UNIVERSITY OF TECHNOLOGY SYDNEY

Women Who Travel Without Men Solo or With Other Women Across Australia in Self-Contained Accommodation: Their Travel Experiences, Health, Social Wellbeing and Access to Healthcare

by Margaret Mary Yates

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of Distinguished Prof Tracy Levett-Jones, Prof Emeritus Jenny Onyx and Prof Lin Perry

University of Technology Sydney
Faculty of Health

June 2025

CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Margaret Mary Yates, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Nursing and Midwifery, Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research was supported by an Australian Government Research Training Program (RTP) Scholarship doi.org/10.82133/C42F-K220.

Signature:

Production Note:
Signature removed prior to publication.

Date: 31/05/2025

ACKNOWLEDGEMENTS

First and foremost, I acknowledge my three exceptional supervisors:

Distinguished Professor Tracy Levett-Jones for her enthusiasm, encouragement and faith in this work and me, always caring, affirming and always generous in her comments and guidance;

Professor Emeritus Jenny Onyx, my mentor and inspiration, for her confidence and belief in this work and me, always making it seem possible and always showing me what it's like to think beyond my nurse's brain; and

Professor Lin Perry, who is the most patient person I have ever met. Lin kept me moving forward when I didn't think I could or want to, who taught me so much about being a research student and being me. Without Lin I would not have contemplated let alone undertaken such an important achievement in my life.

Professor Diana Keating (RIP) was always caring encouraging and supportive, graced with enviable determination and strength as my line manager and friend, who saw something in me I couldn't see. Sadly, she died before I could begin this quest and realise her ambition for me.

My very dear friend Dr Nerida Ambler, my sounding board and unofficial supervisor, who understood every step I took, who listened to every conversation, even when I'm sure she had better things to do.

My sister Diane, my best friend and biggest fan. She meant the world to me but is no longer with me to share this moment.

My mother and father, long gone, who aren't here to share this achievement with me.

Elizabeth Negline, my sister-in-law who inspired me with her stories of travelling this country. Our conversations were the genesis of this work. Sadly, Elizabeth died in 2024.

I am grateful to Dr Campbell Aitken, who provided professional editing services in accordance with the Institute of Professional Editors' *Guidelines for Editing Research Theses*.

And finally, thanks to the 12 health service managers and the 29 exceptional women who openly and willingly shared their experiences and inspired and energised me. Thank you for the privilege of telling your stories.

STATEMENT INDICATING THE FORMAT OF THIS THESIS

This thesis is by compilation and is structured as a single manuscript that comprises a combination of chapters, three published papers and a fourth paper currently under review.

INCLUDED PUBLICATIONS

Paper 1:

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2021). Exploring the 'grey nomad' travelling population of Australia and its health: an integrative literature review. *Australian Journal of Primary Health*, *27*(3), 163–177. https://doi.org/https://doi.org/10.1071/PY20023

Author 1: Margaret Mary Yates

Contribution: 75%; developed concept, designed paper, conducted searches, extracted data, conducted analysis, drafted versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 2: Lin Perry

Contribution: assisted with development of concept and design, assisted with searches and conduct of analysis, commented on draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 3: Tracy Levett-Jones

Contribution: assisted with development of concept and design, assisted with conduct of analysis, commented draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 4: Jenny Onyx

Contribution: Assisted with development of concept and design, assisted with conduct of analysis, commented draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Paper 2

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2022). 'Grey nomad' travellers' use of remote health services in Australia: A qualitative enquiry of hospital managers' perspectives. *BMC Health Services Research*, *22*, 151. https://doi.org/https://doi.org/10.1080/08952841.2024.2431412

Author 1: Margaret Mary Yates

Contribution: 75%; recruited and interviewed participants, documented and collated data, conducted analysis, designed and drafted versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 2: Lin Perry

Contribution: present for data collection, assisted with conduct of analysis, commented draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 3: Jenny Onyx

Contribution: assisted with data analysis, commented on draft versions of manuscript, approved the final version

Signature:

Production Note:
Signature removed prior to publication.

Author 4: Tracy Levett-Jones

Contribution: assisted with data analysis, commented on draft versions of manuscript, approved the final version

Signature:

Production Note:
Signature removed prior to publication.

Paper 3

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2024). Women travelling solo or with other women across Australia: A montage of narratives. *Journal of Women & Aging*. https://doi.org/https://doi.org/10.1080/08952841.2024.2431412

Author 1: Margaret Mary Yates

Contribution: 75%: recruited and interviewed participants, recorded, transcribed and collated data, conducted analysis, designed paper, drafted versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 2: Lin Perry

Contribution: assisted with conduct of analysis, commented draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 3: Jenny Onyx

Contribution: assisted with data analysis, commented on draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 4: Tracy Levett-Jones

Contribution: assisted with data analysis, commented on draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Paper 4

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. The experiences of women who travel solo or with other women across Australia: A qualitative study and thematic analysis.

Status: under review

Author 1: Margaret Mary Yates

Contribution: 75%; Recruited and interviewed participants, recorded, transcribed and collated data, conducted analysis, designed paper, drafted versions of manuscript, approved final the version.

Signature:

Production Note:
Signature removed prior to publication.

Author 2: Lin Perry

Contribution: assisted with conduct of analysis, discussed and commented draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 3: Jenny Onyx

Contribution: Contribution: assisted with data analysis, discussed and commented on draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

Author 4: Tracy Levett-Jones

Contribution: assisted with data analysis, discussed and commented on draft versions of manuscript, approved the final version.

Signature:

Production Note:
Signature removed prior to publication.

RELATED PUBLICATIONS

Yates, M., Perry, L., & Jackson, D. (2018). Women travelling without men, and their healthcare needs. *International Journal of Nursing Practice*, *24*(5), https://doi.org/10.1111/ijn.12701

PRESENTATIONS

a) A video created by Michele Ford

This captures the spirit of the phenomenon of interest of this study and is available at: https://youtube/4FqqJnt2O9k

b) Conferences / Research Meetings

Yates, M.M., Perry, L., Jackson, D. Travelling as 'grey nomads': What does this mean for their health and healthcare access? *Australian College of Nursing National Nursing Forum*, '**Nursing Now – Power of Policy'**, August 2019, Hobart, Tasmania.

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. Exploring the "grey nomad" travelling population of Australia and their health: An integrative literature review. UTS Student Research Forum, UTS. June 2019.

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. Participant recruitment in the field during drought-breaking floods and the COVID-19 pandemic. UTS Student Research Forum, UTS. November 2020.

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. Women travelling without men across Australia. Wallsend Probus Club, January 2025.

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. Women Travelling Without Men Across Australia. Port Stephens Country Women's Association, March 2025

c) Media presentations

Media release issued by:

UTS Media Office

M: +61 419 293 261

E: newsroom@uts.edu.au

Research paper link: Women travelling solo or with other women across Australia: A montage of narratives

Radio interviews

- *Best Medicine*, Southern FM 02/04/25
- *Life Matters*, Radio National 05/02/25
- *Weekend Mornings* ABC Sydney and NSW 26/01/25
- *The Two Murrays*, 2CC Talking Canberra Radio 26/01/25

Other media coverage

Rowan Cowley, Freedom: Why older women are trading daily routine for the Grey Nomad life. *The Senior NSW/ACT* 24/01/2025. https://www.thesenior.com.au/story/8874210/older-women-embrace-grey-nomad-life-and-find-freedom-on-the-road/?cs=6787

Dellaram Vreeland. I'll see you in a year: the Australian women over 60 hitting the road solo. *The Guardian (Australia)* 02/02/2025. https://www.theguardian.com/australia-news/2025/feb/02/ill-see-you-in-a-year-the-australian-women-over-60-hitting-the-road-solo

Maeve Bannister. Surprising group take on new life out on the open road. *St George & Sutherland Shire Leader* 15/01/2025. https://www.theleader.com.au/story/8866719/surprising-group-take-on-new-life-out-on-the-open-road/

Jane Nicholls. The time of their lives. *The Australian. Travel & Luxury.* 24-25 May 2025. https://www.theaustralian.com.au/subscribe/news/1/?sourceCode=TAWEB_WRE170_a&dest=https%3A%2F%2Fwww.theaustralian.com.au%2Ftravel%2Fmeet-the-83yearold-widow-who-trekked-pakistans-glaciers-alone%2Fnews-story%2F80c3ec6bcc79d22bc8fb00cb454fc874&memtype=anonymous&mode=premium&v21=GROUPB-Segment-1-NOSCORE&V21spcbehaviour=append

PREFACE: THE IMPACT OF THE COVID-19 PANDEMIC ON THIS RESEARCH

The initial design chosen for this research was ethnography and I planned to travel with a woman companion, towing a caravan and being a participant observer of the lifestyle that was the phenomenon of interest. The intention was to live and observe the lifestyle of women travellers and recruit them as research participants.

My first trip was planned for March 2020 and was intended to provide access for recruitment of participants to both Phase 1 (women travellers) and Phase 2 (health service managers) of the study. In the initial weeks I focused on Phase Two of the study, arranging interviews with health service managers in rural and remote New South Wales (NSW) on the initial stages of the outward journey. This section required forward planning to arrange interview dates and times. This component was achieved, but within days of the last interview a travel ban was announced and state borders were closed to limit the spread of COVID-19. The trip was hastily terminated.

State and territory border closures and travel bans or restrictions were imposed and lifted intermittently from March 2020 until February 2022. Once the initial pandemic lockdown directives were rescinded, frequent changes continued in relation to where people could or could not travel. NSW, Victoria, Queensland, South Australia and Tasmania were the most seriously and consistently affected. As a resident of NSW, these restrictions had a serious and persistent effect on my ability to travel and conduct research. Nonetheless, I travelled as much as possible, in accordance with health orders, during 2020–22 and was able to experience and study the “grey nomad” lifestyle. However, many other women were unable to travel, meaning my planned face-to-face recruitment strategy had to be rethought. I began snowball sampling from my few initial participants to recruit subsequent ones, conducting interviews using Meta’s messenger audio-visual platform or by telephone, and (once pandemic restrictions lifted sufficiently) eventually conducted a total of four face-to-face interviews. This strategy enabled the successful completion of my project but is possible that the lack of in-person, face-to-face contact between me and most of my participants reduced the depth and richness of the interview data. Reorganisation of research methods and the need to obtain additional ethics committee approvals also delayed study progress and the time available to collect and analyse data.

TABLE OF CONTENTS

CERTIFICATE OF ORIGINAL AUTHORSHIP ii
ACKNOWLEDGEMENTS iii
STATEMENT INDICATING THE FORMAT OF THIS THESIS iv
INCLUDED PUBLICATIONS v
PRESENTATIONS x
PREFACE: THE IMPACT OF THE COVID-19 PANDEMIC ON THIS RESEARCH xii
TABLE OF CONTENTS xiii
LIST OF FIGURES xviii
LIST OF TABLES xviii
LIST OF ABBREVIATIONS xix
ABSTRACT xx
CHAPTER 1: INTRODUCTION 1
1.1 THE ORIGINS OF THIS STUDY 1
1.2 WOMEN'S STORIES 2
1.3 TRAVELLERS ACROSS AUSTRALIA 4
1.4 HEALTH SERVICES IN RURAL AND REMOTE AUSTRALIA 6
1.5 TRAVELLERS' HEALTH NEEDS 7
1.6 OVERVIEW OF THE STUDY 8
1.7 THE RESEARCHER AS ETHNOGRAPHER 9
CHAPTER 2: LITERATURE REVIEW 15
2.1 ABSTRACT 16
2.3 INTRODUCTION 16
2.4 RESEARCH AIM 17
2.5 RESEARCH QUESTIONS 18
2.6 LITERATURE SEARCH AND REVIEW METHODS 18
2.7 DATA EXTRACTION AND ANALYSIS 20
2.8 THE RIGOR OF THE STUDY 39
2.9 FINDINGS 39
2.9.1 Question 1: The Characteristics of Grey Nomads 40
Age and Gender 40
Relationship Profile and Social Identity 41
Socio-Economic Considerations and Ethnicity 42
Mode and Motivation to Travel 42
Social Networks, Connection and Sense of Community 43

2.9.2 Question 2: Pre-Travel Health-Related Planning and Preparation 44
2.9.3 Question 3: Grey Nomads' Experiences in Relation to Their Health and Healthcare Provision 44
2.10 DISCUSSION 46
2.10.1 Health and Health Planning 47
2.10.2 Health and Healthcare Experiences 48
2.10.3 Limitations 48
2.11 CONCLUSION 49
2.12 CHAPTER SUMMARY 50
CHAPTER 3: RESEARCH METHODS 51
3.1 Phase One Research Aim and Objectives 51
3.2 Phase One Research Design 51
3.2.1 Conceptual Basis 54
3.3 Phase One Sample, Sampling Strategy and Sample Size 55
3.4 Phase One Data Collection Methods 56
3.5 Phase One Data Analysis 57
3.6 Phase One Ethical Considerations 58
3.7 Phase One Data Management 58
3.8 Phase Two Research Aim and Objectives 59
3.9 Phase Two Research Design 59
3.10 Fieldwork Settings 59
3.11 Phase Two Sample, Sampling Strategy and Sample Size 60
3.12 Phase Two Data Collection Methods 61
3.13 Phase Two Data Analysis 62
3.14 Phase One Data Management 62
3.15 Triangulation of Data 62
3.16 Phase Two Ethical Considerations 62
3.17 The Rigor of the Study 63
CHAPTER 4: PHASE ONE FINDINGS (THEMATIC ANALYSIS) 64
4.1 PREAMBLE 64
4.2 INTRODUCTION 64
4.3 BACKGROUND 65
4.4 METHODS: AIM 66
4.5 DESIGN 66
4.6 PARTICIPANTS, SAMPLING AND SAMPLE 67
4.7 DATA COLLECTION 67

4.8 DATA ANALYSIS 68
4.9 STUDY RIGOUR 68
4.10 ETHICAL CONSIDERATIONS 68
4.11 FINDINGS 69
4.11.1 Freedom 70
4.11.2 Adventure and Being in Nature 71
4.11.3 Safety and Risk 74
4.11.4 Evolving from Fear and Anxiety Into Self-Confidence and Growth 77
4.11.5 Home 79
4.11.6 Health 79
4.12 DISCUSSION 81
4.12.1 Strengths and limitations 83
4.13 CONCLUSION 84
4.14 CHAPTER SUMMARY 84
CHAPTER 5: PHASE ONE FINDINGS (MONTAGE NARRATIVE) 85
5.1 PREAMBLE 85
5.2 CHAPTER SUMMARY 96
CHAPTER 6: PHASE TWO FINDINGS 97
6.1 PREAMBLE 97
6.2 CHAPTER SUMMARY 107
CHAPTER 7: DISCUSSION, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION 108
7.1 INTRODUCTION 108
7.2 AUSTRALIA AS AN ADVENTURE PLAYGROUND 108
7.3 THE POPULATION OF WOMEN TRAVELLERS 109
7.3.1 Existing Data Sources 109
7.3.2 Social Media Platforms 109
7.3.3 Study Data 110
7.4 CHARACTERISTICS OF WOMEN TRAVELLERS 110
7.4.1 Prior Literature 110
7.4.2 The Study Sample 111
Women as Adventurers 111
Personal Development and Growth 112
Personal Safety 113
Home 114
7.5 AGEING 116

7.6 HEALTH AND ACCESS TO HEALTHCARE WHEN TRAVELLING 117
7.6.1 Participants' Accounts of Health Maintenance 117
7.6.2 Healthcare Managers' Accounts of Travellers Health Presentations 118
7.6.3 Met and Unmet Expectations 119
7.6.4 Unsustainable Workforce in Rural and Remote Areas 120
7.7 STRENGTHS AND LIMITATIONS OF THIS STUDY 120
7.8 SUMMARY 122
7.9 IMPLICATIONS AND RECOMMENDATIONS FROM PHASE ONE FINDINGS 123
7.9.1 The Need for Population Data 123
7.9.2 The Future Needs of Women Travellers 124
7.10 IMPLICATIONS AND RECOMMENDATIONS FROM PHASE TWO FINDINGS 125
7.11 CONCLUSION 127
APPENDIX 1: TOURISM DATA 129
Table 1: Visitor numbers, nights 129
Table 2: Tourism Research Australia National Visitor Survey data: 130
APPENDIX 2: SOCIAL MEDIA DATA 131
Figure 1.1: Facebook post 1 131
Figure 1.2: Facebook post 2 132
APPENDIX 3: PERMISSION TO REPRODUCE The published integrative review 133
APPENDIX 4: WOMEN TRAVELLERS' INTRODUCTORY SCRIPT AND INTERVIEW QUESTIONS 149
APPENDIX 5: HUMAN RESEARCH ETHICS COMMITTEE APPROVALS 151
Approval of Original Proposal 151
Approval of Amendments to Research Design in response to travel restrictions due to COVID-19 153
APPENDIX 6: PARTICIPANT INFORMATION AND CONSENT FORMS: WOMEN TRAVELLERS 155
APPENDIX 7: FIRST PLANNED FIELD TRIP LOCATION MAP INCLUDING HEALTHCARE FACILITIES 159
Healthcare Facilities on Field Trip Route 160
NSW Health Services 160
Queensland Health Services 160
APPENDIX 8: HEALTHCARE PROFESSIONALS INTEVIEW SCRIPT 165
APPENDIX 9: PARTICIPANT INFORMATION AND CONSENT FORMS: HEALTHCARE PROFESSIONALS 166
APPENDIX 10: PERMISSION TO REPRODUCE THE PUBLICATION OF the PHASE 1 MONTAGE FINDINGS 170
APPENDIX 11: PERMISSION TO REPRODUCE THE PUBLICATION OF THE PHASE 2 FINDINGS 172

APPENDIX 12: PHASE 2 FINDINGS, CASE STUDY EXAMPLES.....173
REFERENCES.....177

LIST OF FIGURES

Figure 1. Flow diagram of literature searching and screening 21

LIST OF TABLES

Table 1. Australian Facebook groups for women travellers 6
Table 2. Search strategy example for Ovid PsychINFO 19
Table 3. Critical appraisal of included publications using CASP tool 22
Table 4. Included publications 24
Table 5. Findings from included publications 30
Table 6. Bed capacity for study site facilities 61
Table 7. Participants' demographic characteristics 70

LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
CASP	Critical Appraisal Skills Program
ED	emergency department
GP	general practitioner
HCP	HealthCare Professional
HREC	Human Research Ethics Committee
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
RFDS	Royal Flying Doctors Service
UK	United Kingdom
WA	Western Australia
WHO	World Health Organization

ABSTRACT

Growing numbers of Australians are travelling domestically for extended periods of time in caravans, campervans and motorhomes, amongst whom are women travelling by themselves or with other women. Little is known about this group, their healthcare needs and healthcare seeking practices.

Aims

The primary aim of this research was to examine the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation, particularly their experiences and health and social needs while on the road. The second aim was to explore the utilisation of health services in rural and remote Australia by grey nomads, particularly women travelling without men, from the perspectives of local healthcare professionals.

Methods

In Phase One, an ethnographic exploratory field trip was planned, involving the researcher and a women companion towing a caravan and recruiting participants in the field. COVID-19 travel bans and movement restrictions meant this phase was modified; snowball sampling was used to recruit participants, and interviews were conducted predominantly via videoconferencing software or telephone. Phase Two employed a qualitative descriptive approach, with semi-structured interviews conducted with managers of healthcare facilities in remote New South Wales and Queensland. Data were analysed using thematic analysis.

Findings

Phase One participants were 29 women aged 35–76 years; 69% were aged over 60 years and retired. They were active, engaged, capable women who considered themselves healthy regardless of their chronic diseases. The main themes to emerge from the women's stories were freedom and independence, adventure in nature, safety and risk, anxiety and fear evolving into self-confidence, and home and health.

In Phase Two, 12 health service managers described a strong service and community ethos. They did not regard travellers as an impost on their services and treated them as they would any members of their community. Most travellers were described as well prepared for managing their health on the road and presenting with acute health events similar to those seen in local populations.

Conclusion

This study is the first of its type to explore the lifestyle choices and experiences of a group of mainly older women travelling across Australia. Defying the predominant models of decline in older age and stereotypical roles of women, they exemplified a new form of positive ageing. Dispelling the myth of travellers as burdensome to rural and remote communities, the findings revealed that grey nomads were welcomed and valued by health services in rural and remote areas.

CHAPTER 1: INTRODUCTION

In 2018 I learnt of the existence of a population of Australian women travelling around Australia in mobile accommodation, often alone but without men, and about whom little was known. I set out to identify the characteristics of these women travellers and their experiences in relation to their health and social needs and access to healthcare when travelling. This was achieved by meeting members of this population group and conducting semi-structured interviews with them (Phase One). In order to study these women's lifestyles, I employed an ethnographic approach and spent time travelling across two states of Australia with a woman companion. I also explored the utilisation of healthcare services in rural and remote locations in Australia by grey nomads, particularly women who travel without men, from the perspective of healthcare professionals working in these locations. To achieve this aim, I interviewed managers of health service facilities located along a popular travel route through remote New South Wales (NSW) and Queensland (QLD) (Phase Two). The findings from the two phases were synthesised and integrated to produce a comprehensive view of these women's lifestyle experiences, healthcare usage, health and wellbeing.

1.1 THE ORIGINS OF THIS STUDY

In February 2018 my partner and I took a short caravan holiday on the South Coast of NSW. During the trip we met my brother's widow, in a caravan park. She told us numerous stories about her adventures as a grey nomad, travelling either by herself or with a women companion. In one story she described driving to Katherine (Northern Territory – NT), then turning left and continuing to Kununurra (Western Australia – WA), 514 kms and approximately 5 hours away. I wondered if there was a street sign that said, 'this way across the desert to Western Australia.' I had little idea about what it would mean to travel that route, what the highway (if there was one) would be like, how many towns there were to pass through, and what the landscape or vegetation would be like. It fired my imagination, but also, being a nurse, I was curious about how people managed their health when in (what I considered to be) the middle of nowhere. I was especially curious about the experiences of women in their fifties, sixties or seventies travelling without a man and with one or more chronic illnesses, as my sister-in-law and some of her friends were. This conversation and subsequent discussions about women's lives, experiences and stories was the genesis of this study.

1.2 WOMEN'S STORIES

Women's lives and stories are often not told, particularly in cultures and times in which their place is seen to be exclusively in the home. In the last century, the Australian experience in this regard has undergone substantial change.

Before the Second World War, the social script of suitable behaviours established a uniform path for women, entailing marriage, children and homemaking (Price and Dunning (2019). The woman's place was in the home, not in business, careers or politics. According to Tong (2007), the subordination of women to men was embedded in gender identities designed to ensure women bore the burden of domestic work and caregiving, and that their access to the public world was limited. However, this was not the universal experience; small numbers of women have always created or taken opportunities to live lives not bounded by the gender stereotypes of society (Fessenden, 2025). However, their stories were rarely recognised publicly at the time, or in subsequent decades.

Since World War II, in Western countries in particular, the options for how women live their lives have undergone a series of radical transformations. In the early post-war years, any gains in equality accrued by the need for a female workforce to support the war effort were eroded rapidly, and it was again assumed that, once married, women would dedicate themselves to home-making and family life, a view reinforced in popular women's magazines of the time (Beaumont, 2017). In Australia during this post-World War II era the breadwinner model prevailed, entailing a general expectation that men worked outside the home as provider and the wife stayed at home, had children and cared for the family (Pfau-Effinger, 2004; Trappe et al., 2015). Women were dependent on their male breadwinners (Broomhill & Sharp, 2005), who therefore had much greater power in the world, including over their wives and women overall. Exceptions to this were regarded as aberrations, discouraged and often punished. This social norm created a sameness in the expected roles for girls and women, and whilst this suited some women, others experienced it as a prison. Moreover, the consequent dependency of the majority of women led to imbalances of opportunity and power, outside as well as within the family (Murphy, 2002), and many women were denied fulfilment of their potential. The invisibility of any alternative version of this story for women meant women had no role models or examples to follow. Increasingly, however, not all women acquiesced to this situation.

The 1960s and 1970s were times of major female rebellion, recognised as the second wave feminist movement (Nicholson, 2010). The daughters and granddaughters of the 'scripted' generation found new ways to break away from the universal script and the structural disadvantages for women living in a patriarchal society (Schuster, 2017). Attitudes changed, and opportunities for women evolved from an almost exclusive focus on motherhood and homemaking to encompass more diverse choices. Women began creating their own ways of living; for many, this meant participation in the workforce, with or without husbands and children.

By the 1990s the daily lives and longer-term aspirations of Australian women had undergone significant changes, alongside shifting cultural and personal concepts of mothering, employment and female identity (Leahy, 2019). The picture of work undertaken by women in Australia looked very different to that only a few decades earlier, with women working in diverse fields ranging from manual labour to skilled, professional and managerial occupations (Lake, 2013). The working lives of the female children of the postwar brides were a far cry from and enabled a much broader life experience than that of their mothers and grandmothers, and occurred in parallel with changing opportunities in the later years of their lives. This postwar generation and subsequent cohorts feature among the women profiled in this study, and reflect that transition and the development of women's potential for independence and self-confidence to explore well beyond the family home.

In recent decades women's exceptional lives have begun to be rediscovered, with the emergence of stories previously 'manhandled' by history (Summers, 2016). Simultaneously, the search for individual experience and expression continues today for many older and retired women, and this study describes a continuation of this evolution of the possibilities for them. For increasing but unknown numbers of women this has led to their literally abandoning conventional homes for an itinerant lifestyle on the road, in the pursuit of ambitions and aspirations that extend beyond homemaking despite increasing age.

Establishing the size of this population of women travellers is difficult. In contrast, people with fixed homes are easily counted and described in the Census, which provides reliable and accurate information about the population. The Census, the most comprehensive survey of the economic, social and cultural makeup of the country, includes the option of reporting 'no usual address'. Initially added to identify people experiencing homelessness, this broad definition is used to identify those who are unlikely to be homeless, and grey nomads are included in the latter group but are not separately identified (ABS, 2012). The Australian Bureau of Statistics (ABS) defines homelessness as

when a person does not have suitable alternative accommodation; they are considered homeless if their current living arrangement is a dwelling that is inadequate, or where they have no tenure, or if their initial tenure is short and not extendable, or they do not have control or access to space for social relations (ABS, 2012). This definition was also applied for the 2016 Census report on homelessness, which subsequently detailed people categorised as living in improvised dwellings such as tents or sleeping out (rough sleepers); living in supported accommodation for the homeless or staying temporarily in other households; or living in boarding houses, severely crowed dwellings or other temporary lodgings (Australian Institute of Health and Welfare, 2021). No mention was made of grey nomads, domestic travellers or, importantly, women travellers.

1.3 TRAVELLERS ACROSS AUSTRALIA

Caravanning has been a popular form of tourism in Australia for over seven decades, with caravans being built as early as in the 1920s (Prideaux and McClymont (2006). The combination of a national highway network, the relatively low cost of caravanning as a form of accommodation, the capacity to garage a caravan at home and the vast distances needing to be traversed in order to visit places of particular interest have all contributed to the popularity of caravanning (Prideaux & McClymont, 2006). Traveller numbers are growing, probably due to the ongoing retirement of the 'Baby Boomer' generation, and more recently the travel restrictions imposed to slow the COVID-19 pandemic and their subsequent lifting whilst international travel was still restricted.

Recent tourism data reveal that between 2011 and 2016, caravan and campervan registration numbers grew by 30% and 20% respectively, totalling 615,301 in the year to January 2016 (Caravan Industry Association of Australia, 2019); by 2021, more than 750,000 such recreational vehicles were registered (Caravan Industry Association of Australia, 2021). In 2023 almost 859,000 caravans and campervans were registered, a 21% increase since 2019 and an all-time record (Bureau of Infrastructure and Transport Research Economics, 2024). Tourism data for the year to September 2017 suggest people took an estimated 11.8 million camping or caravanning trips in Australia. This increased to an estimated 15.3 million in 2023, the highest year on record for caravan and camping trips (Tourism Research Australia, 2025). From these earlier traveller data, an estimated 29% were people aged 55 and over (Tourism Research Australia, 2019).

Tourism Research Australia is part of the Australian Government Trade and Investment Commission. It collects data on caravan and camping, publishing monthly snapshots of tourism activity and an annual State of the Industry report on Australia's tourism sector. Data reported for the year to

March 2022 showed almost 50.5 million nights were booked in commercial and non-commercial caravan parks and camping grounds (Appendix 1, Table 1; Australian Trade & Investment Commission and Tourism Research Australia (2023)). Slightly more detailed data averaged for the four years 2016–19 shows that women spent more than 13 million nights travelling alone across Australia; they took an estimated 61,000 trips with more than 21 stopovers (Appendix 1, Table 2; Australian Trade & Investment Commission and Tourism Research Australia (2025)). This is the most detailed, granular data available on Australia's domestic women travellers, but does not enable differentiation of short-term holidaymakers from longer-term travellers.

Many of the recreational vehicle owners, visitors to caravan parks and camping grounds and women solo travellers captured in the research mentioned above were likely to be 'grey nomads.' This term is commonly used to describe retired or semi-retired individuals, 50 years of age or older, who tour within Australia in caravans, campervans, motorhomes (etc.) for a minimum of three months at a time (Onyx & Leonard, 2007). They are well recognised and organised to some degree; for example, the Grey Nomads website provides information about planning trips, where to go, advice about tow and accommodation vehicles, and other information of interest to grey nomad travellers as well as a forum for online discussion (Grey Nomad administration, 2023). The website also provides information that encourages people to maintain their health whilst travelling. However, data to differentiate grey nomads or women who travel without men within the larger travelling population in Australia are lacking. The numbers of women who live permanently or semi-permanently in their recreational vehicles or are long-term travellers for weeks or months at a time, rather than short-term holidaymakers, remains unknown.

Difficulties in accessing itinerant groups such as women who travel without men have resulted in predominantly small-scale and localised studies (e.g., De Bellis et al. (2020), Hillman (2013), Patterson (2011) and Tate et al. (2006)). Details about these travellers' demographic characteristics are scant; even gender is not always reported. Brayley and Obst (2010), in exploring the identity characteristics and connectedness of older travellers, concluded that they saw themselves primarily as couples, with social group identity such as 'grey nomad' being a secondary consideration. Similarly, Darley (2017) found that most travellers aged 55 years and older travelled as couples; whether any were in same-sex or platonic relationships was not stated.

Many women travellers' groups exist on social media. As **Table 1** shows, their combined membership numbers have increased substantially since I first accessed these sites in September

2019. The sites and members' posts on Facebook pages do not describe the members; there is no indication of the proportion of women travellers and with whom they travel. The main topics of conversation on these Facebook pages are destinations, including photos, and details about life on the road such as the purchase of new vehicles, the renovation of old ones, people who leave their rubbish at camping sites, the best free camping areas, and so on. Few of these Facebook conversations are about travellers' health (see, e.g., Appendix 2), so this also remains a largely unknown phenomenon. These travellers, many of whom are aged over 50 years, are likely to use healthcare services while travelling in rural and remote areas, but very little is known about their healthcare needs and healthcare seeking practices (Yates & Perry, 2019).

Table 1. Australian Facebook groups for women travellers

Facebook Group	Number of members September 2019	Number of members July 2021	Number of members February 2025
Women Caravanning Camping and Travelling Solo Australia	4,927	15,400	30,600
Solo Women Campers Meetups	1,355	10,600	18,000
Chics Camping Crew	4,321	7,000	6,900
Solo Women Travelling Australia Live	-	628	683
Aussie Glamper Girls		4,500	5,000
Lady Campers		13,200	13,800
Australian Sisterhood of Campervan and Motorhome Owners		2,100	2,300
Total	16,673	53,428	77,280

1.4 HEALTH SERVICES IN RURAL AND REMOTE AUSTRALIA

The continuing rise in the cost of healthcare and ongoing difficulty in recruiting and retaining healthcare professionals hampers the delivery of healthcare in rural and remote areas (Bradford et al., 2016). Inability to recruit and retain a sufficiently large skilled workforce in rural and remote locations is recognised worldwide as impairing the provision of care and the health of local people (Abelsen et al., 2020; Russell et al., 2017). This is not a new issue for Australia; in 1928, the difficulties of providing health services outside urban settings led to the establishment of one of the oldest and largest aeromedical services in the world, the Royal Flying Doctors Service (RFDS) (Royal

Flying Doctor Service, 2023). The challenge remains, with shortages and maldistribution of healthcare professionals reported throughout this century (Australian Institute of Health and Welfare, 2022; National Rural Health Alliance Inc, 2008).

In recent decades telehealth has demonstrated its potential to transform the delivery of healthcare in rural and remote areas. Telehealth allows access to metropolitan healthcare professionals and specialists via video conferencing or telephone technology; its take-up was initially slow because it entailed new equipment and dedicated staffing with new skills. However, many rural and remote areas were early adopters of the technology, and take-up accelerated to manage delivery of services during the COVID-19 pandemic (MBS Review Advisory Committee, 2024). The new technologies make more services available at healthcare facilities and for individual patients, who can have virtual appointments with their healthcare providers. Virtual care platforms have been deemed to be safe and secure (NSW Government, 2023b). In conjunction with telehealth across Australia, the RFDS provides access to aeromedical retrievals, primary health clinics with general practitioners (GPs), nurses and allied health practitioners, remote telehealth consultations, dental and mental health outreach, and essential emergency medical supplies (referred to as 'medical chests') (Department of Health and Aged Care, 2023). However, whilst telehealth delivers specialist consultations and RFDS their unique service, numbers of frontline healthcare professionals located in rural and remote areas remain low compared to regional and metropolitan areas (Australian Institute of Health and Welfare, 2022). Due to these enduring staff shortages, previous researchers have raised concerns that travellers represent an impost on scarce rural and remote health services (Tate et al., 2006). Whilst there seems a logic to assuming that travellers (and other visitors to remote locations) might be regarded so, and these concerns have been echoed in more recent studies (Halcomb et al., 2017), the literature contains little empirical data that substantiate the idea that travellers are an unsustainable burden for rural and remote services.

1.5 TRAVELLERS' HEALTH NEEDS

Whilst the increasing numbers of travellers, and grey nomads in particular, are postulated to place a burden on healthcare services (Halcomb et al 2017; (Tate et al., 2006), relatively little is known about the healthcare needs and healthcare seeking practices of this population. Prior to my study, the sole published review of the literature on this topic found only a small number of predominantly qualitative studies (Raven, 2016). However, previous work has characterised grey nomads as reflective of the age-matched sector of the Australian population in that many live with one or more chronic illnesses (Australian Bureau of Statistics, 2013). Tate et al. (2006), for example, reported 55%

of travellers had chronic disease and 70% took regular medication. Halcomb et al. (2017) surveyed 316 long-term travellers and reported 40% had hypertension, 23% arthritis, 30% diabetes, and smaller percentages had other chronic health conditions. Of these, almost a quarter required ongoing prescription medication, and almost half reported that their illness(es) affected daily life.

Calma et al. (2018) interviewed eight grey nomads with at least one chronic condition and found that they were aware of their health needs and what was required for self-management, and that they 'planned ahead' to manage their health. Similarly, in interviews with diabetes educators in South Australia and 14 travellers with a cancer diagnosis, both Abigail et al. (2016) and Stephens et al. (2018) reported them as generally well organised, arranging their travel to dovetail with their health needs and planning ahead to ensure unbroken access to the medications they required. Nonetheless, concerns about the deleterious impact of these travellers on rural and remote health services have persisted (Calma et al., 2018; De Bellis et al., 2021; Tate et al., 2006). Originating from what Raven (2016) described as 'largely anecdotal' reportage, this contention has not been tested or supported by primary data. If such a burden exists, it could have serious implications for the provision of health services, policy, health infrastructure, education, and workforce planning in rural and remote communities.

Given the size and growth of this itinerant Australian population, it is important to understand their characteristics, health status, healthcare needs and health-seeking behaviours. In particular, I considered it important to study women travellers, because their characteristics and needs are likely to differ from those of people travelling in couples, with other couples or as larger groups in convoy. For example, solo travellers may struggle with ongoing maintenance where jobs require more than one person. In case of serious illness or injury, they may encounter difficulties in calling for or accessing health support; in obtaining safe storage for their vehicle and caravan or temporary care for a dog if incapacitated. I also deemed it important to gauge the impact of women travellers (if any) on the health services available in rural and remote areas, given that these resources are well recognised to be scarce.

1.6 OVERVIEW OF THE STUDY

My research is presented in the form of a thesis by compilation. The thesis includes three published articles (Chapters 2, 5 and 6); the fourth manuscript (Chapter 4) is currently under review with a Q1 journal.

The first aim of Phase One of my study was to examine the characteristics of women travellers across Australia and explore their experiences in relation to their health and social needs and access to healthcare when travelling.

My second aim (Phase Two) was to explore the utilisation of healthcare services in rural and remote locations in Australia by grey nomads, particularly women who travel without men, from the perspective of healthcare professionals working in these locations.

To achieve these aims, I began with an integrative literature review to identify and appraise the available literature about this topic (Chapter 2).

Phase One was an ethnographic study undertaken to generate new knowledge about women who travel around Australia in self-contained accommodation with or without other women and without men. I studied their experiences relating to their health, healthcare needs and access to healthcare services whilst travelling (Chapters 4 and 5).

In Phase Two I explored the experiences of health service managers in NSW and directors of nursing in QLD to determine how travellers including women access and affect health services in rural and remote locations in Australia (Chapter 6).

I analysed and synthesised data from Phases One and Two and considered the results in relation to the contemporary literature and other data on this topic (Chapter 7).

Finally, in Chapter 7, I presented the implications of the work as a whole and made recommendations in relation to health and social care policy and practice, further educational needs and opportunities and future research.

1.7 THE RESEARCHER AS ETHNOGRAPHER

Ethnography was the methodology that underpinned the data collection and analysis for my study. As a beginning researcher and ethnographer, I undertook a field trip with another woman researcher in order to find out what it is like to travel around the country towing a caravan and living the same lifestyle as my proposed research participants. The aim was to be a participant observer, travelling in the same way and living the same life, as well as observing the day-to-day social behaviours and

actions and conducting in-depth interviews (Pelto, 2016) to reveal or uncover women travellers' already present but hidden stories (Wolcott, 2005).

I began preparing for what was, to me, a completely unknown lifestyle. Initially, this entailed gathering information from caravan and camping shows, and online searches to determine what type of vehicle and caravan would best meet our needs. My partner and I eventually purchased a four-wheel-drive vehicle and a 13-foot caravan, the intention being to continue to travel across Australia after I had completed my research. We acquired new knowledge and many skills by completing a driver education program to learn how to tow a caravan safely. Among other things, we learned:

- that we needed towing mirrors (a legal requirement) and electric brake controllers;
- about the jockey wheel (which aids in lifting and lowering the caravan coupling while hitching and unhitching to the tow ball, and steadying the caravan whilst manoeuvring it); how to load a caravan for correct weight distribution to optimise safety and avoid sway;
- operating a UHF radio;
- sharing the road with trucks;
- tyre pressures and speed limits, which affect fuel consumption as well as safety; and
- towing speed limits, which can vary from state to state.

Of particular concern was the ability to reverse the caravan, which turned out to be a very intimidating task that requires complete focus because essentially it entails the mirror image of driving forward. Up to this point I was captivated by the acquisition of all this new information and felt the excitement and anticipation of a completely new and different life experience. However, it is also essential to know and understand everything about the vehicle's towing capacity, which is determined when the vehicle is manufactured, information (whilst essential) I found much less captivating. I learned our vehicle's kerb weight, tare weight, maximum towball mass, gross combination mass and gross vehicle mass, and where to find the compliance plate on the caravan. Towing overweight is against the law, and if these measurements are exceeded, insurance is voided and fines may apply. Remarkably, there are no special licensing requirements to tow in any state or territory in Australia, although each jurisdiction provides specific information and recommendations pertaining to towing a caravan (Northern Territory Government information and services, 2023; NSW Government, 2023a; Queensland Government, 1995-2023; South Australian Government, 2023; Victorian Government, 2023; WA Government, 2021). Much of this information is readily available on websites, blogs and social media, but we didn't know this at the time.

It was daunting to tow a caravan for the first time. Every time we set off I had to constantly reassure myself that I could do it. I felt anxious mainly because I didn't know what I didn't know. I asked myself a constant stream of questions: what if a tyre blows, what if the caravan becomes unhitched, what if a big truck runs us off the road, what if we hit a kangaroo, how will I deal with that type of situation? None of these scenarios eventuated, and the more I drove the more my confidence grew and the less stressed I felt. By the end of each day, I was exhausted.

