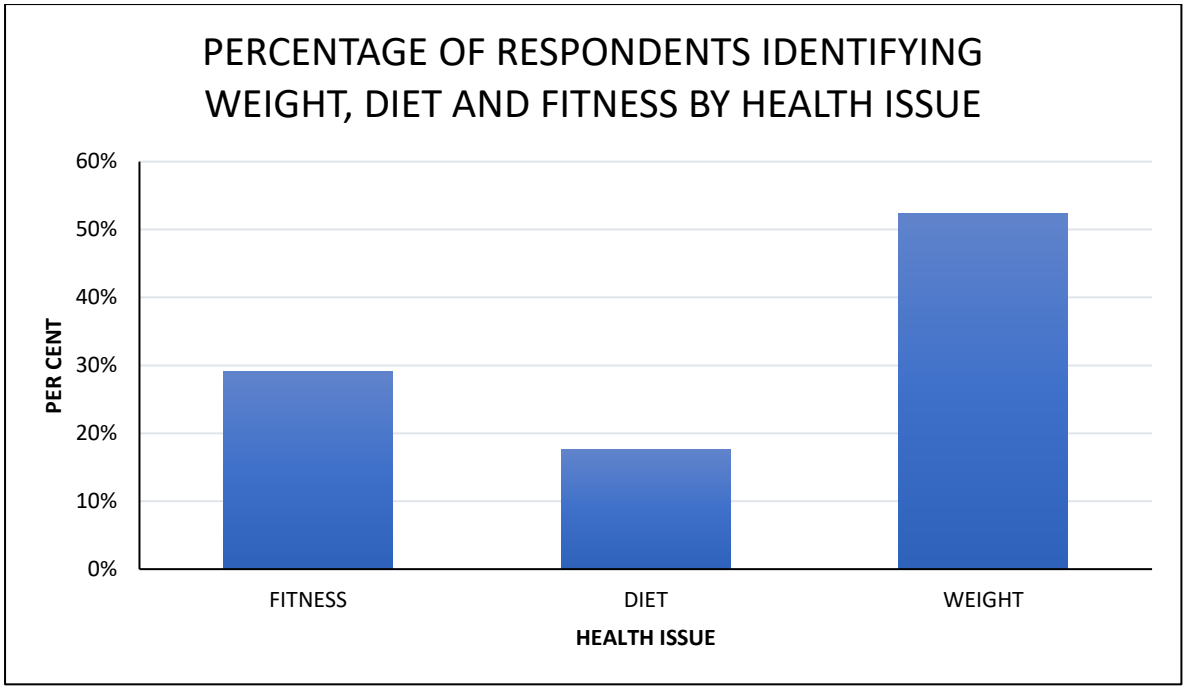

Figure 11. Distribution of respondents identifying weight, diet and fitness by health issue.

Health issues by age

Mental health

Mental health was the number one issue for the three youngest age groups and the second and third most important issue for the 55-64 and 65+ age groups.

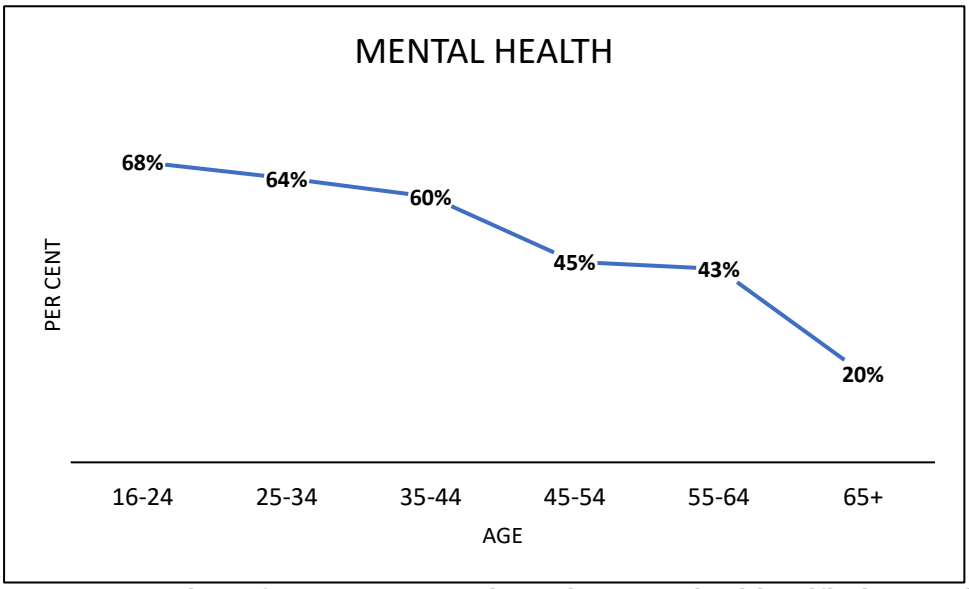

Figure 12. Proportion of survey respondents by age who identified mental health as a health issue.

Mental health issues decreased as the major identified health issue as women aged.

Mental health issues were identified by a larger percentage of respondents in the 16-24 age group (68%, n=27) and then decreased as a percentage for the remaining age groups, with the lowest percentage of respondents identifying it in the 65+ age group with 20% (n=10) identifying it as a health issue.

The mental health categories of anxiety and depression showed a similar pattern, with a decrease in reporting prevalence across the age groups. A slight exception existed with the number identifying anxiety increasing by 2% from the 16-24 age group to the 25-34 age group.

Stress, however was identified at different points across the age groups with respondents between the ages of 35-44 and 55-64 identifying stress as the main mental health issue.

It is interesting to note that participants in the 35-44 age group reported the same percentage (13%, n =17) across all three categories of stress, anxiety and depression.

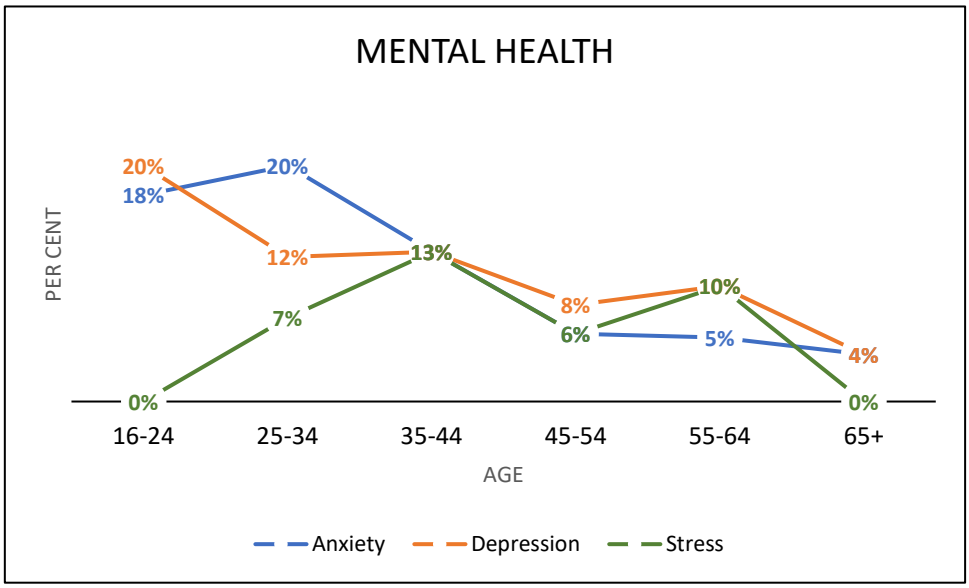

Figure 13. Proportion of survey respondents by age who identified specific mental health conditions.

Chronic conditions

In contrast, the identification of chronic conditions by women respondents increased in the older age groups, as did the identification of heart health as a health issue.

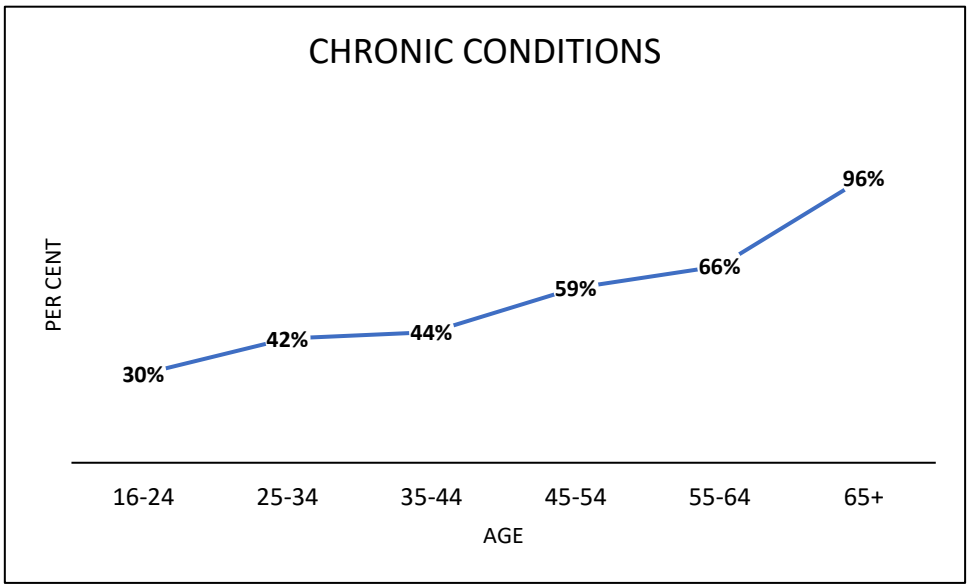

Figure 14. Proportion of survey respondents in each age group who identified chronic conditions as a health issue.

