

ORIGINAL RESEARCH

Health and access issues among Australian adolescents: a rural-urban comparison

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ABSTRACT

Introduction: Previous research has reported rural-urban differences in health concerns and access issues. However, very little of this has concerned young people, and what has been published has been mainly from countries other than Australia and may not generalise to Australian youth. The study described in this paper is a subset of a larger study on health concerns and access to healthcare for younger people (12-17 years) living in New South Wales (NSW), Australia. This paper reports findings on rural-urban similarities and differences. The specific study objective was to identify and describe rural-urban differences, especially those associated with structural disadvantage.

Methods: The reported findings form part of a larger state-wide cross-sectional study of access to healthcare among NSW adolescents. Adolescents were drawn from high schools in ten of the 17 Area Health Services in NSW. These Area Health Services were selected because they represent most aspects of rural-urban NSW with respect to population characteristics and health services. Eighty-one focus groups were conducted with adolescents (35 with boys and 46 with girls), of which 56 were conducted in urban, 22 in rural and 3 in regional areas. The focus groups were tape-recorded, transcribed and analysed using the computer software package NUD*IST 4.



Results: The analysis revealed certain health concerns that were common to both rural and urban adolescents: use of alcohol and illicit drugs, bullying, street safety, diet and body image, sexual health, stress and depression. However, certain concerns were mentioned more frequently in rural areas (eg depression), and two concerns were raised almost exclusively by rural youth (youth suicide and teenage pregnancy).

There were also structural differences in service provision: adolescents in rural areas reported disadvantage in obtaining access to healthcare (limited number of providers and lengthy waiting times); having only a limited choice of providers (eg only one female doctor available), and cost (virtually no bulk billing – ie direct charge to Medicare with no patient co-payment). A lack of confidentiality as a barrier to seeking service access was raised by both rural and urban youth, but was a major concern in rural areas. No issues specific to urban areas were raised by urban youth. Male and female rural adolescents were more likely than urban adolescents to express concerns over limited educational, employment and recreational opportunities, which they believed contributed to their risk-taking behaviour. Gender differences were evident for mental health issues, with boys less able to talk with their peers or service providers about stress and depression than girls. These gender differences were evident among adolescents in both rural and urban areas, but the ethos of a self-reliant male who does not ask for help was more evident among rural boys.

Conclusions: While Australian rural and urban youth shared many health concerns, rural-urban differences were striking in the almost exclusive reporting of youth suicide and teenage pregnancy by rural adolescents. The findings suggest that structural disadvantage in rural areas (limited educational, employment opportunities, and recreational facilities) impact adversely on health outcomes, particularly mental health outcomes, and contribute to risk-taking behaviour. Such disadvantages should be considered by health-service policy makers and providers to redress the imbalance. Gender differences were also evident and efforts to target the specific needs of Australian adolescent boys are warranted.

Key words: adolescents, Australia, risk-taking behaviour, rural-urban, access, suicide, teenage pregnancy.

Introduction

Failure to receive timely treatment for common health problems may result in substantial threats to health from otherwise benign conditions. A major concern in adolescent medicine has been how best to facilitate the access of young people to appropriate health services. In Australia few studies have been published which specifically address the issue of access to healthcare among young Australians^{1,2}. Most youth studies are North American^{3,4} and may not generalise to young Australians. Research in North America and the United Kingdom (UK) suggests that certain subgroups are less likely to access healthcare⁵⁻⁸.

In Australia, while little research has been conducted on health, and access to health services among young

people, there are many anecdotal reports that a large proportion of young Australians do not seek healthcare when they have health concerns. In 2000 a State-wide access study for New South Wales (NSW) was envisaged that would encompass several phases, and in 2001-2002, phase one of that study was conducted, funded by the NSW Health Department, consisting of formative research involving needs assessments of young people.

