



* ARIA (Accessibility/Remoteness Index of Australia) categories:⁴

- Highly accessible: areas with relatively unrestricted access to a wide range of goods and services and opportunities for social interaction.
- Accessible: areas with some restrictions to accessibility of some goods, services and opportunities for social interaction.
- Moderately accessible: areas with significantly restricted accessibility of goods, services and opportunities for social interaction.
- Remote/very remote: areas with very restricted or very little accessibility of goods, services and opportunities for social interaction.

† Relationship between area disadvantage and GP use is adjusted for number of full-time equivalent GPs per 10 000 population.

‡ Each tertile comprises approximately a third of the statistical local areas (SLAs) in the six Australian states. The high and low tertiles comprise the 33% least and most socioeconomically disadvantaged SLAs, respectively.

2-year period 1996–1997. Our analysis included a measure of the number of full-time equivalent (FTE) GPs per 10 000 population in each SLA as a test of equity: similar or higher rates of GP use in disadvantaged SLAs independent of GP availability suggest equity of access.

In areas classified as “highly accessible”, rates of GP use were significantly (10%) higher in disadvantaged SLAs after adjusting for GP availability (Box). The reverse was found in “remote/very remote” areas, where rates of GP use were about 36% lower in disadvantaged SLAs. Also, the strength of the relationship between GP availability and GP use differed across the ARIA categories. In “highly accessible” areas, a unit increase in the number of FTE GPs per 10 000 population was associated with a 1% increase in GP use, whereas in “remote/very remote” areas it was associated with a 15% increase (data not shown). This suggests that disadvantaged groups in rural and remote areas experience disproportionate difficulty accessing GP services. These areas are underserved by GPs, who charge more for their services and are less likely to bulk-bill.⁵

It seems that in metropolitan regions the Medicare principle of equity of access to GP services is being realised (ie, people with higher levels of morbidity are making greater use of GP serv-

The association between licit and illicit drug use and sexuality in young Australian women

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TO THE EDITOR: Studies of non-representative population samples show that recreational drug use is more prevalent among non-heterosexual women than heterosexual women.¹ The Australian Longitudinal Study of Women’s Health² allowed an examination of the links between sexuality and recreational drug use in a representative sample of 9260 women aged 22–27 years in 2000.

Respondents reported their history of tobacco, alcohol and illicit drug use. Reported frequency and volume of alcohol consumption were recorded according to National Health and Medical Research Council guidelines.³ Use of illicit drugs in the last year was dichotomised between marijuana and other illicit drugs (see Box). Respondents also indicated whether they had ever injected illicit drugs.

Analyses compared exclusively heterosexual women with all other women. Data were weighted to correct for over-sampling in non-metropolitan areas. Odds ratios were adjusted for age, region of residence, and father's occupation (as a measure of social class).

Younger women were significantly more likely to report risky drinking and illicit drug use. Women from urban areas were significantly more likely to be non-heterosexual and to use illicit drugs, but less likely to report risky levels of alcohol consumption. Women whose fathers were professionals or managers were significantly more likely to be non-heterosexual and more likely to use illicit drugs, but less likely to smoke or report risky drinking. Details are available from the authors.

Non-heterosexual women were significantly more likely than heterosexual women to have ever smoked, to be current smokers, to report risky levels of alcohol consumption, to have used marijuana and other illicit drugs in the last year, and to have ever injected drugs (Box). Although these relative differences are important, so too are the absolute values — 45.6% of non-heterosexual women were smokers, and 45.6% reported alcohol consumption of concern. In the last year, 58.2% used mari-

juana and 40.7% used other illicit drugs. One in 10 had ever injected illicit drugs.

Although women are generally less likely than men to use drugs, and may not be a high-priority target for drug education, non-heterosexual young women's rates of illicit drug use are at least as high as those of young men.⁴ Higher levels of drug use among young non-heterosexual women may be the result of individual experiences of homophobic discrimination, where drugs are used as an — albeit, short lived — panacea.¹ Greater drug use may also be the result of normalisation of recreational drug use within lesbian communities.⁵ There is a need for specific interventions in young non-heterosexual women, and for further research to determine the reasons for their high levels of recreational drug use.

Acknowledgements: Women's Health Australia is conducted from the University of Newcastle. This analysis is funded by Women's Health, Victoria and the Department of Human Services, Tasmania. LH is supported by a National Health and Medical Research Council Fellowship. AK is supported by a VicHealth Senior Fellowship.

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New driving guidelines: ethical and legal uncertainties

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TO THE EDITOR: Seizure disorders are often the most scrutinised medical conditions in relation to road accidents.¹ Epileptologists internationally have reached some consensus on the role best played by treating doctors:

- ensuring patients receive proper medical care;
- advising on assessed risk and its minimisation; and
- reporting (if necessary, without patient consent) when a patient becomes a risk yet continues to drive.²

In a recent editorial on sleep disorders and driving,³ McEvoy also emphasises the essential role of first establishing the therapeutic relationship, and refers to the impending release by the National Road Transport Commission of new medical standards for all vehicle types.⁴

Australian neurologists and the Epilepsy Society of Australia find that the new guidelines are imprecise in defining the role played by doctors and Driver Licensing Authorities (DLAs), and are excessively detailed with cumbersome processes that are open to confusion. The instructions for using four separate forms (3.3) are complex and imprecise, giving no indication about discretion in their use or non-use. Moreover, it is not the role of doctors to define specific restrictions for holders of conditional licences (3.3.1), but that of the DLA. Demands on doctors for surveillance and enforcement are excessive, and by interfering with the maintenance of proper rapport may prove counter-productive. The roles for consultants are not clearly defined.

A more desirable model is one in which the DLA takes responsibility for

Frequencies and adjusted odds ratios for drug use among 9260 heterosexual and non-heterosexual Australian women aged 22-27 years, 2000

Drug use	Exclusively heterosexual	Bisexual and lesbian	Adjusted odds ratio* (95% CI)
Smoking status	(n = 8284)	(n = 755)	
Never smoked	60.8%	37.0%	1.00
Former smoker	14.2%	17.4%	2.15 (1.65-2.79)
Current smoker	25.0%	45.6%	3.18 (2.61 - 3.89)
Alcohol consumption†	(n = 8419)	(n = 796)	
No risk	36.7%	23.9%	1.00
Low risk (no bingeing)	31.5%	30.6%	1.33 (1.05-1.69)
Low risk (with bingeing)	27.9%	38.6%	2.01 (1.60-2.52)
Risky	3.9%	7.0%	2.50 (1.68-3.72)
Illicit drugs	(n = 8409)	(n = 797)	
Marijuana (in the last year)	21.5%	58.2%	4.68 (3.91-5.61)
Other illicit drugs‡ (in the last year)	10.2%	40.7%	5.50 (4.51-6.71)
Injected drugs (ever)	1.2%	10.8%	12.26 (8.53-17.63)

* Adjusted for age, region of residence, and father's occupation.

† According to National Health and Medical Research Council guidelines.³

‡ Amphetamines, LSD (D-lysergic acid diethylamide), ecstasy/designer drugs, tranquilisers, natural hallucinogens, cocaine, inhalants, heroin, barbiturates.