Towing is one of the many roles of a participant observer in this context. It necessitates a new level of awareness of yourself and your driving ability, your two vehicles (towing and towed), and the enhanced driving skills needed to tow. Understanding the road environment is also important. Roads in remote areas of Australia are not like urban roads: they can be narrow with soft edges, with extremely variable surface quality, including on both unsealed and gravel roads. Wildlife such as emus, kangaroos, camels and livestock can roam freely on the roads and are unpredictable. One of the most harrowing experiences of travelling on remote outback roads was sharing the road space with agricultural machinery and road trains. Road trains (very long trucks anything up to 53 metres long and 80–120 tonnes in weight) are a regular feature on remote roads, being the main means of transport for freight such as livestock and other heavy haulage items (Smart Trucking, 2023). They are difficult to overtake, and when the road was narrow and of poor quality, we didn't even try. Even more intimidating was a road train passing us; the wind drafts in both directions threaten to push you off the road, testing both nerve and driving ability.

Like many of my study participants, prior to this study, I had no experience of caravanning or camping, even though I had travelled extensively in Australia. The prospect of visiting parts of Australia I had never seen was very exciting. It was a huge learning curve to become both a participant and an observer of travellers on the roads, wrangling our caravan and interacting with other travellers.

In a journal entry I described the very first caravan park as 'an unremarkable but clean place with hot showers in the amenities block, next to the railway line but the four trains during the night didn't disturb us.' Subsequent caravan parks were sometimes much better but often worse. They offered choices from very basic and cheap, as per our first experience, to more expensive but with better surroundings and amenities, to very large parks with little vegetation but plenty of space. Being inexperienced caravanners, we stayed in parks so that we could have electricity and wifi. This was essential for the first few stops, so that we could watch YouTube instructions on how to put our

caravan's external awning out (it took several viewings to learn). We did not consider our very small caravan (or ourselves) to be equipped to stay in unpowered free camping areas, but in any case recent floods had made many of these sites inaccessible.

Space management was another part of the learning curve. I found the confined space of a 13-foot caravan – consisting mostly of a bed and a kitchenette – difficult at first but eventually became used to it. The outside space under the awning, where we spent most of our non-driving time, made up for the confines of the inside. Cooking, eating, reading, talking and generally relaxing outside was great, even during a prolonged period of rain at one stop and unbelievable numbers of bush flies at other locations. We needed veils to cover our faces against the flies, because no amount of insecticide made any difference. Bush flies are attracted to human sweat, tears and saliva, and can remain on and around a person for long periods, creating a serious nuisance. The flies do not have biting mouthparts but can transmit eye infections (leading to conjunctivitis) and enteric disease (Webb et al., 2013). I realised that a shift in thinking was needed if the privations I experienced during these short-term holidays were going to be tolerable as part of a long-term lifestyle.

My first data collection trip (March 1 – April 1 2020) was undertaken in the early days of the COVID-19 pandemic, after major flooding in the areas I'd planned to visit. We were on a strict timeline to reach certain towns to conduct prearranged interviews with health service managers, participants in Phase Two of this study, planned to be conducted ahead of recruitment of women travellers for Phase One. We had to adjust our travel plans and find alternative routes at times because of road closures due to flooding. Water often surrounded us on both sides as we drove to each destination. At some points, even though the roads were open, there was water over the road; we had to stop and walk into it to evaluate its depth and speed of flow before deciding whether to drive through. Trying to reverse the caravan on a narrow road, surrounded by wet paddocks and nowhere wide enough to turn around, was an even greater challenge, so going forward through the water was always the best (often only) option. We encountered few travellers on this first trip; the roads and caravan parks were all but empty.

State border closures due to the COVID-19 pandemic truncated my initial trip and required a hasty return to our home state. Subsequent trips followed during the years of fluctuating pandemic public health measures, which meant there were fewer travellers than usual in the locations we visited; we still found plenty to do, including visiting historic sites, local art galleries and places of local interest or natural beauty. My partner and I enjoyed these trips because we developed a new understanding

of life in different parts of the country. Staying in caravan parks allowed us to observe other travellers and their vehicles, accommodation and equipment. We encountered predominantly older couples, some travelling in small groups, but mostly in single vehicles. Gathering in the camp kitchens with other travellers for meals was very enjoyable, and we got to know some people well because we were (coincidentally) travelling the same route and staying in the same parks. Talking to people having similar experiences enhanced camaraderie, familiarity and pleasure.

My experience of being an ethnographer and living this life evidenced that this lifestyle is different, interesting, exciting and educational. The more we travelled the easier it became, the more relaxed we became, and the more confidence I gained in driving a big four-wheel-drive vehicle and towing a caravan. I was increasingly able to focus on living the lifestyle rather than concentrating on practical details of towing and setting up camp. Each day brought new experiences of new towns, cultures and landscapes. We read books, visited local attractions, bought groceries, walked, talked, ate and slept. Non-driving days were especially relaxing and enjoyable. However, there were many moments when I asked myself 'do I really want to do this and would I if I was not doing this study?' I concluded the answer was yes on some days, no on others. On occasion I asked myself whether I could do it alone, like so many of my study participants. I imagined being on the road by myself or maybe with my dogs and how I would feel. I wondered if, like the participants who described a degree of anxiety when they started to travel alone, if I would feel the same way, and I concluded I would.

I completed four separate trips, with the duration of each influenced by COVID-19 restrictions, bad weather and flooding. These factors closed roads that went in the directions I wanted to take and generally curtailed my ability and time to travel, learn and experience being a participant observer and conduct interviews in the field. Consequently, my experience was predominantly that of a novice, with practical matters dominating my thoughts more than the holistic experience of enjoying new places and new experiences, meeting people and the complete relaxation and peace the lifestyle brings. Nonetheless, it was always pleasurable to park somewhere for a few days, go exploring and have a reprieve from the aspects of travel I found stressful.

In summary, the process of this study enabled me to move from having no experience of a travelling lifestyle and the practical knowledge and skills that this required, to having at least an adequate competence and confidence to do this. Simultaneously, I learned to be a researcher and an ethnographer, although circumstances restricted my ability to participate in field work to gather data in the way I had intended. During this period I also learned from other researchers of this topic, and this literature is set out in the following chapter.

CHAPTER 2: LITERATURE REVIEW

This chapter presents the contents of a published article that describes an integrative review of the literature about grey nomads across Australia. The review was intended to achieve my aim of identifying the characteristics of grey nomads, in particular women travelling without men, their experiences in relation to their health and social needs, and their access to healthcare when travelling.

I used the established framework for integrative reviews set out by Whittemore and Knapfl (2005). My report of the review (the aforementioned article) complied with the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021).

My initial literature search included material published up and including June 2019; I updated it in September 2022 to maintain the currency of the evidence base for my research. However, only two additional relevant publications (by the same author) (De Bellis et al., 2020; De Bellis et al., 2023) were identified. I incorporated them in the review and updated the methods to represent the entire literature search and review process in this chapter.

The published version of the integrative review (without these additional publications) is shown in Appendix 2, along with a letter from the publisher giving permission to reproduce it (Appendix 3).

Article citation: Yates, M., Perry, L., Levett-Jones, T., Onyx, J. (2021) Exploring the 'grey nomad' travelling population of Australia and their health: An integrative literature review. *Australian Journal of Primary Health*, *27*, 163–177. https://www.publish.csiro.au/py/pdf/PY20023.

2.1 ABSTRACT

Increasing numbers of baby boomers are retiring and taking to the road in rural and remote Australia, often for extended periods. Knowledge about the characteristics of these 'grey nomads' travelling across Australia, and their experiences in relation to their health and social needs and their access to healthcare, has not been collated and examined to date. To this end, an integrative literature review with narrative analysis was conducted. Studies of Australian grey nomads, published from January 1999 to September 2022, were sourced from Ovid Emcare, Medline/PreMedline, Embase, PsychINFO, Academic Search Complete and Google Scholar.

Sixteen articles, based on 13 studies, described grey nomads as predominantly older heterosexual couples who defied conventional stereotypes of ageing by seeking adventure and new experiences. Many planned for their health needs while travelling, and their health was overwhelmingly reported to improve after they adopted the nomadic lifestyle.

This review demonstrates the paucity of data about grey nomads. Lack of information on travellers' healthcare needs and service usage undermines regional and rural service planning and the provision of healthcare services, and represents a considerable challenge for healthcare providers such as GPs, pharmacies and emergency departments.

Keywords: grey nomad, health, systematic review, travellers, women.

2.3 INTRODUCTION

Growing numbers of Australians are reported to be travelling domestically for extended periods of time. According to the Caravan Industry Association of Australia, the number of caravan and campervan registrations grew by 30% and 20%, respectively, between 2011 and 2016, to a total of 615,301 combined registrations by January 2016 (Williams, 2017). It is likely that many of the owners of these vehicles were 'grey nomads', a term commonly used to describe retired or semi-retired individuals, 50 years of age or older, who tour Australia in caravans, campervans, motorhomes and the like for a minimum of three months at a time (Onyx & Leonard, 2007). However, the proportions that are long-term travellers, as opposed to short-term holidaymakers, is unknown, as is the proportion of women travelling alone or without men.

Numerous women traveller groups exist on social media, such as the Facebook groups Women Caravanning Camping and Travelling Solo Australia (30,600 members in February 2025), Solo Women Campers (18,000), and Chicks Camping Crew (6,900). These membership numbers are more than double those reported in 2024. Whilst the ending of COVID-19 lockdowns may have spurred an unusually large increase in the number of people travelling, the membership of the abovementioned Facebook groups increased by an average of 48% in the five months pre-COVID (October 2019 to February 2020). An unknown number of women travellers are not members of these Facebook groups, so these numbers undoubtedly underestimate the true population size. Other groups, such as travelling families who home-school, are also reportedly growing in number, but the characteristics and travel patterns of them and other members of the Australian travelling population remain largely unknown.

The sole review of Australian grey nomad literature undertaken to date found only a few, predominantly qualitative studies (Raven, 2016), which cannot represent the characteristics or needs of the entire Australian travelling population. Whilst some literature discusses the North American travelling population, often referred to as 'snowbirds' or 'sunseekers', a comparison of the characteristics and activities of Australian and North American travellers found the latter population was 'quite different … despite superficial similarities' (Onyx & Leonard, 2005). These authors identified that most North Americans tend to travel to and stay at a single destination, unlike the largely 'nomadic' Australians.

That health infrastructure in regional, rural and remote Australia is thinly spread relative to regional or urban areas is well known (Australian Institute of Health and Welfare, 2022). Increasing numbers of grey nomads, including women, may place a burden on already stretched healthcare services, but little is known about travellers' healthcare needs and healthcare seeking practices and whether women travellers have specific needs and behaviours. Given the size and growth of this itinerant population, it is important to understand their characteristics, the reasons why they travel and what their lifestyle means to them, and their activities, health status, healthcare needs and health-seeking behaviours. This review sought to identify and appraise the available literature on this topic.

2.4 RESEARCH AIM

The aim of this review was to identify the characteristics of grey nomads, in particular women travelling without men, in Australia, their experiences in relation to their health and social needs, and access to healthcare when travelling.

2.5 RESEARCH QUESTIONS

The questions that guided the review were:

1. What are the characteristics of grey nomads (older people who travel Australia for weeks, months or years), including their motivation for travel, distances travelled, duration of their trips and the chosen destinations? What is known about women who travel without men (solo or with other women)?
2. Prior to travelling, what planning do grey nomads carry out in relation to their social and healthcare needs, such as medications and self-management of chronic disease?
3. What are grey nomads' experiences in relation to their health and healthcare provision during their travels?

2.6 LITERATURE SEARCH AND REVIEW METHODS

In creating the search strategy, terms were organised in relation to 'population' and 'situation' (DiCenso, 2005).

Population: For the purposes of this review, grey nomads were defined as older people who choose to travel across Australia in self-contained mobile accommodation for prolonged periods of time.

Situation: The descriptive characteristics of this population, and all aspects of their health, healthcare needs and services accessed.

Inclusion criteria: English-language journal articles (published no later than 20 September 2022) about Australian grey nomads or travellers, adult populations, male and female, and their health and wellbeing. A majority of the population examined in each article had to be aged >45 years and/or retired from paid employment. All English language publications, published from the earliest date of the databases to 20 September 2022.

No travel duration criteria were set other than, where reported, this should represent, on average, months.

Exclusion criteria: Literature related to religious pilgrims and short-term holiday travellers or vacationers was excluded. Publications other than primary research (e.g. conference abstracts, discussions, commentaries, editorials, literature reviews) were excluded, but their reference lists were searched.

The search strategy was set up (**Table 2**) and run, with some minor modifications, on five databases and the search engine Google Scholar. Each database was searched from inception for the following date ranges:

- Ovid Emcare (1995 – November 2022)
- Medline and PreMedline (1996 – November 2022)
- Embase (1988 – November 2022
- PsychINFO (1987 – November 2022)
- Academic Search Complete (1992 – November 2022).

Table 2. Search strategy example for Ovid PsychINFO

Search Number	Search Terms
1	Grey nomad*.mp
2	(Motorhome* or camper*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
3	(Snowbird* or Sunseeker*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
4	((Health or ill) and health).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
5	Exp Chronic illness/ or chronic disease*.mp.
6	Long term condition*.mp.
7	Drug therapy*.mp.
8	1 or 2 or 3
9	4 or 5 or 6 or 7
10	8 and 9

The final search output of each database was exported to Endnote X9 (see **Figure 1**) and duplicates were identified and deleted. Records were then screened for eligibility checking title, abstract and keywords. Records not meeting inclusion criteria or meeting exclusion criteria were removed. All remaining full-text publications were read to assess relevance to the research questions; reference lists of relevant publications were hand-searched for additional studies. Sixteen articles were retained.

The 16 retained articles were critically appraised using the Critical Appraisal Skills Program (CASP) tool for qualitative research (see **Table 3**). For surveys, the CASP tool was modified to add instrument validity and reliability. All 16 publications were retained for inclusion in the review.

2.7 DATA EXTRACTION AND ANALYSIS

A data extraction table was created with headings to identify the main characteristics of each article (**Table 4**). Data were extracted in relation to the research questions (**Table 5**).

Figure 1. Flow diagram of literature searching and screening

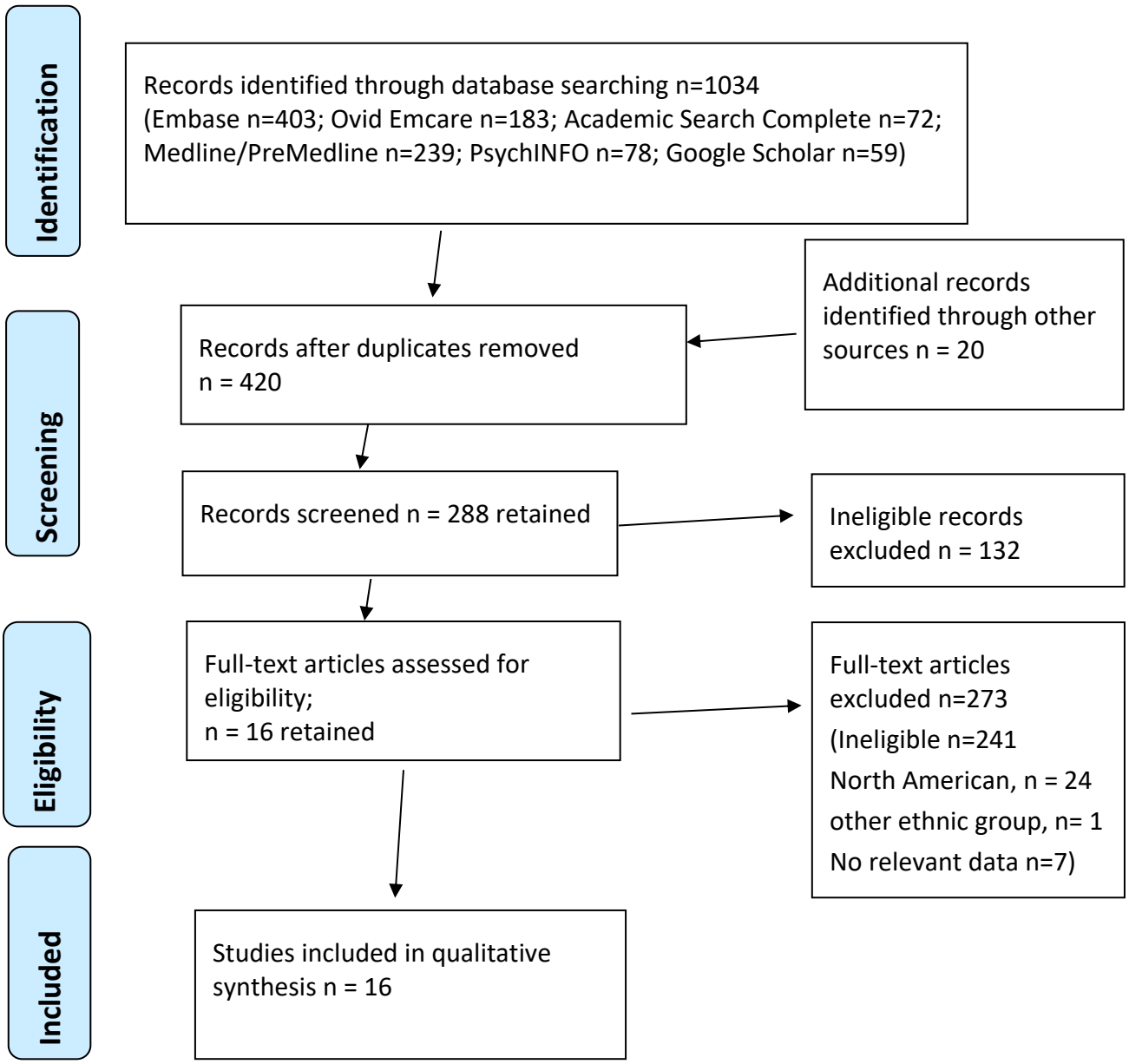


Table 3. Critical appraisal of included publications using CASP tool

	1 Aims	2 Appropriate Methodology	3 Design Appropriate to Aims	4 Appropriate Recruitment Strategy	5 Data Collection	6 Researcher Participant Relationship	7 Ethical Issues	8 Data Analysis	9 Findings	10 Research Value	Survey Tool Validity and Reliability
1 White & White 2004	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes	Adequate	N/A
2 Onyx & Leonard 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Adequate	N/A
3 Prideaux & McClymont 2006	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Yes	Adequate	N/A
4 Tate et al. 2006	No	Yes	Can't tell	Yes	Yes	Can't tell	Can't tell	Yes	Can't tell	Adequate	N/A
5 Onyx & Leonard 2007	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Adequate	N/A
6 Cridland 2008	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Adequate	N/A
7 Obst et al. 2008	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Yes	Adequate	Can't tell
8 Holloway 2009	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Adequate	N/A
9 Braley & Obst 2010	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Adequate	N/A
10 Patterson 2011	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	Yes	Yes	Adequate	N/A

11 Hillman 2013	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Adequate	N/A
12 Halcomb et al 2017	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Adequate	Can’t tell
13 Calma et al.2018	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Adequate	N/A
14 Stephens 2018	Yes	Yes	Yes	Yes	Yes	Can’t tell	Yes	Can’t tell	Yes	Adequate	N/A
15 De Bellis et al 2020	Yes	Yes	Yes	Can’t tell	Yes	Can’t tell	Yes	Yes	Yes	Yes	N/A
16 De Bellis et al 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

Table 4. Included publications

Reference	Aim	Type of study	Setting/ Recruitment Location	Sample/Method Description	Source of Findings
1 White & White 2004	Examine how mid-life and older long-term travellers describe their motivations for travelling and their experiences in outback Australia and if their stories evidence long-term travel as transition between endings and new beginnings	Ethnography	The observational sites included caravan parks, camping areas or campgrounds in national parks and roadside stops in the central, northern, and western Outback areas of Australia over a period of 3 months	Participant observation, conversations and semi-structured interviews with 45 long-term travellers	The data were analysed thematically. The themes were guided by the conceptualization of the study and issues emerging from the data. The transcripts and notes were read twice, recurring points of view noted, and exemplars of repeating themes cited
2 Onyx & Leonard 2005	Identify the motivational patterns of Australian grey nomads, the similarities and differences with North American Snowbirds	Ethnographic account using in-depth taped semi-structured interviews in order for respondents to tell their own story.	The first researcher travelled 16,000kms in a motorhome over 2.5month, stopping at camping sites, free rest areas, commercial caravan parks, National Parks, including some known and targeted sites in Western Australia, Northern Territory, and Queensland	Convenient sampling using a brief survey to identify basic demographics, an ethnographic survey, with 1 questionnaire per travelling vehicle and tape-recorded in-depth interviews of 215 men and 203 women	The questionnaire was used to identify basic demographics, place of origin, number of weeks travelled and planned and the type of vehicle used. The narrative interview asked about what motivated people to become grey nomads

3 Prideaux & McClymont 2006	Investigate the demographic characteristics of caravanners	Paper based snapshot survey	Managers of 2 caravan parks in Goondiwindi distributed surveys over 3-month period	1 Person per travel party > 16 years was approached. 200 Questionnaires were distributed 161 returned, 12 incomplete 74.5% response rate	Survey instrument developed and pilot tested no information provided
4 Tate et al. 2006	Investigation of the health burden of travellers on limited healthcare services in remote Australia	Survey conducted by face-to-face interview and by telephone	Fitzroy Crossing River Lodge Caravan Park in the Kimberley District of Western Australia. All doctors and nurses in the Kimberley providing primary healthcare	Two groups: 1. Travellers in the caravan park were recruited face to face between 2.30pm and 5.30pm over 5 days. n260 travellers 2. Local doctors and nurses (HCP) in the Kimberley recruited by phone; 40 Doctors and 24 nurses	Traveller survey items included current medical illnesses, frequency of use of medical services, written health information HCP survey items included the importance of different components of written health information about the travellers
5 Onyx & Leonard 2007	To explore the experience of grey nomads (minimum age 50 years) in relation to the literature on aging in particular the dominant decline model of ageing	Ethnographic account using in-depth taped semi-structured interviews in order for respondents to tell their own story	The first researcher travelled 16,000 kms in a motorhome over 2.5 months, stopping at camping sites, free rest areas, commercial caravan parks, National Parks, including some known and targeted sites in Western Australia, Northern Territory, and Queensland	216 Questionnaires; interviews of 23 couples, 2 single informants and 1 group totalling 'some 400 travellers'	The questionnaire was used to identify basic demographics, place of origin, number of weeks travelled and planned and the type of vehicle use. The narrative interview about health status and episodes of health scares over the previous 2 years, difficulties encountered while travelling, travellers' networks, access to information and resources

6 Cridland 2008	Examine the internal temporary mobility patterns of seasonal movers to Northern Australia during the winter months	Surveys and face to face interviews	Caravan parks and camping sites at coastal and inland destinations in Tropical Australia (above the Tropic of Capricorn)	Grey Nomads visiting or residing above the tropic of Capricorn. Questionnaire distributed; structured and semi-structured audio recorded face-to-face in-depth interviews with individuals Convenience sample	Quantitative and supportive qualitative data regarding the socio-economic/ demographic status and movement patterns of grey nomads visiting different types of destinations across northern Australia
7 Obst et al. 2008	To detail distances, trip duration and places visited by grey nomads; the health and road safety risks and current knowledge and management of those risks. Identification of and access to road safety information	Survey	Participants were recruited at the Queensland Caravanning and Camping Show in Brisbane June 2008	Show visitors randomly approached, who had taken a long-term road trip in the last 2 years. Invited to participate by filling out the survey and returning it to the boxes provided or by reply paid envelope. 136 participants were over 50 years of age and had undertaken a long- term road trip in the last two years; 93 males, 43 females	The survey asked for demographic information, details of trips undertaken in the last 2 years, the occurrence of road or safety incidents, and other issues related to road safety
8 Holloway 2009	To develop insights and arrive at provisional conclusions about how grey nomads gain meaning and pleasure from their	Ethnography using interviews	Caravan parks, camping areas in national parks, tourism sites, roadside rest areas in northern and mid- west Western Australia, Uluru and the Nullarbor	Convenient sampling of 40 young 55-65 years, intermediate 65-70 years and older > 70 years self-drive retirees travelling with their own caravan, campervan, mobile homes and/or tents	Reponses to ethnographic interviews

	travelling lifestyle choice.				
9 Braley & Obst 2010	Explore what travellers understood as their sense of social identify the level of community they experienced	Survey conducted face to face and electronic	Surveys distributed at recreational vehicle events and rallies and caravan parks in 6 States. Electronic survey to membership of camping and caravan clubs.	Convenience sampling of (a) recreational road travellers 50years – 80+ years in 6 States (b) Camping and caravan club members	Survey developed for the study including the Three Factor Model of Social Identity and Sense of Community Index
10 Patterson 2011	Investigate grey nomads' engagement with friends and family while 'on the road'	Ethnography and a narrative research technique was also used	Data collected from four couples on an extended, multi-destination holiday in the Northern Territory and Western Australia over a 7-week period	The sample consisted of four female and four male partners, all over 50 years of age, retired or semi-retired	Narratives were used to illustrate themes about the everyday experiences of grey nomads on tour. Travel diaries and photos and a questionnaire returned by email were all submitted at the end of the trip and thematic analysis was applied
11 Hillman 2013	Investigate how grey nomads in Australia perceive their health and social needs and activities when these were limited or maximised by their travel plans and aspirations	Qualitative interview study using grounded theory technique as an inductive interpretive approach	In a caravan park in a Central Queensland coastal over a 2-month period	20 Participants were interviewed comprised of nine couples and two individuals all over the age of 56 years Open ended semi-structured in-depth face to face interviews accessed using snowballing	18 Questions included standard demographic questions, travelling times and duration, mode of transport, travelling companions and accommodation; health concerns, community engagement and social activities

12 Halcomb et al 2017	Explore the health needs and health planning of Australian long-term travellers and their current planning strategies for health and healthcare	Online survey	Recruited online using Facebook, Twitter, blogs, forums and web newsletters, social media Sept 2015-Feb 2016	N316 survey respondents had been travelling continuously for 3 months or more or had done so in the last 12 months	Survey items included demographics, travel, health conditions, planning and needs; QOL-BREF (an internationally validated tool)
13 Calma et al.2018	Explore the experiences of grey nomads travelling with chronic conditions i.e. older people with chronic diseases, travelling across Australia and the challenges in accessing healthcare services	A qualitative descriptive phase of a larger mixed method study which used telephone interviews of participants.	Online survey through social media and caravanning forums Subsequent telephone survey	The participants were individuals recruited from social media sites and caravanning forums who had travelled around Australia for more than 3 months for the last year. Of those consented to participate, people aged over 60 years, living with at least one chronic condition. Potential participants were contacted randomly until data saturation was achieved i.e. emergent themes recurred and no new patterns were evidenced	Questions focused on health needs as they relate to chronic illness, health preparedness and wellbeing whilst travelling
14 Stephens 2018	Explore the experiences, health needs and	Prospective qualitative phase of a larger, sequential, explanatory,	Respondents of an online survey recruited through social media and caravanning forums	Of the survey respondents who volunteered to be interviewed purposive	Semi-structured, in-depth interviews were conducted over six months in 2016, and

	strategies of grey nomads living with cancer	mixed-methods project using semi-structured interviews by telephone	who agreed to a subsequent telephone survey. Geographical location was not identified	sampling of 14 people who self-identified with a diagnosis of cancer	analysed using thematic analysis
15 De Bellis et al 2020	This study explored the experiences of Diabetes Educators providing services to travellers with diabetes	Qualitative study using Interpretive Description; Semi-structured open-ended questions were used in telephone interviews	Purposive sampling using an existing email communication network of rural and remote nurses in South Australia	48 rural and remote nurses in South Australia were invited by email to participate. Seven respondent nurses who were also Credentialled Diabetes Educators were interviewed by telephone	The 2018 interviews were audio-recorded and transcribed verbatim. Inductive thematic analysis used a six-step process of qualitative analysis and systematic coding resulting in themes (Braun & Clarke, 2006). The data was cross checked by four researchers resulting in constructed interpretation and analysis
16. De Bellis et al 2022	Explore the travel preparation and experiences of grey nomads with diabetes to identify self-management strategies used and the preparation undertaken	Survey with structured and unstructured questions	Online survey advertised on grey nomad and diabetes specific social media sites in Australia	Participants were survey respondents diagnosed with type 1 type 2 or pre-diabetes	Newly developed survey not validated but piloted by 17 people

Table 5. Findings from included publications

Reference	Travellers' age data	Travellers' other demographic data	Travellers' duration of travel	Health planning for the trip	Health Issues and Concerns	Implications for Healthcare Services
1 White & White 2004	45 interviewees in 3 major categories of mid-life and older people: parents with children, people approaching retirement, retirees No data supplied	Not reported	'Some three months into their journey, others six months, others had been traveling for a year or longer	Not reported	Not reported	Not reported
2 Onyx & Leonard 2005	Average (SD): males 64.5 (6.3), females 61.3 (6.1) years	215 men, 203 women 93% travelled in couples 7%, including 1 female, travelled alone; 34% from major urban centre; 33% regional centre; 33% rural centre; 74% travelled with caravans; 7% motorhomes; others: campervan,	All > 3 months; 15% >1 year. The researchers themselves travelled for 2.5 months	Almost all respondents had a pre-prepared response for emergency which included a communication device such as a CB or UHF radio and could access the trucker's channel for help; Some made special arrangements e.g., informing local homesteads of their riskier adventures.	1.4% Male 1.5% female reported health poor; 14% Male 9.4% female fair; 47.9% male 45.8% female good; 36.7% male 43.3% female excellent; 32% Male 21% female had experienced a health scare in the previous two years. 18 of 26 Groups reported a major health issue. e.g., heart attacks, aneurism, angina, cancer, limb amputation, spinal	4 of 216 experienced a medical emergency, e.g. requiring helicopter evacuation, removal of gall bladder at a hospital in a town close by.

		reconditioned bus, car with trailer; 66% 4WD, 44% Vehicle less than five years old; 83% Anglo-Saxon; 12% UK born; 3% Northern European		Most understood and accepted the risk associated with health and travel All were aware of mutual support with other grey nomads by giving and receiving assistance with each other at some point	injury, diabetes and arthritis. Serious health issue often the trigger to travel.	
3 Prideaux & McClymont 2006	89% were aged 45 to 74-years; 4.8% younger (3.4% aged 35 to 44 years, 1.4% aged 18 to 24 years) and 6.1% older, at 75+ years.	92 Males, 56 females 87.9% middle age to retirement aged 45-74 years 3.4% 35-44 years 6.1% 75+ years 1.4% (2 respondents) 18-34 years 72.3% retirees 7.4% professionals 15.6% various other occupations	Median trip length 54 days. Average length of stay exceeded 10 weeks Mean 71.4 days SD 80.4 49% between one and three months 19.3% two – four weeks 17.2% three – six months	Not reported	Not reported	Not reported
4 Tate et al. 2006	Median age 61.3 years	18.5% Western Australia usual place of residence	Median length of planned trip 14 weeks	57% Had sufficient medication for their entire trip 19% Had a list of medications	55% Reported chronic disease of which: 9.6% Heart disease 6.5% Diabetes Mellitus 26.2% Hypertension	Healthcare practitioners considered the following as important: 95% Healthcare summary

		76.9% Another State in Australia 4.6% From outside Australia		9% Of those with chronic illness had a health summary from their GP	6.1% Lung disease 21.1% Dyslipidaemia 4.8% Mental illness 16.7% Other	47% Pathology results 91% Active problem list 92% Allergies 87% Past medical history 31% Previous hospital admissions 100% Medication list 69% Usual GP 22% Radiology results 30% Usual specialists
5 Onyx & Leonard 2007	As above	As above	As above	As above	As above	As above
6 Cridland 2008	Mean age of males 65.4 years and females 64.2 years; median age per vehicle 64 years.	95% traveling as heterosexual couples; <2% same sex couples; 3% singles	12 months or less	N=63 18% plan to be at specific destinations to access medical facilities, for prescriptions, GP or specialist blood tests	Grey nomad lifestyle improved their quality of life and health; males more ailments than females; females higher incidence of osteoporosis and depression; n=21 5% no medical condition reported; n=652 75% two or more conditions; n=136 16% more than 3 conditions; n=207 25%	Not reported

					one condition requiring ongoing medication and treatment	
7 Obst et al. 2008	23% <55 years, 50% 56-65 years, 19% 66-70 years, 8% >70 years	93 males and 43 females over 50 years. 80% were born in Australia, 7% were born in the United Kingdom, 5% born in New Zealand and the remainder from countries including Zimbabwe, Holland, Germany and the USA. 38% held junior certificates, 20% senior certificates, 15% trade certificates, 27% a tertiary degree	Trip duration range: 1-104 weeks with a median of 4 weeks. Kilometres travelled range: 600-40,000. 36% travelled in Autumn 28% in winter, 18% in spring and 18% in summer.	Not reported	6% experienced a road crash with no injuries reported. 5% experienced a medical emergency including minor falls, 3 resulted in two broken bones 1 injured knee; one participant painful kidney stones. 14% experienced other health scares such as chest pain, back injuries, deep vein thrombosis, sever arthritis, pneumonia, cervical cancer diagnosis and fainting fits.	The health issues were treated at local regional hospitals or local GPs
8 Holloway 2009	3 categories: 'young', 55-65years; 'intermediate' 65-70 years; 'older', 70+ years	18 Heterosexual couples, 3 single males and 1 single female	Not reported	Health checks pre-travel, plan destinations in accordance to treatments and self-protective behaviours; accessibility of medications including	General health and well being improves; more meaningful lifestyle; stiff arthritic joints, cancer, major heart problems, physical losses associated with aging	Better policy resourcing and infrastructure to improve provision of healthcare services in rural and remote Australia is needed

				Authority medications; the reluctance of some doctors to prescribe to a stranger, thus limiting ability to self-care and diminishes autonomy; travel fewer kilometres and fewer destinations as health and strength decline		
9 Braley & Obst 2010	N=631 50years - >80years	N= 440 Males 139 females 52 not reported 73.4% from Queensland Most were couples	Not reported	Not reported	Not reported	Not reported
10 Patterson 2011	4 heterosexual couples > 50 years	Couple A and B were retired from private business; couple C retired foundry manager and laboratory technician; Couple D retired accountant and homemaker	Seven weeks	What medications to take for medical care and emergencies; access to medical care while on the road were outlined in Table 3 – Predeparture Decisions, however no findings were reported	Not reported	The study results suggest that important social connections with family and newfound friendships were strengthened. Evening 'happy hours' were considered important for socializing and as a means of obtaining information about where to travel next, and what to see and do. Participants remained reliant on family support

						to stay away for an extended period. Family members looked after pets, home/garden, and personal finances
11 Hillman 2013	Nine couples 2 individuals >56 years	All retired, identified as 'grey nomads' and came from somewhere other than Queensland	All respondents > three months. 15% > one year. 20 % two years or indefinitely. For most respondents it was the second or third trip of that kind	Most had contingency plans for unforeseen medical emergencies. Bi-annual check-ups and the agreement of GPs before travelling in-between check-ups. Carrying a list of medications, letters from GPs outlining medical history and other relevant information Some travelled with enough prescription medication for the trip duration. Staying at destinations close to a hospital	Many responded that their health was a concern. Travel regardless of deteriorating health; travel as a potential last life experience Less-stressful lifestyle led to health improvement, one respondent remarked 'that stress is 90% of the illness'	One couple visited a GP close to their travel destination and were on file at the practice. Nothing else reported
12 Halcomb et al 2017	Mean (SD) 60.2 (10.9) years, 62.3% retired, 52.8% female, 76%	n=149 males, n=167 females 62.3% retired; 28.2% received aged pension, 11.4% a	19.9% travelled >46 weeks in preceding year	n=206 65.2% of respondents and n= 179 74% travel companions health	37.3% of respondents BMI >30; 5.7% and 3.7% of companions, smokers; 49.7% and 50.2% of	Not reported

	reported a travelling companion	disability pension; 7 .3% were on paid leave from their employment. Main accommodation 67.1% caravan, 15.5% a motorhome		check with GP before travel; n=102 32.3% travelled with information prepared by GP; n=72 22.8% visited an ED; n=63 19.9% visited another health provider	companions consumed 1-3 standard drinks per day; 27.2% and 34.8% consumed alcohol 6-7 days per week; 40.2% hypertension, 22.8% arthritis, 17.1% other health conditions, 13.0% diabetes. 11.1% ceased work because of illness or disability; 42.7% reported long term illness affecting their everyday life. 8.9% returned from travels because of poor health	
13 Calma et al. 2018	Selection criteria >60 years; n=8, 62-69 years	Selection criteria $\geq$ 1 chronic illness; all had 2-5 diagnoses n=4 female, n=4 male	All >3 months in last year	Travel experience improved self-awareness about limitations and boundaries; several travelling with information from GP about their condition	Challenges, e.g., of insulin storage when travelling; developed self-management skills in recognition of exacerbations and deterioration and acting accordingly; use of health app to measure BP and heart rate; positive	Some participants had difficulty accessing health services in rural and remote areas; inability to get into a GP meant attendance at ED; lack of shared medical information; limited pharmaceutical stock in some pharmacies

					impact travel has on health	
14 Stephens 2018	Not reported	14 Self-identified grey nomads with diagnosis of cancer	4 months – 15 years	Integration into travel of organisation and management of cancer treatment and follow-up; travel routes taken in accordance with health needs, supplies and services; took medication and cancer treatment histories	Ongoing oral chemotherapy, acquisition and storage	Not reported
15 De Bellis et al. 2020	Not reported	Not reported	Not reported	Most grey nomads with diabetes were described as well prepared and highly motivated to manage their diabetes. However, nurses also noted problems with maintenance of equipment, medications and unpredictable events, noting ways to enhance their diabetes self-management that	Challenges were identified to glycaemic management from long days of driving, more sedentary lifestyles and poor diets; from hypoglycaemia when driving; from not prioritising blood glucose monitoring or ensuring an ongoing supply of medication	Travellers' lack of understanding about service provision and the limited resources outside metro areas resulted in unrealistic expectations. The need identified for appropriate and targeted pre-travel education and preparation

				travellers needed to consider		
16 De Bellis et al. 2022	Of n=103, 59% aged 60-69 years	Of n=103, 47% female, 32% male, 20% NS 79% travelling with spouse, 18% female solo traveller, 8% male solo traveller	63% travel for 3-6 months	Pre-travel diabetes consultation, GP 43%, diabetes educator 14%, pharmacist 11%, no one 28% Carrying emergency food and medicines always 37%, usually 12%, sometimes 10%, never 14%, 18% NS 36% action/sick day plan Carry a health summary from GP always or most of the time 37%, carry a list of current medications 68% 46% had correct storage for all medications	78% felt they self-managed their diabetes well, Wide variation in reported frequency of glucose monitoring and understanding of readings and response if out of target Few carried ketone test strips or checked ketones when unwell, some participants affected by COVID-19 travel restrictions	Flagged increasing numbers of people with diabetes travelling but only a minority had sound knowledge of diabetes and potential complications, flags need for informed pre-travel preparation for self-management including a pre-travel check list

Conventional content analysis was applied, because this approach is suitable for topics with little theory or prior literature (Hsieh & Shannon, 2005). Included papers were repeatedly read and initial categories in relation to the research questions emerged from the data and were coded. Coded data were then reviewed to identify patterns and any discrepant data, collated, and summarised.

2.8 THE RIGOR OF THE STUDY

Two authors worked separately and compared findings in relation to screening and data extraction. A 20% sample of included publications was independently appraised by the second author. Throughout the process of data extraction and content analysis, coding and analyses were discussed and consensus reached.

2.9 FINDINGS

The 16 included publications were based on 13 studies. Two were doctoral theses, one using face-to-face interviews (Holloway, 2009), and the other a paper-based survey and face-to-face interviews (Cridland, 2008). Five publications took an ethnographic approach (Holloway, 2009; Onyx & Leonard, 2005; Patterson, 2011; White & White, 2004), one used grounded theory (Hillman, 2013) and three described a qualitative approach (Calma et al., 2018; De Bellis et al., 2020; Stephens et al., 2018). Seven publications reported quantitative surveys (Brayley & Obst, 2010; Cridland, 2008; De Bellis et al., 2023; Halcomb E et al., 2017; Obst et al., 2008; Prideaux & McClymont, 2006; Tate et al., 2006). Several publications combined approaches, such as participant observation, semi-structured or ethnographic interviews and telephone surveys (**Table 4**).