The main aim of phase one was to investigate the conditions or concerns under which young people resident in NSW do, or do not, seek healthcare, and the reasons for this. The study also sought to improve understanding of the factors associated with failure to receive appropriate healthcare in terms of intra-



personal, social service and structural factors. Particular emphasis was given to understanding how these factors vary across population groups on the basis of selected socio-demographic variables: sex, age, socioeconomic status and geographic location. Its methodological strategy was to conduct comprehensive and systematic research by collecting data from stratified groups of young people in order to identify common concerns and also concerns specific to particular sub-groups. This article reports the findings by geographic location, and also reports gender differences where relevant. (Findings by socio-economic status have been reported elsewhere, and, contrary to expectations, no clear associations between socio-economic status and reported barriers to healthcare were identified⁹).

People living in rural Australia have higher mortality rates for some diseases and higher rates of hospitalisation¹⁰. Certain barriers to rural Australians accessing services have been reported, including long distances and cost¹¹ and attitudes¹². The objective of the analysis by geographic location was to compare health concerns and access issues of male and female adolescents living in rural and urban NSW in order to identify differences, especially those associated with structural disadvantage.

Methods

In consultation with the NSW Health Department, ten of the 17 Area Health Services (AHS) were selected from which to draw the sample. Five were metropolitan AHS (Western Sydney, South Western Sydney, South Eastern Sydney, Central Sydney, Northern Sydney). Four were rural AHS, of which two were inland (Macquarie, Mid-Western), one coastal (Southern) and one remote (Far West). In addition, one regional AHS (Illawarra) was included (for the purposes of the present research, 'regional' refers to towns with a population in excess of 250 000, and 'rural' refers to smaller towns or villages). These AHS were selected

primarily because they represented most aspects of rural and urban NSW, including population characteristics, health services and the type and availability of adolescent health-related activities.

A combination of sampling procedures was used to achieve the most desirable sample relevant to the topic of interest¹³. Quota sampling by required characteristics (socioeconomic status and location) was used to select the high (secondary-level) schools from which the school students were recruited for each selected AHS. Within the high schools, purposive sampling (a form of non-probability sampling) was used to recruit school students who were stratified by sex and age¹⁴. The full report contains further detail of the sampling and recruitment¹⁵.

Because the present study was an exploratory study, a qualitative open-ended data collection approach was appropriate¹⁶. Focus groups¹⁷⁻²⁰ were used to obtain the range of views on health and access issues from high school students. This qualitative data collection method also enabled recording of verbatim interactions which occurred between group participants. Homogeneity (putting like with like) is recommended for the composition of focus groups to encourage participants to interact freely. Because some of the issues raised could have proven gender sensitive, students were interviewed in single-sex groups. In addition, because age differences may inhibit younger participants from speaking freely, participants were grouped into three age categories, based on high-school year.

Given the range of socio-demographic characteristics (age, gender, socio-economic status and geographic location) by which the sample was stratified, it was necessary to conduct a large number of focus groups in order to obtain sufficient numbers for analysis within each cell. In all, 81 focus groups were conducted during the time period 2001-2002. While the majority of the focus groups were conducted in urban areas ($n = 56$), there was a strong representation of rural areas



(22 groups) and some representation of regional areas (3 groups). The focus groups consisted of from 6 to 10 students with an average size of 8 students, which gave a total of more than 650 participants.

All focus group discussions were facilitated by the same experienced qualitative researcher. The 81 focus group sessions were tape-recorded and transcribed. Given the large number of focus groups only 51 (33 urban, 15 rural and 3 regional), were entered into the NUD*IST software program²¹, because entering more than this would be prohibitively time consuming. However, to ensure no loss of information, the remaining 30 transcripts were searched manually for any information not already identified. Because the number of regional groups was small ($n = 3$), and the findings similar to the rural groups, the findings for the regional groups have been combined with the rural groups for the purposes of the present article.

Issues for discussion²² included adolescents' views on what they considered the main health concerns for people their age and perceived barriers to accessing services. While certain issues were raised by the focus group facilitator in all group sessions, other issues were raised by the participants.

Ethics approval

Ethics approval for the study was obtained from the Children's Hospital at Westmead's Human Research Ethics Committee, the NSW Department of Education and Training, and the Human Ethics Committees of the participating Area Health Services. In addition, all adolescent participants and their parents gave written informed consent.