Weight, diet and fitness

The self- identification of weight/diet/fitness by women respondents increased for each age group with 96% of those in the 65+ age group identifying it as one of their top health issues, compared to 30% of the 16-24 year old age group.

As shown in Figure 15, respondents in the 45-54 year age group were more likely to self-identify weight as the key issue than younger participants.

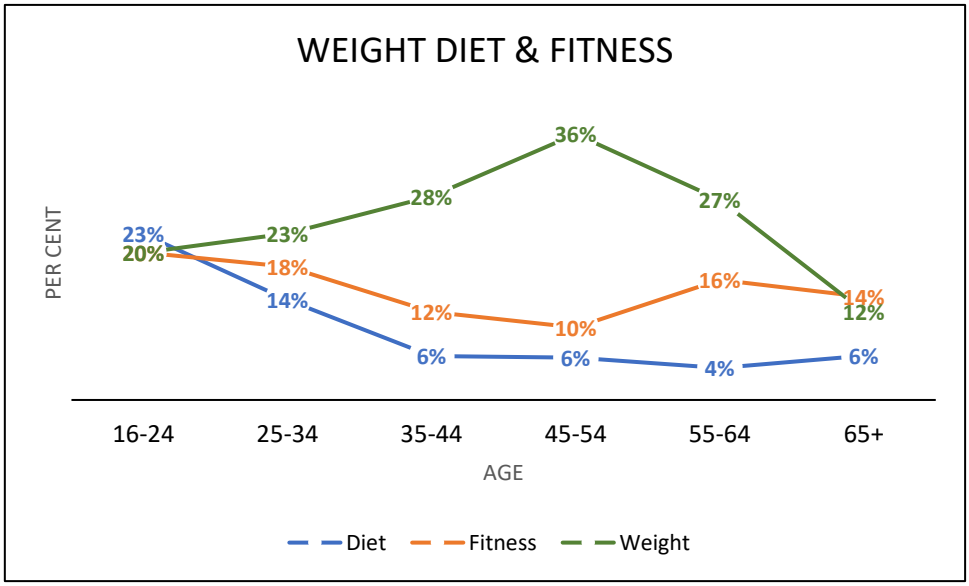

Figure 15. Proportion of survey participants concerned with issues of weight, diet or fitness across the age groups.

Gynaecological health

Figure 16 shows the identification by respondents of women's gynaecological health as a health issue across the age groups. Reproductive health as a key health issue peaked in the 25-34 age group which is when women are statistically more likely to experience childbirth, with the average age of mothers in the ACT as 31.7 years. This stopped being identified as a main health issue by respondents from 55 years old, which aligns with the end of women's primary reproductive years.[228]

The age group of 45-54 was the age group who identified menopause most as a health issue, and this is consistent with when women are most likely to experience this life stage.[229]

Sexual health issues were more predominant for younger participants and their identification as a health issue decreased with age.

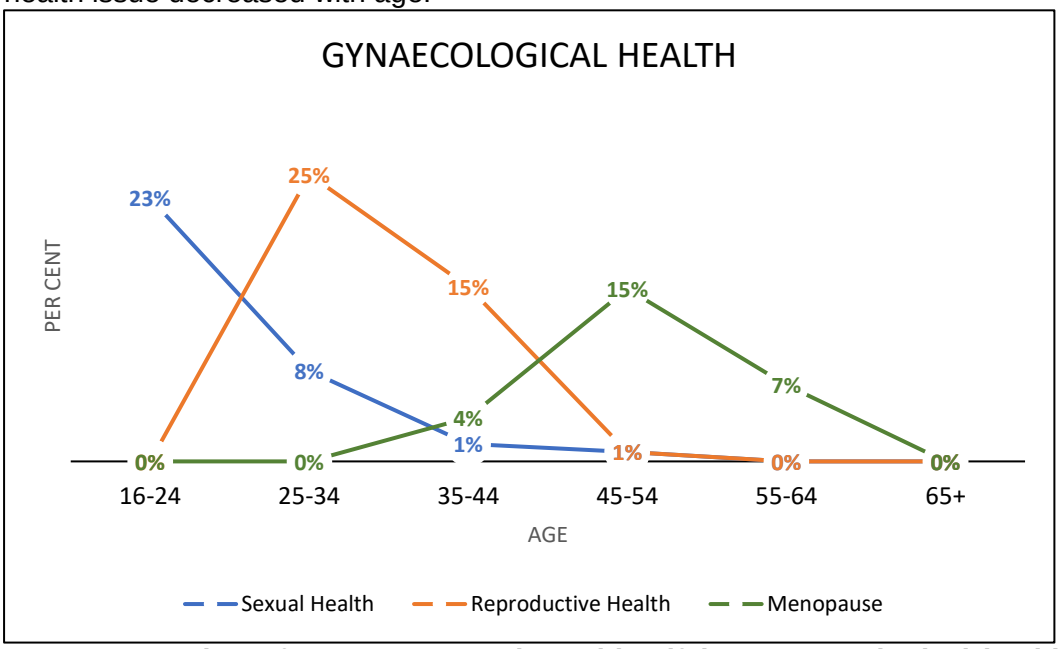

Figure 16. Proportion of survey respondents identifying gynaecological health as a health issue across age groups.

Other

Skin issues were of greater concern to younger participants, with more respondents in the two youngest age groups, 16-24 and 25-34, reporting it as a concern than older age groups.

Dental health was identified as a health issue across all age groups.

<u>Health issues by age group</u>

16-24 age group

The 16-24 age cohort represented 7% (n=40) of survey respondents.

[228] Australian Bureau of Statistics, *'States and Territories' 3301.0-Births,* Canberra, 2015, retrieved on the 2nd of August 2017; http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3301.0Main%20Features52015?opendocument&tabname=Summary&prodno=3301.0&issue=2015&num=&view=

[229] Sexual Health and Family Planning Clinic (SHFPACT), *'When do women reach menopause?' About Menopause and you, Canberra,* 2017, retrieved on the 2nd of August 2017; http://www.shfpact.org.au/menopause-centre-of-canberra/about-menopause

Mental health was the number one health identified by women in this age group, with 68% (n=27) identifying it. Issues of anxiety and depression were identified as the main mental health concerns.

'*mental health has been a long-term challenge'*

The second highest issue identified by 16-24-year-old respondents was weight/diet/fitness with 63% (n=25) listing it within their top three health issues. The issues with weight, diet and exercise, were of equal concern to this age group.

> *'I tend to find I try and manage my weight on my own (with varying levels of success), I rely on advice from friends and occasionally professional sources like my GP. I find however that there's no low cost consistent service to support me in losing weight, or support healthy eating and I fall off the bandwagon quickly when I become stressed at work or university.'*

Chronic conditions were the third highest health issue for this age group with 30% (n=12) identifying some form of chronic condition as a concern. Endometriosis and PCOS were the two chronic conditions identified, however, respondents also identified fibromyalgia, diabetes, irritable bowel syndrome (IBS), autoimmune conditions, epilepsy and asthma.

> *'I was in agonizing pain every day for 18 months, presenting normally for endo'*

This age group had the lowest proportion of women who identified chronic disease as a health issue compared to other age categories, and the highest percentage of respondents who identified sexual health and contraception as a health issue.

Service barriers were also identified by 20% of the 16-24 age group.

> *'Cost of SHFPACT [Sexual Health and Family Planning ACT] (who I've been seeing for contraception issues) is quite high for non-concession holders, as I only work part time.'*

> *'Mental health …. availability of services. If you want to access free services, waiting times are not ok- a matter of weeks.'*

> *'Lack of transport and inability to pay for non-bulk billed doctors have made it difficult to seek fairly routine treatment for tonsillitis at short notice - but waiting over a week for treatment of this kind of condition is also impractical'.*

> *'I had a great experience with a gynaecologist in Charnwood at the Health Clinic, but it was very expensive, very little was covered by Medicare, and I definitely wouldn't have been able to go had my parents not paid because it was an important issue.*

25-34 age group

The 25-34 age cohort made up 26% (n=155) of the total survey respondents.

Mental health was the largest identified health issue for the 25-34 age group with 64% (n=99) of the respondents in this age category identifying it. In line with the overall survey results, anxiety was the highest mental health condition identified in this age cohort, followed by depression and then stress.

> *'Anxiety and high stress is manageable with previously learnt coping mechanisms however work stress keeps piling on and it gets bigger.'*

The second largest identified health issue for this age group was the category of weight/ diet/ fitness with 54%(n=84) of respondents in the 25-34 age group self-identifying this as one of their three top health issues. Weight was the main issue followed by physical activity and fitness. Respondents spoke about the need to establish regular exercise habits. While eating habits was the smallest identified health issue in this category, respondents spoke about wanting to establish healthy eating habits, diet and nutrition. There were several participants who identified experiencing vitamin deficiencies.

Chronic conditions was the third largest health issue for respondents in this age group, with 42% (ne=65) identifying issues such as gastrointestinal issues, chronic pain such as back problems, endometriosis, PCOS and hormonal conditions, as well as asthma and diabetes.

34% (n=53) identified gynaecological health as a health issue with pregnancy and fertility of prominence, as well as sexual health and contraception.