A variety of sampling methods were used. One study relied on participants referring the researchers to other possible participants (snowballing) (Hillman, 2013). One study relied on paper questionnaires distributed by caravan park managers (Prideaux & McClymont, 2006), and another on questionnaires distributed at a caravan show (Obst et al., 2008). One (Halcomb et al., 2017) of the two online surveys (De Bellis et al., 2023; Halcomb et al., 2017) was used to recruit participants to two further studies involving telephone interviews (Calma et al., 2018; Stephens et al., 2018) (**Table 4**).

Seven research teams travelled to recruit participants: five were peripatetic (Cridland, 2008; Hillman, 2013; Holloway, 2009; Onyx & Leonard, 2005; Patterson, 2011) and two stayed at single locations (Hillman, 2013; Tate et al., 2006). The geographic settings of these studies ranged across much of

Australia. Three ethnographic studies were conducted in camping sites, caravan parks, free rest areas and national parks in Western Australia, the Northern Territory and Queensland (Holloway, 2009; Onyx & Leonard, 2005; Patterson, 2011). One study pre-selected caravan parks with powered tourist sites and distributed a questionnaire to participants, followed by in-depth interviews. One study distributed questionnaires at recreational vehicle events and rallies and caravan parks in six states and conducted an online survey of the membership of camping and caravan clubs (Brayley & Obst, 2010). Other researchers distributed questionnaires at a caravan show in Brisbane (Obst et al., 2008) and caravan parks in Goondiwindi, on the New South Wales–Queensland border (Prideaux & McClymont, 2006). Interviews were carried out with healthcare professionals in the Kimberley District of Western Australia (Tate et al., 2006) in rural and remote areas of South Australia (De Bellis et al., 2020), and with travellers in multiple caravan parks and camping sites above the Tropic of Capricorn (Cridland, 2008). For the online surveys and subsequent telephone interviews, participants' locations were unknown (Calma et al., 2018; De Bellis et al., 2023; Halcomb et al., 2017; Stephens et al., 2018).

Ten of the 16 publications were published before 2011 and focused on defining and describing grey nomads, their movements and motivations, the logistics of a travelling lifestyle and the meanings derived from the experiences, their sense of social identity and community, and their experience of road safety (Brayley & Obst, 2010; Cridland, 2008; Holloway, 2009; Onyx & Leonard, 2005, 2007; Prideaux & McClymont, 2006; Tate et al., 2006). Health status was part of the description of the participants given in these publications. A more recent cluster of papers (Calma et al., 2018; De Bellis et al., 2023; Halcomb et al., 2017; Hillman, 2013; Stephens et al., 2018) shifted the focus to people who travel with chronic illness and how they manage their health on the road. Two papers focused on healthcare professionals' experiences and opinions of travellers (De Bellis et al., 2020; Tate et al., 2006).

2.9.1 Question 1: The Characteristics of Grey Nomads

Question 1 asked about the characteristics of older people who travel Australia for months, and what is reported about women who travel without men. Responses reported in the 16 papers came from a total of 3,383 participants.

Age and Gender

Eight studies set participant age as a recruitment criterion (Brayley & Obst, 2010; Calma et al., 2018; Cridland, 2008; Holloway, 2009; Obst et al., 2008; Onyx & Leonard, 2005, 2007; Tate et al., 2006),

identifying grey nomads as people aged over 50 years. In one thesis the target population was 55 years and older, in three categories: 'young' (55–65 years), 'intermediate' (65–70 years), and 'older' (70+ years) (Holloway, 2009). The other thesis specified a minimum age of 50 years, but in the event recruited 15 women and two men under this age (Cridland, 2008).

One study reported all its participants as 56 years and older (Hillman, 2013). Prideaux and McClymont (2006) found that most of their participants (89%) were aged 45–74 years. Halcomb et al. (2017) included travellers who were younger or travelling with a family in addition to grey nomads, and referred to the whole group as 'domestic self-drive travellers'. These participants' ages ranged from 26 to 89 years, with a mean of 60.2 years and a mean of 59.8 years for their travel companions.

Onyx and Leonard (2005) recruited 215 male and 203 female participants; Prideaux and McClymont (2006) identified 92 (62.2%) as male and 56 (37.8%) female. From the online surveys, Halcomb et al. (2017) reported 52.8% of their participants were women, and De Bellis et al. (2023) stated that 47% of those who reported their gender were female. Brayley and Obst (2010) found that of their 631 participants, 440 were men and 139 women, with 52 not reporting their gender. No other study identified participants by gender.

De Bellis et al. (2023) reported 26% of survey participants with diabetes were solo travellers, 18% of whom were women. None of the publications identified or outlined any specific information or findings on women who travelled alone, with other women, with children, or without men.

RELATIONSHIP PROFILE AND SOCIAL IDENTITY

Cridland (2008) reported that most grey nomads in their sample were heterosexual couples (95%), including 5% de facto couples; singles made up 3% and same-sex couples <2%. Most single men travelled independently, while single women travelled in parties of two or more vehicles with other singles or couples. Onyx and Leonard (2007) found that most participants travelled as couples, as did De Bellis et al. (2023) (79%). According to Brayley and Obst (2010), older recreational road travellers considered 'couple' their primary social identifier, with other social group identity, such as grey nomads, as secondary.

Not all studies sought or reported detail of the participants' relationships; some referred only to 'participants' and 'travel companions' (Hillman, 2013; Stephens et al., 2018; Tate et al., 2006).

Several papers reported participants as 'couples' (Brayley & Obst, 2010; Cridland, 2008; Holloway, 2009; Onyx & Leonard, 2005; Patterson, 2011; Prideaux & McClymont, 2006). In other studies of participants who were mostly couples, almost all were heterosexual couples (Cridland, 2008; Onyx & Leonard, 2005; Prideaux & McClymont, 2006). In the Cridland (2008) sample, the men were typically employed in trade or management positions and the women as housewives or in clerical duties.

Socio-Economic Considerations and Ethnicity

Halcomb et al. (2017) studied travellers with widely ranging ages (at 26–89 years), but most (62.3%) were retired; 28% received the aged pension and 11.4% the disability pension, and 7.3% were still employed but on paid leave. Cridland (2008) noted marked differences between grey nomads who 'camped' and those who stayed in caravan parks with those who chose caravan parks more likely to have greater retirement income and trip expenditure, but more health issues and longer length of retirement. Preferences were also expressed for camping grounds or caravan parks based on whether pet-friendly caravan parks were needed or available, and the types of activities at the destinations (for example, whether cultural visits were preferred or physical activities such as hiking). De Bellis et al. (2023) found that travellers with diabetes preferred free camping sites without power (53%), and caravan parks (46% occasionally, 20% always), rather than motels or hotels.

For Onyx and Leonard (2005), 83% of participants were Anglo-Australian, 12% were Australians born in the United Kingdom (UK) and 3% were from Northern Europe, with all having lived most of their working lives in Australia. Few studies reported grey nomads of other ethnicities, although Cridland (2008) identified a small number from New Zealand. Obst et al. (2008) reported 80% of participants were born in Australia, with 7% born in the UK, 5% in New Zealand and the remainder in Africa, Europe or the United States. The remaining papers did not mention ethnic origin; neither Aboriginal status nor country of birth were recorded in any paper.

Mode and Motivation to Travel

Researchers' definitions of 'grey nomad' included travel for prolonged periods of time, ranging from at least months or longer. (Onyx & Leonard, 2007) described participants as travelling with self-sufficient accommodation such as caravans (74%), motorhomes (7%), camper trailers and campervans; 66% had four-wheel-drive vehicles. Holloway (2009) described the caravan or motorhome as an extension of the family home in which grey nomads continued their everyday activities on a smaller scale. Cridland (2008) reported that their sample of grey nomads had been travelling on average for 126 days (median 115 days); 14.8% <60 days, 19% for 61–89 days, <16%

131–179 days and 14.3% >180 days. More than one third (36%) reported being away from their usual place of residence for 90–130 days per trip. For participants of one online survey (Halcomb et al., 2017) the average trip duration was 24.6 weeks; 19.9% had travelled for more than 46 weeks in the preceding year, and 53.3% planned to travel for 10 months or more, some indefinitely. Of the De Bellis et al. (2023) survey respondents with diabetes, 63% reported travelling for 3–6 months.

According to Cridland (2008), over 42% of participants travelled to northern Australia during winter to escape the cold; in another study, many grey nomads described this as a 'must do' (Hillman, 2013). Cridland (2008) also said that 22% wanted to see Australia, its historical sites and landscapes whilst 11% wanted adventure and to get away. Patterson (2011) found that many wanted to see more of Australia while young and healthy enough to enjoy travelling with friends, exploring new places, and meeting new people. Onyx and Leonard (2005) found a consistent pattern of motivation to travel for adventure: to discover places never seen before; to enjoy the beauty and wonder of the scenery; to be independent; to have the freedom of time that is not duty-bound; to have a less organised, more relaxed life, moving slowly, noticing, appreciating and learning; heightening their senses and expanding their understanding and appreciation of the country as a whole.

Taking a different approach, White and White (2004) discussed 'endings' as a motivation to travel: changed family circumstances such as children leaving home, the death of a partner, anticipation of the end of good health, and work changes. These participants regarded travel as a transitional experience between one thing and another, and noted its significant effect on personal identity. Regardless of their motivation and age, they considered travel a rite of passage.

SOCIAL NETWORKS, CONNECTION AND SENSE OF COMMUNITY

One of the most positive aspects of travelling was the experience of meeting other people on the road, some of whom remained lifelong friends (Onyx & Leonard, 2005). Grey nomads are part of a larger age-related cohort of people who have retired from the workforce; social interaction amongst them is common because retirement has separated them from work-related interactions and social connections (Holloway, 2009). New social networks developed with new-found friends who were fellow travellers (Patterson, 2011). At the same time, travel was seen in terms of continuance of familiar domestic roles and lifestyles, with grey nomads continuing their everyday home activities on a smaller scale (Holloway, 2009).

Of the total 3,383 participants described in these 16 papers and 13 studies, only a few solo women were identified — by Holloway (2009), Onyx and Leonard (2005), and De Bellis et al. (2023) (of

whose participants 18% were solo women travellers). No specific information was supplied about the solo women travellers in the samples, and no other studies referred to women travelling solo or without men.

2.9.2 Question 2: Pre-Travel Health-Related Planning and Preparation

The included papers show that prior to departure, travellers recounted a range of planning in relation to their social and healthcare needs. Tate et al. (2006) found that 9% carried health summaries from their GPs. De Bellis et al. (2020) found that diabetes educators reported most travellers with diabetes were well prepared and highly motivated to manage their diabetes while travelling, a finding confirmed in a subsequent survey of travellers with diabetes (De Bellis et al., 2023). These survey findings included that 37% of travellers carried a health summary from their GP 'always' or 'most of the time'. According to Halcomb et al. (2017), 23.7% carried a list of medications, which for 44% was self-prepared and for 42.7% came from a doctor. Halcomb et al. (2017) focused on health needs for those with chronic illness, their health preparedness and wellbeing whilst travelling; an offshoot study focused on people with a diagnosis of cancer, reporting that they travelled regardless and/or because of their diagnosis (Stephens et al., 2018).

Brayley and Obst (2010) explored the effect of reducing health status, such as deterioration in visual acuity and slowing of cognitive processing as part of the aging process, on road safety. They noted that grey nomads' road travel can be very different to that of most older drivers. Many grey nomads embark on extended road trips, driving and towing heavy vehicles in rural and remote areas. They may have little experience or training that would allow them to cope with conditions such as dirt or narrow bitumen roads, road trains, wildlife on the road, and strong cross winds while towing. Brayley and Obst (2010) also noted the risks associated with fatigue when driving long distances. The combination of unfamiliar environmental hazards and stressors and health-related ageing effects may result in additional health and road safety risks and incidents with undesirable outcomes. Travellers with diabetes were characterised as vulnerable to specific effects related to managing their blood sugar levels with a largely sedentary travelling lifestyle, as well as an increased intake of takeaway food, hotel food and alcohol, and inadequate rest time and hydration (De Bellis et al., 2020).

2.9.3 Question 3: Grey Nomads' Experiences in Relation to Their Health and Healthcare Provision

Many of the participants described in the included papers had one or more age-related or chronic illnesses. Tate et al. (2006) found 55% of travellers had one or more chronic disease, and 61.9% took

regular medication. Halcomb et al. (2017) reported 40.2% of the long-term travellers in their sample had hypertension (40.2%), 22.8% arthritis, 13% diabetes, and 17.1% other serious health conditions. Of these long-term travellers with chronic disease, 11.1% had ceased work due to illness or disability, 42.7% reported that their illness affected their daily life and 23.7% required ongoing prescription medication (Halcomb et al. (2017). Travellers with diabetes commonly reported a range of other health conditions, such as hypertension (56%), high cholesterol (44%) and heart disease (15%) (De Bellis et al., 2023). However, the health of these grey nomads was not dissimilar to that reported by this age group of the Australian community generally (Australian Bureau of Statistics, 2013).

Onyx and Leonard (2007) considered the health of grey nomads in relation to the dominant decline model of ageing, which is diametrically opposed to what many participants wanted: adventure, freedom, learning and positive ageing. These authors proposed that grey nomads were illustrating a 'Ulyssean' model of ageing, which entails the exploration of new ideas, activities and learning as well as intellectual, psychological and emotional growth. This theme was echoed by other authors (Cridland, 2008; Hillman, 2013; Holloway, 2009) in reporting their participants' desires to improve health and wellbeing when travelling. Onyx and Leonard (2007) participants reported their health improved due to the grey nomad lifestyle, which they explained as resulting from no responsibility and therefore no stress. Over 80% of grey nomads reported good to excellent health (Onyx & Leonard, 2007).

A minority of participants experienced health emergencies. De Bellis et al. (2023) reported that 26% of travellers with diabetes had required urgent medical attention for problems including hypoglycaemia, gastroenteritis, cardiac issues, bites and stings, cellulitis and septicaemia. Obst et al. (2008) found that 5% had experienced a medical emergency while travelling, such as falls resulting in broken bones, and painful kidney stones that required immediate attention. A further 14% had experienced health scares including severe chest pains, back injuries, deep vein thrombosis, severe arthritis, cervical cancer diagnosis, pneumonia and fainting. Onyx and Leonard (2007) reported that 32% of men and 21% of women had experienced a major health scare in the previous two years and were treated locally at regional hospitals or by GPs.

One study, set in a very remote area of the Kimberley Ranges, proposed that grey nomads represented an impost on local healthcare services (Tate et al., 2006); this was the only included study other than De Bellis et al (2020) to recruit healthcare professionals. Concern at the burden

travellers imposed on rural health services was also flagged by Calma et al. (2018). Travellers with diabetes recounted diabetes-related problems attributed to failure to incorporate established diabetes self-management habits into their lifestyles on the road; however, many stated they had a travel companion who was well-informed about diabetes management (59%) or had at least basic competence (24%) (De Bellis et al., 2023). Diabetes educators reported most travellers were well prepared but also noted that many were poorly informed about services available in rural and remote locations. Despite noting that their capacity to support travellers was sometimes minimal, diabetes educators welcomed the diversity that travellers introduced to their normal practice (De Bellis et al., 2023). Several studies described self-reported improvements in participants' health due to adoption of a nomadic lifestyle (Cridland, 2008; Hillman, 2013; Holloway, 2009), but also some health service need and usage. Of Halcomb et al. (2017) online survey participants, 24% had sought medical attention to obtain a prescription, 57% reported having prescriptions filled during their travel; 8.9% had returned home due to poor health. Of respondents with diabetes, 13% had accessed emergency hospital clinics, 3% had sought help from local primary care nurses and 1% from GPs during their most recent trip (De Bellis et al., 2023).

2.10 DISCUSSION

Onyx and Leonard (2005) referred to the emergence of grey nomads in Australia as a phenomenon: a remarkable occurrence of people over 50 years travelling for extended periods in self-sufficient accommodation vehicles. They became a topic of research interest in Australia because of the ageing population and the increasing number of retired people with the time and resources to travel the country (Holloway, 2009). The studies included in this review fell primarily into two groups. Publications before 2011 were mainly concerned with describing travellers. These early studies (Cridland, 2008; Holloway, 2009; Obst et al., 2008; Onyx & Leonard, 2005, 2007; Prideaux & McClymont, 2006; Tate et al., 2006; White & White, 2004) described their samples as primarily Australians older than 50 years, either retired or close to retirement, travelling mostly in heterosexual couples. They examined why they travelled and reported the desire to experience a sense of freedom, adventure, and to avoid the winter climate. In publications dated from 2011 onwards, the health of travellers began to emerge as a topic, from health and illness as social characteristics and part of healthy ageing to clinically oriented studies of people living with diabetes and other chronic disease and how they managed their conditions while travelling (Calma et al., 2018; De Bellis et al., 2023; Halcomb et al., 2017; Stephens et al., 2018). Included studies were published in health or ageing related journals, but grey nomads were also considered an important niche tourism market and clientele for the caravan and motorhome industry. It was proposed that

the study of these people would produce valuable information about social trends relating to an ageing population and early retirement (Onyx & Leonard, 2007).

The main characteristic of the participants in the included papers was that they were predominantly people aged 50 years or more. Few other age groups were described. In a recent large survey of travellers, which focused on health (Halcomb et al., 2017)and did not apply age criteria, only 15.1% of participants were aged <50 years. However, the included papers did not consistently report participants' demographic characteristics, and recruitment criteria were not always clearly articulated or adhered to. Hence, the parameters of this grey nomad population have yet to be defined clearly and consistently in the research literature.

Women travelling without men stand out as a particularly poorly identified and described subgroup of domestic travellers. Of the 3,383 participants in the included studies, only 691 were identified as female (not all studies reported gender) (Halcomb et al., 2017; Onyx & Leonard, 2005; Prideaux & McClymont, 2006). Almost all women were travelling in heterosexual couples. Of the 16 publications, only three identified any solo women travellers (De Bellis et al., 2023; Holloway, 2009; Onyx & Leonard, 2005). However, social media platforms, including Facebook, indicate hundreds, possibly thousands, of women are regularly travelling solo or with other women in Australia. At least eight closed groups on Facebook™ are exclusively for women travelling domestically in self-contained vehicles, sharing their experiences and destinations via photographs, travel stories and discussions.

2.10.1 Health and Health Planning

Of the 16 included publications, 13 reported on health planning. Most studies identified the elements of planning as having health checks before trips, carrying letters from their GP regarding their health status and needs, lists of current medications and a sufficient supply of prescriptions, medication and the necessary storage requirements (Calma et al., 2018; Cridland, 2008; De Bellis et al., 2020; De Bellis et al., 2023; Hillman, 2013; Holloway, 2009; Tate et al., 2006). Some travellers planned their routes so as to arrive at specific destinations to access relevant healthcare, or stayed at destinations close to healthcare services (Cridland, 2008; Hillman, 2013; Stephens et al., 2018). Some carried equipment for use in medical emergencies, including communication devices such as UHF or CB radios, and some notified local homesteads when undertaking particularly remote or risky adventures (Hillman, 2013; Onyx & Leonard, 2005). Less than half the travellers with diabetes had an action or sick day plan (De Bellis et al., 2023), but neither do many community-living adults; for

example, approximately one quarter of a large sample of patients with type 2 diabetes recruited from GP lists in the UK did not know whether and how medication should be altered in acute ill health (Hewitt et al., 2011).

Two studies included health practitioners' views, reporting that travellers should carry and make available to clinicians information such as healthcare summaries, allergies, previous medical history and lists of active problems and medications, radiology and pathology results, and hospital admissions (De Bellis et al., 2020; Tate et al., 2006). Many but not all participants prepared for their trips by following healthcare practitioners' instructions. Some authors suggested a universal electronic medical record (EMR) would improve availability of health information for travellers' physicians; this has yet to be fully achieved in Australia, and in 2020–21, less than half of a sample of travellers with diabetes had signed up for an EMR (De Bellis et al., 2023; Hewitt et al., 2011). Holloway (2009) felt that better policy resourcing and infrastructure was needed to improve healthcare services in rural and remote Australia. De Bellis et al. (2020) recommended specific resources for travellers with diabetes, such as a diabetes checklist and other relevant information to be made available on the Diabetes Australia website.

2.10.2 Health and Healthcare Experiences

Some participants accessed healthcare services without difficulty (Calma et al., 2018; Hillman, 2013; Obst et al., 2008; Onyx & Leonard, 2005). A few reported problems linked with the inability to access medical information held by other providers and poor access to prescription medications at some pharmacies; one couple had problems accessing health services in rural and remote areas, was unable to see a GP and consequently attended an emergency department (ED) (Calma et al., 2018). Most reported improved health while travelling and no major problems, although in one study a small proportion terminated their trip because of health problems (Halcomb et al., 2017).

2.10.3 Limitations

The search strategy employed terms related to grey nomads and travellers, as well as their modes of travel and accommodation, but may have missed literature that used none of these specific words. The search was run on five health-related databases and Google Scholar, but searching papers' reference lists identified some studies published in travel and tourism journals that were not indexed in health databases. These papers solely reported demographic characteristics of travellers but were excluded because it was not possible to differentiate holidaymakers from longer-term

travellers. Nonetheless, it is possible that relevant material on tourism-related databases may have been missed.

2.11 CONCLUSION

In the early 2000s, researchers explored the characteristics of grey nomads in Australia, including their health status and motivations to travel. They were identified as primarily older and almost exclusively heterosexual couples. They reported similar patterns of chronic illnesses as the age-matched general population but generally believed their health had improved as a result of adopting the low-stress grey nomad lifestyle. After 2011, fewer studies were published and the emphasis changed from the broader experience of grey nomads to travellers managing chronic illness, including diabetes. A focus on older people (i.e. those aged over 50 years) remained.

By contrast, recent statistics suggest the age profile of domestic travellers in Australia has changed and is no longer dominated by grey nomads. In the year ending March 2017, of the 12.9 million domestic camping and caravanning trips reported by the Caravan Industry Association of Australia, only 29% of travellers were aged over 55 years. These tourism statistics represent market segments for the caravan industry, and do not differentiate holidaymakers from longer-term travellers. No data are available on current grey nomad populations.

A few studies reported participants made minimal use of healthcare services while travelling. Of the two studies of healthcare practitioners, one single site study of multiple different professional groups concluded that grey nomads burdened local healthcare services but provided no details or evidence. The other study, which recruited only diabetes educators from across South Australia, noted that travellers with diabetes accessed health services only sporadically, but advocated for better pretravel education and planning. The implications of the presence of grey nomads in rural and remote areas and their use of healthcare services for policy, planning and infrastructure for healthcare services in rural and remote communities have not been demonstrated, although the need for better policy and infrastructure to improve the provision of healthcare services is mentioned.

This review covered 13 predominantly qualitative studies (16 publications). The quality of reporting was mixed, and the trustworthiness of the work was seldom addressed. The review demonstrates the paucity of information about grey nomads, and the invisibility of women who travel without men; little is known about their health and other needs. Recent data suggests millions of people,

including grey nomads and women, are visiting regional, rural and remote areas of Australia every year. Better understanding of these travellers, particularly those on the road for long periods and far from familiar health services, is required. Moreover, the impact of travellers on Australian health services and other infrastructure is unknown. The implications of this travelling population for the provision of health services, policy, health infrastructure, education and workforce planning in regional, rural and remote communities are unknown; more research is needed.

2.12 CHAPTER SUMMARY

The findings of this review supported the value of conducting the primary research, which was the subject of Phases One and Two of this study.

CHAPTER 3: RESEARCH METHODS

This chapter sets out the methodology and methods of my research, with an earlier section (1.7) having set out my research role as an ethnographer. Two phases of the study were designed to achieve two distinct aims (see section 1.6). The findings from these phases are synthesised in the Discussion (Chapter Seven), which crystallises the contribution of the work as a whole.

3.1 Phase One Research Aim and Objectives

The aim of the first phase of the research was to examine the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation, in relation to their travel experiences, health and social needs when on the road.

The objectives of this phase were to:

- locate, interview and describe women who travel without men;
- examine why and where they travel and their travel experiences;
- discover with whom they travel; and
- identify their health and social needs and how they are met.

3.2 Phase One Research Design

Ethnography was chosen as the qualitative method for this study. It was an eloquent way to explore participants in their day-to-day grey nomad context and answer my research questions in an organic way. According to Wolcott (2010), an ethnographic research design is open, flexible and adaptive, the assumption being that if you are present in the setting, you are best placed to identify the appropriate research question and how to approach it. Data shape the theory, not the reverse. He goes on to say that an ethnographer is someone who makes it their business to learn about how others go about living their lives. He describes ethnography as an authentic, real approach because the research is conducted in an everyday setting and the researcher is on site and in person. The behaviour observed and recorded is natural and not artificial; there are no control groups or hypothetical situations, just people acting in mundane settings, in their own context. Hammersley (2019) writes that ethnographers investigate aspects of people's lives, their activities, the situations they face, how they regard themselves and how they regard each other. The process of discovery for the researcher begins with an interest in a specific area of social life, a situation, group of people or topic. The researcher observes and participates in the small-scale social setting which best affords the gathering of detailed data, which is then interpreted and analysed (Holloway, 2009). This

theoretical approach was highly suited to my investigation of the experiences and the choice of lifestyle of women travellers.

As described in section 1.1, this study originated from a personal encounter with a family member and her stories about travelling Australia and being intrigued by women 'doing the lap' (circumnavigating Australia) by themselves or with other women, and the desire to experience the kind of adventures that my family member described. These factors underpinned my choice of ethnography for this study which as Hammersley (2019) describes, aims to gain the meanings and perspectives that participants place on their own experience against their own context, worldview and socio-cultural understandings.

Participant observation is the central strategy of an ethnographic approach. It requires the researcher to spend time in the participants' setting, to behave like and be accepted as a member of the group, and observe in order to learn about them, their behaviours and activities. Immersion in and acceptance by the group in order to build trust takes time, but this approach is likely to generate meaningful information (Roper & Shapira, 2000).

Conventionally, ethnographic fieldwork is carried out at a single location. However, grey nomads stay for short periods at a range of locations such as free camping sites, often in isolated places off the highways, in national parks, local council showgrounds and caravan parks (Holloway, 2009). According to Holloway (2009), ethnographic fieldwork with peripatetic groups can be problematic because their movement complicates immersion in people's everyday lives, listening, observing activities and asking questions. I needed to operate at multiple locations to observe potential participants.

To research my target group, I travelled extensively and stayed at various locations to engage with other grey nomads as an insider; I observed them, collecting and analysing data to answer my research questions about the experiences, characteristics and adventures of women travellers. Like Cridland (2008), Holloway (2009), Onyx and Leonard (2005) and White and White (2004), I utilised a mixture of locations and sites such as low-cost showgrounds and caravan parks, depending on what was available at each stopping point.

The movement restrictions imposed during the COVID-19 pandemic forced some changes to research design and methods. I had intended to spend two months travelling with a woman

companion, overnighting in frequented locations such as free camps and national park campgrounds, to recruit participants and collect data. I also planned a second two months of travel to recruit additional participants to test the trustworthiness of my initial findings. However, COVID-19 pandemic restrictions precluded travel between and within states for long periods in 2020, 2021 and 2022. This drastically reduced the time available for travel during my PhD candidature, necessitating modifications to my research design and methods (as outlined in section 3.3).

The research design utilised for Phase One remained grounded in an ethnographic approach but had to be revised due to the movement restrictions imposed in response to the COVID-19 pandemic. The influence of the original ethnographic approach remained important as the researcher was able to gain firsthand experience of travelling with another woman, towing a caravan, living the lifestyle that was the phenomenon of interest for this study. This provided the lens through which data collected from participants was viewed and understood. Nonetheless, with very few women participants able to be recruited, observed and interviewed in the field, the research design had to be modified.

A qualitative descriptive design (Sandelowski, 2010) was adopted, because this was feasible during the pandemic, while still suitable for investigating a little-known topic. Qualitative descriptive design seeks to describe rather than explain; as the hallmark of honest curiosity and enquiry has been cited as the researcher not knowing in advance what they will be observing and noting, explanatory frameworks and theories are not required to underpin or frame such studies or to analyse their results (Kim et al., 2017). This made it particularly suitable, given the paucity of previous study of this population (Yates et al., 2021).

Further, qualitative descriptive design allows flexibility in the use of methods that are effective for obtaining rich data to achieve understanding of a phenomenon. Semi-structured interviews and a narrative approach were the chosen methods to collect data from participant travelling women, predominantly via audio-visual software or telephone. The semi-structured template provided a loose framework covering the topics that the researcher wanted to explore to address the research aims. The narrative approach allowed participants to give an account of their actions and experiences, constructing not just a listing of occurrences but a story, in which they set the parameters of context, content and timing. Their accounts enabled reconstruction of social events from their perspectives as directly as possible (Jovchelovitch & Bauer, 2000), to meet the research

aim of describing their experiences in relation to their health and social needs and access to healthcare when travelling.

For Phase Two, a similar rationale as to its use in Phase One guided the choice of a qualitative descriptive design (Sandelowski, 2010) to explore the experiences and perspectives of healthcare professionals working in remote towns along a popular travel route frequented by grey nomads. In addition, participants took the researcher and her companion for brief tours around each of the facilities, allowing for some brief observation of the context and environments of this phase.

3.2.1 CONCEPTUAL BASIS

This was an exploratory study of an under-researched population group about which very little was known, so no specific conceptual approach was adopted a priori. Whilst I did not elect to use feminist theory for this work, it was about women and their experiences, conducted by a woman researcher (Webb, 1993). The role of women has evolved markedly over the last century, and particularly for the generation of women in this study, during the postwar period of the 1960s and 1970s and beyond. Women began moving beyond the homemaker role (Price & Dunning, 2019) and the gender-specific burden of domestic work and caregiving (Tong, 2007) to seek new experiences and different lifestyles in the wider world. The women in this study explore the Australian countryside, embracing roles usually associated with men such as driving large vehicles, towing caravans and camper trailers, and performing vehicle maintenance and repairs. In so doing these women defy stereotypes of feminine characteristics and behaviours. Thus, this study was undertaken against a background of (declining) social stereotyping of the roles of women, and of recent challenges to previously broadly established social norms. As such it has some links to feminist theory, but as a study of a previously unresearched population, it was not planned or proposed to be conceptualised as such.

I focused on women who were mostly in their sixties and seventies. Their activities and the self-confidence with which they approached them were out of step with conventional expectations of women of their age. Their activities contradicted the conventional idea of ageing as a process of reduced activity and competence, increasing fragility and enfeeblement; instead, they demonstrated their unique version of positive ageing. This study was not preconceived in relation to positive ageing or feminist theory; rather, these links emerged as the work progressed.

Finally, the Australian landscape formed an intrinsic and essential element of the research. It is hard

to imagine or appreciate the vastness and diversity of the Australian continent unless it is experienced firsthand. Its terrain ranges from snow-covered mountains to desert, from tropical rainforest to treeless plains. Australia is home to the Great Barrier Reef, the world's largest coral reef system; to Uluru and Kata Tjuta, two extraordinary monoliths; the Flinders Ranges, 600 million-year-old mountains; and a multitude of national parks and World Heritage Sites (Tourism Australia, 2023). Australia is also home to the world's oldest continuous culture, with a 65,000-year history. Travel in such exceptional environments has been described as transformational and a force for emancipation and empowerment (Pung et al., 2020).

3.3 Phase One Sample, Sampling Strategy and Sample Size

Sample

The sample for this study was women travelling across Australia in mobile accommodation on a permanent, semi-permanent or casual (occasional but extended) basis.

Sampling Strategy

My original aim was to use purposive sampling to recruit women travellers encountered during a field trip. As a consequence of COVID 19 pandemic, lockdowns and border closures, this was not possible, and recruitment had to move from in-person to telephone or audio-visual encounters.

Snowball sampling was used as the primary sampling strategy. I asked newly interviewed participants to refer or help me contact new potential participants or groups, and repeated this process with subsequent interviewees (Pelto, 2016).

Three contacts were used to initiate snowballing. One woman traveller, already known to me, was the first participant and provided the names and contact details of other women who had consented to having their contact details shared. I contacted two administrators of social media sites (who were also women travellers) directly; they agreed to participate and subsequently provided contact details of other consenting potential participants. Once recruited and interviewed, these participants, in turn, provided contact details for other consenting potential participants.

Sample Size

Sample size was determined by data saturation; that is, sampling continued until no new information or additional descriptions of experience were observed (Boddy, 2016; Guest et al.,

2006). Recruitment ceased once a series of interviews did not produce any additional descriptions of experience (Guest et al., 2006). A total of 29 women were interviewed.

3.4 Phase One Data Collection Methods

For Phase One, semi-structured interviews were the chosen method of data collection, delivered using a narrative approach. Interviews were chosen as a method which enables identification of individual experience and meaning, with collection of rich, in-depth data. A semi-structured format with a series of open questions was used to ensure that participants were asked about the topic areas of the research aims: i.e. to ensure that the data collected addressed the research aims. The interview guide (see Appendix 4) provided a structure with flexibility in how and in what order questions were asked, whether and how particular areas were followed up with participants, allowing unexpected content to emerge (Lewis-Beck et al., 2004). A narrative approach was used; this places participants in the centre of the process, gives them space to make choices and actively construct their responses. and privileges the meanings that they assign to their own stories (Anderson & Kirkpatrick, 2016). Their narratives were seen not just as a list of occurrences but as a construction related in time and meaning in ways that ascribed them coherence. It recognised the data as an active construction by participants of their stories as they regard and choose to present them (Anderson & Kirkpatrick, 2016). The medium of data collection was determined pragmatically; whilst face to face interviews were preferred as providing better opportunities to engender trust between interviewer and interviewee leading to better quality data (Dialsingh, 2008), these were mostly precluded by COVID-19 movement restrictions. Consequently, most interviews were conducted via audio-visual software or telephone.

Of 29 interviews, seven were conducted face to face at campsites, 19 via audio-visual software (the Meta Messenger platform), and three by telephone (because the internet connection was too poor for a videoconference). All interviews were conducted by me, but transcripts were shared and discussed with members of the supervision team.

Semi structured audio-visual interviews were used for flexibility to adjust the questions to elicit individual stories. A narrative approach was used, aiming to create a comfortable conversation in which the interviewee would be able to tell their story about travelling around Australia. I employed an interview guide (Appendix 4) based on the interviews conducted by Holloway (2009) and Onyx and Leonard (2007). The draft questions were discussed and revised amongst the research team,

then pilot-tested with a solo woman traveller (my family member, mentioned in sections 1.1 and 3.2). No changes to the questions or their order were suggested or made.

Interviews were digitally recorded using an Olympus DM-720 Business recorder and a mobile phone application for backup; the recordings were stored on the university secure server and manually transcribed verbatim. After each interview was transcribed, the transcript was checked against the recording for accuracy.

Undertaking thematic analysis concurrently with data collection allowed ongoing minor refinements to and expansions of questions according to the information provided by interviewees. It also allowed recognition of the point of data saturation. My approach to data saturation was based on cessation of identification of new codes or themes, following Saunders et al. (2018) model. Labelled 'inductive thematic saturation', this approach was a suitable method for a study of a phenomenon with little prior information and no relevant theory. Once data saturation was achieved and recruitment stopped, I proceeded to the next stage of thematic analysis, described below.

3.5 Phase One Data Analysis

The transcribed interview data were loaded into NVivo12 (Lumivero, 2017) for analysis. Concurrent analysis with ongoing data collection enabled both ongoing refinement of questions and follow-up of emerging issues. I employed Braun and Clarke (2006) six-step framework for thematic analysis:

- becoming familiar with the data during verbatim transcription of interviews and repeated readings of the transcripts;
- the generation of initial codes (i.e., particular ideas or points of interest);
- collating relevant data under codes;
- collating of codes under possible overarching themes;
- the identification of relationships amongst the themes; and
- ongoing analysis of the data within the themes.

Thematic analysis enabled a synthesis of the findings derived from the women's data, presenting a broad overview of the participant group as a whole (Chapters Four and Five).

To give a detailed profile of my participants and capture the essence of their experiences, I created a montage of narratives of four participants around four prominent themes. The montage illustrates dominant themes that emerged from the analysis. A montage has been likened to quilting; the quilt maker creates a composite picture constructed from a collection of unique individual contributions, different voices, perspectives and points of view all happening simultaneously rather than sequentially, thus presenting a picture of the whole (Denzin & Lincoln, 2000). To construct a montage is to assume that reality is multiple, with many different pieces or fragments at play, creating a context in which differences are preserved in a new entity that is quite beyond what any one fragment might depict (Kennedy et al., 2015) (Chapter Five).

3.6 Phase One Ethical Considerations

The Human Research Ethics Committee (HREC) of the University of Technology Sydney approved my research (registration numbers ETH19-4511 (Original proposal) and ETH-4565 (amended proposal to comply with COVID Health Orders; see Appendix 5). In accordance with the approved protocol, I obtained verbal informed consent from participants to collect and analyse their data and to audio record their interviews. I read the approved participant information and consent forms (see Appendix 6) to participants and audio-recorded their verbal responses. The participants are referred to using pseudonyms in the transcripts (and in this thesis) to protect their identities. Where verbal consent to participate was collected, the audio recordings including consent were retained alongside the transcripts in secure storage, in line with HREC requirements. Where written consent was collected, signed consent forms were stored in a locked container in a locked compartment inside my caravan until they could be transferred to a locked cupboard in a secure office for long-term storage.

Interviewees were offered a copy of their transcribed interview, and a copy of the final report, once published.

3.7 Phase One Data Management

I developed a data management plan based on Stash, the university-based secure data management system. As noted above, with participants' consent, I audio recorded interviews using an audio recording app, which stores the audio files in my passworded iCloud account. Transcribed interviews were stored using my Stash account and imported into NVivo 12 for analysis after participants had been given the opportunity to comment.

Once the analysis was completed, the original audio files were permanently deleted. After thesis submission, the NVivo files will be retained in the university's secure research storage with the transcribed interview files for five years, after which all files will be permanently deleted. All files are maintained in passworded secure storage accessible only by me (although the password is saved in a location known to my supervisors in case separate access is required).

3.8 Phase Two Research Aim and Objectives

The aim of this phase was to explore the utilisation of healthcare services in rural and remote locations in Australia by grey nomads, particularly women who travel without men, from the perspective of healthcare professionals working in these locations.

My objectives in this phase were to:

- interview healthcare professionals to seek their experience of service delivery to grey nomads, including women travellers;
- identify what services are sought and
- determine the impact, if any, of grey nomads' demand on local health services.

3.9 Phase Two Research Design

Using the same rationale as was set out for Phase One (section 3.2), I employed a qualitative descriptive design (Sandelowski, 2010) to explore the experiences and perspectives of healthcare professionals working in remote towns along a popular travel route frequented by grey nomads. This design was chosen because it is suitable for use when little is known about the topic of study. Using the same rationale as was set out for Phase One (section 3.4) I conducted semi-structured interviews to explore each individual's understanding of the day-to-day reality of care delivery to grey nomads at their facilities (Wolcott, 2005).

3.10 Fieldwork Settings

The study sites were all in small towns on the highway situated in areas nationally designated as remote and very remote (Australian Bureau of Statistics, 2020) in NSW and Queensland. These towns were selected because they were located on a route that was very popular with travellers (see Appendix 7). I collected Phase Two data during a field trip in March 2020.

At the time of the field study, in March 2020, heavy rain had broken a five-year drought and the resulting significant flooding had cut roads and isolated towns. This forced multiple changes to the route that was planned. The towns visited included tourist destinations, fuel stops and/or overnight stay options. All are classified as small towns (Australian Bureau of Statistics, 2020), with populations ranging from 335 to 3,335 people. Research participants in all but two towns mentioned that population decline was occurring.

The facilities managed by participants in these small towns offered a combination of acute hospital services, aged care and community services. All had less than 20 acute hospital inpatient beds, most less than 10. Most of the beds were designated for aged care; most of the hospitals' small EDs contained only two beds. The NSW facilities also provided renal dialysis services (

Table 6). At the time of the interviews, the participants were being briefed on state COVID-19 planning for their facilities.