Results

Many health issues raised were concerns common to young people living in rural and urban areas: use of drugs, bullying and street safety, sexual health, diet and

body image, stress and depression. Depression was a major issue raised and boys were more likely than girls to say that they would find it difficult to seek help for depression. For example, in a group of 17-year-old boys, one said:

Boys bottle things up and don't talk to each other like girls do. It's the macho thing, where it's themselves versus the world, and to say there is a problem would be weak.

The following interaction occurred in a focus group of 17 year old boys:

If I had depression I don't think I'd go and see anyone about it. [Boy A]

Yes, I'd keep it to myself, that's what you do. [Boy B]

You'd turn to your mates, but you don't want to lose face with depression... [pause] you could. It's a male ego thing. [Boy C]

A lot of people are afraid of rejection by their mates. [Boy D]

Major health concerns in rural areas

While depression was raised as a health concern in both rural and urban areas, youth suicide, which was viewed by participants as linked to depression, was raised almost exclusively in rural areas (11/18 rural groups; 2/33 urban groups). Depression was raised as an issue by both rural girls and boys, but it was primarily considered a problem for boys.

Suicide is like an issue [in rural areas] especially for guys, because it's hard for us to talk. [Boy L]



Yeh. I don't think guys are as open as girls. [Boy M]

The following interaction during a focus group with 17-year-old boys illustrates the range of health problems raised by young people; and the emphasis on depression and its association with suicide, particularly for boys:

What do you think are the main health issues for young people like you? [Facilitator]

Chicks [Boy N]

STDs [Boy O]

Alcohol [Boy P]

Depression [Boy Q]

Yeh, in ...[names a nearby rural area] ...and [names another nearby rural area] two guys committed suicide. One got a shot gun, the other hung himself in the school toilets. [Boy R]

What do you think drives guys to suicide? [Facilitator]

Stress [Boy N]

Depression [Boy Q]

They like to deal with it themselves [Boy R]

Yeh, not look weak. They wouldn't trust other people. [Boy Q]

In schools and communities where youth suicide had occurred, rural youth and particularly boys, emphasised the importance of talking about depression to prevent it resulting in suicide, as illustrated by this interaction between 16- and 17-year-old boys:

We were all disturbed. [Boy S]

Yeh, you get shocked into help. [Boy T]

There should be more help before it gets to the suicide stuff. Like concerts where people who've gone through depression can talk about how they got help. [Boy U]

Yeh, that helps guys open up. [Boy V]

The other health concern raised almost exclusively in rural areas was teenage pregnancy. This issue was raised by adolescents in 12/18 rural groups, but in only 1/33 urban groups. Girls were more likely to consider teenage pregnancy as a major health concern. General reasons given for teenage pregnancy were: getting drunk, not thinking it would happen to them, girls believing contraception was the boy's responsibility and, for boys, not wanting to use condoms. Specific rural reasons were concerns over confidentiality and visibility in a small town making it difficult to purchase contraceptives, seek contraceptive advice or obtain an abortion.

You can buy them [contraceptives] but most people are embarrassed, and you might know someone. [Girl, 15 years]

The 'morning-after pill' was frequently discussed as a preferable option to normal contraception, although access to this was also an issue because of fewer general practitioners (GPs; particularly female GPs) in small towns, and concerns about confidentiality.

Pregnancy is the main health problem for our age. Some people don't even know where to get the [contraceptive] pill and are too scared to get it, especially as it's meant to be confidential. This is a small town and everyone knows everyone, and it's going to get around ... and that isn't what people want. And if you go to the chemist most of the time you know someone working there. There are no abortion facilities so a lot of people go to [nearest city]. [Girl, 15 years]



Teen pregnancy was not considered by many young girls (or their families) to be a catastrophe, rather a mistake that was then adjusted to. Limited education and employment opportunities meant that becoming a mother gave girls a purpose and role in life. Many rural parents had had children at very young ages themselves and had limited formal education. Families often supported the young girls financially to bring up their babies, or provided child care and accommodation.

You think it wouldn't happen here, but I hear about a lot of girls who get pregnant. Even lately from this school. They are 14 or 15. They just have it. They are scared about going to a doctor and then they can't have an abortion. In some families it is more acceptable. One girl I know had the support of her friends and family. She said her Mum had had her and her sister at 16 and 18 so it's not such a big deal. [Girl, 14 years]

There was also reference to the high rates of teenage pregnancy among Indigenous Australian (Aboriginal) girls.