The 25-34 age group also identified the issue of fatigue and sleep more compared with other age groups. They also identified general illness and migraines more often than any other age group.

35-44 age group

The 35-44 age cohort made up 22% (n=134) of the total survey respondents.

Mental health was the largest self-identified health issue for this age group with 60% (n=80) identifying it as a concern. Anxiety, depression and stress were identified equally with all three accounting for 13% each of the mental health issues for the 35-44 age cohort. Other health issues identified by women within this age group were posttraumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), bipolar disorder and addiction.

Weight, diet and fitness was the second highest health issue by 46% (n=61) of those aged 35-44. Weight was the main issue identified followed by physical activity, then eating habits/diet.

The third largest health issue identified by this age group was chronic conditions accounting for 44% of respondents (n=59) in this age group. Many of them identified experiencing chronic pain resulting from various conditions with the most prominent being back pain. Other identified issues included arthritis, asthma, endometriosis, thyroid conditions and gastrointestinal issues.

Other health issues identified by this age group included gynaecological health (reproductive issues and menopause) and the health concerns of family members.

45-54 age group

The 45-54 age cohort made up 20% (n=122) of the total survey respondents.

The main self-identified health issue by respondents in this age group was chronic conditions, with 59% (n=72) identifying some form of chronic condition. Diabetes and cancer were the most prevalent chronic health conditions mentioned by this group, but other conditions identified included asthma, bone disease, thyroid conditions, and chronic pain.

Weight, diet and fitness was the second largest health issue for 52% (n=63) of this age group. Weight was the main concern. Respondents were less concerned with physical activity, though when it was discussed it was primarily in terms of fitness. Strength and flexibility were more frequently raised by than they this age group than younger groups. A small number of respondents in this age group were also concerned about issues of diet and eating habits but this seemed to be more closely related to managing chronic disease such as sugar levels for diabetes or managing vitamin deficiencies.

Mental health was the third largest health issue for this age group with 45% (n=55) of respondents self-\ identifying it. Depression was the main mental health-related issue followed by anxiety and stress, with mentions of addiction, ADHD, eating disorders and PTSD.

This age group was the group who self-identified the issue of menopause most across the survey population. This age group also reported a wider range of physical complaints such as liver problems, kidney problems, incontinence issues, injury and eye issues which were not raised by younger women.

55-64 age group

The 55-64 age cohort made up 15% (n=92) of the total survey respondents.

The largest identified health issue category for this age group were chronic conditions with 66% (n=61) identifying some form of chronic condition. Chronic pain (including joint pain, fibromyalgia and back pain) was the category of conditions most identified by respondents in this age group, followed by bone disease (the most frequently identified issue being arthritis). Other chronic conditions included diabetes, cancer, gastrointestinal issues, hormonal conditions, liver issues, autoimmune conditions, and respiratory conditions such as asthma.

The second largest health issue was weight, diet and fitness with 48% (n=44) of respondents in the 55-64 age category raising it. Again, weight was the primary concern in this category, with respondents identifying being overweight and obese, needing to lose weight, managing weight, or reflecting on weight gain. Physical activity was discussed primarily in terms of wanting to gain and maintain fitness. In this age group, respondents focused less on exercise and more on promoting strength and flexibility, or eliminating inactivity. Eating habits were mentioned infrequently with food allergies being the largest issue mentioned.

> *'Physical strength & fitness - big decline in last few years'*
>
> *'How to balance diabetes and food allergies'*

Mental health was the third highest health issue for this age group with 43% (n=40) of respondents identifying it. Depression and stress were the highest mental health-related concerns, followed by anxiety. A few women mentioned experiencing PTSD, attention deficit disorder and addiction.

This age group also identified heart health, ageing, and physical ailments as health issues.

65+ age group

The 65+age group made up 8% (n=50) of the total survey respondents.

Chronic conditions were the main health issue self-identified by this age group, with 48 (96%) of the 50 respondents identifying some form of chronic condition as an issue. Bone health accounted for the largest category with the most common condition being arthritis. Respiratory conditions, including asthma, were also mentioned often, as were cancer and gastrointestinal issues. Other chronic conditions included diabetes, oedema and thyroid conditions.

Weight, diet and fitness was the second main health issue for this age group with 16 (32%) of the respondents in this age group identifying it. Physical activity was the number one concern for women in this age group with strength and balance training, or maintaining fitness and exercise mentioned. Issues with weight and physical activity were then mentioned by a similar number of respondents.

Heart health was the third health issue for respondents in this age group with 28% of the respondents (n=14) in this age group identifying it as an issue.

Mental health was identified by 10 (20%) of the respondents in this age group, and general illness by 18% (n=9).

Availability of supports for top health issues

Survey respondents were asked whether there were health services and/or supports in place to help them address their top health issues. The majority of respondents indicated that there were supports in place to address the top three health issues that they had identified. As figure 17 shows for their top health issue, 66% of respondents replied yes. For their second top health issue, 53% of respondents replied yes. And for their third top health issues, 37% replied yes.

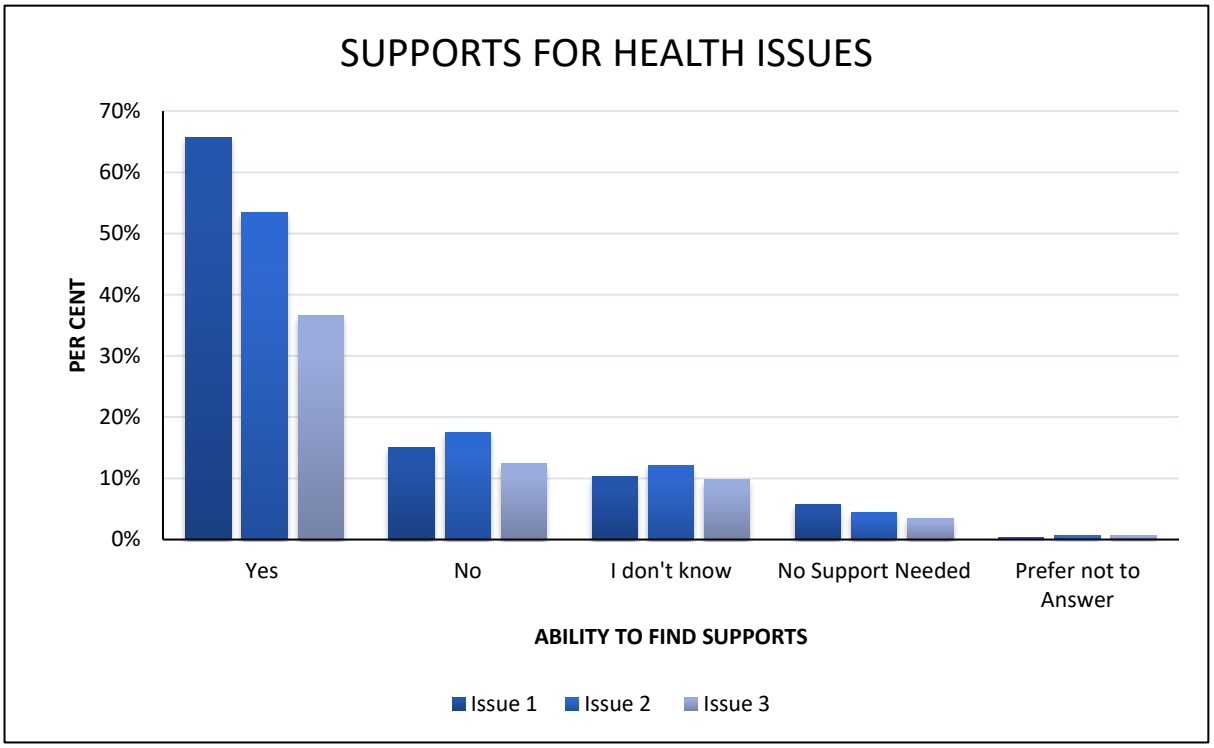

Figure 17. Availability of services/supports to help address top three health issues.

The types of services and supports that participants identified as their top health issues varied greatly depending on the health issue they had identified.

Primary care

GP/Specialists

When it came to managing conditions, the main place that women identified they went to for support were generally GPs, followed by specialist services.

> *'I have a wonderful GP which makes everything so much easier in terms of management and seeking help.'*
>
> *'lucky to have a doctor who is supportive and open to trying things besides medications.'*
>
> *'I have a very good G.P who helps me with any issues I have.'*

Allied Health

Many women also identified allied health professionals such as physiotherapist, or chiropractors as a means of support to help them manage their health issues.

> *'have regular blood tests and checks with dietician, optometrist and podiatrist to manage diabetes'*

> *'currently seeing a physiotherapist to reduce painful knees'*

Alternative Therapies

Some participants also identified accessing alternative therapies such as naturopaths, acupuncture or massage to help manage their health issues.

> *'I am also fortunate to be able to afford private extras cover which offsets the cost of alternative therapies such as acupuncture.'*

> *'I have been using Pilates and homoeopathic medicine to address these issues'*

Condition-specific support

Condition-specific support services such as Arthritis ACT or cancer treatment centres were also identified as providing support.

> *'Accessing services in cancer centre and support staff have been excellent.'*

> *'Over the years I have consulted support organisations such as Diabetes Australia, Arthritis Australia, and Lung Foundation. I see a specialist regularly to manage the COPD (which is moderate and being kept that way),'*

<u>Mental health</u>

When it came to mental health, most respondents accessed support through their GP first because a mental health plan referral was needed to receive Medicare rebates.