3.11 PHASE TWO SAMPLE, SAMPLING STRATEGY AND SAMPLE SIZE

I recruited healthcare managers and clinicians working in the towns described above using a combination of purposive and convenience strategies. I contacted facility managers by telephone, using publicly available contact details, invited them to participate, and emailed study details to willing potential participants. I planned visits (with another women researcher, one of my supervisors), to the work locations of participants whose positions in these organisations identified them as likely to be knowledgeable on this topic, and interviewed a minimum of one healthcare manager per location at a mutually convenient time.

Sample size was determined by data saturation; that is, sampling continued until no new information was observed (Boddy, 2016; Guest et al., 2006). Thirteen hospital managers working in 12 hospitals in remote towns in New South Wales and Queensland were purposively sampled and 12 managers of 11 sites were recruited. Two managers at one site were interviewed together (at their choice).

Table 6. Bed capacity for study site facilities

Facility Number	Total Inpatient Beds	Acute Sub/Acute Care	Emergency	High Dependency	Short Stay	Aged Care	Renal Dialysis
1	42	6				36	4
2	35	11	2	2		15	2
3	20	8				12	6
4	16	8				8	8
5	30	4	4		2	20	
6	24		2				
8	8	4	2	8	1		
9	8		2			6	
10	19	15	4				
11	17	8	3			6	
12	13	1	2		2	8	

Facility 7 was contacted but did not respond or participate in the study.

3.12 PHASE TWO DATA COLLECTION METHODS

I conducted 10 face-to-face semi-structured interviews at hospitals, and one by telephone. The face-to-face interviews took place at the hospitals at mutually convenient times in rooms chosen by the interviewees. Interviews were digitally audio recorded with consent, using an Olympus DM-720 Business recorder and a mobile phone application for backup; audio recordings were maintained on a secure cloud server.

Semi structured audio-visual interviews were undertaken for flexibility and the capacity to adjust the questions to elicit individual perspectives. I used a narrative approach to create a comfortable conversation in which the interviewee would feel free to describe the incidence of travellers (particularly women) presenting to their facilities, and their experiences of those presentations. The interview schedule (see Appendix 8) was drafted in line with the research aim and discussed and refined with my supervisory team.

3.13 PHASE TWO DATA ANALYSIS

The interviews were manually transcribed verbatim and imported into NVivo Version 12 for thematic analysis. Analysis was undertaken concurrently with data collection to enable ongoing refinement of interview questions and follow up of emerging issues. The Braun and Clarke (2006) six-step framework was used (see section 3.5). I was principally responsible for the analysis, but a second researcher conducted independent coding and analysis, and we compared and discussed our results, resolving the few differences encountered by consensus. My supervisory team discussed my draft findings to support the rigor of the analysis (see section 3.17). The participants' transcripts were deidentified, with each participant being referred to as HCPX (HealthCare Professional X), with X ranging from 1 to 12.

3.14 PHASE ONE DATA MANAGEMENT

Refer to section 3.7 for a full description of data management procedures.

Signed consent forms were stored in a locked container in a locked compartment inside my caravan until they could be transferred to a locked cupboard in a secure office for long-term storage.

3.15 TRIANGULATION OF DATA

I triangulated my semi-structured interview data in Phase One with the data from Phase Two. Triangulation was applied to strengthen the trustworthiness of the process and to provide a more complete picture of women grey nomads, particularly in relation to their access and use of healthcare in rural and remote areas. In practice, this meant I synthesised, compared, contrasted and discussed the data collected from women travellers about their experience of health service utilisation with that from healthcare managers to strengthen the confirmability of my findings (Bowling, 1997; Denzin & Lincoln, 2000; Halcomb & Andrew, 2005)

3.16 PHASE TWO ETHICAL CONSIDERATIONS

University Human Research Ethics Committee approval was obtained, with registration number ETH19-4511 (Original proposal) and ETH-4565 (Amended proposal to comply with COVID Health Orders; see Appendix 5).

Ethics procedures in Phase Two were the same as for Phase One (see section 3.6). Participant information and consent forms for Phase Two interviewees are shown in Appendix 9.

3.17 THE RIGOR OF THE STUDY

To support the rigour of this study and demonstrate dependability and confirmability, I maintained an audit trail of project activities and discussed my progress with my supervisory team frequently, both of which supported researcher reflexivity (Korstjens & Moser, 2018) (see section 1.7).

Data collection and analysis was undertaken principally by me, in regular consultation with my supervisors. As noted earlier, one of my supervisors coded two transcripts independently and compared her coding with mine; we resolved the few discrepancies by consensus. All members of the research group discussed the progress of the analysis regularly.

To enhance rigour, I sent participants in both phases of the study their individual transcripts and invited them to comment on or correct the text and offered them a copy of the final analysis as reported in the publications. No participant required changes or corrections to their interview transcript.

CHAPTER 4: PHASE ONE FINDINGS (THEMATIC ANALYSIS)

4.1 PREAMBLE

This chapter presents analysis of data collected in interviews with 29 women travelling across Australia by themselves or with other women, living in mobile accommodation such as caravans or motorhomes. The results achieve the first aim of the study: to examine the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation, in relation to their travel experiences, health and social needs when on the road. They paint a picture of these women as individuals, their motivation to travel and their experiences along the way, and how they managed their health whilst travelling. The result is a story of 29 women as central characters, rather than (as is historically common) as supporting roles (mother, wife, girlfriend, daughter, etc.) for someone else. In combination with results presented in Chapter 5, this chapter provides new knowledge on this previously under-researched and little understood population group.

This chapter is based on a manuscript that is currently undergoing review with the following citation:

> Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2025). The experiences of women who travel solo or with other women across Australia: A qualitative study and thematic analysis.

4.2 INTRODUCTION

The genesis of this study was a conversation between me and an older women family member. This woman described her many trips towing a caravan across Australia, and how adventurous, exciting, enjoyable and liberating she found them, despite living with and managing multiple chronic diseases. I was a woman in my sixties at the time, and had travelled extensively across the country myself, and I wondered whether my family member's experience was common, or typical. In particular, as a registered nurse familiar with the well-recognised sparsity of health services in regional and remote areas of Australia (National Rural Health Alliance, 2023; Yates et al., 2022), I was curious about how travellers, especially women, manage their health and chronic diseases when travelling. This paper describes the research I undertook to answer these questions.

4.3 BACKGROUND

The health and life expectancies of Western populations have seen enormous changes within the last century, with a large and growing segment described as older or elderly people (Australian Bureau of Statistics, 2019), many of whom have retired from paid employment. Older women make up a growing proportion of this population. In Australia, approximately 4.2 million people (16% of Australia's total population) were aged 65 years or more in 2020, more than half (53%) of whom were women (Australian Institute of Health and Welfare, 2024b). The predominance of women in this age cohort is explained by the fact that between 1968 and 2017, life expectancy for Australian women increased from 74.2 to 84.6 years, (Australian Bureau of Statistics, 2018).

In Western societies the dominant view of older people, particularly once they are no longer engaged in the workforce, has tended towards negative characteristics, such as incompetence (Fiske et al., 2002). Younger people perceive that growing older involves primarily loss and decline, that changes with ageing are beyond a person's control, permanent and irreversible, and that older adults are a burden on society (Diehl et al., 2020). A seminal paper recognised this stereotyping as constituting a form of systematic prejudice, and the term 'ageism' was coined (Butler, 1969). Globally, one in two people are reported to be ageist (WHO, 2025), yet ageism is largely implicit and its subconscious nature renders it socially acceptable (Officer & de la Fuente-Núñez, 2018). Ageist attitudes have become entrenched, with prejudices and stereotypes about ageing and older people often presented as amusing truisms, such as 'having a seniors moment' (Nelson, 2016), and are seldom contested (Gullette, 2017).

Ageism has been recognised as entailing a raft of negative and discriminatory attributes and effects (Chang et al., 2020). Ageist stereotyping can harm the physical and psychosocial wellbeing of older people, decreasing will to live, impairing memory and reducing interest in healthy preventive behaviours (Nelson, 2016). Many older Australians have reported a sense of invisibility when ignored by service people who do not see value in spending time with an older person or being overlooked by corporate Australia despite their financial capacity. Some older people feel like a burden on friends and family and that they are overlooked, devalued or ignored, resulting in feelings of shame, anger and sadness (Australian Human Rights Commission, 2013). These problems are compounded for older women by social stereotypes of them as less competent or independent than older men (Dougherty et al., 2016).

Women's lives have seen enormous changes in quality as well as longevity within the last century, and particularly in recent decades (as indicated in the Australian life expectancy data shown above). The prospect of an active lifestyle in 'older' age has become a reasonable expectation for most. The World Health Organization (WHO) portrays healthy ageing as a process of developing and maintaining functional capacity that facilitates wellbeing in old age (WHO, 2015). In Australia, many older people, colloquially referred to as grey nomads, spend their retirement travelling around the country in mobile accommodation for months or even years at a time. Whilst well recognised by the general population, this highly mobile group has been little studied; a recent narrative review found only 16 papers (Yates et al., 2021). All of the studies included in this review employed selective, non-probability sampling, revealing little of the population demographics except their generally older age ($\geq$ 55 years) and the predominance of heterosexual couples. Of 3,273 research participants, only two solo female travellers were identified. However, women travelling alone or with other women are evident in many social media groups (e.g., 'Women Caravanning Camping and Travelling Solo Australia', 'Van Dykes', 'Chicks Camping Crew' and 'Solo Women Travelling Australia Live'). Unlike other older people who relocate to warmer climates for winter months (such as Victorians to Queensland, and 'snowbirds' in Canada to southern states of America (Onyx & Leonard, 2005)), these women do not target a specific destination or primarily seek warmer weather. In recent years their numbers appear to be increasing (Yates et al., 2021) although little is known about these women and their travelling lifestyle. This study sought to establish a profile of women who travel by themselves or with other women in Australia, why they travelled and what this meant to them, before exploring issues around their health and wellbeing.

4.4 METHODS: AIM

The aim of this study was to examine the characteristics, experiences and perspectives of women who travel across Australia by themselves or with other women (without men) for weeks, months or years in self-sufficient accommodation, their motivations for travelling and travel experiences, their health and how they managed their chronic disease when on the road, particularly in rural and remote areas.

4.5 DESIGN

Ethnography was the initial choice of research design, because it is an appropriate way to investigate aspects of people's lives, their activities, the situations they encounter and how they regard themselves and each other (Hammersley, 2019). However, the design and methods had to be

modified in response to COVID-19 movement restrictions, which prohibited most travelling, preventing direct observation and face-to-face recruitment and data collection. When possible, the researcher travelled (towing a caravan) with another woman researcher, staying in campsites, caravan parks and showgrounds in regional and remote locations across New South Wales and Queensland, Australia, in order to immerse herself in the research situation, engage with the topic as an insider and to experience and understand the lifestyle of women travelling this way. Whilst remaining grounded in an ethnographic approach, the study had to be revised to adopt a qualitative descriptive design (Sandelowski, 2010), because this was more feasible during the pandemic, while still suitable for investigating a little-known topic.

4.6 PARTICIPANTS, SAMPLING AND SAMPLE

The study participants were women who travel across Australia in motorhomes, campervans or vehicles towing caravans on a permanent, semi-permanent or casual basis. Three people were used to initiate snowball sampling from this population: the first author's previously mentioned family member, and two women travellers (administrators of travel-related social media sites) who responded to a direct invitation. These participants subsequently contacted potential participants known to them, those who shared their contact details were then invited to participate, and the process continued (Pelto, 2016).

Sampling continued concurrently with transcription, familiarisation and generating initial codes (the first stages of thematic analysis (Braun & Clarke, 2006)). This allowed recognition of the point at which no additional data were emerging – that is, thematic saturation was reached (Saunders et al., 2018). In total, 29 women were recruited between June 2020 and March 2022.

4.7 DATA COLLECTION

Study participants were interviewed using an interview guide informed by earlier studies (Holloway, 2009; Onyx & Leonard, 2007) and refined and revised by the study authors (see Appendix 4). A narrative approach was chosen so that participants guided the interview as they recounted their experiences (Chase, 2011). This allowed them to determine the course of the interviews and the disclosure of their travelling experiences. The first author, a registered nurse and doctoral student, conducted all interviews and led data analysis. Of the 29 study participants, 19 were interviewed via digital audio-visual media, seven face to face at campsites, and the remainder via telephone calls

(because the internet connection was inadequate or a face-to-face interview was not possible). All interviews were audio recorded and lasted between 38 and 116 minutes, averaging 76 minutes.

4.8 DATA ANALYSIS

Interview audio-recordings were transcribed verbatim and uploaded to QSR NVivo version 12 (Lumivero, 2017) for thematic analysis in accordance with the six phases described by Braun and Clarke (2006). Both semantic and latent analysis was undertaken, maintaining the focus on the participants while mapping the elements of their stories as the interviews unfolded. Coding was undertaken inductively to achieve the study aims. Once inductive thematic saturation was achieved, based on cessation of identification of new codes or themes (a suitable method when prior information about the phenomenon of interest is scarce and no relevant extant theory exists) (Saunders et al., 2018), recruitment ceased and the next stages of thematic analysis proceeded: generating themes, and reviewing, naming, defining, mapping and reporting them (Braun & Clarke, 2006). The first author coded all interview transcripts but to support the trustworthiness of the analysis, the second author coded two transcripts independently and compared them with the first author's work; any differences were resolved by consensus. All authors monitored and discussed the analysis and its interim outcomes at regular intervals.

4.9 STUDY RIGOUR

To support the rigour of this study and demonstrate dependability and confirmability, an audit trail of project activities was maintained. Frequent discussions with the supervisory team supported researcher reflexivity (Korstjens & Moser, 2018). Data collection and analysis was undertaken principally by the first author, in regular consultation with her supervisors. As noted above, the first author and a supervisor coded two transcripts independently and compared the results as a method of quality assurance. Participants were sent their individual transcripts and invited to comment or correct the text ,and were offered a copy of the final analysis. Finally, this paper adheres to the Standards for Reporting Qualitative Research guidelines (O'Brien et al., 2014).

4.10 ETHICAL CONSIDERATIONS

Ethics approval was obtained from the relevant university Human Research Ethics Committee (registration number ETH19-4511) and later amended (ETH-4565) to comply with COVID health orders. Written informed consent was obtained where possible, and if not, audio recorded verbal consent was collected. Confidentiality was maintained with the use of pseudonyms in the

transcribed data. Participants were assured that their data would remain confidential, so data are not publicly available.

4.11 FINDINGS

The 29 women interviewed constituted a diverse group (

Table 7) from a variety of social backgrounds; one woman identified as Indigenous Australian. Their ages ranged from 35 to 76 years, but more than two thirds (69%) were over 60 years and retired. More than half (55%) had a government pension as their income source. Almost two thirds (62%) travelled alone and just over one third (37.9%) were in a relationship; seven (24%) travelled with a dog and one with a cat. Ten women (34.5%) lived on the road permanently, whilst the others had a fixed home base and travelled regularly for various periods of time. The permanent travellers lived and travelled in motorhomes (n=3) and in mini passenger buses converted to self-contained mobile homes (n=3); three women towed caravans and one a fifth wheeler (the largest type of towable caravan, designed to be towed by utilities or trucks and named for the truck-style fifth wheel hitch they use).

Table 7. Participants' demographic characteristics

		Number (%)
Age, years	30–40	2 (6.9)
	>40–50	1 (3.4)
	>50–60	6 (20.7)
	>60–70	13 (44.8)
	>70	7 (24.2)
Occupational Status	Retired	20 (70)
	Employed	9 (30)
Income source	Government pension	16 (55.2)
	Private pension	5 (17.2)
	Salary	8 (27.6)
Travel Status	Full-time	10 (34.5)
	Part-time	19 (65.5)
Marital Status	Widowed	1 (3.4)
	Divorced	4 (13.8)
	De facto relationship	10 (34.5)
	Single	11 (38)
	Married	1 (3.4)
	Separated	2 (6.9)

Thematic analysis of the women's interview data revealed the following overarching themes: freedom; adventure and being in nature; safety and risk; evolving from fear and anxiety to self-confidence and growth; health, and home.

4.11.1 FREEDOM

Freedom was a key characteristic of the travelling lifestyle. It was consistently described as the absence of obligation to others, doing whatever they chose to do whenever they chose to do it. Previously constrained by running a business, Jill explained:

> *I love doing what I want to do when I want to do it … yeah freedom to me is the key. […] If I had sat down and constructed that lifestyle for myself years ago, I don't know if I would have been able to envisage it but now that I'm living it, I mean, why wouldn't I? I owe nothing to anybody; I have no responsibility to anyone*.

Maree, a divorced mother of four children, considered living in a caravan and travelling around Australia for six months uncomplicated compared to living in her fixed home. She described her sense of freedom similarly, but explained that for her this meant not just having her own choices but being first, not after or in consideration of anyone else:

> *I don't have to consult with or consider anybody else for a change.*

After her retirement, Colleen packed up and headed off regularly whenever she wanted:

> *… freedom you know under the stars…I just feel like I'm free all the time because … I'm not going to spend the next twenty years trying to fit into boxes that people try to put me into*.

Edith described freedom as:

> *I love the fact that you are not in a routine … you can just go out there whenever you like, you just wake up and you can do what you like and you can see Australia*.

Mary, a widow, mother and grandmother, compared living in a caravan positively to living in her house:

> *Life is complicated when you are at home, you make it more complicated than it needs to be. When you think about the size of the van [12 feet] and you can live your life with that. I could have done it forever and I still would have had enough stuff … I just think when I look around the house, I've complicated my life with stuff*.

The freedom the participants described was something that they had come to appreciate after what they saw as a lifetime of constraints due to marriage and relationships, children and work. Freedom meant they were no longer defined by roles, role obligations or others' expectations. This was regarded as a priceless feature of their life stage as older women.

4.11.2 Adventure and Being in Nature

The next key theme that emerged from the analysis was the adventure of exploring Australia, being in nature and having new experiences. Once experienced, this was hard to leave. Simone was clear about her desire to use her "absolute sense of freedom" to see new places and do new things. Similarly, Mary said:

> *By the time I got home* [from the first caravan trip]*, which was three months, I started to think oh God, I'm home, now what do I do? And I thought I knew now there was more to the world than what I had been doing.*

Participants' travel experiences ranged from short trips within their home region to circumnavigation of Australia, colloquially referred to as 'doing the lap'. The participants appreciated and took the opportunity to go to new places, see new things and meet new people. They described the joy of being outside in natural settings, away from towns and cities, experiencing silence in locations far from cities and other people, and enjoying the sounds of running water in creeks and rivers, wind in the trees and birdsong. Aria enthused:

> *I just love the colours, you've got the white sand and the contrast of the red iron ore dirt and then you've got the blue sky and the aqua water, just the colours, it's stunning and just the remoteness of it all and the vastness ….*

The experience of being in nature, and particularly being alone in nature, brought a sense of spiritual renewal or revitalisation to many interviewees. Sue described her sense of connection to the land and sea and how being in nature energised her, particularly when she was near water. Her love of nature was an extension of her spiritual belief and trust in a higher power or God. For others, the feeling was one of wonder in a new and different environment and excitement at the experience. Mary recalled:

> *It was exciting, it just opens up so much of the country to you and it's completely absorbing and fun and educating*.

New experiences could be big adventures, such as driving across the Nullarbor Plain (a vast semi-arid area), or mundane, with their newness derived from the departure from their non-travelling lifestyles, such as:

> *driving those long distances, just doing things you normally wouldn't do like poaching chicken at ten o'clock at night at a truck stop.* (Barb and Bec)

Some interviewees described continuing their regular recreational pursuits, such as bushwalking, crafting, kayaking, cycling, fishing, swimming, horse riding and photography, but with the freedom to pursue these activities at will. Others described developing a heightened sense of place and historical significance. Olivia, for example, described intentionally being on the same routes and in the same places as early Australian colonial explorers. She and other women spoke of the excitement of the prospect of seeing new places and experiencing the unknown.

> *You just don't know, and what you think could be 'oh I don't really want to do this', can turn out to be the most amazing experience with the people that you potentially meet… the most*

unexpected things can happen, and I love that lack of routine or lack of certainty about what's going to happen. (Regina)

Nonetheless, experiencing adventures demanded something more of these women: to be daring.

[You need to be] *a little bit game sometimes … everywhere you turn is an adventure and you probably have to go with that outlook.* (Joan)

... just never knowing where you are going to go, being very flexible and just taking in new experiences. (Jill)

This sense of daring and adventure contrasted with their experiences in their previous lives, in which they recognised that they had been subject to, and complied with, social stereotypes of what was expected of older women.

I think that's because we are taught we don't know how to do things and we can't do things so therefore it is a challenge … so if you break down or something went wrong there were all these blokes, like oohh you know, 'two women thinking they could come out to Birdsville on these rough roads' … and I think if you said to a lot of women I think they'd think 'I couldn't do that'. (Regina)

In providing examples of what they could do and had done, these women acknowledged the sense of achievement they felt in tackling a wide range of activities. These could be relatively simple, and related to their daily routine:

… achievement … of getting from point A to point B and also following directions and apps. (Barb and Bec)

However, participants also reported achievements of much greater significance, such as overcoming dangerous situations and events, such as Aria described in the following quotation.

I went oh my God there's a metre thick of bulldust [fine, powdery aeolian red dust that can be dangerous if disturbed on dirt roads] *and I'm not joking, I'm not exaggerating it's a metre, and there were tracks everywhere and I'm thinking I'm not going to get through this … and I stopped and I thought about it. And I went OK … the first time I got through it and I just sat there and cried ... it was such a challenge … a major achievement*.

For some, this sense of achievement had another layer: they were doing things they had always wanted to do.

> *I think it's always been there* [for me]*, the sense of adventure.* (Olivia)

Meeting new people and the subsequent social interaction was considered an important part of the adventure. Edith, Elsie and Colleen commented that the people they met were usually very friendly and open to connection. Participants felt they were never really alone when travelling because of these social interactions. Some women met previous acquaintances in new locations and created long-lasting friendships. In contrast, eight participants (27%) commented that while male partners in couples were often very friendly and willing to help them with mechanical issues, their female partners were not always as open and friendly. These participants reported trying to befriend the women first in order to make conversations with their male partners easier.

4.11.3 SAFETY AND RISK

All participants discussed safety and risk at length. These women were conscious of the risks that all women face in any situation, not just when travelling alone in remote places.

> *Some of those long stretches* [of road]*, you are very vulnerable, you do have to be sensible you know, try to pull up where there are other people, it's an awareness thing.* (Vivien)
>
> *It's always in the back of your mind, rape let alone murder or robbery you know, all those sort of things … I think it's always good to be a little bit worried and not to be too complacent.* (Aria)

All participants described an 'awareness' of their own safety and the ways this might best be served.

> *I have a good look around and get a sense of who is in the camp and um you know if I get a funny feeling I don't stay. It's a gut instinct thing … I've also got a campervan so I can just crawl into the driver's seat if needed … I wouldn't leave my annex out overnight. But having said all that, I've never had a dodgy experience anywhere.* (Hester)

> *I'm always wary of where to park and not to park, as in don't park under trees and things like that* … [a friend] *and I recently camped fairly quite remotely, I may not have been that comfortable if I had been by myself. We had two of us, we are both pretty strong women, we felt comfortable, we checked with each other that we were comfortable … we did have telephone reception so we could ring each other if we thought there was a need.* (Maree)

Frequent strategies for choosing a free campsite included to arrive early and 'park up' early (3–4pm). Participants reported talking to any people already there and assessing them for threats. If they were uncomfortable, they would move on, trusting their gut instincts. The women considered this to be a routine form of risk assessment. Other campsite safety strategies included not lowering the built-in external awning on their vehicles or leaving any belongings outside to enable a quick getaway if needed. Some mentioned leaving a pair of men's boots or setting two chairs outside the van to give the impression of travelling with a man. Most of the participants who reported these safety practices said they dispensed with them once they were more experienced and confident in travelling alone. Some discussed the virtues of keeping a can of wasp spray on hand, perceiving a 6-metre spray jet to be a potent defensive weapon. However, when questioned, none of the women admitted to having wasp spray or ever feeling the need for it.

The women who drove motorhomes considered these vehicles the safest option because they didn't have to leave the vehicle to drive away. One valued her high-security screen door, which she kept locked when in the motorhome. Some women considered caravan parks safer than free campsites because they are managed (and often surveilled) environments. One woman stayed at showgrounds because they often have a caretaker on site but are still low cost. One couple travelled in convoy with a married couple because they felt safer having a man around. These women explained that when they began to travel, they liked to do so with other people, with one describing herself as 'not brave' and fearing the unknown. Two other women travelling together felt 'vulnerable' and 'very wary' when, on one occasion, they stopped at a site where two men were parked in separate campervans. The men did nothing that posed an obvious threat, but the women were uncomfortable and did not stay long.

> *We pulled into a stop … and there were two vans in there and two blokes, and we just stopped for lunch. After we left, we said to each other, we didn't really like the idea that something might have happened there.* (Bec and Barb)

Mary discussed how women who travel together can look out for each other and help if something goes wrong. She also explained how she and another participant used each other for safety backup, keeping in telephone contact so that someone was aware of their location. Mary described awareness and safety consciousness in relation to a situation where she wouldn't '*risk it*', such as in some caravan parks where young male workers live in shipping containers, often sitting outside and watching or just hanging around; she described that scenario as:

> *scary … they might do nothing; I don't know but I wouldn't risk it.*

Other people could also be a source of security rather than threat; for instance, some women, when parked at an empty free campsite, reported relief when other travellers arrived.

Safety was not just about threats from other people but the potential for mechanical problems and accidents. One woman recognised that women travellers are vulnerable to the same safety risks as any driver on rural and remote Australian roads. Conditions vary widely in outback areas; roads are often very narrow, sometimes gravel, sometimes bitumen, or a combination of both. They are not always in good repair and, paradoxically, road maintenance crews are a common sight. Whilst there are fewer vehicles on outback roads than in more populated areas, drivers must overtake or pass other vehicles with caution – particularly road trains, which can be 50 metres or more in length. The conditions can test driving skills, especially given that no special license is required to tow a caravan or drive a large motorhome in Australia.

> *… the road, kangaroos, um and tiredness, so* [I'm] *more* [afraid of] *those kind of things than afraid that a bloke is going to come and rape me.* (Hester)

In the event of serious mechanical breakdown, women had to find, engage and pay for vehicle towing and repairs and (often) accommodation. Not all participants were well prepared for these financial risks.

> *18 kms from Devonport ferry* [Tasmania] *my motor conked out and I knew instantly, knew it was something serious.* (Iris)

Interviewees reported multiple strategies to cope with mechanical breakdowns and other safety problems. A UHF radio was considered essential, and two participants travelled with GPS personal locator beacons that can transmit a signal to emergency services when out of mobile (cell) phone range. Fundamentally though, safety awareness while travelling was seen as an inevitable extension of what was described as routine for women:

> *You walk back to your car from the supermarket, you look around you, you don't leave your handbag in the trolley. I unlock the car, put my handbag in the car before I unpack the groceries and I'm always aware of my surroundings and you lock the car before you drive, things like that, you're just aware of security.* (Jill)

This kind of security consciousness was understood as standard and automatic for women and a matter of common sense:

> *… the way we've been socialised.* (Barb)

… quite honestly it's common sense you just don't get yourself in that situation; if you're not sure, don't go there. (Aria)

Two women, both with professional backgrounds, had noted that novice and potential travellers often raised safety topics, so they distributed general safety advice through social media and face-to-face seminar presentations at group meet-ups. However, it was notable that none of the 29 participants recounted any incident in which an unknown person or people compromised their personal safety.

4.11.4 Evolving from Fear and Anxiety Into Self-Confidence and Growth

Anxiety and fear were reportedly common emotions for many women in their early days on the road. Many described hyper-awareness of their vulnerability as solo travellers, or as a woman, or even as two women travelling together, and that not knowing what to expect was perceived as a potential threat rather than adventure.

… if I pulled up on the side of the road to have lunch or something I was very nervous at that time. I was very conscious of being on my own … you think to yourself, what if someone else pulls up, what if, what if ... Nobody ever did. I would just go inside and lock the van and have a cup of tea or whatever. (Joan)

[I was] *a bit nervous at night by myself listening for sounds, sometimes you hear things outside and it's animals … but you don't know that for sure.* (Mary)

Simone talked about many women in a social media group she frequented often expressing anxiety about travelling alone. Whilst describing this as irrational, she could empathise because, despite overcoming many major challenges in her life and her experience as a traveller, she had been anxious about driving across the Nullarbor:

It doesn't seem like the hardest thing I've ever done but for some reason my brain just thinks it's so much scarier than anything else I've been through. (Simone)

However, the advice that all the interviewees proffered for new travellers and any woman considering the traveller lifestyle was *not* to be afraid – or even if they were, not to let that hold them back. They questioned whether staying home was a solution to anxiety:

you can be scared in your own home. (Vivien)

If I wasn't doing this trip and I was at home you'd still go through the same aspects of loneliness or scaredness or anxiety or whatever. (Aria)

The only thing stopping these women is themselves … if I can do it anyone can do it. (Simone)

Colleen, Hester, Joan and Maree all gave examples of possible situations that they regarded as genuinely frightening, including vehicle breakdown, falling asleep at the wheel, losing concentration while driving long distances, a collision with a kangaroo, and a serious health problem when alone in remote areas. These women became adept at dealing with situations as they occurred and considered them a source of learning and confidence building. The travelling lifestyle provided multiple opportunities to challenge themselves, and especially because most of the interviewees were managing difficult situations alone.

…[you meet] *a couple and they say 'yes we've done that' and sometimes you just let it go and other times you say 'yeah but you did it with a partner, I've done it by myself' … there's only one brain not two working on it.* (Aria)

The participants talked about the cumulative effect on their self-confidence of rising to challenges, of learning and practising new skills and doing things that pushed their personal boundaries. It was clear that a virtuous circle could develop, so that the more they took on, the more they were willing to take on. This had positive benefits for their perceptions of themselves and their self-confidence. Whilst this could be a matter of choice it could also, to some extent, be driven by circumstances: they perceived that they had options, but not all were equal choices.

If you are in a situation where you're in the middle of nowhere and you get a flat tyre and there's nobody about, you go well … I've got to deal with it, if I don't deal with it I'm stuck here. (Vivien)

I'm doing this [expletive] and I'm doing it well …it's that feeling of inner strength and resilience that I'll have a go. (Hester)

Barb described her and her partner's growth in confidence in relation to driving a big vehicle, maintaining it and doing running repairs themselves. However, this was not just about physical issues but psychosocial challenges. Once again, pushing through personal barriers could reap wider gains.

You see women hiding in their vehicle because they think they are safe but you've got to get out, you've got to say hello and that can be a bit of a challenge, not because I was frightened of them, but because you are shy or reserved … it's self-confidence, … if you look confident, you'll be safe, if you feel safer, you'll be safer. (Iris)

… recognising in yourself that you can accept another challenge that you haven't had before. (Maree)

4.11.5 HOME

All the women who lived permanently in their vehicles described them as home. None considered themselves homeless. Other women needed to have a house as a home base to come back to after travelling and had no desire to live permanently in a mobile home. For some, their mobile home was purely a preference; for others, their choice was driven by what they could afford.

Some people are really lucky and have nice vans. That's all they can afford [but it's] *a really nice van and at least they've got a home, but a lot of women have got the cheapest and they have to stay in the free camps and they have to stay for weeks if something goes wrong with their car until they can get it fixed, or something happens.* (Isabell).

At the extreme, home maintenance could be a precarious matter attended by difficult situations.

A *woman I gave some money to the other day, was living in the back of her car … and she couldn't pay the registration so … the shopping centre had her towed … she couldn't afford to get [the car] back so it's that cycle of poverty that so many people don't understand.* (Isabell)

However, there could be an element of chance at play in relation to their life situations, with Isabell recognising,

"*I'm lucky I don't have that* [poverty]*".*

The interviewees who reported travelling permanently had made a deliberate choice, driven by a variety of reasons, from economic insecurity and social disadvantage to the pursuit of adventure and travel. In this, their choice of 'home' was also a choice of lifestyle.

4.11.6 HEALTH

Participants reported good health regardless of the presence of chronic illnesses such as diabetes (Wendy, Mary), cardiovascular disease (Mary, Elsie, Joan, Jill, Barb, Bec), thyroid problems (Barb), respiratory disease (Jill, Linda), arthritis (Bec, Jill) and chronic back problems (Maree, Jill, Regina). However, they did not let their health problems deter them – they were not:

putting their life on hold just because you've got health issues. (Alex)

They associated the less-stressed travelling lifestyle with better health, but chronic disease still needed to be managed while travelling; this was often described as fundamentally about medications. In collaboration with their GPs, they formulated plans to ensure sufficient medication for the duration of their travels. If they ran out, they contacted their GP to fax a prescription to the nearest pharmacy. Wendy, with Type 1 diabetes, was very aware of and attendant to the storage requirements of insulin.

Almost one third (n=9, 31%) of the interviewees disclosed some form of mental illness. Their approach to managing mental illness when travelling was no different to that for chronic physical illness. Six of the women who disclosed mental illness (21% of all interviewees) volunteered that they had been subjected to domestic violence or sexual assault by a family member during their childhoods. Both Regina and Astri stated that what had happened to them as children was indescribable. To cope with the lingering effects of this trauma, Regina had received ongoing counselling for more than 20 years, and Astri had embraced a spiritual approach to her life.

Only two participants described experiencing acute illnesses when travelling, one being shingles (Joan) and the other cellulitis (Mary). Their descriptions of their acute illnesses were much more detailed than those of chronic illnesses. Others described trips, falls and accidents (Mary, Suzanne, Maree, Vivien), sometimes resulting in broken bones (Simone). All were managed and dealt with as a matter of course, but an acute incident was more likely to interrupt or restrict their capacity to travel than their chronic illnesses.

Interviewed during the COVID-19 pandemic, these participants, like other Australians, reported that the measures taken to control disease spread had profound impacts on their lives. Whilst none mentioned contracting COVID-19, many described travel restrictions as a consequence of border closures and lockdowns across the country:

> *We're locked up … everyone's ready to go but we can't.* (Joan)

When interviewed, six women who were travelling permanently were isolated and locked down together in the same location for over three months. They made the most of it, treating it as a new kind of experience and adventure; they camped some distance apart to respect each other's space but came together during the day, went walking and generally looked out for each other, but were alone much of the time. Vivien said:

This adventure is quite amazing … we're all in a very difficult situation, whereas it could have been very negative, we've turned it into a positive um and we've made things work as a group. (Vivien)

4.12 DISCUSSION

Analysis of the interview data revealed key themes of freedom, adventure in nature, safety and risk, evolving fear and anxiety into self-confidence and growth, home, and health. Despite common experiences of anxiety and fear at the beginning of their journeys, in doing things not generally done by women of any age, by themselves or with other women, the participants became more confident in themselves and their lifestyle choices. Their experiences were generally perceived as life affirming, and they reached new levels of self-awareness, appreciation and acceptance of self. With increased self-assurance, the women felt healthier, regardless of chronic illness.

Findings emergent from this study relate to the depiction of ageing women. The generally accepted stereotype of ageing, and ageing women in particular, is predominantly negative and of incompetence (Fiske et al., 2002). This stereotype was recognised by participants, who talked freely of being 'taught we don't know how to do things', as a consequence of which most women fulfill the expectation of incompetence. The women recognised the social stereotype of older age as a time of increasing helplessness, physical vulnerability and dependency; of failing abilities and health, reduced mental clarity and diminished productivity (Lemish & Muhlbauer, 2012); of loss of independence, mobility and financial security (Denmark & Zarbiv, 2016). However, in contrast to the pervasive images in the media of older people as low status, sick and lonely, the pictures of older age painted in the women's narratives defy the conventional decline ideology (Gullette, 2017; Onyx & Leonard, 2007; Onyx & Wexler, 2017; Yates et al., 2024).

The findings challenge misconceptions of ageing as inevitable loss and decline. The participants recognised but had moved beyond being unduly influenced by the negative social and medical stereotypes of growing older, choosing instead to take advantage of the opportunities offered by this life stage. The findings depict not decline but growth, especially personal growth, the development of new skills and improvement in physical and cognitive health. This is not a picture of ignorance; the participants were very aware of the health and safety risks of their chosen lifestyle and planned to manage risk where they could. Their stories and the study findings refute the stereotypes of older women as dependent and feeble (Dougherty et al., 2016) or lesser beings. Rather, their stories showed women in control of their lives, doing what they wanted when they

wanted; experiencing travelling as a means to enjoyment, adventure and growth; and older women as adventurers making use of the opportunities afforded to be and do what they value and achieve wellbeing in old age (WHO, 2015).

These findings have some similarities to ideas promoted in tourism literature, in which the mobility provided by cars and campervans is associated with freedom to travel (or not) when and where one pleases (Wilson & Hannam, 2017). Such images and characterisations of older people, portraying them as interesting and appealing, are important to challenge the ageist status quo (Gullette, 2017) and refute the dominant ageist stereotyping of older women.

The participants' experiences also had an ageless aspect. Similar to the current study, in their study of women aged 20–70 years in the United Kingdom and United States, Jordan and Gibson (2005) found that through independent travel women achieved a sense of empowerment that corresponded to an increase in confidence, independence and strength, particularly after overcoming constraints and challenges. Pung et al. (2020) also described women's experiences of travel as transformational and talked of travel leading to a process of emancipation and empowerment. The three youngest women in the current study, all aged under 50 years, conveyed similar stories and experienced travelling in the same way as the older women. Thus, travel may offer an ageless experience, further dispelling ageist preconceptions. However, most participants in this study were older, and were only able to avail themselves of the opportunity to travel once they had discharged their responsibilities as mothers, wives and workers. For most of these women, it took being older to arrive at a point where they had the confidence to consider the travelling lifestyle and the financial independence to support it.

When asked about their health, these women did not elaborate on their illnesses or symptoms; rather, they readily stated that they were healthy, regardless of chronic illness. In the first author's experience (as a registered nurse), these conversations were not typical of people living with chronic disease. Many nurses will recognise the experience of being bombarded with descriptions of symptoms. In contrast, these women generally affirmed their health rather than detailed their symptoms, with many attributing it to their lifestyle. They regarded their health as more than a medical matter, in common with the WHO and many other older people (Song & Kong, 2015). This enlightened perception of health may be why Yates et al. (2022) found that rural and remote healthcare providers reported neither grey nomads nor women travellers as burdensome.

This study's findings about travellers seeking adventure and personal growth bear similarities to those of Onyx and Leonard (2007) and Holloway (2009). However, these earlier studies of grey nomads found that travellers were predominantly heterosexual couples who continued their everyday routines and sociabilities whilst travelling. Whilst adventure and new experiences were important, these occurred within a familiar domestic relationship context. For Holloway (2009), the gendered nature of the grey nomad lifestyle was readily observable, with the continuation of the 'intimate domestic space', whether for good or ill. More than 20 years later, the current study focused on a different group of women travelling without men, living a lifestyle of adventure and personal growth. These women, however, stressed the importance of freedom, of being able to do what they wanted, as and when they wanted. Unlike the couples described in earlier studies, these women's lifestyle choices took them beyond the conventional female stereotype of home-maker. These women were not just defying society's misconceptions of ageing but flouting its expectations. These stories of older women reflect a major shift in the social boundaries previously very tightly applied to women. Onyx and Leonard (2007) described what they saw as 'a new script for ageing' and Holloway (2009) talked of travel as a 'transition' between the end of a working life and what comes later, but the women in the current study are living beyond society's preconceptions of what they should be and do. Therefore, an important message of the current study is that society should not underestimate older women, who they are or what they can do.

4.12.1 STRENGTHS AND LIMITATIONS

This study recruited a relatively large sample for a qualitative study to ensure of thematic saturation, because it focused on a little-researched group. Rigorous methods were used for data collection and analysis to maximise the trustworthiness of the work. The possibility of bias due to the first author's status as a healthcare professional was addressed through researcher reflexivity within the supervision team. Gatekeeping by the three participants used to initiate snowball sampling may have hindered or biased recruitment, although their enthusiastic and proactive participation gave no indication of reluctance or ambivalence about facilitating access (McFayden & Rankin, 2016). Self-selection of participants through snowball sampling may have resulted in over-emphasis of some sample characteristics, and this sample is not necessarily representative of all women travellers. Some participants were recruited whilst they were immobilised by COVID-19 travel bans, and this atypical situation may have influenced their accounts. There are still no data on the size of this population or details of their overall characteristics, so further work is needed in this area.