The Aboriginal girls in our year were pregnant before they got to years 8 and 9. You see them walking in the street with their second kid. They don't think about getting a job - just marry some guy. [Girl, 15 years]

Perceived barriers to accessing services

Cost and lengthy waiting period: There were few doctors (GPs) available and due to high demand there seemed to be no bulk billing (direct billing to Medicare with no patient co-payment) available in all the rural areas visited, making the possibility of seeing a GP 'cost prohibitive' for some. For example:

...It's expensive. They [GPs] charge you 'cause they're busy... Mine is triple booked. [Boy, 17 years]

The limited supply of GPs was also perceived as the reason for lengthy waiting periods:

The doctors that are here are expensive and you have to wait 3 weeks to get in. [Girl, 17 years]

For certain conditions such a wait was considered unreasonable:

I'd like to go to a doctor for STDs and stuff, but I wouldn't want to wait 3 weeks. And say if it happened [unprotected sex] on a Saturday it would take that long [3 weeks] to get in. [Boy, 17 years]

Limited choice of health professionals: Of the limited number of GPs available, few were young and even fewer were female. Female and/or younger doctors were preferred by most girls and there was invariably a lengthy waiting period due to demand.

I'd like to see someone who isn't an old codger [elderly and set in his/her ways], but there are only 3 doctors in town and they're all men and they're all old. [Girl, 17 years]

I feel more confident with female doctors, but if you have something wrong you have to book weeks in advance and by the time you get there the problem has resolved itself. It's always booked out so you don't feel you can go unless there is something really serious or you will be wasting their time. [Girl, 15 years]

Limited public transport: For those young people who lived out of town, access was further prohibited by distance and infrequent public transport.



Limited opportunities in rural areas

Other issues were raised by participants in rural but not urban groups. These were limited educational, employment and recreational opportunities. These deficits were reported frequently and as major concerns. Although not health issues in themselves, they impact on health outcomes, and were viewed as such by participants.

Limited educational and employment opportunities: Participants were keenly aware of limited employment opportunities.

If you stay here you haven't got much to live for. There isn't much for boys either. You can't go off and get jobs and girls can't do anything unless they work in a fast-food place. [Girl, 15 years]

The participants recognised that they would have to leave town if they were to pursue educational and employment opportunities.

There's a big unemployment thing down here – not many jobs. If you want a good job you go to [city]. Not many post-high school courses either. [Boy, 17 years]

In some instances young people reported staying on at school because there were no jobs available. There were also limited apprenticeships and educational institutions in most towns. While some young people were fearful of leaving and expressed a desire to stay in the rural area, close to family and friends and their strong social support networks, others wanted to leave because of the greater opportunities (educational, employment, social) that would be available. This created a source of stress which was not evident among the urban participants.

There are no proper jobs where you can earn good money when you leave school. Only places like [a chain store]. You probably have to move away. That's scary. You'll be leaving all your friends and things. [Boy, 15 years]

The financial costs involved in moving away from home to study concerned many young people who were acutely aware of the financial stress it would place on their families to cover the costs of transport, food and accommodation.

I want to go uni [university], but that means going to [nearest city] and then I would have to live and eat. I don't know how my Mum and Dad can afford that. I know it is something they worry about [Girl, 17 years].

Limited recreational opportunities: Limited recreation opportunities was an issue discussed frequently in rural areas but not in urban areas. It related particularly to girls and was about the range of options young people had to socialise or to participate in their communities. The lack of opportunities was regarded by young people to contribute at times to greater risk-taking behaviour (such as drug taking/drinking/sexual activity) as 'something to do'.

A lot of people have nothing to do so they just get drunk, stoned or on drugs. I think that has a lot to do with health as well, having nothing to do, so you just do stupid stuff. There's nothing else to do that's safe. [Girl, 15 years]

Limited recreational opportunities, together with limited educational and employment opportunities, were seen as being linked with depression, which could lead to suicide.