Respondents also mentioned accessing psychologists and counsellors or specialist mental health services such as Headspace or PANDSI.

> *'I have had really positive experiences aiding my depression - PANDSI has been extremely helpful'*

> *'Headspace also provides a great mental health service for young people'*

Mental health promoting activities such as art therapy and meditation were also identified.

Support Groups

Many of the women identified support groups as an alternative helping to manage their health issues and share knowledge for both mental and physical conditions.

> *'Making a like-minded group where you can talk freely, I think that helps a lot.'*

'Despite having a really awesome supportive immediate family, they still can't understand me. They still cannot empathise at all. They only people that can are the people I talk to in my group.'

Weight, exercise and diet

The supports identified were mainly in relation to exercise and nutrition. Respondents identified gyms and personal trainers for support for physical activity, as well as group fitness classes including walking groups or water aerobics.

'I am watching what I eat and going to the gym (I'm not overweight, just not happy with my weight as I have never weighed this much before).'

'The last 4 months I have joined a walking group, undertaken a diet program and tailored it to my family lifestyle, I walk every day before work for 20 to 30 minutes. I have lost 9 kilos

'I've got a good gym that I can go to regularly, that I really like going to - it's a very supportive environment.'

Some respondents mentioned online sources as a means of accessing information, and weight loss companies such as Lite n' Easy and Jenny Craig were another area of support.

Respondents mentioned the importance of positive role models and programs that promoted body positive messaging. Women who attended the focus group identified the effect that a positive role model, who was not body conscious, could have on increasing their own body confidence and self-perceptions.

'I actually became friend with a beautiful young woman, a very large women, and she had such a beautiful attitude towards her body, and she just changed my whole concept of what body image is'

Messages about *'How beautiful the body is, no matter what size you are'* were identified as helpful to create positive self-image.

Respondents also mentioned access to primary care support to help manage issues of weight, diet or fitness - such as GPs or nutritionists - but they were not always successful with this method and identified cost and stigma as prohibitive.

'If the ACT had a low cost nutritionist and counselling services that were easily accessible and routinely easy to get appointments, I would be using them often.'

Some of the Canberra services where women accessed support included:

- The Canberra Hospital
- Calvary Hospital
- Headspace
- The Home Doctor Service
- Health Co-op
- PANDSI
- SHFPACT
- Women's Health Centre
- Arthritis ACT

Barriers preventing women from addressing main health issues

Survey respondents were asked to identify if they experienced any barriers that prevented them from addressing their top three health issues. As shown in Figure 18, 52% of respondents had experienced barriers for issues one, 43% for issue 2, and 33% for issue three.

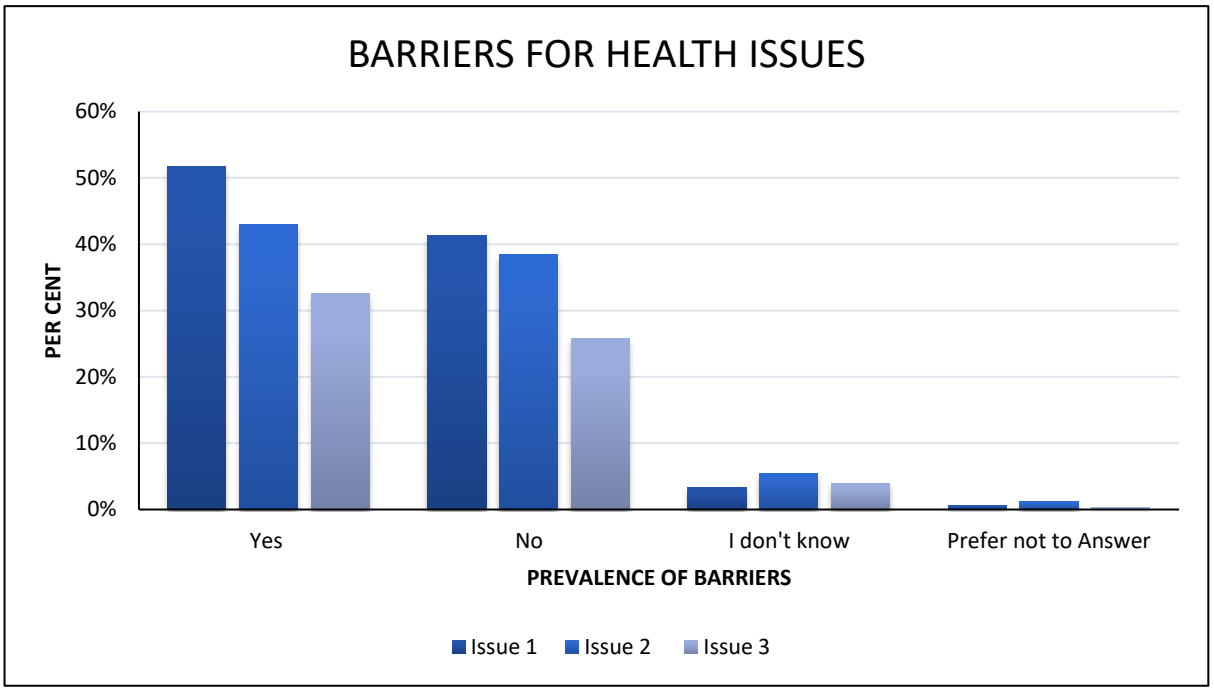

Figure 18. Proportion of survey respondents experiencing barriers to addressing top three health issues.

Affordability

When exploring the barriers respondents experienced when addressing their self-identified top health issues, overwhelmingly the most reported barrier for women in the ACT who participated in the survey was affordability.

> *'The cost of accessing medical care in Canberra is often prohibitive'*
>
> *'Money always an issue'.*
>
> *'High cost of health care'*

The most common concern was the cost of specialists and GPs, closely followed by the cost of accessing allied health or alternative medicine services such as physiotherapy, chiropractors or naturopaths. The cost of medical testing including scans and pathology concerned many participants as did the expense of dental services.

> *'Cost is also a barrier - for GPs but especially for extra services such as a psychologist, dentist etc"*

A common theme was the difficulty of finding services in the ACT that bulk billed which was often associated with the high costs of Private Health insurance.

'there are not many GPs that offer bulk billing services'

'I cannot afford private health insurance and have no choice but to be on public list.'

Other costs cited were income losses associated with taking time off work to attend appointments, travel costs of getting to and from appointments and the cost of prescriptions.

'Time off work = time not paid.'

'Costs for consults and prescriptions'

Affordability was reported more commonly by women in the highest and lowest age brackets.

'My main barrier is cost as I have recently retired and can no longer afford private health cover.'

Time

The second biggest barrier participants reported hindering them from addressing health concerns was time. There was a very strong relationship between affordability and time with many women mentioning them in combination.

'Barriers are time and money"

'It comes down to costs. By the time you pay for the family you are left at the end and there isn't enough money to pay and time. when you work full time and have a family it is really hard to fit everything in.'

Work and family commitments were the most common obligations filling participants time and inhibiting their ability to access services. Respondents were concerned about taking time off work to attend appointments due to both a fear of colleague's judgement and income losses. Participants also put the needs of their family first, limiting the time available to access services or engage in health promoting behaviours for themselves such as sleep and exercise.

'I feel like a burden taking time off to attend appointments.'

'general overload' of commitments, responsibilities, work, parenting, partner's work and attitude'

'I'm time poor so tend to prioritise my own health after the health of my family.'

'It is difficult fitting everything in while working full time'

'I am finding it hard to get enough sleep due to time pressures'

Issues of time pressures were most prevalent for respondents in the middle age brackets. Women who were often working full time and had young dependent families.

Wait times

Wait times and a lack of service availability were another significant barrier reported by survey participants. Wait times for specialist appointments could be up to five years with it being common to wait months for appointments. This has led many participants to seek treatment interstate contributing to additional travel costs and time burden.

> *'Have had to wait 2 years usually for any surgery e.g. hip replacements and then get very little follow up. 2 years is a long to wait in pain.'*
>
> *'The waiting lists at Canberra Hospital for diagnostic imaging and neurology are stupidly long (five years in one case)'*
>
> *'My endometriosis is complicated abs severe and I travel to Sydney for treatment'*
>
> *'Getting a diagnosis and adequate treatment in Canberra for these conditions has not been possible. I have had to travel to Sydney for accurate and satisfactory treatment of 2 of these conditions.'*

Experience with health professionals

Another barrier limiting women were their experiences with health professionals. Numerous participants reported feeling belittled and dismissed by health professionals; instances of GPs having limited knowledge about their conditions; and not being believed when describing symptoms. These stories were particularly prevalent for participants with chronic conditions, including endometriosis or ADHD, and often led to years of misdiagnosis, pain and suffering.

> *'The biggest barrier I had to face was convincing my GP that my irregular periods were not a result of me being overweight and that something else was wrong. It took me to have over a 100 day cycle for her to realise it wasn't weight related. When the results came back I felt as if I could scream it to her face'*
>
> *'I have had a lot of problems trying to get help with this condition, I have been accused of it being all in my head'*
>
> *'Coeliac disease is not well understood and supported in the ACT community.'*

Other issues

Other barriers that women raised included a lack of appointments outside of work hours, transport issues, difficulty accessing female health professionals, difficulty finding continuity of care, issues in the workplace, lack of motivation, and a lack of knowledge of where to access services.