Some women live on the road to escape homelessness, financial abuse and/or domestic violence. The researchers did not ask about these topics, and no-one volunteered such information other than three women who mentioned childhood trauma. It is possible that some participants had such experiences, but these topics were outside the scope of the study.

4.13 CONCLUSION

The participants' stories illustrated these women's experiences in their chosen lifestyle and what this meant for them. In doing so they debunk society's misconceptions about ageing. They contradict common perceptions of ageing as about inevitable loss, decline and decay, and of older women as incompetent, dependent and frail. Rather, the participants exemplified 'can-do' attitudes that opened new opportunities for personal growth and exposure to new experiences that enriched their lives. Despite living with chronic illness, they embraced the adventure and challenges of their chosen lifestyle. The findings contribute to refuting outdated, prejudicial and misleading stereotypes about older women, and indicate the importance of further work to characterise and to better understand the health and social needs of this population group.

4.14 CHAPTER SUMMARY

The findings set out in this and the following chapter addressed the first aim of my study – to describe the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation, in relation to their travel experiences, health and social needs when on the road. The themes I distilled from their data reveal a group of women who have made confident decisions about lifestyle choices that eschew mainstream social norms and expectations, and exhibit competence in managing the practical self-care and safety consequences of these decisions. My analysis shows them focused on the advantages of this lifestyle, including enjoyment and wonder at new experiences and a sense of adventure, and better health and wellbeing. These findings represent new knowledge about women who travel without men, a recently identified and little researched population group.

CHAPTER 5: PHASE ONE FINDINGS (MONTAGE NARRATIVE)

5.1 PREAMBLE

This chapter includes a published article presented as a montage of women travellers' narratives. The narratives were derived from a reanalysis of the qualitative data from Phase 1. The work presented in this chapter achieved the first aim of this study, which was to examine the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation. While the article was informed by the interview data from 29 women, the four profiled narratives illustrate the individuality of the members of this participant group. In combination with Chapter 4, this article provides new knowledge about this previously under-researched and poorly understood population group.

Article citation: Yates, M., Perry, L., Onyx, J., Levett-Jones, T. (2024) Women travelling solo or with other women across Australia: A montage of narratives. *Journal of Women and Ageing*, 12, 1–11. https://doi.org/10.1080/08952841.2024.2431412

Permission to reprint the article is displayed in Appendix 10.

This article generated considerable media interest – four radio interviews and four print articles (see Media Presentations, page xii).

JOURNAL OF WOMEN & AGING
https://doi.org/10.1080/08952841.2024.2431412

Routledge
Taylor & Francis Group

Check for updates

Women travelling solo or with other women across Australia: A montage of narratives

Margaret Yates[a], Lin Perry[a], Jenny Onyx[b], and Tracy Levett-Jones[a]

[a]School of Nursing and Midwifery, Faculty of Health, University of Technology Sydney, Ultimo, Australia; [b]Business School, University of Technology Sydney, Ultimo, Australia

ABSTRACT

Increasing but unknown numbers of women are adopting itinerant lifestyles on the road, in the pursuit of ambitions and aspirations that extend beyond the conventional role of women as they age. Using data from a study that aimed to describe women who travel without men, either alone or with other women, across Australia in self-contained accommodation, this paper illustrates the richness and diversity of these lives through the narratives of four women. The study from which these data were taken was informed by an ethnographic approach. A montage has been used to present four narratives that together illustrate dominant themes that emerged from the analysis. Initially 29 women, travelling either alone or with other women in mobile accommodation across Australia, were interviewed using audio-visual media or telephones between March 2020-March 2022. From the thematic analysis of these interviews, four participants' narratives were chosen to represent the main themes derived from the analysis while at the same time retaining the women's individual perspectives and voices. The four narratives included in this montage paper exemplify four key themes: the adventure of exploring Australia; experiencing the new and unknown; developing self-knowledge and self-confidence; and taking control of one's life. The women's stories demonstrate commonality as well as diversity, of a chosen lifestyle beyond the conventional view of women as homemakers, and redefining the conventional view of ageing as one of decline and deterioration. These narratives demonstrate older women living lives that provide new and different pathways to personal growth, independence and self-confidence.

KEYWORDS

Ageing; Australia; qualitative study; montage; travellers; women

Introduction

Since the Second World War, in Western countries in particular, women's lives have undergone radical transformations. Before the war, the social script prescribing suitable behaviours established a uniform path for women, entailing marriage, children, homemaker (Price & Dunning, 2019). In the early post-war years, any gains accrued by the need for a female workforce for the war effort were eroded and married women were once again expected to dedicate themselves to family life (Beaumont, 2017). This enforced dependency on male breadwinners (Broomhill & Sharp, 2005) suited some but not all women, and exceptions were regarded as aberrations to be discouraged and often punished. As women age, these patterns of dependency have been compounded by a commonly-held understanding of ageing as decline, physically, cognitively and socially (Onyx & Wexler, 2017). Consequently, many women have been denied fulfilment of their

CONTACT Margaret Yates margaret.m.yates@student.uts.edu.au School of Nursing and Midwifery, Faculty of Health, University of Technology Sydney, Ultimo, Australia.

© 2024 Taylor & Francis Group, LLC

potential even into retirement. Increasingly, however, women have stopped acquiescing with this situation and are defying conventionally held views of their roles.

The 1960s and 1970s saw major rebellion (Nicholson, 2010). The daughters and granddaughters of the "scripted" generation began to find new ways to "break out" of the script and the structural disadvantage created for women (Schuster, 2017). Attitudes changed and more diverse choices evolved for women. They began creating their own ways of living, and for many this included participation in the workforce. By the 1990s the daily lives and aspirations of Australian women had undergone significant change, alongside shifting understandings of mothering, female employment and identity (Lake, 2013; Leahy, 2019). The working lives of the post-war daughters and granddaughters were a far cry from and enabled a much broader life experience than that of earlier generations, and their changed work lives broadened opportunities for later life. These latter generations feature in the women's stories portrayed in this paper. They reflect the transition and development of women's potential for independence and self-confidence to explore well beyond the family home.

With the search for individual experience and expression continuing, a more recent but limited literature describes and provides advice for predominantly younger women travelling as international tourists (for example Wilson and Harris (2006) and Barrett and Douglas (2020)). However, these are mainly holiday makers: women seeking a change or a break from their normal lives. By contrast, the women in this paper exemplify the increasing but unknown numbers of women who have literally abandoned a conventional "home" for an itinerant lifestyle on the road, in the pursuit of ambitions and aspirations that continue to extend beyond homemaking despite increasing age (Yates et al., 2021). Our literature review demonstrated the paucity of information available on this specific group of travelling women (Yates et al., 2021).

This paper features four women who were participants in a study that aimed to describe women who travel either alone or with other women, without men, across Australia in self-contained accommodation, along with their motivations to travel and their experiences when on the road. Women such as this appear in social media groups, where their numbers appear to be increasing. However, little is known about them and their travelling life experiences (Yates et al., 2021). Given the growing numbers of older women in the Australian (and other western) populations (Australian Institute of Health and Welfare, 2023), this is an important gap in understanding contemporary society. This paper contributes new knowledge to address this omission, aiming to illustrate the richness and diversity of these women's travelling lives as reflected in key themes evident in the narratives of four women.

Materials and methods

Design

The study from which these data were taken was informed by an ethnographic approach. Narrative interviews were conducted with travelling women to develop an understanding of their motivations to travel and their experiences. This paper employs a montage approach, which has been likened to quilting in that a composite picture is constructed from a collection of unique individual contributions (Denzin & Lincoln, 2011). The montage provided a framework to demonstrate the individualism of the participants and the diversity of their characteristics, personalities and motivations in the pursuit of the common goal to travel and explore Australia, while at the same time illustrating four key themes that emerged from the study. This report adheres to the Standards for Reporting Qualitative Research guidelines (O'Brien et al., 2014).

Participants, sampling and sample

The participants reported in this paper are a sub sample from a larger study. The participants for the larger study were women who were travelling across Australia in mobile accommodation on a

permanent, semi-permanent or casual (occasional) basis. As the health measures introduced in response to the COVID-19 pandemic precluded face to face recruitment and interviewing, snowball sampling was adopted. Three contacts were used to initiate snowballing; one woman traveller was previously known to the researcher and two were administrators of social media sites (and also women travellers). These participants subsequently provided contact details of other consenting potential participants and the sample was expanded by this process (Pelto, 2016).

Sampling until data saturation was achieved, in total 29 women were recruited between March 2020-March 2022. From these 29 participants, in line with the montage approach, four women were chosen to exemplify the key features and the diversity of the group as a whole (Guest et al., 2006), as well as four key themes that emerged from data analysis.

Data collection

Study participants were interviewed using an interview guide informed by an earlier study (Onyx & Leonard, 2007) (see Appendix). A narrative approach was chosen so that the participants guided the narration and their experiences were recounted personally (Chase, 2011), to demonstrate the diversity of their individual selves and their travelling life experiences. The first author, a registered nurse and doctoral student who travelled towing a caravan with another woman to immerse herself in the research situation, conducted all interviews and took the leading role in data analysis. Of the 29 women, 22 were interviewed by audio-visual media and the remainder via telephone calls. All interviews were audio recorded. Interview duration ranged from 38 to 116 minutes, with a mean of 76 minutes.

Data analysis

Interview audio-recordings were transcribed verbatim and uploaded to QSR NVivo version 12 for thematic analysis (Braun & Clarke, 2006). Coding inductively in response to the aim of the study, this method was chosen to maintain the focus on participants so that their perspectives were synthesized as they emerged from the data. Primarily undertaken by the first author, to support the trustworthiness of the analysis, two transcripts were independently coded by the second author and compared with the first author's coding. The progress of the analysis was documented and discussed regularly between the four authors. The montage approach provided a framework to guide choice of key informants to demonstrate how the main themes were reflected through the individualism of the participants and the diversity of their characteristics and motivations in the pursuit of the common goal to travel in Australia.

Ethical considerations

University Human Research Ethics Committee approval was obtained 11/06/2020, with registration number ETH19-4511 (original proposal) and ETH-4565 (amended proposal to comply with COVID health orders). Written informed consent was obtained where possible, or audio recorded verbal consent by telephone. Confidentiality was maintained with the use of pseudonyms in the transcribed files.

Findings

Of the four women chosen, two were aged in their sixties and two in their seventies; two were self-funded retirees and two received a government pension. Three of the women were single and one was married; two women lived permanently on the road and the other two travellers

returned to a home base between trips. These four participants exemplified major themes emergent from the narratives: that of adventure (theme (T) 1), of experiencing the new and unknown (T2), of developing self-knowledge and self-confidence (T3), and of taking control of their lives (T4).

Aria

Aria's story can be described as primarily one of *adventure* (T1). She was in her early sixties, a fulltime traveller who had been living on the road for more than four years, although she did have a fixed home base where family members resided while she travelled. Aria travelled with her dog Rusty, "I really don't think I could do it without him." She wrote a daily journal and posted regularly on social media describing her adventures. Aria also published her many photographs to represent pictorially the locations she wrote about. While her adult children drew her back to visit her house from time to time, adventure had become a way of life for Aria and she had become an adventurer (T1).

> I knew it is an amazing country and you see things in magazines, TV and travel shows but it's not until you get on the road that you will see there's so much more (T1). …I originally thought I'd only be doing it for one year, when I left home the plan was only to go away for one year, but I've just fallen in love with what I am doing and years later I'm still going and still loving it.

One of the exceptional things about Aria was that her spirit of adventure took her to such remote, uninhabited locations on the vast continent of Australia, alone.

> I did Mt Augustus in northeast Western Australia (a thousand kilometres from Perth), which I didn't know existed (T1). It's the biggest (and oldest 1,650 million years) rock in the world, bigger than Uluru, and it's remote; the closest town, if you can call it that, is three or four hundred kms away and most of these little towns are living ghost towns where they might have a fuel station, if you're lucky they might have an IGA (small independent supermarket) but most have nothing but the history.

Aria's adventures could involve a significant degree of risk. She described an occasion when she was on the Oodnadatta Track (an unsealed 612 km road following an Aboriginal trade route) on her way to Mt Dare, on the Western edge of the Simpson Desert:

> The local publican suggested I leave the caravan behind. I took off in my car (with) a small tent to sleep in…I dropped my tyres (pressures) down as there was lots of bull dust (fine, powdery and highly hazardous red dust). There was a sign off to the left saying to Mt Dare and right in front of me was this massive big amount of bull dust and I went (expletive!) I took a deep breath and got through it. Then there was another one but this one's on a hill … so I've only got one choice …so off I went (T1). Got to the top, took a big breath, had a little tear in my eye, oh God I made it. I made it, my own achievement. (T3, T4)

This lifestyle could be difficult, but Aria grew in self-confidence (T3) as she went through episodes such as this, confirming her ability to embrace the risks that were part of adventuring (T1). Her choices included being open to the unknown and the unexpected (T2), like the bull-dust she encountered travelling solo in one of the most remote desert regions of Australia.

> I've got a GPS on my phone, offline which wasn't working, I have the one on the car which obviously wasn't working. I have three maps in my car…. It took I reckon 15–20kms before I saw one tiny little sign on one hard map that I knew I was heading in the right direction and from there I got to Mt Dare which was quite a challenge (T2).

For Aria, a life of adventure was not just being able to do what she wanted, but also challenging herself and pushing the boundaries of what women would conventionally be expected to do (T3, T4). Aria was a well-resourced woman who had chosen, rather than continuing to live in the house she owned, to spend these years of her life in pursuit of new experiences, adventure and challenge (T1, T2); she was not a typical Australian woman in her sixties. Aria did mention

occasional loneliness but was happy to continue doing what she wanted when she wanted by herself and with her companion dog Rusty.

Vivien

Vivien's story was also one of taking control and creating a new life (T4). She made a conscious choice to sell her business and live on the road permanently and considered it "the best choice I ever made" (T4). In her mid-sixties, she had been living on the road nine years.

> … when you've got a business and you're a woman by yourself, it's like you're on a merry-go-round and you can't step off because if you step off, well then, who's going to run it, who's going to be there to do everything? (T4)

Making this decision took her out of her comfort zone (T2) and grew from talking to her sister, who was already living permanently on the road. Vivien felt she was wearing herself out working seven days a week doing the physical work that was her business. The genesis of her decision was a discovery scuba dive in Far North Queensland.

> …It (the holiday and the scuba dive) made me step away and re-think my lifestyle, and my life really (T2, T3, T4).

This became the catalyst to sell her business, rent her house out and move away from the town she lived in. She set a date, left the town and never returned other than to visit people. The decision to leave her business, her house and her previous life opened up a new chapter for her (T4). Facing new challenges gave her opportunities to grow (T3).

> … I knew it wouldn't be easy and I knew there'd be hurdles and tough times but that probably made me even more determined… I've done a lot of things over the years that made me think about things, or go – well, you can do this, you've just got to have the determination. It's quite daunting when you first start to travel as a woman by yourself, but you just break through those parts of it (T3, T4).

Vivien's decision to start a new life was made in the face of considerable opposition from her friends who questioned whether she would be able to manage by herself. She persevered, trusting her own judgement, remained determined and grew in confidence as she did so (T3, T4).

> …when I was making the decision to travel so many people were negative, so many people were against me doing it. Close friends were, "well what are you going to do, how are you going to manage?" And I just went, "I'll be fine." So many of us I think listen too much to what other people think rather than going for what our gut says. And I just went for what my gut says and I just went you know I know it's going to work because I am going to make it work (T3, T4).

Vivien's story featured her internal journey and the processes of self-questioning and personal development that she underwent (T3). This allowed her to make the decision to leave her previous life and embrace an entirely different lifestyle of adventuring (T1, T4). After almost ten years on the road, she still felt the same enjoyment.

> I think, um the adventure, just the adventure of it (T1)…. … I knew that in the long run it would definitely extend my life. I knew I'd be a happier person (T4).

Vivien described herself as a confident person who had worked on building her confidence over the years (T3). She believed it was a necessary attribute for a single woman traveller.

> …because if you are in a situation where you're in the middle of nowhere and you get a flat tyre and there's nobody about, you go well, I've got to deal with it. If I don't deal with it, I'm stuck here… I've learnt a lot about myself, like my weak points and my strong points as well (T3, T4).

Stepping away from the life that friends and other people define you by takes courage and resolve. Vivien did just that and remained satisfied with her decision.

Olivia

Olivia's story is also one of creating an independent lifestyle (T4). It grew out of a love for the bush, the natural landscape and the worlds of Australian literature; her travelling habits evolved from this. At the time of interview, Olivia was a retired nurse in her seventies, married and with adult children and grandchildren but none of her family travelled with her. She lived in a city and travelled throughout Australia on trips of various duration. She started travelling in a four-wheel drive car with a tent and her primary reason for travel was to bushwalk. Over time, walking carrying a full backpack became increasingly arduous. She transitioned to travelling in a campervan, for the adventure without the physical effort of bushwalking (T1). She continued to travel extensively in her vehicle alone, but usually in convoy with other people.

Olivia explained she has always had a sense of adventure and has been happy to follow someone out exploring (T1). Her first experiences travelling the outback were in the Flinders Ranges in South Australia where she car camped (set up camp with a tent next to the car). Once she decided to buy a campervan, she travelled that way ever since.

> It's very hard to explain, it was a sense of wonder (T1, T2) … I felt I was on the pages of a Henry Lawson poem when I'm camped on the Warrego or Cooper's Creek or the Paroo, you know: all of those places we read about in poems when we were still in school. I guess through Henry Lawson and Banjo Patterson and the like … it was pretty amazing. And the Diamantina (vast arid remote landscape), going through the Diamantina gates, really absolutely astonishing, it is iconic, that's the best word for it.

Her sense of wonderment and of her place in history that this lifestyle afforded (T3, T4) was balanced by pragmatic consideration of practicalities and her responsibility for herself and her travelling companions (T3).

> When you are out there with a group of friends in three or four vehicles, you have to be independent, but you are also interdependent. You've got to consider each other and consider what your own capacity is; what's safe for you to do. But one of the things I remember that gave me pause, I was travelling with a friend and we were coming home from Darwin and I took her down some of those back roads that I knew and we almost ran out of fuel and I was furious with myself. She'd been driving and I hadn't been watching and when I got back in to take my turn driving, I did all the checks I always do and I realized the fuel was too low. I was so annoyed with myself and then I was kind of annoyed with my friend for not watching and then I thought, this is down to me because I'm the person with the experience out here and I got a bit anxious, so I felt solely responsible. We had to go out of our way and buy very expensive fuel … but we got through. We were going to go to the Diamantina (very remote region), but that experience made me anxious about going there with just the two of us and no back up vehicle or anything so in the end I pulled the plug on going into the Diamantina …. I knew it was just sensible not to go really because there was just the two of us, it made me feel a bit nervous and that hadn't happened before. I'm, usually I'm Mrs Intrepid, I used to say I'm intrepid, I'm not stupid; it just suddenly occurred to me that going into the Diamantina just with my friend was probably bordering on the stupid rather than intrepid (T3, T4).

Olivia travelled to visit the places she wanted to see (T1, T4) taking trips of various but generally substantial lengths of time and distances, returning to her house and family life between times. Her campervan enabled her to continue her relationship with the bush once she could no longer carry everything she needed, continuing her strong sense of herself within the landscape of geography and time. More than that, her travels had given her opportunities to grow in confidence, acting within the bounds of her capability to take responsibility for herself and others (T3).

Iris

Iris' story illustrated a strong theme of freedom of choice (T4), extending through years of travel to the end of the road. At the time of interview, Iris was in her seventies, retired and funded by a government pension. She had been living for 18 years in a converted bus, the interior of which had been rebuilt and customised into a motorhome.

Iris developed an enthusiasm for travelling and motorhomes during a trip she shared with her brother in his motorhome. He was having some financial difficulties and Iris agreed to pay for fuel so they could travel through Queensland together. It was during this trip that she decided to buy her bus and travel once she retired, anticipated for five years later. She purchased a bus, converted and lived in it while she continued to work until she retired (at age fifty five) and then "hit the road." Prior to the trip with her brother, Iris had never even been camping.

> It's the freedom of going, pulling up wherever you want to go and doing whatever you want to and then if you are somewhere for a couple of days and the neighbours get too noisy you move on, if the grass gets too long you can move on, you can do whatever you want, that's what got me, the freedom of choice in everything (T1, T2, T3, T4).

As Iris described, freedom of choice was about having control of her life, doing what she wanted, when and why she wanted without having to put any other person's needs before her own (T4). However, unlike most of the women who traverse vast areas of the country, a feature of Iris's travels was that her daily trips were mostly of a short duration. A careful record-keeper, she recalled:

> I remember my shortest trip... was about 1.8 kilometres because you find a nice spot and you camp the night and you set off the next morning and 1.8 kms later I thought oh this is even nicer so instead of skipping it you stop again (T4).

While duration varied depending on which part of the country she was travelling in, on average Iris travelled 42kms a day. In the early days of her retirement, she worked on a strict budget because her industry pension was small and she was not eligible for a government pension until she was 65 years. Iris budgeted $80 per week for fuel and only increased it to $100 per week after she could draw her government pension. With such a small amount of money for fuel, this restricted the distances she could travel, so Iris kept strictly within her budget with the exception of a couple of big trips across country. Iris made the point that in order to travel very long distances, she had to be prepared to travel for months in order to keep within a budget. At times Iris did take months and travelled longer distances, for example one trip took thousands of kilometres to Western Australia, another from Brisbane to Tasmania via Melbourne took eight months (T4). In the last ten years Iris had mainly stayed in free or low cost camping sites:

> I always looked for a spot where my bus fitted, where it was discrete and usually illegal um yeah I'd spend the night and move off in the morning.

As with the other travellers, Iris sought to see new places, had experiences and saw sights which she described as, "magic absolutely magic" (T2). She travelled to Tasmania where she stayed because of its exceptional beauty and because, and in contrast to the Australian mainland, it is a small geographical area with smaller distances between locations. Like Aria she travelled with a dog for company and, occasionally, with other women but in separate vehicles. Primarily a very solitary individual, she took each day as it came and never got sick of the lifestyle (T4).

During the COVID-19 pandemic Iris was confined to Tasmania and remained stationary for long periods because of lockdowns and travel restrictions. Whilst limited to one location, she was parked on "a really good camping spot" on a private property of thirty acres with access to water but not power. During this period, after eighteen years travelling, she came to appreciate a stationary lifestyle. Continuing to live in her bus, she purchased a car which enabled her to move around independently without having to drive the bus. Iris realised that, whilst she did not want to stop travelling, she had slowed down and was travelling less. Subsequently, her bus broke down, and she could not afford the repair cost. She applied for community housing and, luckily, friends offered her a property to rent. At the time of interview Iris was intending to sell her bus and purchase something smaller to continue to travel (T1, T4).

Iris epitomised self-determination and self-reliance (T3). She had the confidence to travel widely by herself and maintained a travelling lifestyle for 18 years until the pandemic forced her to be stationary, which opened up new opportunities to re-think her future (T4).

Discussion

These four women, who stories are profiled in this paper, illustrate the willingness to live a life that, in a unique way, exemplifies self-determination and confidence to move outside what might be expected of women in their sixties and seventies. The women's ages, backgrounds, social and financial situations were diverse, as were their motivations and experiences of travelling. The brief narratives illustrate how they took advantage of means to adventure and explore places they would not otherwise visit, taking control to create new and different lifestyles as a way to move beyond adversity, thrive and grow. Despite their differences, there were commonalities amongst these women. These included a proactive mindset, and a love of Australia and the landscape in its many forms. The women all relished a degree of challenge, ranging from Aria (self-described as an "adventurer"), Vivien's new life, to Olivia as Mrs Intrepid (avoiding bordering on stupid) and Iris averaging 42 kilometres a day on a very small budget.

These women spent extended periods travelling in self-contained mobile accommodation, and for some this was their permanent lifestyle. Our previous research of social media entries suggests that solo women traveller numbers are increasing, yet our literature review found limited studies exploring this phenomenon (Yates et al., 2021). Whilst there is literature on "grey nomad" travellers in Australia, most studies focus on heterosexual couples (Yates et al., 2021). There is also literature on women travelling (often solo) for leisure (for example, Shaw, 1994, Wilson & Little, 2005, Douglas & Barrett, 2020). The women featured in these studies tend to be holidaying (taking "time out" from their normal lives), which contrasts the women recruited for this study, for whom travel is their daily lifestyle. Their travel is not just about leisure nor is it the type of holiday-making experiences that the travel literature describes. For the women in our study, travel is a lifestyle whereby they maintain a transportable home and lifestyle, either one away from home or permanent.

Further, studies of women's leisure activities have described these as occurring within a framework of gendered constraints, restricted by social, emotional and behavioural expectations and vulnerabilities (Douglas & Barrett, 2020; Shaw, 1994; Yang, 2021). However, our findings did not align with these previous studies. None of the women in our study suggested that they were constrained; they grew in confidence and capability by trying and succeeding in activities they had not undertaken in their previous conventional lives. They did not express any particular vulnerability or inability to travel by themselves or with other women. They experienced leisure on their own terms and were not constrained by gender-based expectations of what older women can or cannot do.

Where our findings do concur with the travel literature, however, is in seeing travel as adventure and as a route to transformative learning, self-discovery and identity creation (Barrett & Douglas, 2020; Yang, 2021). This aligns with themes emergent from the women's narratives of developing self-knowledge and self-confidence, of self-expression and taking control of their lives. This picture of older women experiencing adventure and developing self-knowledge and confidence is in stark contrast to the stereotypical view of older women confined to a more sedentary and domestic lifestyle, declining as they age.

In addition to their geographical journeys, the women in our study described going through another journey, that of ageing. Decline models of aging continue to dominate, emphasising the need to maintain a healthy lifestyle as the best way to delay the inexorable deterioration for as long as possible. While some decline with aging is inevitable, there is growing evidence that aging can also be marked by a sense of freedom and exploration, of new learnings and challenges

(Onyx & Leonard, 2007; Onyx & Wexler, 2017). The four women in this montage paper exemplify an alternative approach to ageing being enacted by contemporary older women along the back roads and camp sites of Australia.

Iris' narrative raises another issue: she faced the challenge of what happens after many years of travelling and, reaching her mid-70s, what happens next. Well-resourced travellers such as Aria and Olivia have the option to live in their base home once travelling is no longer viable. For women like Vivien and Iris, their future lacks this option. For Iris, the kind offer from friends to rent a house provided at least a temporary solution, but raised questions about what travelling women with few resources do if they can no longer travel. This may pose a challenge, not just for these women, but for the wider society.

Strengths and limitations

The novelty of these narratives is a strength of this work, addressing the recent and developing phenomenon of women travelling rural and remote Australia without men. This study makes a substantial contribution to our understanding of the changing identities and roles of women, demonstrating a different way of living as they age. This paper demonstrates how individual women can express a matrix of specific key themes of experience. A more comprehensive report of the full thematic analysis will be reported elsewhere (Yates et al., 2024). However, as there are still no reliable data to indicate how many such women currently travel Australia alone, further research is required to determine the scope and scale of this population and their current and future social and health needs.

Conclusion

These four women profiled in this paper chose to experience the latter years of their lives as stimulating, educative and fulfilling by immersing themselves in different and challenging situations, far beyond a life of family, work or hobbies. In doing so, they are defying the conventional models of decline in aging. Uplifted by the adventures offered travelling the vast, varied and largely uninhabited expanses of regional and rural Australia, they grew to extend their sense of themselves as individuals, their confidence and capability. Expressing their belief that their experiences were meaningful, fulfilling and affirming far beyond their previous lives, these women exemplify the capacity for older women, not to be underestimated but to live beyond a stereotypical understanding of what it means to be an older woman.

Acknowledgements

With grateful thanks to the women who participated in this study

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research is supported by an Australian Government Research Training Program Scholarship.

ORCID

Margaret Yates http://orcid.org/0000-0001-9266-9913

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy restrictions.

References

Australian Institute of Health and Welfare. (2023). *The health of Australia's females*. http://www.aihw.gov.au/reports/men-women/females-health/contents/who-are

Barrett, A. E., & Douglas, R. (2020). Footloose and fancy-free: Online travel advice to older and younger women. *Journal of Women & Aging, 32*(4), 424–439. https://doi.org/10.1080/08952841.2020.1766943

Beaumont, C. (2017). What do women want? Housewives' associations, activism and changing representations of women in the 1950s. *Women's History Review, 26*(1), 147–162. https://doi.org/10.1080/09612025.2015.1123029

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Broomhill, R., & Sharp, R. (2005). The changing male breadwinner model in Australia: A new gender order? *Labour & Industry (Brisbane, Qld.), 16*(1), 103–127. https://doi.org/10.1080/10301763.2005.10722033

Chase, S. E. (2011). Narrative inquiry still a field in the making. In Densin, N.K., & Lincoln, Y.S. (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 421–434). Sage.

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research* (4th ed.). Sage Publications Inc.

Douglas, R., & Barrett, A. E. (2020). Bounded explorers: Online constructions of solo women travelers. *Sociological Forum (Randolph, N.J.), 35*(3), 765–784. https://doi.org/10.1111/socf.12627

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods, 18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Holloway, D. J. (2009). *Grey Nomads: Retirement, leisure and travel in the Australian context*. Edith Cowan Universtiy.

Lake, M. (2013). Women's and gender history in Australia: A Transformative Practice. *Journal of Women's History, 25*(4), 190–211, 369. https://doi.org/10.1353/jowh.2013.0043

Leahy, C. P. (2019). From the little wife to the supermom? Maternographies of feminism and mothering in Australia since 1945. *Feminist Studies, 45*(1), 100–128, 264.

Nicholson, L. (2010). Feminism in "waves": Useful metaphor or not? *New Politics, 12*(4), 34–39.

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine: Journal of the Association of American Medical Colleges, 89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

Onyx, J., & Leonard, R. (2007). The Grey Nomad phenomenon: Changing the script of aging. *International Journal of Aging & Human Development, 64*(4), 381–398. https://doi.org/10.2190/G4N9-3627-3G7J-W454

Onyx, J., & Wexler, C. (2017). A review of aging literature: looking for more than decline. *Arts & Humanities Open Access Journal, 1*(4), 122–123. https://doi.org/10.15406/ahoaj.2017.01.00020

Pelto, P. J. (2016). *Applied ethnography guidelines for field research*. Routledge.

Price, M., & Dunning, K. (2019). Social scripts for inclusive excursions. *Agora, 54*(2), 44–48.

Schuster, J. (2017). Why the personal remained political: Comparing second and third wave perspectives on everyday feminism. *Social Movement Studies, 16*(6), 647–659. https://doi.org/10.1080/14742837.2017.1285223

Shaw, S. (1994). Gender, leisure, and constraint: Towards a framework for the analysis of women's leisure. *Journal of Leisure Research, 26*(1), 8–22. https://doi.org/10.1080/00222216.1994.11969941

Wilson, E., & Harris, C. (2006). Meaningful travel: Women, independent travel and the search for self and meaning. *Tourism: An International Interdisciplinary Journal, 54*(2), 161–172.

Wilson, E., & Little, D. (2005). A "relative escape"? The impact of constraints on women who travel solo. *Tourism Review International, 9*(2), 155–175. https://doi.org/10.3727/154427205774791672

Yang, E. C. L. (2021). What motivates and hinders people from travelling alone? A study of solo and non-solo travellers. *Current Issues in Tourism, 24*(17), 2458–2471. https://doi.org/10.1080/13683500.2020.1839025

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2021). Exploring the 'grey nomad' travelling population of Australia and its health: an integrative literature review. *Australian Journal of Primary Health, 27*(3), 163–177. https://doi.org/10.1071/PY20023

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2024). The Experiences of Women Who Travel Solo or With Other Women Across Australia: A Qualitative Study and Thematic Analysis.

5.2 CHAPTER SUMMARY

The research presented in this and the previous chapter achieved the first aim of this study, which was to examine the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation. The four profiled narratives illustrate the individuality of the members of this participant group. Their determination and confidence to exceed ageist (and sexist) expectations of women in their sixties and seventies exemplify an alternative approach to ageing. In combination with Chapter 4, this article provides new knowledge about this previously under-researched and poorly understood population group.

CHAPTER 6: PHASE TWO FINDINGS

6.1 PREAMBLE

This chapter includes a published article based on interviews with the managers of hospitals located in remote NSW and Queensland. The results contribute to achievement of the second aim of the study, which was to explore women travellers' experiences in relation to their health and their access to healthcare when travelling. The findings represent new knowledge about the impact of grey nomads and women travellers on the health services of rural and remote NSW and Queensland from the perspectives of those managing these services.

Article citation: Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2022). 'Grey nomad' travellers' use of remote health services in Australia: A qualitative enquiry of hospital managers' perspectives. *BMC Health Services Research*, *22*, 151. https://doi.org/10.1186/s12913-022-07580-8.

Permission to reprint the article is displayed in Appendix 11.

The case examples referred to in this manuscript as contained in a supplementary file are available in Appendix 12.

Yates et al. BMC Health Services Research (2022) 22:151
https://doi.org/10.1186/s12913-022-07580-8

BMC Health Services Research

RESEARCH Open Access

'Grey nomad' travellers' use of remote health services in Australia: a qualitative enquiry of hospital managers' perspectives

Margaret Yates[1*], Lin Perry[2], Jenny Onyx[3] and Tracy Levett-Jones[4]

Abstract

Background: For more than the last two decades, older Australians travelling domestically in self-sufficient accommodation and recreational vehicles for extended periods of time have been referred to as 'Grey Nomads'. By 2021 more than 750,000 such recreational vehicles were registered in Australia. Tourism data for the year to September 2017 show 11.8 million domestic camping and caravanning trips in Australia, 29% of which were people aged 55 and over. As the 'baby boomer' generation increasingly comes to retirement, the size of this travelling population is growing. This term applies to the spike in birth rates after World War II from 1946–1964. This growing group of domestic travellers are potential healthcare consumers in remote areas but relatively little is known about their travel, healthcare needs or care seeking practices. Grey nomads have been described as reflective of the age-comparable sector of the Australian population in that many live with chronic illness. Early concerns were raised that they may "burden" already stretched rural and remote healthcare services but relatively little is known about the impact of these travellers.

Methods: The aim of this study was to explore the utilisation of healthcare services in remote locations in Australia by grey nomads including women travellers, from the perspective of healthcare professionals working in these settings. The study objective was to interview healthcare professionals to seek their experience and details of service delivery to grey nomads.

In March 2020 [prior to state border closures due to the COVID-19 pandemic] a field study was conducted to identify the impact of grey nomads on healthcare services in remote New South Wales and Queensland. A qualitative approach was taken to explore the perspectives of nursing healthcare managers working in remote towns along a popular travel route. With appropriate Research Ethics Committee approval, managers were purposively sampled and sample size was determined by data saturation. Thirteen managers were contacted and twelve interviews were scheduled to take place face to face in the healthcare facilities (small hospitals with acute care and aged care services) at mutually convenient times. A semi-structured interview schedule was developed in line with the research aim. The interviews were audio-recorded, transcribed and thematic analysis was undertaken concurrently with data collection for ongoing refinement of questions and to address emerging issues.

Results: These nursing managers described a strong service and community ethos. They regarded travellers' healthcare needs no differently to those of local people and described their strong commitment to the provision of

*Correspondence: Margaret.M.Yates@student.uts.edu.au
[1] School of Nursing and Midwifery, Faculty of Health, University of Technology Sydney, Broadway, Ultimo, NSW 2000, Australia
Full list of author information is available at the end of the article

© The Author(s) 2022. **Open Access** This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/. The Creative Commons Public Domain Dedication waiver (http://creativecommons.org/publicdomain/zero/1.0/) applies to the data made available in this article, unless otherwise stated in a credit line to the data.

healthcare services for their local communities, applying an inclusive definition of community. Traveller presentations were described as predominantly exacerbations of chronic illness such as chest pain, medication-related attendances, and accidents and injuries. No hospital activity data for traveller presentations were available as no reports were routinely generated. Travellers were reported as not always having realistic expectations about what healthcare is available in remote areas and arriving with mixed levels of preparedness. Most travellers were said to be well-prepared for their travel and self-management of their health. However, the healthcare services that can be provided in rural and remote areas needed to be better understood by travellers from metropolitan areas and their urban healthcare providers.

Conclusion: Participants did not perceive travellers as a burden on health services but recommendations were made regarding their expectations and preparedness. Australia's national transition to electronic health records including a patient—held record was identified as a future support for continuity of care for travellers and to facilitate treatment planning. With no current information to characterise traveller presentations, routinely collected hospital data could be extracted to characterise this patient population, their presentations and the resources required to meet their care needs.

Keywords: Nursing managers, Health services, Hospitals, Travellers, Rural and remote, Grey nomads, Healthcare needs, Australia, Qualitative study

Introduction

For at least the last two decades, older Australians travelling domestically for extended periods of time have been referred to as 'Grey Nomads.' This term is applied to retired or semi-retired individuals, usually 50 years of age or older, who tour within Australia in caravans, campervans, motorhomes and the like for a minimum of three months. Onyx and Leonard [1] referred to the emergence of grey nomads in Australia as a phenomenon: a remarkable occurrence of people travelling for extended periods in self-sufficient accommodation vehicles. Perhaps due to the increasing retirement of the large post World War II 'Baby Boomer' generation, and more recently the travel restrictions imposed for the COVID-19 pandemic, traveller numbers are growing. Between 2011–2016, caravan and campervan registration numbers grew by 30% and 20%, respectively, totalling 615,301 for the year to January 2016 [2]; by 2021 more than 750,000 such recreational vehicles were registered [3]. Tourism data for the year to September 2017 showed 11.8 million domestic camping and caravanning trips in Australia, 29% of which were people aged 55 and over [4]. These travellers are potential healthcare consumers in rural and remote areas but relatively little is known about their travel patterns, healthcare needs and healthcare seeking practices [5].

Previous work has characterised grey nomads as reflective of the age-comparable sector of the Australian population in that many live with one or more chronic illnesses [6]. Tate et al. [7], for example, reported 55% of travellers had chronic disease and 70% took regular medication. Halcomb et al. [8] surveyed 316 long-term travellers and reported 40% with hypertension, 23% with arthritis, 30% with diabetes and other health conditions; almost one-quarter required ongoing prescription medication and almost half reported that their illness affected their daily life. Interviewing eight grey nomads with at least one chronic condition, Calma et al. [9] found them aware of their health needs and what was required for self-management, and that they 'planned ahead' to manage their health. Similarly, in interviews with diabetes educators in South Australia and fourteen travellers with a cancer diagnosis, both Abigail, McCloud [10] and Stephens, Halcomb [11] reported them as generally well organised: arranging their travel to dovetail with their health needs and planning ahead to ensure they took with them medications they required, or to ensure their availability.

However, concerns about the impact of these travellers on rural and remote health services persist [7, 9, 12]. Originating from what the author described as "largely anecdotal" reportage [13], this has not been tested or supported by primary data. This has implications for the provision of health services, policy, health infrastructure, education, and workforce planning in rural and remote communities.

Study aim and objective

The aim of this study was to explore the utilisation of healthcare services in remote locations in Australia by grey nomads, including women travellers, from the perspective of healthcare professionals working in these settings. The study objective was to interview healthcare professionals to seek their experience of service delivery to grey nomads, to identify what services are sought, how this is managed, and what impact, if any, this has on local health services.

Methods

Study design

As one component of a larger study of women travellers, in March 2020 a field study was conducted to identify the impact of grey nomads, including women travellers, on healthcare services in remote New South Wales and Queensland. A qualitative descriptive approach was employed [14], chosen to explore the experiences and perspectives of healthcare professionals working in remote towns along a popular travel route frequented by grey nomads. Semi-structured interviews were chosen to explore each individual's understanding [15] of this aspect of the familiar, day to day reality of care delivery at their facilities.

Fieldwork settings

The study sites were all in small towns on the highway situated in areas nationally designated as remote and very remote in NSW and Queensland [16]. At the time of the field study, in March 2020, a five-year drought had recently broken with significant flooding which had cut roads and isolated towns. The towns visited included a mix of tourist destinations and locations without any particular attractions but rather fuel stops or suitable for an overnight stay. All are classified as small towns by size [17], with populations ranging from 335 to 3,335 people. Population decline in their towns was described by participants with the exception of two towns which were expanding.