I see a lot of suicide in this town, compared to how small we are. They're not all young, more



like 19. I think it is depression, that sort of thing, especially with guys. You are stuck here. If you drop out of school you've got nothing else and boys don't talk. [Girl, 17 years]

In addition to the limited venues for social interaction, the lack of anonymity when meeting other young people was a commonly reported constraint.

People are so conservative here. It's like there are 3 young people hanging out on a corner and they must be doing drugs or something. Why can't they [adults] understand that we just want to meet and hang out. [Girl, 15 years]

Girls expressed frustration at the small town mentality and how easy it was to be given a bad name.

I think girls have more pressure. We are the ones who get the bad name, and get talked about straight away. If the boy does anything [sexual] no-one cares – they congratulate him. [Girl, 17 years]

Discussion

This analysis has highlighted health concerns which are either specific to rural adolescents, or given greater emphasis to such concerns. (No concerns or barriers were raised that were specific to urban young people). While depression was a common concern for rural and urban youth (well documented in the adolescent literature²³⁻²⁶), teenage suicide which was viewed as associated with depression was a major issue raised by rural youth. The relationship between unemployment and youth suicide has been documented in Australia²⁷, especially for rural and remote areas¹⁰, where a culture of self-reliance may create reluctance to seek help for mental health problems¹². The issue of teenage pregnancy and acceptance by parents has also been reported in Australia²⁸. The fact that youth suicide and teenage pregnancy were not raised as issues by the

facilitator in any focus group, but were raised almost exclusively by young people in rural focus groups, emphasises the centrality of these issues for rural youth.

An important finding was that many rural young people consider that limited educational, employment and recreational opportunities increase the likelihood of adolescents engaging in high risk-taking behaviour, which is a view that has been canvassed in the Australian literature²⁹. Major structural changes are required to create educational, employment and recreational opportunities in rural areas so that more adolescents are actively engaged which should reduce the incidence of risk-taking behaviour attributable to 'having nothing to do'. A recent American review³⁰ of the literature regarding risk-taking behaviours among urban and rural youth found that there is a gap in the literature for rural youth, but the view that rural adolescents are engaged in fewer or less severe risk-taking behaviours than urban youth is misleading.

Major health policy changes are also required to overcome the disadvantages in accessing health services reported by adolescents in rural areas, and these have been noted elsewhere: limited numbers of health professionals, inadequate numbers of female professionals, limited bulk-billing facilities, long waiting periods, limited opportunities for discreet consultations³¹. The documented national decline in bulk-billing rates^{32,33} particularly in rural areas where the current availability is already low³⁴, has adverse implications for young people accessing rural health services in the future.

While rural-urban differences exist in health concerns and barriers to access, gender differences are also evident. For girls requiring sexual healthcare, previous research has found that the rigid societal gender norms operating in rural towns are viewed as a greater threat to them (due to acquiring a sullied reputation) than any physical consequences of sexual activity³⁵ as was found



in our study. Girls also indicated a clear preference for (young) female health professionals with whom they believed they could communicate more effectively, which is consistent with the literature^{36,37}. The limited supply of such professionals in rural areas means that this preference is not being met.

The difficulty that boys (both rural and urban) face in communicating their health concerns to health professionals and peers, particularly on mental health issues, is apparent in the focus group dialogue, and this is also consistent with the literature^{38,39}. This difficulty was not evident among rural or urban girls to the same extent. Gender differences appear exaggerated by the tough stoical male image in rural areas, making it even more difficult for rural boys to seek help than urban boys. It would therefore seem reasonable to focus health promotion efforts on boys, particularly those living in rural areas.

Conclusion

While Australian rural and urban youth shared many health concerns, rural-urban differences were striking in the almost exclusive reporting of youth suicide and teenage pregnancy by rural adolescents. The findings suggest that structural disadvantage in rural areas (limited educational, employment opportunities, and recreational facilities) impact adversely on health outcomes, particularly mental health outcomes, and contribute to risk-taking behaviour. Such disadvantages should be considered by health-service policy makers and providers to redress the imbalance. Gender differences were also evident and efforts to target the specific needs of Australian adolescent boys are warranted.

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