> *'Accessing services out of regular working hours is not usually possible. It can be difficult to take time off work to take care of health concerns.'*
>
> *'time off work to attend, transport issues going back and forth to hospital, parking, pay parking'*

'Don't drive so transport to different health service locations across Canberra is an issue. Additionally, I work so these health services are only accessible during work hours'

'I struggled to find a female gynaecologist. For someone who is also the victim of sexual assault finding a female gynaecologist was crucial'

Mental health barriers

Affordability

Affordability was again the biggest barrier for women endeavouring to address mental health concerns. ACT women who participated in the research felt that the 10 sessions covered under Medicare rebate was insufficient to deal with complex issues. Even upon receiving this rebate, on most occasions women were required to pay an out of pocket gap fee for services.

'For most of us with ongoing or severe issues, that 10 sessions does nothing, 10 sessions wouldn't tell you anything about my life and what I've gone through. Where's the build-up of trust, where's the support.'

'I pay $100 for my psychologist on top of what is covered under my mental health care plan'

Respondents also commented on the high cost of mental health promoting activities such as meditation or art therapy and expenses associated with travel. The cost of services were so prohibitive that participants reported delaying treatment

'I've got a psych appointment on Tuesday and I'm about to cancel it because the washing machine's broken down and I have to pay for that.'

Service availability

The second biggest barrier to address mental health concerns was the difficulty of finding and accessing appropriate services. Respondents noted that navigating the complex healthcare system had acted as a barrier inhibiting them from promoting their health. Not only did survey participants find it very difficult to find information about services specific to their needs, but when they did manage to find services they then faced great difficulty procuring appointments with many waiting weeks for treatment.

'It is also impossible to get a psychiatrist in Canberra so I still travel to Sydney for appointment""

'when requiring counselling, you are placed on a list. It took one week before a 'counsellor' was able to get back?? Just as well I wasn't suicidal'

'PTSD; due to a very serious assault and rape. I have tried very hard to access support but am getting nowhere'

'when people are at their most vulnerable and stressed is when they actually need the most help. So it needs to be the least complicated way of accessing help and the most helpful way.'

Continuity of care

A lack of information sharing between and within services meant that participants often had to repeat their stories on numerous occasions which could be triggering and difficult for those who had experienced traumatic events, contributing to their mental illness.

'In many cases, specifically re: mental health, individuals were asked to share their story several times over to different people and at times, to staff who were not directly needing all of the traumatic and in-depth information about the person's trauma and psychological and family history (e.g. staff member conducting initial interview was not the person providing ongoing service or did not have qualifications in the area).'

Some participants reported a lack of sensitivity from services around sharing their stories. They did not feel that environments were supportive and safe, nor did they feel their privacy and confidentiality would be ensured and respected. This limited their abilities to receive holistic continued care.

'I attended the Women's health centre--Civic--where I felt comfortable for pap smears and mammograms. Then some years ago a new rule was introduced. The Women's Health Centre was for women who had suffered abuse--one had to declare this fact. I was told it could be overlooked if I chose. But you see I am an incest survivor and I found it particularly difficult to say I was not a victim while at the same time I was not prepared to announce it to a receptionist. I had no idea where this information may have ended up. I have not had a pap smear or mammogram since.'

Relationship with health professional

Finding a qualified professional, they felt comfortable sharing with was a barrier for some women.

'My psychologist is also fantastic, but it took ages to find someone I actually felt comfortable talking to.'

This relationship was considered vital as it could often be the difference between participants continuing with treatment or not.

'The personal rapport was missing and eventually I did not continue because well apart from the costs of the consults, I didn't enjoy my time with them'

The importance of this relationship and the difficulties associated with finding and maintaining a connection, was identified by women in terms of managing and addressing mental health issues when they were unable to find and maintain a relationship with a suitable professional, particularly with the restrictions of only 10 sessions covered under the Medicare rebate.

Other

Other barriers that many participants reported were judgement and stigma. Respondents were reluctant to address mental health concerns because of the perceptions of others. They were fearful of facing stigma or discrimination in the workplace, or from family and friends.

> *'I am reluctant to speak out due to perceived pressure that it would affect my position at work"*
>
> *'We are so quick to judge people with mental health issues'*
>
> *'People sitting in judgement of you and what does that do, make you feel even worse, more worthless and it's a dangerous cycle'.*

Self-stigma was a further inhibitor. Participants delayed or rebuffed treatment because of their belief that they should be able to manage everything themselves.

> *'Feel that I should be able to manage myself & that I will engender unnecessary attention from friends, family if I do - also that matter is not "serious" enough"*
>
> *'It's like, what are you depressed about? You've got a partner, you've got children, you've got a house to live in. Why are you depressed?'*

Self-stigma and guilt were often linked to the experience of motherhood and the burden of caring placed on women within society. The transition to motherhood was identified as a period where participants were particularly vulnerable to experiencing mental health issues.

> *'I remember when I had my son, the judgie stuff came in.'*
>
> *'Barrier is childcare but also the stigma around addiction as a parent. I did access treatment prior to becoming a mum but now I worry about being judged and/or potentially reported for this issue.'*

Women felt pressure to maintain an appearance of having it all together and presenting well to the world.

> *'I slip on my little happy face.'*

Their self-stigma inhibited participants from being honest with themselves and with health professionals thus sometimes inhibiting effective treatment.

> *'I find myself, sometimes when I fill in the form, self-censorship. I'm not going to put down that I'm quite that bad because that's a bit humiliating and I look like I'm in control and I don't want to look like that'*

Overcoming this stigma, guilt, and shame and allowing themselves to promote their health was particularly difficult for participants.

> *'Knowing that I was worth it, that I was allowed to invest time in making myself well because I thought I was ok but it doesn't matter for me, I have a family I have children*

to raise, I've got to be there for them, I've got to do this, I've got to do that. Women mostly put ourselves last.'

'And I think that message needs to get out there. Stop judging each other.'

Weight, diet and fitness barriers

Time

When it came to addressing issues of weight, diet and fitness, the biggest barriers observed in research participants was time. Respondents described having insufficient time to exercise or prepare healthy meals after dealing with all the commitments and obligations of their daily lives.

'Work life family balance makes it hard to fit in exercise!'

'I have a gym membership for the others but have no time between family, children, work etc.'

Motivation

Time was closely associated with issues of motivation. Respondents reported feeling tired and unmotivated after busy days. Motivation was greatly affected by weather. The survey was conducted in the cold Canberra winter months and many participants described an unwillingness to exercise in the cold and dark.

'With winter bringing the cold and dark on it's also not encouraging me to go out after work and exercise.'

Stigma

Participants reported experiencing stigma from external sources which impacted their perceptions of self.

'Having family members comment "Oh you chubby little thing"'

'Most of the comments have always been from a negative perspective'

'Overweight is never taken seriously'.

Self-stigma

The high number of research participants that described themselves as unmotivated and lazy suggests a difference in thinking around weight, diet and fitness issues. Participants were more likely to internalise issues of weight and fitness, discussing these issues in terms of personal responsibility and relating failure to faults of character. They displayed strong language and behaviours associated with self-stigma which literature demonstrates can be particularly hazardous to mental health and health promoting behaviour.

'*I always had an excuse as to why my weight and blood pressure was escalating, put it down to getting older, busy life style, hormone changes'*

'I have to work harder than the average person to see results and I'm kind of lazy.'

'Much of it is personal. My own inner motivations and intentions'

'I've got a tummy which is the worst- you know, absolutely the worst thing you can have. It's probably worse than two heads.'

'To try and do something about it, yes, and I'm failing'

'But I'm not exercising. I'm obviously not exercising enough.'

'And I'm just lazy'

Affordability

Cost was another big issue associated with addressing weight, diet and fitness. Participants found the cost of accessing exercise facilities such as gyms or personal trainers prohibitive as was the cost of preparing healthy food.

'It is very expensive to eat healthy and time consuming to prepare, accessing weight loss and gyms and classes i.e. yoga programs is far too expensive.'

In the case of more complex cases where participants sought professional help, for example women experiencing obesity, the cost of accessing dietitians and nutritionists was excessive. These respondents also described difficulty finding services and supports within the community, along with negative experiences of fat shaming and stigma exhibited from health professionals.

'Often Dieticians really don't understand how to work with people who have weight issue and a history of disordered eating - too judgmental, empathy is not from real lived experience'

'I approached my GP for assistance in address obesity. He basically said most obese people never stop being obese so go ahead and try but don't be too unhappy if you fail'

Comorbidities

Issues of weight management were sometimes inhibited, or caused by other conditions such as in the case of PCOS or chronic pain. These relationships were poorly understood not just by the general community, but also by fitness experts and even health professionals which was a significant barrier impacting health promoting behaviours.

'Pain has become the barrier to exercising.'

'Obesity- my depression plays a big part on me trying to manage my obesity.'

'Difficulty of having CFS and PCOS means that I can't exercise to lose weight to help PCOS.'

Top 3 Information Seeking Sources

Women were asked to list their top 3 preferred sources of information when seeking general information on good health and for specific health information.

When it came to seeking general health information, they preferred to turn to online sources first, followed by doctors/GPs and friends.

When it came to seeking specific health information, their preferred source of information were doctors/GPs followed by online, then their friends.

Top 3 sources of general health information

The sources most commonly used for general health information were online (n=522), followed by GPs (n=487), followed by friends (n=250). Family was identified as fourth.