The facilities managed by participants were all in the above small towns. Facilities were a combination of acute hospital and aged care beds, and community services. All had less than twenty acute hospital inpatient beds; the majority less than ten. Most of the beds were designated for aged care, with small Emergency Departments (ED) mainly comprised of two beds. The NSW facilities also had chairs for renal dialysis (Table 1). At the time of the interviews, the participants were being briefed on State COVID-19 planning and what was required for their facilities.

Participants

The sample comprised healthcare managers responsible for the running of these facilities. Sampling employed a combination of purposive and convenience strategies. Two researchers [xx and xx] planned visits to the work locations of participants, who were identified as knowledgeable on this topic. A minimum of one healthcare manager per location was purposively sampled, recruiting those who were available for interview at a mutually convenient time. Sample size was determined by data saturation; that is, sampling continued until no new information was observed [18, 19]. The managers were contacted using publicly available information, provided with study details and invited to interview.

Data collection and analysis

Face to face interviews were conducted wherever possible, and by telephone where it was not. The interviews took place at the healthcare facilities at mutually convenient times. Interviews were digitally audio recorded with consent, using an Olympus DM-720 Business recorder and a mobile phone application for backup; audio recordings were maintained on a secure cloud server. The interview schedule was developed in line with the research aim, discussed and refined amongst the author group. With local health services as the context, participants were asked about local services provided for the community and for grey nomads including women travelers; why grey nomads present to health care services, what they

Table 1 Bed capacity for study site facilities

Facility Number	Total Inpatient Beds	Acute/Sub-Acute Care	Emergency Department	High Dependency	Short Stay	Aged Care	Renal Dialysis Chairs
1	42	6				36	4
2	35	11	2	2		15	2
3	20	8				12	6
4	16	8				8	8
5	30	4	4		2	20	
6	24		2				
8	8	4	2	2	1		
9	8		2			6	
10	19	15	4				
11	17	8	3			6	
12	13	1	2		2	8	

expect and how the health service responds; attitudes towards grey nomads accessing the health services and their presence in the community.

The interviews were transcribed verbatim and imported into NVivo Version 12 for thematic analysis. Analysis was undertaken concurrently with data collection to enable ongoing refinement of questions and follow up of emerging issues. The Braun and Clarke [20] six-step framework was used which included: becoming familiar with the data during the verbatim transcription of interviews and repeated readings of the transcripts; the generation of initial codes i.e., particular ideas or points of interest; collating relevant data under codes; the collating of codes under possible overarching themes and the identification of relationships amongst the themes and the ongoing analysis of the data within the themes. Analysis was undertaken by two authors [xx and xx] and findings were discussed and agreed to consensus amongst the author group.

To support the rigor of this study and demonstrate dependability and confirmability an audit trail was maintained of project activities. Frequent discussions with supervisors supported reflexivity [21].

Ethics approval

The authors confirm that study methods were carried out in accordance with relevant guidelines and regulations including the COREQ guidelines. With the approval of the appropriate Human Research Ethics Committee (registration number ETH19-4565), written or verbal informed consent, where possible, or otherwise audio recorded verbal consent by telephone, was obtained. Confidentiality was maintained with use of code numbers in the transcribed files.

Results

Participants

Thirteen facility managers were contacted and twelve responded to the invitation for interview; eleven were conducted face to face and were approximately one hour long; one telephone interview took approximately twenty minutes. All the managers interviewed were nurses, women and responsible for the management of at least one hospital, and in some instances also community services. Participants explained how their facilities functioned to provide emergency care and recounted their experiences of traveller presentations. No participant had ready access to any reports of hospital routine data on traveller presentations; all accounts were based on their experiences and recollections.

Thematic analysis identified three key themes: services in and for the community, met and unmet expectations, and preparations.

Services in and for the community

This broad theme encompassed an explanation of the healthcare and support services that were provided at the sites (and some of the challenges faced) and the ethos and culture of care for which these participants were responsible.

In describing their culture of care, all participants clearly expressed that they did not differentiate between local people and travellers in relation to how they are managed. Participants stressed the function of their facilities as serving their communities:

> *"We are a community hospital, and we are here to serve the community" [HCP8] and*
> *"... I could get sick, you're sick, that's OK that's what we are here for.." [HCP12].*

They also acknowledged the contributions of travellers to their local economies, for instance when they stop to re-fuel their vehicles, stay overnight or longer, purchase groceries and visit local coffee and gift shops, museums and art galleries.

Participants explained that services were provided on a holistic basis, which could be interpreted more broadly than is generally the case with metropolitan health services. Managers recounted events where the hospital staff had provided care that was extended to meet the needs of their patients' partners and vehicles and even their dog (see Supplementary File 1, Case Example One). This was not viewed as anything out of the ordinary but part and parcel of serving their community, which was what they considered the basis of their role. The care provided was no different for grey nomads than for local community members.

> *"We treat them as we treat our community or anybody... we don't treat them any different to anybody else" [HCP12].*

Nonetheless, all the managers described the recruitment of nursing (and other) staff as a particular challenge in maintaining service delivery and all were heavily reliant on overseas nurses. They expressed disappointment that, unlike for teachers and police officers [in NSW], few incentives were available for nurses to work in remote and very remote areas.

> *"We always have a recruitment problem... there's a perception that everyone needs to be really experienced to work and that's not necessarily the case. The remoteness of and the aging population of our nurses has become a very intricate weave" [HCP3].*

Participants went on to describe the services delivered at their facilities. They explained that they provide emergency care but are not equipped for longer term inpatient

care. In the one nurse-led facility, they were able to keep patients overnight or for a couple of days as the highly skilled nurses could implement nursing interventions, within their scope of practice, to address conditions such as dehydration or mildly unstable diabetes. Telehealth was described at this site, so a doctor could talk directly to the patients. At all sites, emergency care was provided via high resolution digital cameras. Generally, an emergency services doctor was on the other end of the camera reviewing the patient and giving instructions for treatment. In other instances, retrieval services and their networks of specialties were accessed. For example,

> *"We had a penetrating eye injury a few years ago where an ophthalmology surgeon told us what to do to avoid optical nerve damage... If someone's had a stroke and they are in ED ... instead of getting an ED doctor, we get a cardiovascular consultant to talk us through" [HCP11].*

Patients were generally airlifted to larger facilities when their illnesses could not be adequately treated locally. Where tertiary care was required, the patient could be stabilised onsite and then retrieved by the Royal Flying Doctor Services (RFDS).

Some participants expressed their personal purpose as the pursuit of service rather than career development. For some, but not all, this was linked to having grown up in the area.

> *"I try to put back into the community and to help others that need it" [HCP2].*
> *"You just wouldn't come for climbing the corporate ladder type of thing and I mean, I grew up here, so it's because you want to give the best back to the people who live in your community, and I mean I live here I grew up here so I've got that connection" [HCP3].*

Traveller presentations

Participants discussed the frequency and characteristics of grey nomad presentations to their facilities.

The initial point of contact for accessing health services in these remote towns was the hospital emergency departments. With the exception of two participants, the managers agreed that few grey nomads presented to their EDs, and presentations were not often. One manager reported they could increase the ED throughput by about 10% during the main travelling season. Another stated that grey nomads doubled the number of presentations to their ED. This manager had been in the area only six months and requested a telephone interview due to her workload related to COVID-19; she did not elaborate in response to questioning, during what was the briefest of the interviews. The other participants reported the number of presentations fluctuated and are seasonal, depending on what activities were happening locally. They described significant events attracting travellers during the annual seasonal migration north between March—October (although most events were cancelled in 2020 and 2021 due to the COVID-19 pandemic).

Participants reported that generally more men than women travellers were seen in their EDs. They commented that while they might see solo women in the towns, they seldom presented to the hospital. One manager described a convoy of women passing through the town on their way to an event but reported that travellers were predominantly heterosexual couples. However, no site data were available to support these accounts, which derived from their recollections.

When asked about the impact of traveller presentations, participants said that, as numbers were small, the overall impact on their services was no different to that of local people. One participant recounted that grey nomads presented for the same reasons as local people: mainly accidents and exacerbation of chronic illness. This reinforced the view of grey nomads as no different to the local community in terms of service need and demand. No-one reported hospitals requesting an increase in staffing because of grey nomads or suggested this was necessary, irrespective of their recruitment issues. These services were all small (see Table 1), with clinical and administrative staff covering a range of functions. Any presentation that tied up a member of staff impacted these services. In participants' view, whilst grey nomads had some presence in their EDs, this was not anything out of the ordinary. Only one manager saw grey nomads specifically as having an impact, but even she described this as, *"they impact normally..." [HCP5];* that is, no different to other presentations. This was further explained:

> *"Ah look, anyone that is significantly unwell impacts on a small rural site because we have one registered nurse on per shift and that's the only person in this facility who can triage so the triage can take them away from something else they would be doing..." [HCP1].*

Resource-intensive episodes necessarily resulted in significant disruption to routine services, regardless of whether the patients were local people or grey nomads. Examples were provided where local people had experienced serious illness and major traumas such as cardiac events and farm accidents and where presentations by travellers were similarly resource-intensive. For example in one ED a grey nomad died from a ruptured abdominal aortic aneurysm; motor vehicle and caravan accidents were also recounted (see Supplementary file 1, Case Example

Two). Grey nomad presentations were reported as most commonly men attending with chest pain or known cardiac disease. Medication-related attendances were almost as frequent, when travellers had left their medications at home, had run out of pills, or didn't have a prescription to refill. Accidents and injuries also featured, such as:

> *"dropped the tow ball or the trailer on their leg [HCP8]; ...sepsis, fractures, ankles, lots of falling over including the curb, that's quite common; ankles or wrists, just those accidental things that happen..." [HCP5].*

One participant gave accounts of grey nomads presenting to the facility during winter for a dose of annual influenza vaccination (and other vaccines) and explained that this site is allocated additional flu vaccine doses for this population. The consistent picture was that participants applied an inclusive definition of community: they did not differentiate presentations by grey nomads, who were not perceived to be a particular burden, and there was no difference in the care they received from that of local people.

Met and unmet expectations

This theme related to the expectations of some grey nomads of the services they anticipated would be available, what services are normally delivered and what can be provided where staff go out of their way to meet peoples' needs.

The majority of presentation anecdotes illustrated travellers presenting with needs that were within scope for the facilities either to address directly or arrange care delivery elsewhere. However, services that are taken for granted in metropolitan areas are not always available in these remote sites. Some travellers or even urban service providers were not aware of this.

> *"We have people from the city hospitals ring us and want to speak to our CT person or our pharmacist. So that would be me, and that would be me, and that would be me. We don't have a CT scanner, we only have an xray machine. It's not just travellers, it's other people in general... they don't know" [HCP11].*
> *"...So you know most of them are great but there's the odd few who will say "fly me out, what do you mean?" "We don't do that here, we've got to fly you out", and most of them handle it well but being several hours from a Base hospital, I think some of them don't necessarily get the distance and what a rural hospital does..." [HCP6]*

As specialty services are not necessarily available, patients may have to be flown out to larger centres. One participant recounted a conversation with a patient who seemingly did not understand the available services or the requirement to be flown to another hospital, saying:

> *"... do I have to? (be flown out)" [HCP3].*

Where services were available, this could be because people were multi-skilled, for example, where wardsmen and nurses were qualified to take X-Rays.

Sometimes staff rose to the challenge even where expectations were not realistic. In Case Example Three (see Supplementary file 1), despite unrealistic expectations, staff were able to arrange what was asked. In Case Example Four (see Supplementary file 1), advanced practice skills were employed by a single nurse in a Primary Healthcare Centre (PHCC), not just to manage seriously decompensated diabetes but also to understand the mental state of vulnerable people in high-risk situations. In these instances, whilst the expectations were described as unrealistic, they were met.

Grey nomads' unrealistic expectations could extend beyond the services to encompass the countryside and their travel within it. Not all travellers had an awareness of the vastness of the country, the remoteness, the distance between towns, and the need for this to inform their level of preparedness for their travel and their health maintenance.

> *"The towns are an hour apart but ... some people just don't understand the distances" [HCP 11].*

Travel preparations

Participants described grey nomads with various levels of understanding and preparation for their travels. They were more generally characterised as educated and informed, knowing their doctors and conditions, having a care plan, discharge summary or some type of health information pack, and a list of their medications and scripts. Whilst MyHealthRecord (Australian online national voluntary health record) was viewed as potentially useful, not all managers knew how to access it and not all grey nomads had a digital record. Those with chronic illness were described as the most prepared, reflected in having plenty of medication and a medical history from their GP.

> *"...The travellers that come seem to be well prepared and have GPs and things which is always good so maybe that's why we don't see as many as we could, they might take a little bit better care of themselves I'm not sure cause they are planning to be away so maybe they organise that stuff..." [HCP 1]*
> *"...Those who are well prepared usually have chronic health issues; have plenty of supplies such as food water spare tyres; know where they are going; have*

plenty of medication; letter of introduction from their GP and bring a medical history with them". [HCP10]

However, this wasn't always the case. There were other instances, albeit not so commonly described, where forward planning and preparation was lacking, especially for problems or sudden ill-health:

"...Some just get in their car, pack their car up and the car might be 20 years old and off they go. That can be male or female because we do have single male travellers as well not prepared at all. They might only have a little bit of water with them, not even have an idea of the distance between towns..." [HCP 8]
"...Some are, some aren't. Some haven't got a clue and don't understand what resources are and are not available in the outback..." [HCP10].

In one facility the story was recounted of a male traveller and his wife who presented to the ED to have blood collected for pathology tests every couple of days. Although not considered a burden on the service, the participant expressed concern that this man was in such a remote location with a compromised immune system, and questioned how prepared he was, should he become ill enough to warrant admission to hospital. The concern was about the patient, not the impact on the service. Another manager recounted how a man and his wife towed a caravan to the hospital but had no contingency plan when the man became ill and required retrieval to another hospital: the wife could not drive let alone tow a caravan (see Supplementary file 1 Case Example Five). Another manager described a couple who presented where the husband, who was the driver towing the caravan, had dementia and his wife did not drive. In some instances, travellers' preparedness was linked to their expectations of the support available to them in remote Australia: expectations that were not always realistic. Poor preparedness could reflect a failure to think through the implications of remote travel. In other cases, however, good preparedness seemed an extension of usual self-management: of routine accommodation of health needs within their lifestyle, whether in a house or caravan.

"...I do find that people who travel are organised, they'll come with their list of medications and their medical conditions, all their paperwork together and hand it to you...". [HCP6]

Discussion

This study aimed to explore the utilisation of healthcare services in remote locations in Australia by grey nomads, from the perspective of healthcare professionals working in these settings. The interview findings illustrated the strong service and community ethos of managers. This meant they were both inclusive and flexible in how they worked and how their facilities functioned in order to meet the holistic needs of all their patients, sometimes to a much broader extent than would be usual in urban settings. Grey nomads were viewed as members of the community served, for whom care was provided. Whilst they were reported to comprise only a small proportion of remote service workloads, their needs were regarded no differently to those of local people. Very different service configuration and availability were reported in the remote areas compared to metropolitan areas. A mixed picture was presented of travellers' expectations, with some examples where ignorance of what can be provided drove unrealistic expectations. Similarly, their levels of preparedness varied. Most but not all, and particularly those with chronic illness, were described as well-prepared for their travel and for illness self-management and health maintenance during their journeys.

This study adds new knowledge in relation to grey nomads' use of remote health services from the perspective of service providers. These managers regarded grey nomads as part of the community served by facilities and saw no distinction between meeting the needs of the transient group and local populations. The reported frequency of grey nomad presentations varied but was not considered a significant addition to workload or a burden. Grey nomads were described as generally well prepared for travel in relation to the self-management of their health. Their expectations of what services were available were occasionally unrealistic but were usually within scope and able to be met.

Only two previous studies, from Tate, Mein [7] and De Bellis, Hill [22], have surveyed health care professionals. The first study to seek the views of healthcare professionals [7] was undertaken in 2006 in the remote Kimberley Region of Western Australia. This examined, and raised as an issue, the potential "burden" of disease and (un)preparedness of older travellers visiting remote Australia. Findings included that only half the participants had sufficient medication for their trip, only 19% had a list of long-term medications and 9% a health summary. These authors concluded that the presence of chronic illness and the absence of health documentation indicated that older travellers were poorly prepared for such travel and therefore a burden on remote health infrastructure. In the other study seven credentialled diabetes educators working in rural and remote South Australia were interviewed in 2018 about their experiences of providing care for grey nomads with diabetes [22]. By contrast, these educators described the grey nomads as mostly well-prepared although it was the small proportion with poor diabetes education and self-management skills who

were more likely to need their help. They appreciated the diversity that these travellers brought to their working lives, and there was no suggestion of "burden".

Other studies asked grey nomads about their health service usage, and reported a mixed picture. Acute events and medical emergencies were described as few [5], or affecting 5% of travellers [23]. Health scares were more common, reported by 14% [23] and by 32% of men and 21% of women in the previous 2 years, and treated locally in regional hospitals or by GPs [24]. From online survey respondents, Halcomb, Stephens [8] reported that 42% had visited a General Practitioner and 23% an ED. Of the total sample, only 7.6% had sought medical attention to obtain a prescription and 18% had got prescriptions filled while travelling. It is difficult to determine if the mixed results of these sparse and heterogenous studies constitute high usage or imposition on health services.

In the current study travellers were described as generally well prepared, with one participant noting that with the internet people have more access to relevant information, contributing to their better preparation. Studies reviewed by Yates, Perry [5] revealed that themes predominantly described grey nomads as experts in self-management and well-prepared for travel. Raven [13] noted the largely anecdotal nature of the evidence of Tate, Mein [7] for their burden on rural/ remote services, but this concern was nonetheless picked up and repeated in later studies. These concerns, derived from surveys and interviews with grey nomads, contrasted the views expressed by the managers interviewed for this study and the predominant view of the diabetes educators interviewed by De Bellis, Hill [22] where grey nomads were regarded simply as people needing healthcare and no different than anyone in their local communities.

A number of reasons may explain, at least in part, this discrepancy in findings. Tate, Mein [7] interviewed primary care doctors and nurses, whereas hospital managers were interviewed for this study. The context for the two studies was different, for example in terms of staffing models, workload, funding and the care provided. Changes in the age and health literacy characteristics of cohorts of travellers during the sixteen years reflect changes in the general population, which is both ageing and better informed. The studies from Halcomb, Stephens [23], Calma, Halcomb [9] and Stevens [11] targeted grey nomads with chronic illness via an online survey. Altogether, the studies that comprise this body of knowledge vary widely in terms of time, setting and participants and this diversity likely contributed to the varied findings. The current study makes a significant contribution based on the different context of the perspectives of the hospital managers, and the depth of information they provided.

Whilst this study is limited in deriving from a small sample of hospital managers, data saturation was achieved for these interviews. Further, participants worked for the public health providers of two of Australia's three most populous states, on a popular remote travel route. It is regrettable that no hospital activity data were available to support participants' reported experiences.

Conclusion

In conclusion, grey nomads were not perceived to burden remote health services. Managers applied an inclusive definition of community, regarded travellers as part of this community when accessing health services, and their contribution to the local towns was welcomed. Traveller numbers have been increasing over recent decades and the COVID-19 pandemic has resulted in significantly more people buying caravans, campervans and other mobile accommodation and travelling domestically in Australia. Particularly in light of these increasing numbers, further research is required to examine the rates and details of presentations by domestic travellers including grey nomads to remote health services, and to determine what proportion may be sustained rather than transient. Routine data detailing traveller presentations should be collected to support appropriate ongoing resourcing of healthcare facilities in remote areas and to better inform service policy and planning.

Despite the different perspectives described by the healthcare professionals in papers written up to sixteen years apart, the recommendations of earlier studies remain relevant. These include travellers having a health summary including medical history, current problems, medications and allergies; this could now be achieved with a more comprehensive uptake by the population and utilisation in health services of MyHealthRecord.

The healthcare services that can be provided in remote areas needs to be better understood by urban travellers and their regular healthcare providers. This information could be more widely publicised in order to support consistent planning and preparation for travel. It was widely acknowledged that people with chronic illness were better prepared for travelling. Perhaps people who consider themselves healthy and do not have a chronic illness may not anticipate and prepare for acute illness that requires healthcare support. Further research is clearly required to understand the diversity of travellers' needs. Overall, however, the dominant picture was one of healthcare services and managers operating with flexibility and inclusivity, committed to serving their communities, including grey nomads.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-022-07580-8.

Additional file 1.

Acknowledgements
With grateful thanks to the Nursing Hospital Managers who participated in this study

Authors' contributions
All authors contributed to the development of the proposal. MY and LP collected and analysed the data; MY drafted the manuscript; all authors reviewed the findings and advised on manuscript drafts. All authors read and approved the final manuscript.

Funding
This research is supported by an Australian Government Research Training Program Scholarship.

Availability of data and materials
The datasets generated and analysed during the current study are not publicly available as they are part of an ongoing doctoral study but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
This study was reviewed and approved by University of Technology Sydney Human Research Ethics Committee, registration number ETH19-4565. Participants provided informed written consent to participate and for publication of findings.

Consent for publication
All participants provided consent for publication.

Competing interests
The authors declare no financial and non-financial competing interests.

Author details
[1]School of Nursing and Midwifery, Faculty of Health, University of Technology Sydney, Broadway, Ultimo, NSW 2000, Australia. [2]South East Sydney Local Health District and School of Nursing and Midwifery, Faculty of Health, University of Technology Sydney, Broadway, Ultimo, NSW 2000, Australia. [3]Business School, University of Technology Sydney, Broadway, Ultimo, NSW 2000, Australia. [4]School of Nursing and Midwifery, Faculty of Health, University of Technology Sydney, Broadway, Ultimo, NSW 2000, Australia.

Received: 26 September 2021 Accepted: 20 January 2022
Published online: 05 February 2022

References

1. Onyx J, Leonard R. Australian grey nomads and American snowbirds: similarities and differences. The Journal of Tourism Studies. 2005;16:61–8.
2. Williams S. Grey nomad numbers up. The Sydney Morning Herald. 2017 24 February
3. Caravan Industry Association of Australia. Caravan Industry Supports National Road Safety Week as "Grey Nomads" begin to head north 2021 [There are over 750,000 registered recreational vehicles in Australia. Available from: https://www.caravanindustry.com.au/caravan-industry-supports-national-road-safety-week-as-grey-nomads-begin-to-head-north. Accessed 26/11/21
4. Tourism Research Australia. TRA Case Study: Caravan Industry Association of Australia 2019 https://www.tra.gov.au/Data-and-Research/Case-studies/case-studies. Accessed 26/11/21
5. Yates M, Perry L, Onyx J, Levett-Jones T. Exploring the 'grey nomad' travelling population of Australia and its health: an integrative literature review. Aust J Prim Health. 2021;27(3):163–77. https://doi.org/10.1071/PY20023.
6. Australian Bureau of Statistics. Australian Health Survey: Updated Results, 2011–2012. Long-Term Health Conditions 2013 [Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.003Chapter300201-2012. Accessed 26/11/21
7. Tate J, Mein J, Freeman H, Maguire G. Grey nomads–health and health preparation of older travellers in remote Australia. Aust Fam Physician. 2006;35(1/2):70–2.
8. Halcomb E, Stephens M, Smyth E, Meedya S, Tillott S. The health and health preparation of long-term Australian travellers. Aust J Prim Health. 2017;23:386–90.
9. Calma KRB, Halcomb E, Stephens M. An exploration of the experiences of Australian Grey Nomads travelling with chronic conditions. Aust J Prim Health. 2018;24(2):183–8.
10. Abigail W, McCloud C, de Bellis A, Hagger C, Clark R. Who's Maintaining the Health of Australia's Grey Nomads? J Aging Phys Act. 2016;24:S73.
11. Stephens M, Halcomb E, Dewing J. Living on: an exploration of healthful cancer survivorship among grey nomads. Australian Journal of Cancer Nursing. 2018;9(1):19–24.
12. De Bellis A, McCloud C, Giles J, Apolloni M, Abigail W, Hill P, et al. Grey nomads with diabetes self-management on the road – a scoping review. Rural and Remote Health 2021;21[3]:6517.
13. Raven M. Health of grey nomads: On the move and under the health sector radar. Aust J Rural Health. 2016;24(3):182–7.
14. Sandelowski M. What's in a name? Qualitative description revisited. Res Nurs Health. 2010;33(1):77–84.
15. Woolcott HF. The Art of Fieldwork. 2nd ed. Plymouth: AltaMira Press; 2005.
16. Australian Bureau of Statistics. 1270.0.55.003 - Australian Statistical Geography Standard [ASGS]: Volume 3 - Non ABS Structures, June 2020 2020 [Available from: https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1270.0.55.003Main+Features1June%202020?OpenDocument. Accessed 26/11/21
17. Australian Bureau of Statistics. 2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016 2016 [Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Small%20Towns~113. Accessed 26/11/21
18. Boddy CR. Sample size for qualitative research. J Cetacean Res Manag. 2016;19(4):426–32.
19. Guest G, Bunce A, Johnson L. How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. Field Methods. 2006;18(1):59–82.
20. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
21. Korstjens I, Moser A. Series: Practical Guidance to Qualitative Research. Part 4 Trustworthiness and Publishing European Journal of General Practice. 2018;24[1]:120–4.
22. De Bellis A, Hill P, Abigail W, Giles J, McCloud C. Grey nomads with diabetes: the experience of rural and remote diabetes educators in South Australia. Aust J Prim Health. 2020;26(4):300–5.
23. Obst PL, Brayley N, King MJ. Grey Nomads: Road Safety Impacts and Risk Management 2008 Australasian Road Safety Research, Policing and Education Conference; 10–12 Nov 2008; Adelaide South Australia2008.
24. Onyx J, Leonard R. The Grey Nomad phenomenon: Changing the script of aging. The International Journal of Aging & Human Development. 2007;64(4):381–98.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

6.2 CHAPTER SUMMARY

The findings presented in this chapter achieved the second aim of this study by providing new knowledge about travellers' use of healthcare services in rural and remote Australia from the perspective of the managers of these services.

CHAPTER 7: DISCUSSION, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

7.1 INTRODUCTION

This doctoral study was informed by my growing awareness of a new cultural phenomenon – a population of Australian women travelling without men for extended periods or full-time. This group appeared to be largely under-explored, undescribed and unreported. The first aim of my study was to identify the characteristics of this travelling population, their experiences in relation to their health and social needs, and their access to healthcare when travelling. My second aim was to explore the utilisation of healthcare services in rural and remote locations in Australia by grey nomads and in particular women who travel without men, from the perspective of healthcare professionals working in these locations.

7.2 AUSTRALIA AS AN ADVENTURE PLAYGROUND

It is hard to imagine or appreciate the vastness and diversity of the Australian landscape unless it is experienced firsthand. It includes tropical rainforest, coral reefs, alpine country, desert wildernesses and endless beaches. The activities undertaken in this vast landscape are similarly varied. Visitors can, for example, watch a camel race in Alice Springs or a horse race on the edge of the Simpson desert (The Birdsville Race Club, 2025), snorkel on the Great Barrier Reef, enjoy a music festival in the desert (Music Festivals Australia, 2024), help to save bilbies and quokkas from extinction, and learn about the world's oldest living culture (Tourism Australia, 2024). My participants' sense of adventure and enjoyment in exploring the many features of Australia and attending such activities provoked a sense of adventure and discovery that was a major theme in the study findings. My findings are similar to those of Onyx and Leonard (2005), who found that wonder, discovery, vastness, diversity and freedom were features of a less structured, more relaxed travelling lifestyle in which people rediscovered the joy of learning and personal development. Cridland (2008) also noted that for many people, independent travel enabled a connection or reconnection with Australia and Australiana, and that learning more about their country and themselves engendered an almost spiritual experience. The same motivations to travel and experiences of travelling Australia were reported by the grey nomads of 20 years ago (primarily heterosexual couples) as in this current study of solo women. There was almost no evidence of solo women travellers in the literature at that time, and even now, these populations are poorly understood.

7.3 THE POPULATION OF WOMEN TRAVELLERS

7.3.1 EXISTING DATA SOURCES

Establishing the size of this population of women travellers remains difficult. As noted in section 1.3, various sources report information that is relevant in a general sense. Tourism Research Australia's monthly data report gives estimated numbers of overnight trips, nights away and the related spend, but no information disaggregated by age and gender. The number of people travelling around the country on a semi-permanent or full-time basis is unknown. Other organisations such as the Caravan Industry Association of Australia, provide data on caravan ownership, overnight stays, and the travel intentions and purchasing behaviours of domestic travellers, but cannot differentiate holiday-makers from grey nomads and similar long-term travellers. This information deficit has implications for public policy and planning, both in terms of facilities and services to meet the health needs of the community and for disaster and emergency planning in relation to the extreme weather events that are a frequent occurrence in remote Australia and becoming increasingly so due to the escalating climate crisis.

The literature review presented in Chapter 2 identified 16 papers reporting on 13 relevant studies conducted between the years 2004 and 2022. Among the 3383 participants in these studies, only two solo women travellers were identified (Yates et al., 2021). Since this review, only one further paper describing a study of grey nomads (an online survey of grey nomads with type 1 diabetes) has been published. Of the 103 participants in that study, 38 were female, 18 of whom were travelling alone (De Bellis et al., 2023). All of the studies included in the literature review employed non-probability sampling methods such as convenience or purposive sampling. None employed systematic, probability sampling processes that could generate a representative sample, even of travellers encountered at a single location. Consequently, no reliable estimates of the size of the Australian travelling population can be deduced from currently available literature or data sources, and the number of women travelling without men remains unknown.

7.3.2 SOCIAL MEDIA PLATFORMS

The best indication that women travellers in Australia are a non-negligible population came from social media. Social media platforms are well-established digital tools that enable people to connect with family, friends and colleagues. They are also used as a way of meeting new people and keeping in touch with them, often over large distances. In this study, many women participants were members of social media groups (see **Table 1**) for women who travel domestically by themselves or with other women (and in some instances, children). It cannot be assumed that all the women who

are members of these social media groups actually travel; some, or many, may be interested observers rather than travellers. Nonetheless, it is notable that the memberships of these groups have grown significantly since the COVID-19 pandemic (see **Table 1** section 1.3).

First-hand travel experience is not a membership requirement for the aforementioned social media groups, and the groups do not differentiate between women who actually travel and those who simply read or write about travelling. Two of my interviewees were coincidentally group administrators, and they explained that they started the groups to provide information about travelling, vehicle maintenance, how to deal with or avoid hazardous situations, and to answer queries and support other female travellers. Members' demographic and other details are confidential; this is a deliberate strategy to protect women who might, for example, be fleeing domestic violence. Other websites such as The Grey Nomads host discussions and offer information about planning trips and other topics of interest to travellers but provide no information about their target readership. It is noteworthy that this website encourages people to maintain their health whilst travelling (Grey Nomad administration, 2023).

In summary, whilst the growing memberships of women travellers' social media groups suggest this is a growing population, the inability to differentiate members who travel from those who simply read posts mean these membership data give little indication of population size.

7.3.3 STUDY DATA

The data collected for this study were unable to be used to estimate the size of the Australian female travelling population. Ethnographic methods and other qualitative research approaches that employ non-probability sampling are not capable of generating a representative sample or an estimate of population prevalence. However, this study does indicate the existence of a thriving population of women who are largely invisible in terms of formal, civic or academic records.

7.4 CHARACTERISTICS OF WOMEN TRAVELLERS

7.4.1 PRIOR LITERATURE

Previous studies mention the characteristics of female travellers, their health and social needs and access to healthcare only briefly and as part of surveys of broader travelling groups. These included, grey nomads (Cridland, 2008; Obst et al., 2008; Onyx & Leonard, 2005, 2007; Prideaux & McClymont, 2006) and people travelling with chronic disease (De Bellis et al., 2023; Halcomb et al., 2017). No details about female travellers could be sourced from these articles.

7.4.2 THE STUDY SAMPLE

My ethnographically informed qualitative study was conducted to examine the characteristics, experiences and perspectives of women who travel across Australia without men in self-sufficient accommodation. The distribution of this population across the vast Australian continent posed enormous challenges. Many people aspire to 'do the lap', as a trip around the whole country is known (Cox, 2022). My target population was dispersed across many thousands of kilometres, and with travel bans restricting my movements, it was only possible to recruit an opportunistic convenience sample, with snowball sampling the chosen approach.

It is difficult to determine the degree of willingness to participate amongst this population when using snowball sampling, because I do not know if participants approached potential participants who declined to share their contact details. However, of those people who were willing to discuss participation with me, none declined to be interviewed. Each participant was interested in the study, engaging, open and responsive during their interviews.

The research reported in Chapters 4 and 5 demonstrated some common traits amongst participants, with confidence, independence, capability and fearlessness featuring consistently in their narratives. All shared a willingness to try new things, deal with any situation, have fun and enjoy their experiences. Such attitudes among women are well documented in Australian history.

WOMEN AS ADVENTURERS

Despite the predominance of social mores and norms that have largely constrained the role of women to domesticity, Australia has a proud history of tenacious independent individual women challenging the status quo, defying the contemporary conventions of what women should do and be. For example, Emily Creaghe was a member of an expedition across the rugged Gulf of Carpentaria region from Normanton (in Queensland) to Katherine (in the Northern Territory) in 1882. Her diary revealed her courage and endurance in exacting circumstances, as well as a deep appreciation and love for the country (Australian Geographic Staff, 2016). More recently, in 1988 Kate Cottee was the first woman to circumnavigate the world single-handed, non-stop and unassisted in a yacht (Australian Geographic Staff, 2016), and in 2010 Jessica Watson was, at 16 years of age, then the youngest person to sail unassisted around the world (Australian Geographic Staff, 2016). In 2004, Linda Beilharz became the first Australian woman to ski 1100 kilometres from the edge of Antarctica to the South Pole. She followed this in 2009 by traversing the Greenland

icecap and making her first attempt to cross Patagonia's icecap, which she successfully crossed in 2013. In 2010 at age 50 she skied 780 kilometres over 56 days at the North Pole. She described her journeys as a means to explore 'human potential and the spirit of the wilderness' (Australian Museum, 2021). In 2020, Sophie Matterson walked 4750 kilometres with her five camels from Shark Bay in Western Australia to Byron Bay on the east coast of Australia (Sophie Matterson, 2023).

These extraordinary women, like the women in this study and undoubtedly many unknown others, exemplify Australian women living beyond the limitations of a conventional domestic life. However, in earlier decades and centuries the financial independence required to pursue such exceptional lives would have been rare. In more recent decades, Australian women's growing financial independence has offered new opportunities. The study participants did not report having been privileged by birth but enjoyed financial independence due to their previous or current employment, financial settlements following divorce, superannuation and/or pensions. Their financial security enabled them to take advantage of new opportunities.

In general, the participants who were part-time travellers were more focused on reaching specific travel destinations, more likely to plan to reach them by particular dates and were sometimes time-bound by employment commitments. By contrast, many of the women living permanently in their vehicles travelled shorter daily or weekly distances and chose their destinations in a spontaneous fashion, often opting to stay in free campsites in natural surroundings. Such choices were often influenced by their financial position and the costs of fuel and accommodation. Many stayed in a single location for multiple days, without obligations in time or space; their focus was on living on the road rather than travelling the roads. They sometimes met people with whom they had connected via social media groups, or whom they had encountered earlier in their travels. Some would occasionally travel in convoy with other women, but mostly they travelled by themselves.

PERSONAL DEVELOPMENT AND GROWTH

Study findings illustrate that participants believed their lifestyle enabled valuable personal development. They felt able to reject stereotypical female behaviours and roles to pursue their own interests and goals without being obligated to others. For all the participating women, and particularly those who had a 'home life' to return to, travelling represented a break from their other lives and selves and was valued highly. In this they contrasted with many of the travellers described in the review reported in Chapter 2 (Yates et al., 2021) – grey nomads, predominantly heterosexual couples, whose travelling lifestyles predominantly replicated their home-based lifestyles and gender-

based roles (Holloway, 2007).

A strong theme within this study was the women's sense of achievement in overcoming challenges and the resulting development of self-confidence. Many reported experiencing anxiety and uncertainty as novice travellers, but with time they grew in self-confidence and to appreciate their chosen lifestyle, and their apprehensions receded. They described feeling stronger and more resilient, building confidence in their new skills and ability to cope with unexpected situations. As many participants said, 'you just deal with it'.

Most of the women chose to travel alone, with many stating that their confidence in their ability to travel solo was part of their personal development. In this they differed from the broader grey nomad population, in which people commonly travel in groups and frequently socialise at events and around campfires in the evening.

The women relished the development of new skills and tackling problems or challenges that few women of any age could handle. Moreover, they did so by themselves; many grey nomads might boast similar achievements, but as couples. The participants referred to the deeper sense of meaning they developed in multiple ways: through experiences of nature and the landscape, through a sense of wonder at the world, through their expanding appreciation of their 'place', and a nebulous awareness of becoming more than their previous selves. Like Onyx and Leonard's (2007) interviewees, these women referred to and valued the sense of deeper experiences and meaningful personal growth that their travelling lifestyle afforded.

PERSONAL SAFETY

Whilst personal safety was mentioned as a concern for novice travellers, none of the women in the study reported feeling personally threatened by another person, and all considered their travelling lifestyle to be inherently safe. However, parking alone in lonely and isolated locations undoubtedly poses potential risks for women travelling solo, and older women in particular have been identified as a vulnerable group (Boneham & Sixsmith, 2006; Bozzaro et al., 2018). To reduce such risks, some of the novice travellers in this study opted to travel in convoy, sometimes with a man. They also recounted strategies designed to give the appearance of having a man with them (such as placing man-sized boots or other masculine artefacts outside their vehicles). Such activities were rooted in the concept of women as largely incompetent (Fiske et al., 2002), reinforced by stereotypes of older women and ageist attitudes (Butler, 1969, 2009; Byles et al., 2006; Cecil et al., 2022; Chrisler et al.,

2016; Cuddy et al., 2016; Dougherty et al., 2016; Fiske et al., 2002). Study participants did not discuss ageism overtly, but it was reflected in accounts of families trying to talk them out of travelling and questioning their physical and mental competence.

In the future, travellers, including older women travellers, may become regarded as a specific vulnerable group, as has happened for other travelling groups at various times and places. Itinerant groups in Europe such as the Romanies and New Age travellers have been socially ostracised, leading to substantial and enduring disadvantage and inequality in terms of access to community services, including healthcare (Mackenbach et al., 2008; Siebelt et al., 2017; Smith & Ruston, 2013; Šprocha & Bleha, 2021). Widespread social disapproval could pose particular challenges for the older women in this study, all of whom were living with (often multiple) chronic diseases. This topic is discussed in more detail later (see section 7.6), but the participants' accounts do not suggest that this was a current issue.

Motor vehicle accidents were a major risk inherent in the participants' lifestyle. Whether travelling short or long distances, they were at risk of accidents like any other driver on the road. In Australia, fatality rates of road traffic accidents are similar across the age bands from age 26 to 74 years with similarly higher rates amongst younger and older adult groups (BITRE, 2022). However, none of the participants raised the topic of road safety or driving ability as risks to their safety or their health, and none described any actual road incidents or accidents. That these issues were not raised does not mean the women were unaware of or made no provision for them, but the topic was not prominent. Obst et al. (2008) noted that road safety issues for grey nomads had not been examined. They offered anecdotal evidence about hazards such as unfamiliar driving conditions, dirt or narrow bitumen roads, road trains, wildlife, fatigue and lack of awareness of unwritten road etiquette. These remain perennial hazards on non-metropolitan Australian roads.

HOME

Home is usually understood to be where someone lives but is not just a location. Home has an emotional component; it is a place where you feel comfortable, secure, and emotionally connected. However, home can represent different things to different people, including a safe haven, a place to live with family, friends and/or pets; it can also be broken or unsafe. Conversely, lacking a home has been linked with irreparable harms – social, medical, behavioural, economic and moral – for individuals, communities and societies (Chimowitz & Ruege, 2023). None of the permanently travelling participants in this study considered themselves homeless; they described their vehicles as

their homes. Their travel was not necessarily for sightseeing or exploring but rather a continuous nomadic state, entirely of their own choice. These women did not fit the ABS definition of homelessness, which includes a lack of one or more of the elements of 'home', listed as 'a sense of security, stability, privacy, safety, and the ability to control living space' (ABS., 2012). However, they recognised that their status of 'no fixed abode' was often anecdotally equated with homelessness.

