

WOMEN'S HEALTH ISSUES – AGES 40 - 60

Dr Marjorie Cross, General Practitioner

Introduction

It is not possible to discuss policy and health in this country without admitting our first priority as citizens is to actively engage in the tragedy that is Indigenous health. This is a national crisis. The health and living standards of Indigenous people in Australia are the worst in the developed world.

Aboriginal health standards in Australia are now so low that 34% of Aboriginal women and 45% of Aboriginal men do not live to the age of 45.

Health resources must be allocated on the basis of need and Indigenous people must be involved in designing and implementing the solutions. Spending should be directed towards primary health care and towards stopping preventable diseases becoming fatal.

It is going to be important for women's organisations to keep a detailed watch on the changes and development in health policy as the demographics change and the population ages because the system has to improve in all areas, including access, affordability, doctor shortages, independence and choice for patients.

Examples

Long-term care: of people with chronic and complex health issues
 of people with disability
 of the aged

Protection of the Pharmaceutical Benefits Scheme

Public Health: Whatever it takes to improve the health of the public.
 The inequities of the Medicare system and of the private health
 system, including inequities for rural Australians and people of lower
 socioeconomic backgrounds.

Improvement in areas of financial consent in ancillary care, including
dentistry, radiology and pathology.

A General Practitioner's View

I have based this paper on the advice from the patients I see and the doctors I work with every day. Being unaccustomed to detailed research I simply asked the patients I see what were their most pressing concerns around their own health issues.

As I reviewed their comments, several major areas emerged:

1. Prevention/early detection/screening for cancers in particular.
2. Hormonal concerns: contraceptive choices, the menopause, and post-menopausal problems.
3. The plea for information; although it is the information age women find it very difficult to access credible information.
4. Multiple roles in this age group: of parenting, 'partnering', caring for ageing parents whilst dealing with a high workload.
5. Relationships and changing relationships: women are often alone through separation, divorce or death of a spouse.

I took about 40 comments to get this sort of summary, and was as much impressed by what seemed left out, eg women are very concerned about cancers, but seem unimpressed that their risks of cardio and vascular diseases are higher than their risk of cancers.

Much of this overlaps, but with the demographic changes of older aged women having their first pregnancies, women in this age group are caring for younger children and often simultaneously having primary responsibility for ageing family members as they themselves age (or at least negotiate the menopause) and are at higher risk of primary health problems.

It is not enough to simply look at health policy. The overlapping issues of aged care and disability need to be integrated and not fragmented.

Due to increased hospital waiting times and decreased number of hospital beds and women's multiple responsibilities at home, timely and holistic care at GP level is increasingly important as is the availability of respite/community-based services, e.g. 'hospital in the home' etc.

There are issues I see as a General Practitioner which were not highlighted by my own patient focus group but which doctors in my own practice have tried to actively address.

1. Domestic violence. This is a major health risk for women aged 15–44 and thus fits into the age group I am discussing. There is a strong argument for pursuing cost-effective violence prevention. Access Economics has reported that domestic violence costs Australia \$8 billion and that it is especially an issue in the age group 15–44.

I would argue that domestic violence remains an issue throughout the female life cycle, but in the age group I have been given to discuss it is more hidden, including by the victims, and there are fewer resources for women in this age group. Quite properly refugees take women with children first.

2. Smoking-related illness. Others can document the facts, but I can simply attest to the habit of smoking of women now aged 40–60 and its impact on health issues, along with the odd idea that weight may be controlled this way!

3. Obesity. Nowhere is health investment so important.

To improve the health of the public we need greater primary care where high-risk individuals receive treatment for their increased health risk. We need health promotion to galvanise people into taking action for themselves and to promote social change that makes it easier to choose healthy ways of living.

Messages have to change. We see people who don't eat anything because foods are labelled in their minds as bad for you or wrong.

4. The Pharmaceutical Benefits Scheme. Let's work together to ensure it is maintained, that there is genuine cost-effectiveness and that its processes are transparent.

An area that needs much wider discussion is that of alternative/complementary health care. It is this age group of women that turn to this modality and indeed spend huge amounts of money on advice and products and I for one would argue that in this sector the information is not credible. Some of it is now subsidised by private health insurers. Women must be able to get information that enables them to make useful choices.

Conclusion

Finally, I want to address the issues I have been asked to address by putting the question: how am I being influenced to provide care through government initiatives?

It may be that by looking at the here and now you can discuss how that can be improved or changed.

1. National Mental Health Initiatives. Whilst these are to be applauded, women in the age group I am discussing miss out because the 'simple' talking therapies are expensive and difficult to access where much of their mental health issues are around 'stress'. They may get over-prescribed for depression, where the issue is oppression. The State-based mental health teams are not geared to anything but major mental health problems and crisis management.

2. National Screening programs, particularly in early detection of breast cancer and early detection of cervical cancer.

In this area issues around transparency and use of data abound as well and getting the right people, i.e. acknowledged leaders in the field, into Federal Government committees

to present that data and then convince the profession and women of changes that may be worth implementing (for example: liquid Base Cytology for the end point of diagnosing HPV).

The breast screening programs need consumer input from women to be screened and not just from breast cancer survivors. Amongst the patients I have shared this paper with, women remark how they have experienced such pain that they would not return to a screening program. It is a significant area where medical workforce deficiencies are a case in point now. There are not enough radiologists and I for one do not want any other than a highly trained radiologist reporting on my mammograms.

3. Research

I throw this in from 'left field' to highlight two issues:

- (a) that primary care medicine and medicine in general is increasingly a women's profession.
- (b) that there is a shortage of regular evaluation at all levels and variety of health issues. I place it here because if I am never again involved in a pilot project it will be too soon. In all things we need on-going long-term core evaluation where people learn. Pilot projects do not foster learning or change.

There is a lot of qualitative and some quantitative research about women in medicine, much of it done by rural medical organisations. I have been involved in some of it. To date it has not led to changes and has not been well publicised, in part because it found the obvious—that medical practitioners want more family-friendly lives. I doubt that much has been assessed or publicised by/to the rest of the profession or even urban or suburban practitioners. It is certainly not getting through to communities other than a few progressive rural and remote communities, that there is a crisis in supply and commitment of primary care physicians.

Women say they want women doctors and appreciate their listening skills, but do not want to make them feel welcome in the community, and do not want to pay them for the longer time spent on consultations.

4. General Practice

I am sure you will have noticed significant changes. There are many more women graduates in all areas. Today's medical graduates have first of all graduated in another degree.

Many of today's graduates are rurally bonded. This could be a topic for lengthy discussion if you will.

General Practices over the last 10–20 years have been formed into divisions and other organisations. We have programs for continuing education, quality assurance, and our practices are most often accredited. We gain Federal Government incentive payments for

EXPOSURE DRAFT FOR CONSULTATION

primary health initiatives, e.g. immunisation and screening. We are most interested in evidence-based medicine and able to debate the subtleties.

The rhetoric is that General Practitioners are the first-line, the gate-keepers and are fundamental to the Australian health care system. These statements are supported by the facts and by the patients and the buck (i.e. responsibility, not dollars) stops with us.

The reality is that increasingly we are providing holistic, thoughtful, timely care at individual and public health levels. The younger doctors want it this way and there are wonderful role models amongst the older General Practitioners.

In discussing moving policy initiatives forward for women's health and for women's organisations, we want to be in it to see big bold ideas get up and to get the right health infrastructure to serve future generations of Australians.