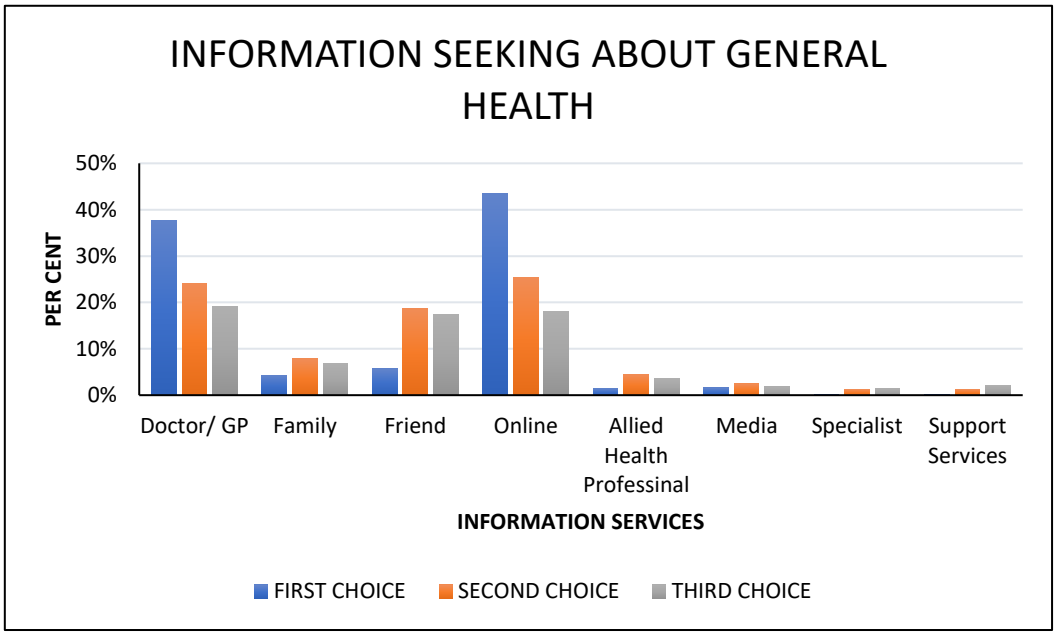

Figure 19. Information services accessed by survey participants when seeking information about general health.

Top 3 sources of information about a specific health issue

Respondents were then asked to identify in order of preference where they would go to access information about a specific health issue.

As shown in Figure 20, the sources most commonly used for information about a specific health issue were GPs (n=543), the internet (n=459) of respondents, followed by specialist (n=90) and friends (n=72).

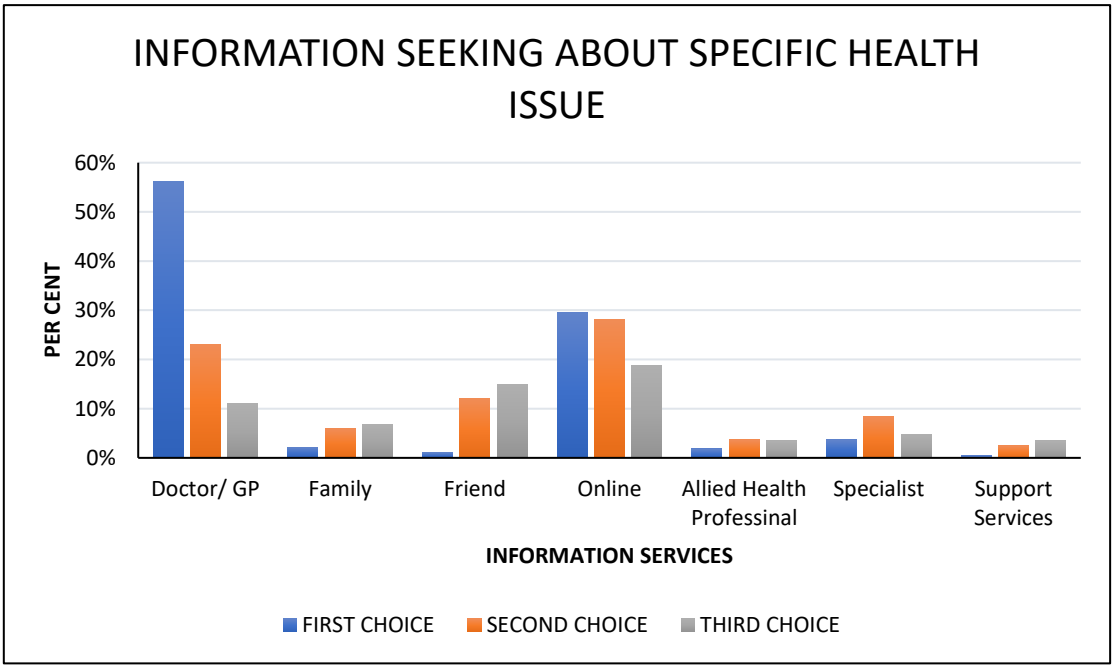

Figure 20. Information services accessed by survey participants when seeking information about a specific health issue

Information seeking by age

The number one preference for seeking information for both a specific health concern and a general health issue by age can be seen in Figures 21 and 22 below:

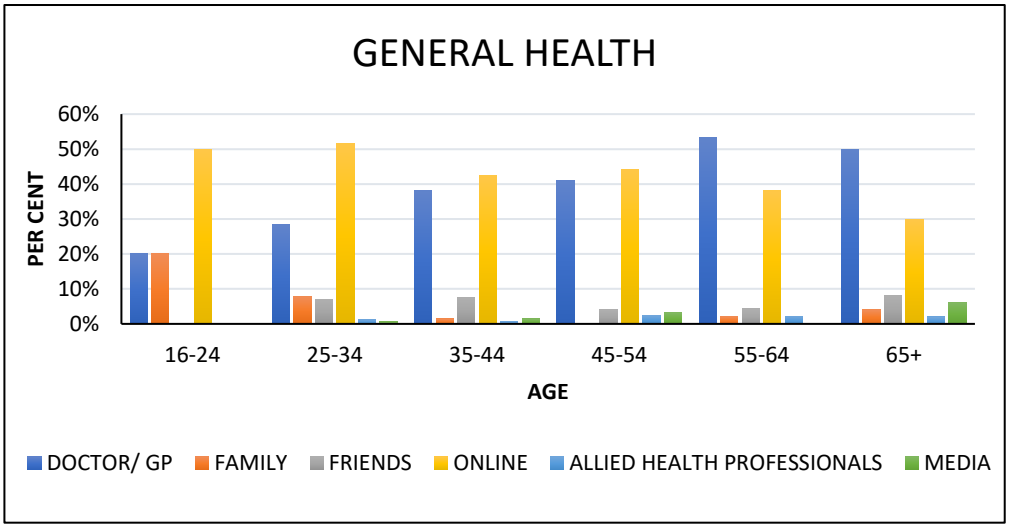

Figure 21. Comparison of information services accessed for general health issues by age group.

When seeking general health information younger respondents were more likely to get their information from online sources whereas older respondents (55+) were more likely to get their information from a doctor/GP. Younger respondents, particularly the 16-24 age group, also identified seeking information from family. Mothers were the most common family member that participants went to for health information with 12 of the 32 (38%) participants who indicated accessing information from a family member specifying this to be their mother.

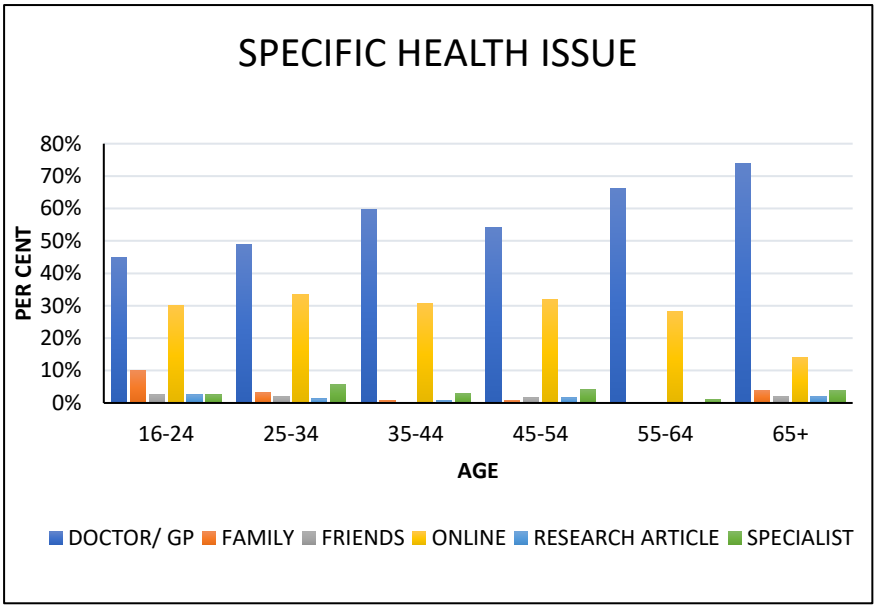

Figure 22. Comparison of information services accessed for specific health issues by age group.

Across all age groups, women were more likely to seek information about a specific health issue from a GP/doctor, followed by online sources.

Health and wellbeing information that women could not obtain

When asked if there was any health and wellbeing information that they could not obtain, 17% out of 581 respondents who answered the question said there was not (n=101).

Discussion

Women in the ACT have different life experiences, health needs, and caring responsibilities, and these differences impact on the way that women interact with and experience health services and supports.