Home, for these participants, encompassed a lifestyle that was largely solitary but in which other travellers were friendly and supportive; many wanted to form and maintain connections, and often agreed to meet up in the future at multiple locations. They expressed the joys of connecting with other people, sharing a campfire, telling stories of their experiences and giving each other advice about their journeys. The women talked of people's willingness to help others facing problems such as mechanical breakdowns and damaged tyres. Some developed longstanding friendships, meeting up in person from time to time. The participants who were stranded in one location for months due to COVID-19 lockdowns were very grateful for the community they developed and were determined to enjoy and make the most of their strange situation.

Many of the women who were travelling full-time reported difficulties in obtaining suitable accommodation when their vehicles needed servicing or repairs. They had made financial provision for ongoing maintenance, but a major breakdown or need for specialised repairs of their vehicles could strain their finances, making even a short stay in a motel or onsite cabin unaffordable. One participant, Iris, had been a traveller for 18 years, but at interview was staying in a house owned by friends; her vehicle required a new engine, which she could not afford immediately. Iris exemplified the vulnerability of older single women living permanently as travellers. She was fortunate in having friends with a property for her to rent while she waited for social housing and pursued the longer-term goal of having her vehicle repaired and returning to travel.

While homelessness is a potential problem for older women travellers, it is a much broader societal issue; indeed, older women are the fastest-growing group of people experiencing homelessness in Australia (Wood & Villiers, 2024). Decades of governmental retreat from housing provision have resulted in a continuous decline in the stock of public housing (Darab & Hartman, 2013) and correspondingly long waiting lists. Simultaneously, low interest rates and generous incentives for investors have pushed house prices and rents to unprecedented levels (AHURI, 2022). These factors increase the risk of homelessness for travellers who want or are forced to abandon their mobile accommodation and travelling lifestyle.

7.5 AGEING

Work and raising a family are commonly and uncritically accepted as part of adult life. It follows that once formal employment ends and children grow up and leave home, the contributions of aged individuals are often valued less (although grandparenting may be an exception) (Leonard & Burns, 2001). Moreover, when ageing is viewed as a medical process entailing deterioration that needs to be remedied, it leaves little room for new opportunities or growth (Leonard & Burns, 2001). The WHO defines ageing at the biological level as the impact of the accumulation of molecular and cellular damage over time, leading to a gradual decline in physical and mental capacity, likely presence of disease, then finally death. Whilst it is acknowledged that there is no 'typical' older person, older age has been characterised by the presence of conditions such as hearing loss, declining eyesight, back and neck pain, lung disease, diabetes, dementia and depression (World Health Organisation, 2022). The picture is one of disease, decline and deterioration, leading to frailty and dependence. Such images feed into and maintain negative social stereotypes prevalent within Western societies that can impose constraints on what older people can do and aspire to, and limit their quality of life and life satisfaction.

Researchers seeking to understand how stereotypes develop and are applied within social groups identified a two-dimensional social model comprised of warmth and competence (Cuddy et al., 2016; Fiske et al., 2002). In these terms, older women were described as warm, likeable and dependent but also incompetent in comparison to other social groups. The stereotype of older women is that they cannot manage by themselves, and this elicits a degree of disrespect. However, whilst such stereotypes might be anticipated to diminish and restrict women, Burns and Leonard (2005) reported evidence of older women's ability to disregard this emphasis on decline and loss. The findings of the current research demonstrate a similar refusal among older women to conform to the image of the 'doddery old lady'.

These study findings indicate that women travellers experience ageing in a different way to other women (or at least, to the stereotype). Although almost all these study participants were older women (over 60 years of age), they demonstrated an energy and activity level that defied the stereotype of incompetence, frailty or deterioration. Their narratives often referred to rising to challenges and achieving tasks that were beyond others' expectations for them, travelling to unfamiliar locations and enjoying new experiences and activities. They wanted to step outside their usual lives, overcome challenges, learn, spend time in nature and meet new people; their perceptions of themselves and their realities were far removed from being infirm, dependent and

burdensome. Their stories contradict the stereotypes of ageing as necessarily a process of decline, and older women as universally incompetent.

7.6 HEALTH AND ACCESS TO HEALTHCARE WHEN TRAVELLING

The second aim of this study was to explore the utilisation of healthcare services in rural and remote locations in Australia by grey nomads and in particular women who travel without men, from the perspectives of both the women travellers and the healthcare professionals working in these locations. I interviewed members of two groups to seek information about women travellers' access and use of healthcare: women themselves, and the managers of small community hospitals in rural and remote Queensland and NSW. I analysed and integrated their responses to identify key themes about women travellers' health and access to healthcare in rural and remote Australia.

7.6.1 PARTICIPANTS' ACCOUNTS OF HEALTH MAINTENANCE

The women reported themselves as essentially healthy, irrespective of the diseases they managed and the effects of advancing years. Many participants reported multiple and/or substantial chronic illnesses, consistent with other Australians in their age group; in 2022, 50.2% of Australians aged 65 years or older reported two or more chronic conditions (Australian Bureau of Statistics, 2023). The participants in this study described themselves as managers of their health and talked about this as a matter of routine rather than a focus of their lives. Whilst they all volunteered details of their travels and expanded on their travelling experiences with enthusiasm, health issues were dealt with in a much more cursory manner. For the most part, their health maintenance whilst travelling entailed maintaining access to their regular health practitioners by telehealth, rather than expecting local practitioners to meet their needs, and planning ahead to maintain supplies of their regular medicines. Whilst their health literacy was comparable to that of the general population in that they had a broadly adequate lay understanding of their own health and self-care of their chronic illnesses, rather than professional knowledge (Sadler et al., 2014), they were proactive in maintaining their health. They described their travelling lifestyles as contributing to their health and regarded themselves as healthier because of it.

Some women described recognising that their travelling lifestyle was ameliorating mental health problems, some of which they said derived from traumatic situations in their childhoods or later years. These topics (childhood abuse, domestic violence) were not a focus of this research and not pursued in the interviews. However, it was clear that women regarded a reduced volume of burdens

and responsibilities associated with their previous roles, including difficult relationships with family members and the demands of home ownership, as one of the key advantages of their lifestyle. All participants talked of feeling generally healthier while travelling.

A few women gave examples of health problems that developed whilst travelling (including a bout of shingles and another of cellulitis). These acute but rare events were managed by visiting local health practitioners and following their directions.

7.6.2 Healthcare Managers' Accounts of Travellers Health Presentations

State, territory and national government health departments have long struggled to ensure sufficient quality and quantity of healthcare services in regional, rural and remote areas of Australia. Government reports have consistently and repeatedly noted the challenges presented by distance and isolation in serving Australia's highly dispersed and diverse rural and remote populations, and despite the various solutions proposed, consistently poorer health outcomes (Australian Bureau of Statistics, 2023; Australian Government Department of Health and Aged Care, 2016; Australian Health Ministers Advisory Councils, 1999, 2002). Despite the evolution of service models, principally around new technologies such as telehealth (Bradford et al., 2016; MBS Review Advisory Committee, 2024), outer regional and remote areas struggle to provide adequate services due to insufficient healthcare staff (Australian Institute of Health and Welfare, 2024a). This problem is exacerbated by rural populations' social determinants of health (lower incomes, lower educational attainment, and higher rates of homelessness and overcrowding than in regional and metropolitan areas). Although the number of full-time-equivalent health professionals per 100,000 rural population has increased substantially in recent years (22% between 2013 and 2022), they remain relatively scarce, particularly medical specialists (Australian Institute of Health and Welfare, 2024a).

Given the already stretched nature of rural and remote healthcare in Australia, it seems reasonable to ask whether travellers, particularly older people with multiple co-morbid conditions, are regarded as a burden to health services and unwelcome as a result. This was the question considered by Tate et al. (2006) in their study of 64 health providers in remote Western Australia. The results indicated that healthcare providers believed many grey nomads were poorly prepared for travel and represented a drain on local health resources. In contrast, seven credentialled diabetes educators working in rural and remote South Australia, interviewed in 2018 about their experiences of providing care for grey nomads with diabetes (De Bellis et al., 2020), described them as mostly well prepared. However, a contemporary diagnosis of diabetes commonly triggers education and training

for self-care from primary care services, so this population should be expected to be better prepared on average.

The two studies mentioned above were the only published research on Australian traveller's health prior to the current work, which presents a very different picture of general health management. The 12 managers of 11 health facilities located in remote NSW and Queensland whom I interviewed in 2020 (see Chapter 6) described travellers as generally well prepared to self-manage their chronic diseases. The data I collected from 29 women travellers supported this perception. Both healthcare managers and travellers identified acute, unplanned, events such as infections or injuries received in falls as the main reasons travellers sought healthcare whilst travelling in remote areas, not their chronic health conditions. Even acute health events such as road traffic accidents and falls were not regarded as burdensome by the managers.

Nearly two decades ago, Tate et al. (2006) reported that the healthcare providers they surveyed held negative views about grey nomads presenting to their practices. The only other study to mention negative attitudes towards grey nomads was Onyx and Leonard (2005), who cited one caravan park owner who described grey nomads as 'freeloaders'. Their interview findings also referred to hostility towards grey nomads leading to temporary closure of free camping sites in some towns. It is likely that itinerant populations – outsiders – will always be vulnerable to prejudice from some community members, despite the economic benefits they bring, and this has been an ongoing topic in the tourism literature for decades (Mansfeld & Ginosar, 1994). However, no evidence of local antagonism toward women travellers or grey nomads in general, was reported in this current study.

7.6.3 Met and Unmet Expectations

The managers reported that some travellers who attended healthcare facilities expected the same level of healthcare they would receive from a metropolitan teaching hospital, sometimes blaming their city providers for not correcting travellers' misconceptions. In one example, a traveller expected the hospital ED to dispense a cancer drug prescription that, aside from being uncommon, would have cost the equivalent of the hospital's annual drug budget. This, and other anecdotes, indicated that travellers from cities may not always understand the realities of healthcare in rural and remote areas (Australian Institute of Health and Welfare, 2023). Better awareness on the part of the general public and metropolitan healthcare professionals about the practicalities of remote services would be beneficial. Such anecdotes were exceptions, though, and perhaps memorable to the managers for this reason. However, whilst this story was one of unrealistic expectations, this

traveller was not turned away; the hospital staff facilitated supply of the drug to a community pharmacy on the traveller's route. This was only one of many stories illustrating remote health practitioners' flexibility in meeting patients' needs: for example, when acutely unwell travellers had to be flown out to specialist services and hospital staff arranged care not just of partners, but caravans and dogs left stranded at the hospitals.

7.6.4 UNSUSTAINABLE WORKFORCE IN RURAL AND REMOTE AREAS

Recruiting and retaining healthcare staff in rural and remote areas is a chronic problem, which current data confirms. The Stronger Rural Health Strategy (Commonwealth of Australia, 2021) offers incentives for healthcare professionals, particularly doctors and nurses, to work in rural and remote areas, and nurses are recruited from overseas to fill some full-time positions. Neither of these strategies appears to have solved the problem. The managers interviewed complained that repeated periods of maternity leave in this predominantly female workforce were a major contributor to staff shortages.

Despite ubiquitous workforce shortages, additional healthcare demand from travellers was not described as deleterious to the provision of community-based public health services. The facilities whose managers were interviewed were open for 24-hour care and cared for presenting patients regardless of their non-local status or healthcare needs. The accounts of both the participating women and the health service managers indicate that, despite workforce shortages, rural and remote health services deliver a level of personal and pastoral care greater than that typically seen in city-based services.

7.7 STRENGTHS AND LIMITATIONS OF THIS STUDY

The publications profiled in previous chapters refer to the limitations of each phase of this study, summarised here. I acknowledge the potential for researcher bias, due to my long career as a registered nurse and regional hospital manager. There was also a risk of bias in the data due to the gatekeeping which is inherent in snowball sampling. These weaknesses and how they were ameliorated, as well as the strengths of the study, are discussed below.

The qualitative design of Phase One of this study was informed by ethnography. Despite COVID-19 movement restrictions, my experience as a participant observer enabled me to generate novel insights into the lifestyles of women travellers. Purposive sampling was employed to recruit participants who could elucidate their characteristics and experiences. This design, and the use of

non-probability sampling, was neither intended nor able to determine the size of this population; without a representative sample, population characteristics could not be estimated. From the perspective of healthcare policymaking and provision, the inability of this research to provide estimates of population size and characteristics is a weakness. Nonetheless, the qualitative approach adopted enabled the collection of rich and detailed data about this sample of women travellers that would have been impossible with a quantitative approach.

A strength of snowball sampling as a strategy is that it enables access to groups that are otherwise hidden or hard to access. As explained in sections 1.3 and 7.3.1, prior to this study no data about women travellers in Australia were available. Further, the information that exists (in the studies reported in Chapter 2 and from the social media sites identified in sections 1.3 and 7.3.2) makes it clear that women travellers are dispersed widely and tend to favour rural and remote settings over the busy and more easily accessible holiday locations of coastal and suburban regions. A further advantage of snowball sampling is that first contact by someone known to a potential participant may encourage recruitment. However, a potential disadvantage is loss of heterogeneity in the sample, because the method tends to support recruitment of likeminded friends, often with similar socioeconomic or ethnic backgrounds. Any of these factors may have skewed study findings (Emerson, 2015).

As the data were collected during the COVID-19 pandemic, the optimal means of collecting rich data – a face-to-face interview in a quiet and comfortable location of the participant's preference – was rarely possible. Most interviews were conducted using videoconferencing software or by telephone. Whilst these modalities did not offer the best opportunity to create an environment conducive to disclosure, nonetheless, the length of the interviews and the continuing contact between the interviewer and some of the participants suggest that good rapport was achieved. More than three quarters of the interviews ran for more than an hour.

The limitations of Phase Two, in which 12 healthcare managers were interviewed, are discussed in section 6.6. These participants were located in only two of Australia's eight states and territories. Whilst these interviews were conducted face to face, in settings of the participants' choice, the timing of this phase was not ideal. Conducted immediately prior to the initial COVID-19 pandemic orders that banned travel and closed state and territory borders in March 2020, increasing recognition of the likely seriousness of the impending epidemic meant that both the healthcare managers and research team members were concerned about infection. I was anxious about how I

would be received at hospitals, whether and how the interviews could be conducted and completed, what would happen if I became infected and whether I could get home. The healthcare managers were dealing with the additional workload involved in preparation and delivery of services to prevent and treat infection. It is not possible to know the extent to which this atypical situation affected my interview style and their responses, and hence the richness or even reliability of the data. However, if the circumstances did bias the managers' responses, this would likely have been in the direction of antagonism or negativity towards travellers. As the data showed, there was no evidence of this.

7.8 SUMMARY

The aims of this study were (1) to examine the characteristics of women travellers across Australia and explore their experiences in relation to their health and social needs, and access to healthcare when travelling, and (2) to explore their utilisation of healthcare services in rural and remote locations in Australia from the perspective of healthcare professionals working in rural and remote locations.

The 29 participants in Phase One of this study were a remarkable group of tenacious women who did not fit the stereotypes of their gender and age group. They were active, engaged and capable women who considered themselves healthy regardless of the presence of chronic diseases. The key findings of the study were that these women travellers enjoyed a heightened sense of freedom and independence, relished adventure in nature, and recognised and appreciated their own personal development, including overcoming anxiety and fear as novice travellers and developing greater self-confidence. These findings are the first detailed insights into the lifestyle choices and experiences of this group of older women. Defying the predominant model of decline in older age, their lifestyle choices and experiences exemplify a new version of positive ageing. Further studies of a more representative sample of this population to obtain broader insights are warranted.

Interviewing managers of rural and remote healthcare services, all of whom were nurses and women, revealed their strong community and service ethos. Unlike the outcomes from an earlier study of (predominantly) GPs, these managers sought to meet travellers' healthcare needs with the same urgency as those of their local community, despite workforce shortages. Their experiences of the health presentations and health service expectations of grey nomads indicated that most were well-prepared to self-manage their long-term conditions as they travelled. However, they also highlighted some unrealistic expectations of metropolitan healthcare providers and their traveller

patients with regard to the health services available and how they function in rural and remote areas.

7.9 IMPLICATIONS AND RECOMMENDATIONS FROM PHASE ONE FINDINGS

7.9.1 The Need for Population Data

The population of women travellers from which I sampled is largely invisible in a civic sense; formal data collections give no indication of their number, how long or where they travel, or what happens when they are no longer able to travel. Whilst the activity and growth in membership of specific social media groups suggest women travellers are a thriving population, these sources cannot be relied on to evidence its size and characteristics. Hence the first and most immediate implication of Phase One findings is the need for reliable and representative data on the size and profile of this population of women travellers, as a distinct subset of the wider travelling population. The data presented in this thesis reveal that these women are a unique group; the version of ageing that they present represents a paradigm shift from society's norms and expectations. As such, it cannot be assumed that these older women will have the same needs as previous generations.

The importance of the need to fill this information deficit about women travellers increases with the growing number of travellers overall; for example, a 9% increase in nights stayed away from home was reported in the three years to 2023 (TRA, 2023). Large numbers of travellers converge on specific attractions in very remote areas: 14,000 people attended the 2024 Mundi Mundi Bash at Broken Hill, a town with a population of only 18,000 (ABC News, 2024), while 6,000 travel every year to the even more remote Birdsville Races (Birdsville Race Club, 2025). Whilst most travellers to events such as this are probably short-term holiday travellers, the overall increase in traveller numbers is likely to reflect increasing numbers of long-term and permanent travellers on Australia's roads, including women; without reliable data this remains unclear.

The lack of information about the travelling population hampers the effectiveness of local, state and national planning, innovation and infrastructure development for rural and remote locations. Better understanding of this population, their characteristics and movement patterns, health and social needs, would support planning for development and maintenance of core infrastructure, not just healthcare but roads and local amenities and services. Better understanding of the needs of this population would enable planners' processes to meet the needs of the community more effectively. Importantly, this includes accommodation options for travellers whose mobile accommodation is no longer fit for habitation or can no longer be driven. However, when state and national politicians are

struggling with the so-called 'housing crisis' (Parsell et al., 2025), caused by the high cost and relative unaffordability of houses to purchase or rent and the short supply of public housing, accommodating a highly mobile group's possible future need for housing is a very difficult task for policymakers.

Another reason why this information deficit about women travellers and grey nomads is important derives from the increasing frequency and severity of heatwaves, droughts, bushfires, cyclones and flooding being experienced in many popular travel destinations due to the climate crisis (see e.g., Government of Western Australia (2025) and State of Queensland (2024)). State and national governments and their operational arms (including the State Emergency Services and the National Emergency Management Agency, responsible for coordinating governmental disaster and emergency preparedness, response and recovery) are increasingly frequently required to evacuate communities to places of refuge during extreme weather events. Real-time, accurate information about the numbers and locations of travellers is essential to keep populations safe. Such data collection must be nationally funded and coordinated, and must be conducted regularly, because the dynamic nature of the travelling population is likely to mean local population parameters will differ significantly over time. A dedicated extension of the national census to travellers might be one way to resolve this problem.

Collecting data about travellers in remote areas faces obvious problems, including the itinerant and seasonal nature of this population and its movement patterns, and the diversity and remoteness of sites in which people choose to stay. It is also possible that some travellers will avoid or resist their data being collected, particularly if they have a background of domestic violence, family conflict or mental illness. However the data are collected, it will be important to differentiate those who have a permanent fixed home base from those who live permanently in their mobile home (caravan, motorhome, tent, etc.). As noted earlier, people living permanently on the road have different activity patterns and needs and are likely to be vulnerable to homelessness when their mobile accommodation is no longer fit for purpose.

7.9.2 The Future Needs of Women Travellers

The women in this study were self-sufficient and independent. How they determine their individual needs, if or when they move beyond their current stage of positive ageing into a period of decline and frailty, is yet to be understood. What seems clear, however, is that women who have spent time travelling solo across Australia, who have revelled in being able to do, go and be whatever they want, are unlikely to choose the sorts of aged care services, including residential care, that currently

dominate the market. These women's strong sense of independence makes it likely that a high proportion of them will opt to remain in their own homes (mobile or otherwise) as long as possible. Accommodating this preference will require development and delivery of support systems and services that are currently not imagined, only selectively available or after prolonged wait periods to meet the diverse physical, social, psychological and spiritual needs of this ageing cohort.

Further research is required to identify the likely future needs of ageing women travellers, and innovative approaches must be developed to plan to meet those needs. Research and planning will require partnerships and collaborations between current and future stakeholder groups, such as state and national governmental departments, academic and clinical facilities, non-governmental organisations including commercial healthcare funders and providers and charitable bodies, to establish funding and governance mechanisms as well as support services.

7.10 IMPLICATIONS AND RECOMMENDATIONS FROM PHASE TWO FINDINGS

The key finding of Phase Two relates to how rural and remote healthcare services function, and the attitudes of health service managers toward members of the travelling population who present for care at their facilities. Recent years have seen enormous changes to models of healthcare provision in rural and remote areas with the emergence of new technologically mediated services, such as telehealth. Healthcare can now be provided via videoconferencing software and high-resolution digital cameras; a physician can visually examine and speak directly to a patient, review their health, and give instructions for treatment despite being hundreds or thousands of kilometres distant. Such technologies have enabled rural services to maintain delivery of cutting-edge specialist first-response care despite having few healthcare professionals onsite. Meanwhile, the health service managers interviewed for this study exhibited a strong ethos of service and provision of care to their communities, defining their community as those people requiring their care, whether locals or not. These research participants were strong female leaders of healthcare teams finding ways to provide care in a context of resourcing and workforce shortages. In sharp contrast to the findings of earlier studies, they emphatically did not regard travellers as burdensome.

Despite the advantages of telehealth described above, highly skilled nurses are still required onsite to monitor patients, provide hands-on emergency nursing care and inform physicians about their patients' status. Unfortunately, longstanding problems of low recruitment and retention of health professionals persist in rural and remote Australia, threatening the effectiveness and sustainability of healthcare in these regions. Further, whilst telehealth may enable staff to cope with current

patient numbers despite ongoing staff shortages, social media and reports from the Caravan Industry Association of NSW and Tourism Research Australia suggest travellers' numbers are increasing. Whilst rural health services may be coping now, will new technology enable this to continue if the annual number of travellers seeking healthcare doubles or triples in coming years?

Questions such as this underscore the importance of health services having up-to-date and detailed information on patient presentations and episodes of care, yet this was not readily available to any of these managers. Such data as were available lacked detail; for example, domicile locally or out of area could only be determined on an individual patient basis and if home residential address had been provided rather than local accommodation. Modelling future service needs requires reliable and detailed contemporary data. Versions of electronic health records have been and continue to be rolled out and upgraded throughout Australia's public health facilities. This should make it possible to set up regular, automated reporting to enable contemporaneous audit of service activities, and provide data for predictive modelling of future service demands. These initiatives will support healthcare quality review and service planning.

The managers interviewed confirmed that their facilities provided emergency care but were not equipped for longer-term inpatient care. The sole nurse-led facility was able to keep patients overnight or for a couple of days so nurses could resolve conditions such as dehydration or mildly unstable diabetes. The success of this model of care opened the possibility of developing suites of advanced nursing practice skills to broaden the scope of future nurse-led models of care for rural and remote locations. Training in rural and remote healthcare could be offered online by universities or the national nursing professional body (the Australian Nursing and Midwifery Federation) and offered as a continuing education opportunity. Moreover, the value of practising in small towns for the breadth of experience offered cannot be overstated and should be promoted as part of any program designed to attract nurses into rural and remote healthcare.

Healthcare facility managers perceived that most, but not all, members of the travelling population were well prepared for self-care of their chronic health conditions. Thus, scope for better preparation exists. Self-care entails a combination of self-care maintenance (maintaining physical and mental stability through engagement in healthy activities), self-care monitoring (being alert to and checking for changes in symptom patterns) and self-care management (taking action in response to symptom changes) (Riegel et al., 2012). Patients with knowledge gaps or misunderstandings would benefit from targeted education aimed at enhancing self-care abilities, education that nurses

could deliver through a variety of media (face to face and digital, individual and group-based, in paper and print and via applications), commercially as independent practitioners and through medical centres, and via primary and tertiary care settings.

To inform nursing practice related to travellers and to ensure patients' needs are met, further research is recommended on travelling populations to identify their information and education needs and devise interventions that facilitate good preparation for health during travelling. Given how little information is available about the travelling population, travellers themselves must be studied to learn what they require. With this information and working with professional groups such as primary care nurses, clinical and academic teachers and educationalists, educational materials to be delivered online, in app form or accommodated within existing nurse education programs, could be developed and promoted to enable nurses to empower travellers to enhance their self-care and facilitate efficient health-seeking behaviour.

7.11 CONCLUSION

The women recruited in Phase One of this study travelled the country at their leisure, living beyond the limitations of the ageist and sexist stereotypes that mould so many women's lives in Australia and elsewhere. They described a sense of freedom, adventure, rich experiences and personal growth. They explained how their health improved after they adopted the travelling lifestyle, seeing themselves as healthy irrespective of chronic disease or episodes of acute illness, and focusing less on their health than is typical for women of their age.

Stories about exceptional women living lives outside accepted conventions open pathways for coming generations. They present examples of ageing that does not inevitably involve decline, but continuing growth and enjoyment. These stories illustrate how older women are capable of achieving anything they choose and should not be underestimated.

Nonetheless, women travellers remain under researched and their needs are not well understood. No solid evidence was found about the size of this population, its characteristics, travel patterns or health service presentations. Whilst some members of this population may have reason to prefer invisibility, these knowledge gaps limit, distort or deter infrastructure and service planning. Further research is needed to provide data on the size and characteristics of this population of women travellers and its current and probable future health and social needs to support planning for future healthcare services.

Opportunities were identified for nurse education to underpin service development and innovation and for nursing role and career development, recruitment and retention to rural areas and to support travellers' education, preparation and self-care management whilst on the road.

The health service managers interviewed, all women, described a strong ethos of community service. In contrast to the findings of earlier studies, they did not regard travellers presenting to their hospitals as burdensome. They noted that few women travellers presented to their facilities, implicitly supporting the women's depictions of themselves as healthy and competent in self-managing their chronic diseases.

Overall, participants' stories of their travelling experiences, corroborated by health service managers, reveal a picture of women choosing to live beyond the bounds of social stereotypes. They chose a path of ageing characterised by growth and development, and of competence and independence, rather than decline and frailty. Their travelling lifestyles were interesting, enjoyable and fun, and promoted their health and wellbeing. For the future, better knowledge and recognition of this travelling population could encourage more older women to embrace non-conventional lifestyles and enjoy the improved health and wellbeing this offers.

APPENDIX 1: TOURISM DATA

TABLE 1: VISITOR NUMBERS, NIGHTS

Visitor nights ('000) YEAR ENDING MARCH 2022	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST [c]
Caravan park or commercial camping ground	8 524	6 038	6 390	3 200	4 777	636	776	np	30 510
Caravan or camping - non commercial	4 636	3 935	5 398	1 274	3 373	675	611	np	19 980
Total nights in caravan parks and camping grounds	13 160	9 973	11 788	4 473	8 150	1 312	1 387		50 490

a. All figures relate to Australian residents aged 15 years and over.
np. Data is not publishable as the survey error is too high for most practical purposes.

Source: Australian Trade & Investment Commission and Tourism Research Australia (2023)

TABLE 2: TOURISM RESEARCH AUSTRALIA NATIONAL VISITOR SURVEY DATA:

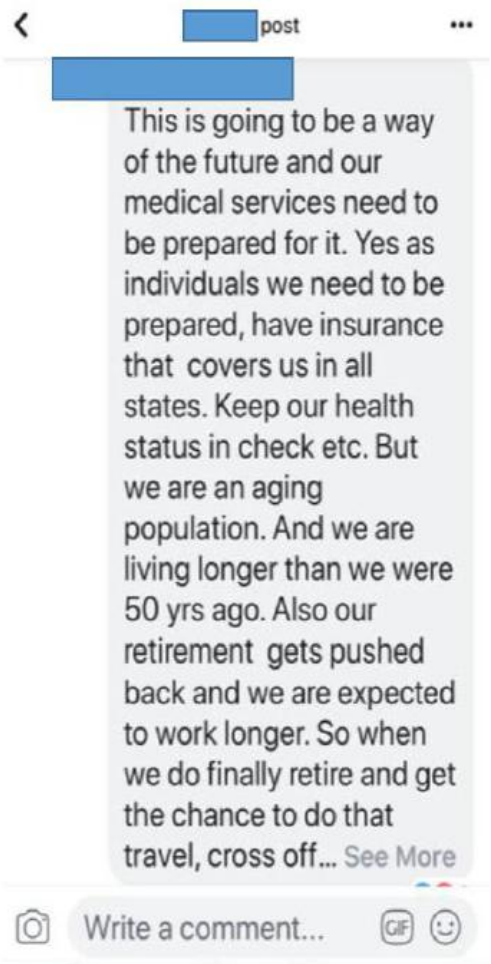
4 years data averaged (2016 - 2019)

Overnight trips (000)	Travel Party Type	Travelling alone	Adult couple	Friends or relatives travelling together	Total Travel Party Type
Total	Caravan park or commercial camping ground	607	2,194	1,905	**6,817**
Total	Caravan or camping - non commercial	1,305	1,272	2,363	**6,217**
Total	Outdoor / nature - Active outdoor / sports	9,987	12,928	12,689	**48,331**
Total	Arts / heritage - Local attractions / tourist activities	5,073	9,170	7,790	**29,182**
Total	Social activities	27,744	23,262	18,505	**89,482**
Total	Other activities - Not asked	5,316	2,134	1,377	**11,385**
Total	Holiday	4,658	13,391	13,363	**41,290**
Total	Visiting friends and relatives	13,300	9,661	6,015	**34,986**
Total	Intrastate	21,254	17,680	14,608	**69,222**
Total	Self drive vehicle	20,368	21,064	16,724	**75,025**
Total	Ages 35-39	2,467	1,097	1,339	**8,245**
Total	40-44	2,990	1,108	1,452	**9,607**
Total	45-49	3,034	1,394	1,302	**8,834**
Total	50-54	3,570	2,474	1,565	**9,956**
Total	55+	10,419	13,562	5,521	**32,244**
Total	**Total**	**33,429**	**25,327**	**20,709**	**102,874**
Total	Female	13,639	12,626	10,998	**48,787**
Total	**Total**	**33,429**	**25,327**	**20,709**	**102,874**
Total	Working full time	20,178	11,261	9,422	**54,868**
Total	Working part time	5,514	4,446	4,485	**19,394**
Total	Retired or on a pension	4,609	7,985	3,381	**16,957**
Total	Single	16,122	1,790	9,968	**33,899**
Total	Part of a couple	17,210	23,510	10,667	**68,680**
Total	Travelling alone	33,429	-	-	**33,429**
Total	Adult couple	-	25,327	-	**25,327**
Total	**Total**	**33,429**	**25,327**	**20,709**	**102,874**

Source: Australian Trade & Investment Commission and Tourism Research Australia (2025)

APPENDIX 2: SOCIAL MEDIA DATA

Figure 1.1: Facebook post 1



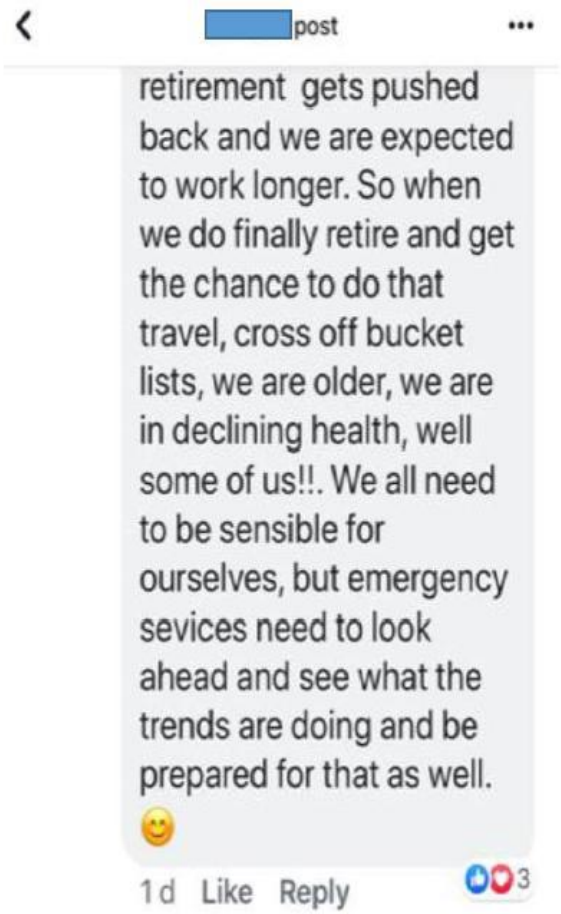
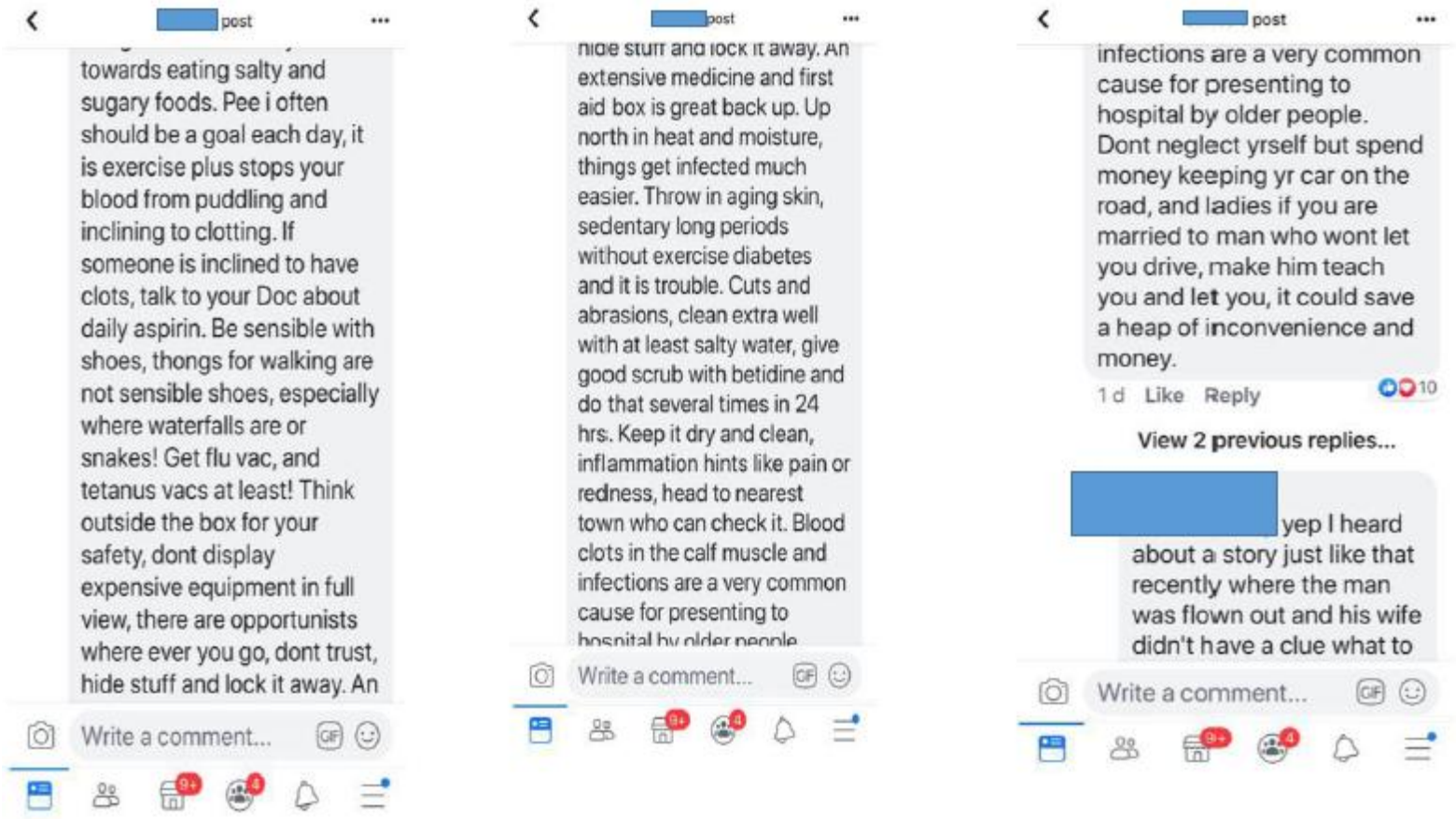


Figure 1.2: Facebook post 2



APPENDIX 3: PERMISSION TO REPRODUCE THE PUBLISHED INTEGRATIVE REVIEW

Article citation: Yates, M., Perry, L., Levett-Jones, T., Onyx, J. (2021) Exploring the 'Grey Nomad' travelling population of Australia and their health: an integrative literature review. *Australian Journal of Primary Health, 27, 163-177* https://www.publish.csiro.au/py/pdf/PY20023.

Under all Licence to Publish forms, the copyright owner(s) retain their copyright. As an Open access journal paper, the copyright owner granted to CSIRO Publishing a non-exclusive copyright licence under the relevant Licence to Publish form.
As a general guidance, academics of universities usually own the copyright in their scholarly works, and an author's employer usually owns any copyright in the paper if the author has written the paper within the scope of the author's employment and the employer organisation is a commercial corporation or Government department or agency.

CSIRO PUBLISHING
Australian Journal of Primary Health
https://doi.org/10.1071/PY20023
Review

Exploring the 'grey nomad' travelling population of Australia and its health: an integrative literature review

Margaret Yates [A,D], *Lin Perry* [B], *Jenny Onyx* [C] and *Tracy Levett-Jones* [A]

[A]Faculty of Health, University of Technology, Sydney, Broadway, Ultimo, NSW 2000, Australia.
[B]South East Sydney Local Health District and Faculty of Health, University of Technology, Sydney, Broadway, Ultimo, NSW 2000, Australia.
[C]Business School, University of Technology, Sydney, Broadway, Ultimo, NSW 2000, Australia.
[D]Corresponding author. Email: Margaret.M.Yates@student.uts.edu.au

Abstract. With increasing numbers of baby boomers retiring and taking to the road in rural and remote Australia, often for extended periods, this review aimed to identify the characteristics of these 'grey nomads' travelling across Australia, their experiences in relation to their health and social needs and their access to health care. To this end, an integrative literature review with narrative analysis was conducted. Studies of Australian grey nomad travellers published from 1999 to January 2020 were sourced from Ovid Emcare, Medline/PreMedline, Embase, PsychINFO, Academic Search Complete and Google Scholar. Fourteen records based on 11 studies described grey nomads as predominantly older heterosexual couples who defied the conventional view of aging by seeking adventure and new experiences. Many planned for their health needs while travelling, and their health was overwhelmingly reported to improve with the nomadic lifestyle. This review demonstrates the paucity of data about grey nomads. Information on travellers' health care needs and service usage is a significant gap, undermining regional and rural service planning and the provision of healthcare services, and represents a considerable challenge for healthcare providers such as GPs, pharmacies and emergency departments.

Keywords: grey nomad, health, systematic review, travellers, women.

Received 24 August 2020, accepted 7 December 2020, published online 29 March 2021

Introduction

Growing numbers of Australians are reported to travel domestically for extended periods of time. According to the Caravan Industry Association of Australia, the number of caravan and campervan registrations grew by 30% and 20% respectively between 2011 and 2016, totalling 615 301 combined registrations for the year to January 2016 (Williams 2017). A significant number of people owning these vehicles were likely 'grey nomads', a term commonly used to describe retired or semi-retired individuals, ≥50 years of age, who tour within Australia in caravans, campervans, motorhomes and the like for a minimum of 3 months (Onyx and Leonard 2007). However, there is no indication what proportion are long-term travellers versus short-term holidaymakers. More recently, the number of women traveller members of groups on social media has increased; for example, the Facebook groups Women Caravanning Camping and Travelling Solo Australia (8100 members), Solo Women Campers (4100 members), Chicks Camping Crew (6600 members) and Wheels Around Oz Women and Children Only (343 members). These membership numbers, posted in October 2020, reflect a more than doubling (225% increase) in the total numbers posted for these four groups in the previous year. Although the situation with COVID-19 lockdowns may reflect greater than usual vicarious travelling, a 48% increase was noted in the 5 months before COVID-19 (October 2019–February 2020). This suggests a reasonable number of Internet-enabled women are travelling. The proportion of women travellers who do not access the Internet is not reflected in these numbers and is therefore unknown. Other groups, such as travelling families who home school, are also growing, but the characteristics and travel patterns of the Australian domestic travelling population is largely unknown.