The National Women's Health Policy focusses on improving the health and wellbeing of women in Australia, especially those at greatest risk of poor health. The Policy encourages having a clearer understanding of the context of women's lives, including the barriers that prevent women from taking up healthier lifestyle behaviours, as well as a focus on mental health and wellbeing (anxiety, depression and suicide); and healthy ageing - including the social, economic and environmental conditions under which women live.

On launching the final report of the Commission of the Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health"* Dr Margaret Chan, the Director General of WHO said:

> "*The Commission's main finding is straightforward. The social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one... This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health... But, let me emphasize, it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place*".

Our current research has shown that even in 2017-18, the determinants of health have an impact on the health of many women in the ACT, and their access to health care and support. Women highlighted family, financial, locational and work commitments which limited their ability to access affordable appropriate health services.

Women in the ACT told us they carried more responsibility for raising children, caring for others and taking care of housework; while working which impacted on their ability to access health services.

> *'Don't have time to look after myself as well as I would like. I work, have three young children, and have three other extended family members who need a lot of support right now.'*

> *'Difficulty prioritising myself in terms of taking time off from work or out of the office to exercise at lunch. If my kids are sick, I care for them. But for myself, time to go to the doctor or dentist feels like I'm shirking. Leaving my desk at lunch to exercise makes me feel guilty because twice a week I leave at 2:45, so I feel like I shouldn't be leaving the office for recreation. And since the suburb where my kids go to school is far from where we live, my time out of the office is mostly spent in the car, making it very difficult*

to find time outside of working hours to exercise when I want to spend time with my family.'

Others talked of the struggle to meet health costs despite being in paid employment. It was especially difficult for those employed in lower paying occupations, or students.

'Wish there were payment plans for things like dentistry. I haven't seen a dentist in 25 years. I'm good with my money and stretch it a long way, but as an aged care worker making just on $20/hour, the prospect of a $500 bill or worse isn't something I can afford all at once.'

'The costs of medical care is rather high and quite hard to afford, especially for those who are either unemployed, can only work casual shifts or are students studying. As a result, i tend to neglect any medical care i may need unless absolutely necessary.'

'I work full time & manage a household so even finding time to explore treatment options or maintain treatment is difficult - Cost of healthcare is prohibitive (community services worker).'

And many women with an ongoing health condition talked about struggling to access health services for themselves and their family and finding it harder to maintain good health.

'Depression, grief and being a sole parent of young children (widowed) combines to make it very hard to be where I would like to be in terms of my health. One impacts the other such that despite my best intentions, and good understanding of what I should do, I am often not able to achieve it. Plus there is the expense both in terms of time and money. I work 4 days a week but pay not high. …… No family living close by.'

'Again I have to shuffle from service to service just to have these check ups completed and then have to do the whole process all over if on going care or testing is required this is very time consuming and expensive not just in the prices of accessing the services but also.in travel costs, parking, time.off from work and the numerous other factors that are required to go in these routine check ups and health concerns.'

Even those who could afford to access health services and supports recognised the difficulty for those who were not on a good income.

'I have concerns about the ability of the general community to access health care, particularly those on marginal incomes. Bulk billing is virtually non existent in Canberra, hospital waiting times are long and for people with significant health issues, the support systems could be inadequate. At the moment good health and access to health care equates with a good income.'

ACT women's understanding of health

The World Health Organisation (WHO) described health as "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*" in 1948. In 1986, the WHO further defined that health is "*A resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.*"

Many of the women in our research used broader descriptions of health that included being independent, engaging in meaningful activities, emotional well-being, and to remain independent.

In contrast to disease and illness-focused definitions or access to medical services most of the women's understandings of health were about being able to do what they wanted to do when they wanted to do it; the ability to maintain an active and connected lifestyle; and having sufficient physical abilities and independence in order to be able to enjoy their daily activities.

Mental and physical health were the two most commonly discussed types of health, as was spiritual health, emotional health, among others. Women understood that physical and mental health are linked, and described how chronic illness impacted on depression and stress.

For most health was more of a background issue in their life than a key concern.

Women's top health issues

The three top issues identified by 85% of the 601 ACT women respondents were chronic conditions (53%), mental health (52%), and weight/diet fitness issues (49%).

Given that women have a longer life expectancy than men, managing chronic conditions well and at an early stage is an important issue challenge for the design and delivery of health services in the ACT and for the implications on health care spending. Because women show differing patterns in the prevalence and treatment of many chronic conditions, it is important to consider gender in the design, delivery and planning of future health services and programs in the ACT.

This is also true for mental health issues, with women using mental health services more frequently than men, As well as wanting a broader range of treatment options than are available currently. Women's mental health conditions and needs are significantly different from those of men and therefore require different responses.

Weight gain was mentioned by many women – they were aware that there were physical and health impacts from excess weight and aimed to improve their exercise and diet. But many women mentioned becoming resigned and losing confidence in their ability to make changes. This was not helped by media or health promotion messages that appeared to be blaming.

Many women also spoke of finding the cost of accessing exercise facilities such as gyms or personal trainers prohibitive as was the cost of preparing healthy food. And where respondents sought professional help, for example women experiencing obesity, the cost of accessing dietitians and nutritionists was highlighted as very expensive for those on lower incomes. It will be important to consider these issues in future design of services and health promotion messages in the ACT.

Barriers

Previous research by WCHM in 2010 showed that women's barriers in the ACT included availability, affordability, accessibility and appropriateness when accessing ACT health services, supports and information — including for preventive health. These are part of the social determinants for ACT women's lives that can lead to health inequalities for women.

The current research showed that many women in the ACT are still facing barriers in accessing health care including the high cost of health care, the very low rates of bulk billing in the ACT, lack of access to a regular GP, difficulties accessing appointments for routine, chronic and urgent problems; difficulties accessing local appropriate life course and age appropriate support and information for health; and a lack of continuity of care.

Women told us of the barriers due to cost of accessing health services, especially for those struggling to earn a living wage in the ACT, which made it harder for them to maintain good health. Because ACT residents generally have higher weekly earnings than the national average, those who don't can experience issues that can impact negatively on their health service access.

The most common concern was the cost of specialists and GPs, closely followed by the cost of accessing allied health or alternative medicine services such as physiotherapy, chiropractors or naturopaths. The cost of medical testing including scans and pathology concerned many participants as did the expense of dental services.

In relation to mental health, women identified that the 10 sessions covered under Medicare rebate was insufficient to deal with complex issues, and that even upon receiving this rebate, on most occasions women were required to pay an out of pocket gap fee for services. 'I've got a psych appointment on Tuesday and I'm about to cancel it because the washing machine's broken down and I have to pay for that.'

Other costs cited were income losses associated with taking time off work to attend appointments, travel costs of getting to and from appointments and the cost of prescriptions.

Women from all age groups raised concerns with the lack of bulk-billing GPs and specialists. Women spoke of the costs of prescription medicine, especially when combined with the cost of attending a doctor to obtain a prescription, including the on-going cost of medications for chronic illnesses.

> *'The cost of medicines seems to also be rising, which really concerns me. On a few occasions this year we have been unable to fill prescriptions because we simply could not afford them that fortnight. I wonder how many other families are also experiencing this.'*

Women spoke of putting other family members needs first due to time and cost.

> *'I'm a low income earner but do not get any health care entitlement due to my husband putting our combined income over the barrier by 1000 per annum. We have four dependant children and receive no government subsidies for our children either. If there is illness in our family as a mother, I will put the gp appointment and fill prescriptions for my children before my own. If there isn't enough money, I will not get my health needs met. There is a gap in women's capacity for complete health, and health services need to understand and amend the inequity.'*

> *'As a single parent who works 35 hours a week and has three children I am not able to access free services but don't have money to access paid services. I don't have time to attend appointments as I have to take time off work which I cannot afford because I have to use all my leave to manage school holidays and sick leave to manage if I am really sick or my children are sick.'*

> *'Just find it hard to get the time to attend the GP for myself and not the children. I'm also worried that if I do have a problem then I will find it hard to have the time or money to address the issue identified too. Family needs are always prioritised above my own.'*

> *'Financial barriers - as a working single parent I earn too much for a health care card, but not enough to pay for health insurance. So every thing comes out of of my pocket for me and my kids. I put them first, but that means I sometimes can't afford to part for health care for myself.'*

> *'As women are effectively forced to work full-time and look after a family, effectively you always put your needs last. I know I should have regular check ups for skin cancer, heart health, pap smears etc., but the cost of all these things and having to take time off work to go to appointments just makes it impossible to get done. Sadly, there are always other priorities.'*

Women told us they were likely to skip or delay medical visits, tests and medications, and expressed concern that this impacted on their health and wellbeing (both physical and mental).

> *'I wish that I was able to see professionals where I could get their expert opinions on things more frequently. I feel that issues would not get to the point where they're*

unmanageable. so I'm not just taking stabs in the dark for how to manage things. i wish i could afford or be able to get in to see anybody in the ACT to begin with.'

'The biggest barrier for me to address all of these issues above is that I have only managed to find one bulk-billing doctor in Canberra, and they are so busy, you have to book in weeks in advance to be seen, and quite often it is during business hours, which is difficult because it requires me to take time off of work.'

'The biggest barrier to accessing appropriate supports is time and money. If I take time off work to see Dr or Other health specialist then I don't get paid. And the cost of the health services or recommended therapies, medications etc are too expensive for me anyway.'

'Getting to and from appointments is difficult, so is affording the medications and scans requested by the doctor. I have a good income, but a large portion of it is just going to managing my conditions.'

Throughout the research, women indicated they were forgoing some things to cover their health costs, or choosing to delay or stop consultations with health professionals, treatment or purchasing medication.

'I needed a colonoscopy and a related study and deferred it because not covered by medicare nor my private health fund.'

'I am a single female on one income with no dependants. I am currently managing mental health and chronic pain at once and seek regular treatment. The biggest barrier for me is financial, even though I don't have dependants. I have private health insurance and claim wherever possible (including Medicare). However, addressing both mental illness and chronic pain from injury are medium to long-term endeavours of which private health and Medicare have only covered parts of. The financial strain of managing these two illnesses, with no second income to fall back on, means that I have had to make many sacrifices to avoid going into debt. I have also put off other routine health check ups like STD checks, pap smears and birth control in the past, as a matter of prioritising my health needs. It is difficult to find good feminine care that allows bulk billing and the money I would normally have to pay. The up front cost of good care is used to favour my mental health and chronic pain issues.'

Many also described family and work commitments which limited their ability to access health services.

'As a full time mother of 5 young children, my health is put last. .... if I can't make it to an appointment allocated to me, because it's during school pickup or dinner time, or the babies are sick, I miss out. Having more flexible appointment times would be beneficial. ... or even temp daycare at the facility.'

While those with long-term chronic conditions need to be supported to manage their conditions, many of the women in our research with long term conditions were impacted by costs and access issues to treatment and support.

> *'Not everyone can afford private health care, which makes getting good treatment for chronic conditions difficult. Getting good care reduces health care costs, cost to the taxpayer and the resulting good health enables people to work/study/parent and remain healthy.'*

> *'Unable to find help with the broader understanding of health. too much emphasis/blame placed on my 'lifestyle choices" when financial struggle and overwhelming caring responsibilities of 4 generations is a major cause of my deteriorating health.'*

Waiting times for an appointment, the limited times that appointments were available, and the lack of time in appointments for discussion were all issues described by women. Timely access to services is an important contributor to good health, and can decrease burden on other parts of the health system and potentially prevent hospitalisations.

Women also told us that opening hours were an issue in accessing GPs, and suggested that GP practices needed to offer opening times and convenient appointments which respond to the needs of women.

> *'Another barrier to services is that few are available outside working hours. It is hard enough to make the time to schedule appointments during the working day let alone attend them.'*

> *'Most GPs have their books full. Impossible to find a bulk billing GP in Canberra and difficult to get access to a GP at all after hours or on the weekend.'*

> *'Accessible hours for working sole parent with limited time due to having a disabled child.'*

> *'Most services are not available on weekends or after hours - that is my main barrier.'*

> *'Terrible experience with getting access to a GP in urgent cases. Sometimes you call to book an appointment with a GP and the excuses are: we are not taking new patients, we have a booking in 3 weeks times, etc etc. Defeats the purpose of getting medical assistance. In one case I ended up going to work very ill because I couldn't see a GP in order to take time off work.'*

> *'Services are only available during the day so they are difficult to access. This means my depression is not as well managed as I would like.'*

> *'It is really hard to get to appointments when working full time. Even in a supportive workplace, it feels inappropriate to take time off frequently for appointments. I find this*

really hard to manage with multiple chronic health conditions. I wish they were open beyond business hours or that the stigma around taking time off for appointments were less powerful.'

Timely and convenient access to health and wellbeing services, in places and at times that fit in with the way they lead their lives, and at a cost they can afford are important for women's health and wellbeing, and if not available may contribute further to costs both for themselves and for the ACT's health system in the future. Services available closer to home or workplace at times of the day suitable to women are more likely to be used and could make a big difference in identifying illness and effective treatment and cure. And to enable access, community hubs need to be close to local centres, public transport and parking.

Women also told us that the limits to access to some public funded services (such as the Women's Health Service which defines 'vulnerable' population groups of women) do not recognise that it can be individual circumstances that change and make women 'vulnerable' - but not eligible to free access to health care in the ACT which emphasises 'financial hardship' and access for low income earners.

Women also commented on the focus in the ACT of acute care rather than community based services.

'A lot of focus is on the acute health care in the ACT. The preventative and community support services are lacking.'

'It is currently a very fragmented and difficult to navigate system for many people. In particular, it does not cater well to the disadvantaged and there should be many more outreach services for the hard to reach populations. The ACT government should stop improving services at the Canberra Hospital ED as this just makes it a more attractive place for people to go. Aren't we trying to stop people from attending ED unnecessarily?'

Continuity of care was also raised as an issue for many women:

'It is difficult to get overall management of health where multiple issues are involved e.g.: menopause + fibromyalgia + tendon/muscle injury. This problem is even worse where people have more serious health conditions especially in hospital settings e.g. cancer + Alzheimers + heart condition + liver problems. Specialists seem to focus on "their" problem and there is no single person overseeing all the aspects.'

'Another problem of course is that even if I had access to adequate medical care I would regularly see two dozen specialists: 24 medical and allied health practitioners involved in the management of one underlying condition is bound to go wrong. I'd need a part-time GP just for me to coordinate all those specialists and go through all the results and reports. Unfortunately I am middle-class and not eligible for concessions …... With my list of chronic conditions (the physical and sensory disabilities are

steadily getting worse) i cannot get affordable private health insurance either. I think the health system fails those who have complex medical needs. I can't coordinate 24 practitioners, my GP has a lot of other patients as well and can't spent hours each week on me. it's like there is no desire to assist me in staying as well as possible for as long as possible. Which is fiscally really stupid.'

'The lack of coordination of health professionals is a major problem. All areas have their view and can only treat you if you have an issue they treat, they are not good at checking with colleagues if it could be something else. Specialists are particular poor at referring patient to other services if they can't help.'

'I also am dealing with multiple health issues and go to different doctors for each but feel I there is no one looking at the overall picture - I often get conflicting advice from different doctors.'

Preferences for community based services

Women spoke of having access to services close to the home and alternatives to GPs and hospitals, and spoke of the success of alternative health and community resources such as specific women's services, walk-in centres and community services.

'ACT breast screening still provides free screening for community members once every two years. This should be maintained. I've been very well served by the ACT health system, including some of those in ancillary roles: - the nurses who 'inducted' me after I was diagnosed with breast cancer, including the information kit they gave me and the big ring-bound journal I was given to record treatment, medications and advice - the support groups that continue to send newsletters, information and case studies (like BCNA) long after treatment is finished - the unsung little niche services (like the shops that provide wigs for chemo patients).'

'Walk in Centres are very responsive and the nurses offer great help after hours (after work and weekends) which has worked well for me.'

'Nurse walk in Centre is a brilliant idea for minor ailments.'

'The drop in centre in Belconnen has been excellent in helping with small issues and reduced greatly the inconvenience and expense of trying to get in to see my GP on short notice. My experience there has always been great.'

'SHFPACT is a phenomenal organisation that deserves more funding than it gets to service more in the community with shorter waiting times. I had a wonderful experience with my first pap smear, as I know many of my friends have as well.

Access to health information

Consistent with WCHM's 2010 report, women still talked about the need for local information that assist ACT women to make informed decisions about their health care and so that they

understood the options available, know they have choices, know where they can go for their health and wellbeing issues and information, and make decisions based on trusted and credible information.

> *'It is hard to find reliable information short of going to the doctor - which is now extremely expensive. Listening to other women and what has worked for them is often more helpful than specialists because they actually listen to you.'*
>
> *'With complex general health issues like mental health and diet it's hard to know where to start. It's also hard to integrate info from different sources (ie doctor and online) and turn it into an actionable plan.'*
>
> *'So many websites, and so much information. It is hard to tell what is valid and useful.'*

Women are still turning to the internet for health advice. And online forums which connect women with shared interests are seen as a valuable source of support. Using an online community to discuss symptoms and treatments, share information, or seek advice and support from others was seen as important. It encouraged feelings of belonging and acceptance, which helped some women to understand and deal with their health conditions and their daily lives.

To be active in their health care, ACT women felt they not only needed access to health information and support, but also to peer networks. For many survey respondents and focus group participants, social networks are the best way to share and receive information, support and referral. Personal stories of others from a similar demographic or who are going through a similar health experience are a useful way to present health and wellbeing information. Listening to personal stories has been shown to help women be more proactive in asking questions of their health providers.

Conclusion

This report about the views and experiences of ACT women adds a local context to the national and international evidence about the factors that influence health, and the barriers that can limit utilisation of and access to health services. It also reinforces that many of the findings from previous research in the ACT are still relevant today.

While the work and caregiving responsibilities of women, their financial and social situations and the different health needs of women may create barriers to accessing health care services, the way that the health care system is organised and designed also creates barriers for women in being able to access effective health care and support when they need it. We also heard from ACT women that organisational barriers can limit the utilisation of and access to health services further.

That is why it is important to consider gender differences in access to care and to ensure that responses are designed to be gender sensitive equitable.

The changes in the ACT including the new Territory-wide Health Services Framework, the consideration of community based health responses, the expansion of points of access such as the additional Walk in Centres, and the considerations in the ACT's mental health responses offer opportunities to adjust the service system to respond to the issues raised by women.

We hope that this report which shares the views and experiences of local women can assist in informing practical actions and solutions to improving the health and wellbeing outcomes for ACT women.