The sole review of grey nomad literature undertaken to date found only a small number of predominantly qualitative studies (Raven 2016), which cannot represent the characteristics or needs of the Australian travelling population. Although a wider body of literature discusses the North American equivalent travelling population, often referred to as 'snowbirds' and 'sunseekers', a comparison of the characteristics and activities found this population was 'quite different…despite superficial similarities' (Onyx and Leonard 2005). Onyx and Leonard (2005) identified that the North Americans have distinctly different travel and lifestyle characteristics to Australian grey nomads, tending to travel to and stay at a single destination, contrasting with the 'nomadic' Australians.

Journal compilation © La Trobe University 2021

The relatively limited health infrastructure of regional, rural and remote Australia is well known. Increasing numbers of grey nomads, including women, may place a burden on already thinly spread healthcare services, but relatively little is known about travellers' health care needs and health care-seeking practices, or whether these may differ for women travellers. Given the size and growth of this whole itinerant population, it is clearly important to understand their characteristics, the reasons they travel and what it means to them, their activities, health status, health care needs and health service-seeking behaviours. Therefore, the aim of this review was to identify and appraise the available literature about this contemporary topic.

Methods

Literature review design

An integrative literature review was undertaken (Whittemore and Knapfl 2005). This form of review was chosen because it can accommodate different types of data derived from different research designs and methods.

Research aim

The aim of this review was to identify the characteristics reported of 'grey nomads' travelling across Australia and their experiences in relation to their health and social needs, as well as access to health care when travelling.

Research questions

Three questions guided the review:

(1) What are the characteristics of 'grey nomads', people who travel Australia for weeks, months or years, including their motivation for travel, distances travelled, the duration of their trips and the destinations chosen?
(2) Prior to travelling, what planning is conducted by travellers in relation to their social and health care needs, such as for medications and self-management of chronic disease?
(3) What are travellers' experiences in relation to their health and health care provision during their travels?

Literature search and review methods

In creating the search strategy, terms were organised in relation to 'Population' and 'Situation' (DiCenso *et al.* 2005).

Population

For the purpose of this review, 'grey nomads' were defined as older people who choose to travel across Australia with self-contained mobile accommodation for prolonged periods of time. Onyx and Leonard (2005) determined that the population of similar domestic travellers in North America referred to as 'snowbirds' and 'sunseekers' have distinctly different travel and lifestyle characteristics to Australian grey nomads. However, one earlier paper referred to Australians using these terms (Mings 1997), which were therefore included in the search strategy.

Situation

'Situation' refers to the descriptive characteristics of this population, and all aspects of their health, health care needs and services accessed.

Inclusion criteria

The inclusion criteria were that papers addressed grey nomads or travellers, adult populations, males and females, and health and wellbeing topics, and that data were collected in Australia. No age criteria were set, other than that the majority of participants or mean age should be >45 years or that individuals should be described as 'retired' (chosen to exclude the younger population of backpackers and holidaymakers). Papers were required to be English language publications, published during the previous 20 years (1999–January 2020).

Exclusion criteria

Literature related to religious pilgrims and short-term holidaymakers or vacationers was excluded. No travel duration criteria were set other than, where reported, the duration should, on average, be months. Publications other than primary research were excluded (e.g. conference abstracts, discussions, commentaries, editorials, literature reviews), but the reference lists in such publications were searched for any relevant articles.

The search strategy was set up as indicated in Table 1 and run, with some minor modifications to meet individual database requirements, on five databases (Ovid Emcare, Medline and PreMedline, Embase, PsychINFO and Academic Search Complete) and the search engine Google Scholar. Search output was filtered to include the years 1999–2020.

The final search output of each database was exported to Endnote X9 (Fig. 1) and duplicates were identified and deleted. Records were then screened for eligibility, checking the title, abstract and keywords. Records not meeting the inclusion criteria or meeting the exclusion criteria were removed. All remaining full-text publications were read and discussed by two researchers (MY, LP) to reach consensus and to assess an individual publication's relevance to the research questions. Reference lists of relevant publications were hand-searched for additional studies. Papers that referred to 'snowbirds' or 'sunseekers' in North America were excluded. Fourteen articles were retained for inclusion in this study.

Table 1. Search strategy example for Ovid PsychINFO

Search no.	Search terms
1	Grey nomad*.mp
2	(Motorhome* or camper*).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
3	(Snowbird* or Sunseeker*).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
4	((Health or ill) and health).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
5	Exp Chronic illness/ or chronic disease*.mp.
6	Long-term condition*.mp.
7	Drug therapy*.mp.
8	1 or 2 or 3
9	4 or 5 or 6 or 7
10	8 and 9

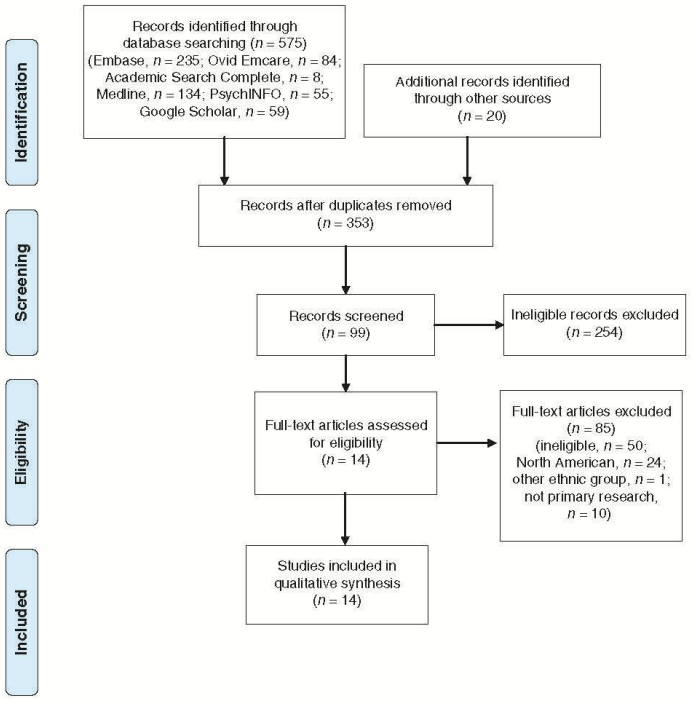


Fig. 1. Flow diagram of literature searching and screening. From Moher *et al.* (2009).

Data extraction and analysis

A data extraction table was created with headings identifying the main characteristics of each article (Table 2). Data were extracted in relation to the research questions (Table 3).

Conventional content analysis was used because this approach is suitable where there is little theory or prior literature (Hsieh and Shannon 2005). Included papers were repeatedly read and initial categories in relation to the research questions emerged from the data. Data were coded in relation to these categories. Coded data were then reviewed to identify patterns and any discrepant data, collated and summarised.

Rigor

Qualitative papers were critically appraised using the appropriate Critical Appraisal Skills Program (CASP) checklist (CASP 2020; Table 4) and for survey studies a modified version of this tool was used. Two authors (MY, LP) worked separately and compared findings in relation to screening and data extraction. A 20% sample of included publications was independently appraised by the second author (LP). Throughout the process of data extraction and content analysis, coding and analyses were discussed and consensus agreement reached among authors.

Results

Fourteen records based on 11 studies were included in the review. Two publications were doctoral theses, one using face-to-face interviews (Holloway 2009) and the other using a paper-based survey and face-to-face interviews (Cridland 2008). Five publications took an ethnographic approach (White and White 2004; Onyx and Leonard 2005, 2007; Holloway 2009; Patterson *et al.* 2011), one used grounded theory (Hillman 2013) and another two described a qualitative approach (Calma *et al.* 2018; Stephens *et al.* 2018). Six publications used surveys (Prideaux and McClymont 2006; Tate *et al.* 2006; Cridland 2008; Obst *et al.* 2008; Brayley and Obst 2010; Halcomb *et al.* 2017). Several studies combined approaches, such as participant observation, semistructured or ethnographic interviews and telephone surveys (Table 2).

Various sampling methods were used. One study used face-to-face interviews and relied on participants 'snowballing' from one couple to another (Hillman 2013). Two studies used paper-based surveys distributed by caravan park managers (Prideaux and McClymont 2006) or at a caravan show (Obst *et al.* 2008). An online survey (Halcomb *et al.* 2017) was also used to recruit participants to two further telephone interview studies (Calma *et al.* 2018; Stephens *et al.* 2018; Table 2). None of these papers

Table 2. Publications included in this study
HCP, healthcare professionals

Reference	Aim	Type of study	Setting and recruitment location	Sample and method	Data collection and analysis
White and White (2004)	Examine how mid-life and older long-term travellers describe their motivations for travelling and their experiences in outback Australia and whether their stories evidence long-term travel as a transition between endings and new beginnings	Ethnography	Observational sites included caravan parks, camping areas or campgrounds in national parks and roadside stops in the central, northern and western outback areas of Australia over a 3-month period	45 long-term travellers; participant observation, conversations and semi-structured interviews	Data were analysed thematically; the themes were guided by the conceptualisation of the study and issues emerging from the data. The transcripts and notes were read twice, recurring points of view noted and exemplars of repeating themes cited
Onyx and Leonard (2005)	Identify the motivational patterns of Australian grey nomads, and the similarities and differences with North American 'snowbirds'	Ethnographic account using in-depth taped semistructured interviews for respondents to tell their own story	One researcher travelled 16 000 km in a motorhome over 2.5 months, stopping at camping sites, free rest areas, commercial caravan parks, national parks, including some known and targeted sites, in Western Australia, the Northern Territory and Queensland	215 men, 203 women; convenience sampling using a brief survey to identify basic demographics, an ethnographic survey, with 1 questionnaire per travelling vehicle and tape-recorded in-depth interviews	The questionnaire was used to identify basic demographics, place of origin, number of weeks travelled and planned and the type of vehicle used. The narrative interview asked about what motivated people to become grey nomads
Prideaux and McClymont (2006)	Investigate the demographic characteristics of caravaners	Paper-based snapshot survey	Managers of two caravan parks in Goondiwindi distributed surveys over a 3-month period	1 person per travel party aged >16 years approached; 200 questionnaires distributed, 161 returned, 12 incomplete (74.5% response rate)	Survey instrument developed and pilot tested; no information provided
Tate *et al.* (2006)	Investigate the health burden of travellers on limited healthcare services in remote Australia	Survey (face-to-face interviews and telephone)	Survey conducted at Fitzroy Crossing River Lodge Caravan Park in the Kimberley District of Western Australia recruiting doctors and nurses in the Kimberley providing primary health care	Group 1, 260 travellers in the caravan park recruited face to face between 2.30 and 5.30pm over 5 days; Group 2, 40 doctors and 24 nurses (HCP) in the Kimberley recruited by telephone	Traveller survey items included current medical illnesses, frequency of use of medical services, written health information; HCP survey items included the importance of different components of written health information about the travellers
Onyx and Leonard (2007)	Explore the experience of grey nomads (minimum age 50 years) in relation to the literature on aging, in particular the dominant decline model of aging	Ethnographic account using in-depth taped semistructured interviews for respondents to tell their own story	One researcher travelled 16 000 km in a motorhome over 2.5 months, stopping at camping sites, free rest areas, commercial caravan parks, national parks, including some known and targeted sites, in Western Australia, the Northern Territory and Queensland	216 questionnaires; interviews of 23 couples, 2 single informants and 1 group, totalling 'some 400 travellers'	The questionnaire was used to identify basic demographics, place of origin, number of weeks travelled and planned and the type of vehicle use. The narrative interview about health status and episodes of health scares over the previous 2 years, difficulties encountered while travelling, travellers' networks, access to information and resources
Cridland (2008)	Examine the internal temporary mobility patterns of seasonal movers to northern Australia during the winter months	Surveys and face-to-face interviews	Participants recruited from caravan parks and camping sites at coastal and inland destinations in tropical Australia (above the Tropic of Capricorn)	964 grey nomads visiting or residing above the Tropic of Capricorn; questionnaire distributed, structured and semistructured audio recorded face-to-face in-depth interviews with individuals, convenience sample	Quantitative and supportive qualitative data regarding the socioeconomic/demographic status and movement patterns of grey nomads visiting different types of destinations across northern Australia
Obst *et al.* (2008)	Detail distances, trip duration and places visited by grey nomads, identify the health and road safety risks and current knowledge and management of these risks, and identification of and access to road safety information	Survey	Participants recruited at the Queensland Caravanning and Camping Show in Brisbane, June 2008	136 participants >50 years of age who had undertaken a long-term road trip in the past 2 years (93 males, 43 females); show visitors were randomly approached, invited to participate by filling out the survey and returning it to the boxes provided or by reply-paid envelope	The survey asked for demographic information, details of trips undertaken in the past 2 years, the occurrence of road or safety incidents and other issues related to road safety

Holloway (2009)	Develop insights into and arrive at provisional conclusions about how grey nomads gain meaning and pleasure from their travelling lifestyle choice	Ethnography using interviews	Participants recruited from caravan parks, camping areas in national parks, tourism sites, roadside rest areas in northern and mid-west Western Australia, Uluru and the Nullarbor	Convenience sample of 40 young (55–65 years), intermediate (65–70 years) and older (>70 years) self-drive retirees travelling with their own caravan, campervan, mobile home and/or tents	Reponses to ethnographic interviews
Brayley and Obst (2010)	Explore what travellers understood as their sense of social identity the level of community they experienced	Surveys (face to face and electronic)	Surveys distributed at recreational vehicle events and rallies and caravan parks in six states An electronic survey was distributed to membership of camping and caravan clubs	Convenience sample of 631 recreational road travellers, 50–80+ years, in six states who were also camping and caravan club members	Survey developed for the study including the Three Factor Model of Social Identity and Sense of Community Index
Patterson et al. (2011)	Investigate grey nomads' engagement with friends and family while 'on the road'	Ethnography and a narrative research technique	Data collected from four couples on an extended, multidestination holiday in the Northern Territory and Western Australia over a 7-week period	4 female and 4 male partners, all >50 years of age, retired or semi-retired	Narratives were used to illustrate themes about the everyday experiences of grey nomads on tour. Travel diaries, photographs and a questionnaire returned by email were all submitted at the end of the trip and thematic analysis was used
Hillman (2013)	Investigate how grey nomads in Australia perceive their health and social needs and activities when these were limited or maximised by their travel plans and aspirations	Qualitative interview study using grounded theory technique as an inductive interpretive approach	Participants recruited from a central Queensland coastal caravan park over a 2-month period	20 participants interviewed, comprising nine couples and two individuals, all >56 years of age; open-ended semi-structured in-depth face-to-face interviews accessed using 'snowballing'	18 questions included standard demographic questions, travelling times and duration, mode of transport, travelling companions and accommodation, health concerns, community engagement and social activities
Halcomb et al. (2017)	Explore the health needs and health planning of Australian long-term travellers and their current planning strategies for health and health care	Online survey	Participants recruited online using Facebook, Twitter, blogs, forums, web newsletters and social media, September 2015–February 2016	316 survey respondents who had been travelling continuously for ≥3 months or had done so in the past 12 months	Survey items included demographics, travel, health conditions, planning and needs; QOL-BREF (an internationally validated tool)
Calma et al. (2018)	Explore the experiences of grey nomads travelling with chronic conditions (i.e. older people with chronic diseases), travelling across Australia and the challenges in accessing healthcare services	Qualitative descriptive phase of a larger mixed-methods study that used telephone interviews of participants	Online survey through social media and caravanning forums, with subsequent telephone survey	33 people aged >60 years, living with at least one chronic condition and who had travelled around Australia for >3 months for the last year, recruited from social media sites and caravanning forums; potential participants were contacted randomly until data saturation was achieved (i.e. emergent themes recurred and no new patterns were evidenced)	Questions focused on health needs as they relate to chronic illness, health preparedness and well-being while travelling
Stephens et al. (2018)	Explore the experiences, health needs and strategies of grey nomads living with a diagnosis of cancer	Prospective qualitative phase of a larger sequential explanatory mixed-methods project using semi-structured telephone interviews	Respondents to an online survey recruited through social media and caravanning forums who agreed to a subsequent telephone survey; geographical location was not identified	14 people who self-identified with a diagnosis of cancer purposively sampled from survey respondents from social media sites and caravanning forums who had travelled around Australia for >3 months for the past year	Semistructured, in-depth interviews were conducted over 6 months in 2016 and analysed using thematic analysis

Table 3. Findings from the included publications

BMI, body mass index; BP, blood pressure; ED, emergency department; DVT, deep vein thrombosis; QoL, quality of life

Reference	Travellers' age data	Travellers' other demographic data	Travellers' duration of travel	Health planning for the trip	Health issues and concerns	Implications for healthcare services
White and White (2004)	45 interviewees in 3 major categories of mid-life and older people: parents with children; people approaching retirement; retirees; no data supplied	Not reported	Some 3 months into their journey, others 6 months, others had been travelling for ≥1 year	Not reported	Not reported	Not reported
Onyx and Leonard (2005)	Mean (±s.d.) 64.5 ± 6.3 years for males, 61.3 ± 6.1 years for females	215 men, 203 women; 93% travelled in couples, 7% (including 1 female) travelled alone; 34% from major urban centre, 33% from regional centre, 33% from rural centre; 74% travelled with caravans, 7% with motorhomes; other modes of transport: campervan, reconditioned bus, car with trailer; 66% had 4WD, 44% had vehicle <5 years old; 83% Anglo-Saxon, 12% UK born, 3% Northern European	All >3 months, 15% >1 year; the researchers themselves travelled for 2.5 months	Almost all respondents had a preprepared response for an emergency that included a communication device (e.g. CB or UHF radio) and could access the trucker's channel for help; some made special arrangements (e.g. informing local homesteads of their riskier adventures); most understood and accepted the risk associated with health and travel; all were aware of mutual support with other grey nomads by giving and receiving assistance with each other at some point	1.4% of males and 1.5% of females reported health poor; 14% of males and 9.4% of females reported health fair; 47.9% of males and 45.8% of females reported health good; 36.7% of males and 43.3% of females reported health excellent; 32% of males and 21% of females had experienced a health scare in the previous 2 years; 18 of 26 groups reported a major health issue (e.g. heart attacks, aneurism, angina, cancer, limb amputation, spinal injury, diabetes and arthritis); serious health issue often the trigger to travel	4 of 216 experienced a medical emergency (e.g. requiring helicopter evacuation, removal of gall bladder at a hospital in a town close by)
Prideaux and McClymont (2006)	89% aged 45–74 years, 4.8% younger (3.4% aged 35–44 years, 1.4% aged 18–24 years) and 6.1% older (≥75 years)	92 males, 56 females; 87.9% middle age to retirement age (45–74 years), 3.4% aged 35–44 years, 6.1% aged ≥75 years, 1.4% (2 respondents) aged 18–34 years; 72.3% retirees, 7.4% professionals, 15.6% various other occupations	Median trip length 54 days; mean length of stay exceeded 10 weeks (mean (±s.d.) 71.4 ± 80.4 days); 49% between 1 and 3 months, 19.3% between 2 and 4 weeks, 17.2% between 3 and 6 months	Not reported	Not reported	Not reported

Tate *et al.* (2006)	Median age 61.3 years	18.5% Western Australia usual place of residence; 76.9% from another state in Australia, 4.6% from outside Australia	Median length of planned trip 14 weeks	57% had sufficient medication for their entire trip; 19% had a list of medications; 9% of those with chronic illness had a health summary from their GP	55% reported chronic disease: heart disease (9.6%), diabetes (6.5%), hypertension (26.2%), lung disease (6.1%), dyslipidaemia (21.1%), mental illness (4.8%), other (16.7%)		Healthcare practitioners considered the following as important: healthcare summary (95%), pathology results (47%), active problem list (91%), allergies (92%), past medical history (87%), previous hospital admissions (31%), medication list (100%), usual GP (69%), radiology results (22%), usual specialists (30%)
Onyx and Leonard (2007)	As above (see Onyx and Leonard 2005)	As above (see Onyx and Leonard 2005)	As above (see Onyx and Leonard 2005)	As above (see Onyx and Leonard 2005)	As above (see Onyx and Leonard 2005)		As above (see Onyx and Leonard 2005)
Cridland (2008)	Mean age 65.4 years for males, 64.2 years for females; median age per vehicle 64 years	95% travelling as heterosexual couples, <2% same-sex couples, 3% singles	≤12 months	63 (18%) plan to be at specific destinations to access medical facilities, for prescriptions, GP or specialist blood tests	Grey nomad lifestyle improved their QoL and health; males more ailments than females; females higher incidence of osteoporosis and depression; 21 (5%) had no medical condition reported, 652 (75%) had ≥2 conditions, 136 (16%) had >3 conditions; 207 (25%) had 1 condition requiring ongoing medication and treatment		Not reported
Obst *et al.* (2008)	23% <55 years, 50% 56–65 years, 19% 66–70 years, 8% >70 years	93 males, 43 females aged >50 years; 80% were born in Australia, 7% were born in the UK, 5% were born in New Zealand and the remainder were from countries including Zimbabwe, Holland, Germany and the US; 38% held junior certificates, 20% held senior certificates, 15% held trade certificates, 27% had a tertiary degree	Trip duration range 1–104 weeks, median of 4 weeks; distance travelled range 600–40 000 km; 36% travelled in autumn, 28% in winter, 18% in spring and 18% in summer	Not reported	6% experienced a road crash with no injuries reported; 5% experienced a medical emergency, including minor falls (3 resulted in 2 broken bones, 1 injured knee); 1 participant had painful kidney stones; 14% experienced other health scares (e.g. chest pain, back injuries, DVT, severe arthritis, pneumonia, cervical cancer diagnosis and fainting fits)		Health issues were treated at local regional hospitals or by local GPs

(*continued next page*)

Table 3. (Continued)

Reference	Travellers' age data	Travellers' other demographic data	Travellers' duration of travel	Health planning for the trip	Health issues and concerns	Implications for healthcare services
Holloway (2009)	3 categories: young, 55–65 years; intermediate, 65–70 years; older, ≥70 years	18 heterosexual couples, 3 single males, 1 single female	Not reported	Health checks before travel, plan destinations in accordance with treatments and self-protective behaviours; accessibility of medications, including authority medications; the reluctance of some doctors to prescribe to a stranger, thus limiting ability to self-care and diminishing autonomy; travel fewer kilometres and fewer destinations as health and strength decline	General health and well-being improves; more meaningful lifestyle; stiff arthritic joints, cancer, major heart problems, physical losses associated with aging	Better policy resourcing and infrastructure to improve provision of healthcare services in rural and remote Australia is needed
Brayley and Obst (2010)	631 participants aged 50–80+ years	440 males, 139 females, 52 sex not reported; 73.4% from Queensland; most were couples	Not reported	Not reported	Not reported	Not reported
Patterson *et al.* (2011)	4 heterosexual couples aged >50 years	Couples A and B were retired from private business; Couple C was a retired foundry manager and laboratory technician; Couple D was a retired accountant and a homemaker	7 weeks	What medications to take for medical care and emergencies; access to medical care while on the road are outlined; before departure decisions, but no findings reported	Not reported	The study results suggest that important social connections with family and new-found friendships were strengthened; evening 'happy hours' were considered important for socialising and as a means of obtaining information about where to travel next, and what to see and do; participants remained reliant on family support to stay away for an extended period; family members looked after pets, home/garden and personal finances
Hillman (2013)	Nine couples and 2 individuals aged >56 years	All retired, identified as 'grey nomads' and came from somewhere other than Queensland	All respondents >3 months, 15% >1 year, 20% 2 years or indefinitely; for most respondents it was the second or third trip of that kind	Most had contingency plans for unforeseen medical emergencies; biannual check-ups and the agreement of GPs before travelling in-between check-ups; carrying a list of medications, letters from GPs outlining medical history and other relevant information; some travelled with enough prescription medication for the trip duration; staying at destinations close to a hospital	Many responded that their health was a concern; travel regardless of deteriorating health; travel as a potential last life experience; less-stressful lifestyle led to health improvement, with 1 respondent remarking 'that stress is 90% of the illness'	One couple visited a GP close to their travel destination and were on file at the practice; nothing else reported

Exploring the Australian grey nomad population
Australian Journal of Primary Health I

Halcomb *et al.* (2017)	Mean (±s.d.) age 60.2 ± 10.9 years, 62.3% retired, 52.8% female, 76% reported a travelling companion	149 males, 167 females; 62.3% retired; 28.2% received aged pension, 11.4% received a disability pension; 7.3% were on paid leave from their employment; main accommodation was caravan (67.1%) or motorhome (15.5%)	19.9% travelled >46 weeks in the preceding year	206 (65.2%) of respondents and 179 (74%) travel companions health check with GP before travel; 102 (32.3%) travelled with information prepared by GP; 72 (22.8%) visited an ED, 63 (19.9%) visited another health provider	37.3% of respondents had a BMI >30 kg/m^2; 5.7% and 3.7% of companions smokers; 49.7% and 50.2% of companions consumed 1–3 standard drinks per day; 27.2% and 34.8% consumed alcohol 6–7 days per week; 40.2% had hypertension, 22.8% had arthritis, 17.1% had other health conditions, 13.0% had diabetes; 11.1% ceased work because of illness or disability; 42.7% reported long-term illness affecting their everyday life; 8.9% returned from travels because of poor health	Not reported
Calma *et al.* (2018)	Selection criteria >60 years; $n = 8$ aged 62–69 years	Selection criteria ≥1 chronic illness; all had 2–5 diagnoses; 4 females, 4 males	All >3 months in past year	Travel experience improved self-awareness about limitations and boundaries; several travelling with information from GP about their condition	Challenges of, for example, insulin storage when travelling; developed self-management skills in recognition of exacerbations and deterioration and acting accordingly; use of health app to measure BP and heart rate; positive impact travel has on health	Some participants had difficulty accessing health services in rural and remote areas; inability to see a GP meant attendance at ED; lack of shared medical information; limited pharmaceutical stock in some pharmacies
Stephens *et al.* (2018)	Not reported	14 self-identified grey nomads with diagnosis of cancer	4 months–15 years	Integration into travel of organisation and management of cancer treatment and follow-up; travel routes taken in accordance with health needs, supplies and services; took medication and cancer treatment histories	Ongoing oral chemotherapy, acquisition and storage	Not reported

Table 4. Critical appraisal of included publications using the CASP tool
N/A, not applicable

Reference	Aims	Appropriate methodology	Design appropriate to aims	Appropriate recruitment strategy	Data collection	Researcher–participant relationship	Ethical issues	Data analysis	Findings	Research value	Survey tool validity and reliability
White and White (2004)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Yes	Yes	Adequate	N/A
Onyx and Leonard (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Adequate	N/A
Prideaux and McClymont (2006)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Yes	Yes	Adequate	N/A
Tate *et al.* (2006)	No	Yes	Cannot tell	Yes	Yes	Cannot tell	Cannot tell	Yes	Cannot tell	Adequate	N/A
Onyx and Leonard (2007)	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Adequate	N/A
Cridland (2008)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Adequate	N/A
Obst *et al.* (2008)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Cannot tell	Yes	Adequate	Cannot tell
Holloway (2009)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Adequate	N/A
Brayley and Obst (2010)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Adequate	N/A
Patterson *et al.* (2011)	Yes	Yes	Yes	Cannot tell	Yes	Cannot tell	Cannot tell	Yes	Yes	Adequate	N/A
Hillman (2013)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Adequate	N/A
Halcomb *et al.* (2017)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Adequate	Cannot tell
Calma *et al.* (2018)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Adequate	N/A
Stephens *et al.* (2018)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Cannot tell	Yes	Adequate	N/A

made any claim to be representative of this population; sampling strategies achieved, at best, a snapshot from one or more locations and time. Overall, study quality was mixed (Table 4).

Seven research teams travelled themselves: five were peripatetic (White and White 2004; Onyx and Leonard 2005; Cridland 2008; Holloway 2009; Patterson *et al.* 2011) and two stayed at single locations (Tate *et al.* 2006; Hillman 2013). The geographic settings of these studies ranged across much of Australia. Four ethnographic studies were conducted in camping sites, caravan parks, free rest areas and national parks in Western Australia, the Northern Territory and Queensland (Onyx and Leonard 2005; Cridland 2008; Holloway 2009; Patterson *et al.* 2011). One paper-based survey was distributed at recreational vehicle events and rallies, as well as at caravan parks, in six states in addition to being delivered as an electronic survey of the membership of camping and caravan clubs (Brayley and Obst 2010). Other paper-based surveys were distributed at a caravan show in Brisbane (Obst *et al.* 2008) and at caravan parks in Goondiwindi, on the New South Wales–Queensland border (Prideaux and McClymont 2006). Interviews were performed in the Kimberley District of Western Australia (Tate *et al.* 2006) and in multiple caravan parks and camping sites above the Tropic of Capricorn (Cridland 2008). For the online survey and subsequent telephone interviews, participants' locations were unknown (Halcomb *et al.* 2017; Calma *et al.* 2018; Stephens *et al.* 2018).

Ten of the 14 publications were published between 2004 and 2011, and focused primarily on defining and describing grey nomads, their motivations, the logistics of a travelling lifestyle, the meanings derived from their experiences, their sense of social identity and community and their experience of road safety (Onyx and Leonard 2005, 2007; Prideaux and McClymont 2006; Tate *et al.* 2006; Cridland 2008; Holloway 2009; Brayley and Obst 2010). Health status was part of the description of the participants. The more recent cluster of papers (Hillman 2013; Halcomb *et al.* 2017; Calma *et al.* 2018; Stephens *et al.* 2018) shifted the focus to people who travel with chronic illness and how they manage their health on the road.

Question 1: characteristics of grey nomads

The first question this study addressed was about the characteristics of older people who travel Australia for extended

periods. Responses in the 14 papers came from a total of 3273 participants.

Age and gender

Eight studies set participant age as a recruitment criterion (Onyx and Leonard 2005, 2007; Tate *et al.* 2006; Cridland 2008; Obst *et al.* 2008; Holloway 2009; Brayley and Obst 2010; Calma *et al.* 2018) and subsequently identified grey nomads as people >50 years of age. In one thesis, the target population was aged ≥55 years, collated in three categories: 'young' (55–65 years), 'intermediate' (65–70 years) and 'older' (≥70 years; Holloway 2009). In the other thesis, a minimum age of 50 years was set; however, 15 females and two males were younger (Cridland 2008).

Other studies simply reported the ages of their participants. One study reported all participants as being ≥56 years of age (Hillman 2013). Prideaux and McClymont (2006) found that most participants (89%) were in the 45- to 74-year age group. A more recent study included travellers who were younger or travelling with a family in addition to grey nomads and referred to the whole group as 'domestic self-drive travellers'. These participants ranged in age from 26 to 89 years, with a mean age of 60.2 years for travellers and 59.8 years for their travel companions (Halcomb *et al.* 2017).

Onyx and Leonard (2005) recruited 215 male and 203 female participants, Prideaux and McClymont (2006) identified 92 male (62.2%) and 56 female (37.8%) participants and Halcomb *et al.* (2017) reported that 52.8% of their participants were women. Brayley and Obst (2010) found that of their 631 participants, 440 were male and 139 were female, with 52 not reporting their gender. No other study identified participants by gender.

Of the 3273 participants in these 14 papers and 11 studies over 14 years, only two solo women were identified (Onyx and Leonard 2005; Holloway 2009). None of the 14 publications identified or outlined any specific information or findings on women, whether travelling alone, with other women or without men.

Relationship profile and social identity

Darley *et al.* (2017) found that although most travellers aged ≥55 years travelled as couples, whether any were same-sex relationships was not stated. Cridland (2008) found most grey nomads were heterosexual couples (95%), with 5% de facto couples, 3% singles and <2% same-sex couples. Most single men travelled independently, whereas single women travelled in small parties of two or more vehicles with other singles or couples. Onyx and Leonard (2007) found that most participants travelled as couples. According to Brayley and Obst (2010), older recreational road travellers considered 'couple' as their primary social identifier, with other social group identity, such as grey nomads, as secondary.

Not all studies sought or reported details of the participants' relationships, and referred only to 'participants' and 'travel companions' (Tate *et al.* 2006; Hillman 2013; Stephens *et al.* 2018). Several papers reported participants as 'couples' (Onyx and Leonard 2005; Prideaux and McClymont 2006; Cridland 2008; Holloway 2009; Brayley and Obst 2010; Patterson *et al.* 2011). In other studies where participants also primarily travelled in couples, almost all were heterosexual couples (Onyx and Leonard 2005; Prideaux and McClymont 2006; Cridland 2008), where the males were employed in trade or management positions and the females were housewives or employed in clerical duties (Cridland 2008).

Socioeconomic considerations and ethnicity

Halcomb *et al.* (2017) reported travellers with widely ranging ages (26–89 years), but most (62.3%) were retired; 28% received the aged pension, 11.4% received the disability pension and 7.3% were employed but on paid leave. Distinctions were noted by Cridland (2008), with marked differences between camping grey nomads and those staying in caravan parks. These reflected differences in trip expenditure, retirement income, health and length of retirement. Preferences were also expressed for camping grounds or caravan parks based on the type of vehicle driven, whether pet-friendly caravan parks were needed or available and the types of activities at the destinations.

Onyx and Leonard (2005) found that 83% of participants were Anglo-Australian, 12% were Australians born in the UK and 3% were from Northern Europe, with all having lived most of their working lives in Australia. Few were of another ethnicity, although Cridland (2008) identified a small number of participants from New Zealand. Obst *et al.* (2008) reported that 80% of participants were born in Australia, with 7% born in the UK, 5% born in New Zealand and the remainder being from Africa, Europe and the US. The remaining papers did not mention ethnic origin; neither Aboriginal status nor country of birth was recorded in any paper.

Mode and motivation to travel

The definition of 'grey nomad' included travel for prolonged periods of time, ranging from at least months to longer. In the papers included in this study, participants were described as travelling with self-sufficient accommodation, including caravans (74%), motorhomes (7%), camper trailers, campervans and other arrangements (19%); 66% had four-wheel drive vehicles (Onyx and Leonard 2005). Holloway (2009) described the caravan or motorhome as an extension of the family home, where grey nomads continued their everyday home activities on a smaller scale. Cridland (2008) reported grey nomads travelling on average 126 days (median 115 days); 14.8% travelled <60 days, 19% travelled for 61–89 days, <16% travelled for 131–179 days and 14.3% travelled for >180 days. More than one-third (36%) were away from their usual place of residence for 90–130 days per trip. For participants of an online survey (Halcomb *et al.* 2017), the average trip duration was 24.6 weeks; 19.9% had travelled for more than 46 weeks in the preceding year and 53.3% planned to travel 10 months or more, including indefinitely.

According to Cridland (2008), over 42% of participants travelled to northern Australia during winter to escape the cold; for many grey nomads this was described as a 'must do' (Hillman 2013). Cridland (2008) also said that 22% wanted to see Australia, its historical sites and landscapes, 10% wanted adventure and to get away and others desired a sense of freedom. Patterson *et al.* (2011) found that many wanted to see more of Australia while young and healthy enough to enjoy travelling with friends, exploring new places and meeting new people. Onyx and Leonard (2005) found a consistent pattern of motivation to travel for adventure: to discover places never seen before, to enjoy the

beauty and wonder of the scenery, to be independent, to have the freedom of time that is not duty-bound, to have a less-organised, more-relaxed life, moving slowly, noticing, appreciating and learning, heightening their senses and expanding their understanding and appreciation of the country as a whole.

Taking a different approach, White and White (2004) discussed 'endings' as a motivation to travel: changed family circumstances, such as children leaving home, the death of a partner, anticipation of the end of good health and work changes. They focused on travel as a transitional experience between one thing and another, and its effect on personal identity. Regardless of their motivation and age, participants considered travel a rite of passage.

Social networks, connection and sense of community

One of the most positive aspects of travelling was the experience of meeting other people on the road, some of whom remained lifelong friends (Onyx and Leonard 2005). Grey nomads are part of a larger age-related cohort of people who have retired from the workforce; social interaction among them is pronounced because retirement has separated them from work-related interactions and social connections (Holloway 2009). New social networks developed with new-found friends who were fellow travellers (Patterson *et al.* 2011). Alongside this, travel was also seen in terms of extension of domesticity, with everyday home activities conducted on a smaller scale (Holloway 2009). In addition, Halcomb *et al.* (2017) reported that most travellers used a mobile telephone, email or social media to maintain contact with family and friends at home.

Question 2: pretravel health-related planning and preparation

Travellers recounted a range of planning before departure in relation to their social and health care needs. Tate *et al.* (2006) found that 9% carried health summaries from their GPs. Eleven years later, 23.7% carried a list of medications, which was either self-prepared (44%) or came from a doctor (42.7%; Halcomb *et al.* 2017). This latter study focused on the health needs of those with chronic illness, their health preparedness and well-being while travelling, whereas an offshoot study focused on people with a diagnosis of cancer, reporting that they travelled regardless and because of their diagnosis (Stephens *et al.* 2018). The participants in the study of Calma *et al.* (2018), all aged >60 years and with at least one chronic disease, described a high level of awareness of their health needs, limitations and health management strategies, with expertise developing through their travel experience.

Brayley and Obst (2010) explored how health status may impact road safety, such as a deterioration in visual acuity and a slowing of cognitive processing as part of the aging process. They made the point that grey nomads' experience of road travel can be considerably different to that generally experienced by older drivers. Many grey nomads embark on extended road trips, driving and towing heavy vehicles in rural and remote areas. They may have limited experience or training relevant to the conditions in those areas, such as driving on dirt or narrow bitumen roads, safely negotiating road trains, dealing with wildlife on the road and strong cross-winds while towing. There is also the potential impact of fatigue due to driving long distances. The combination of unfamiliar environmental hazards and stressors alongside health-related aging effects may result in additional health and road safety risks and incidents with undesirable outcomes.

Question 3: grey nomads' experiences in relation to their health and health care provision

Many of the participants had one or more age-related or chronic illnesses. Tate *et al.* (2006) found that 55% of travellers had chronic disease and 61.9% took regular medication. Halcomb *et al.* (2017) reported 40.2% of long-term travellers had hypertension, 22.8% had arthritis, 13% had diabetes and 17.1% had other health conditions. Of these, 11.1% had ceased work due to illness or disability, and 42.7% reported that their illness affected their daily life. Almost one-quarter (23.7%) required ongoing prescription medication. However, the health of these grey nomads was not dissimilar to that reported by this age group in the Australian community generally (Australian Bureau of Statistics (ABS) 2013).

Onyx and Leonard (2007) considered the health of grey nomads in relation to the dominant decline model of aging as opposed to what many participants wanted: adventure, freedom, learning and positive aging. These authors proposed that grey nomads were illustrating a 'Ulyssean' model of aging that entails the exploration of new ideas, activities and learning, as well as intellectual, psychological and emotional growth. This theme was picked up by others (Cridland 2008; Holloway 2009; Hillman 2013), who reported grey nomads with similar expressions of improving health and greater well-being when travelling. Participants reported their health improved as a consequence of living the grey nomad lifestyle, which they explained as resulting from no responsibility, therefore no stress and better health. Over 80% of grey nomads reported good to excellent health (Onyx and Leonard 2007).

A minority of participants experienced acute events. Obst *et al.* (2008) found that 5% had a medical emergency while travelling, such as falls (three had resulted in broken arms and one in a damaged knee). Another medical emergency in a remote area related to painful kidney stones, requiring a 1-h trip to reach help. A further 14% had experienced a health scare including severe chest pains, back injuries, deep vein thrombosis, severe arthritis, cervical cancer diagnosis, pneumonia and fainting. Onyx and Leonard (2007) reported that 32% of men and 21% of women had experienced a major health scare in the previous 2 years and had been treated locally at regional hospitals or by GPs.

One study set in a very remote area of the Kimberley Ranges proposed that grey nomads could be an impost on local healthcare services (Tate *et al.* 2006); this was the only study to recruit healthcare professionals. Another study flagged this same point as an implication of the study findings (Calma *et al.* 2018). Despite studies reporting improvements in participants' health as they lived a nomadic lifestyle (Cridland 2008; Holloway 2009; Hillman 2013), there were reports of health service need and usage. Of online survey participants, 24% had sought medical attention to obtain a prescription, 57% reported having prescriptions filled during their travel and 8.9% had returned home from their travels due to poor health (Halcomb *et al.* 2017).

Exploring the Australian grey nomad population *Australian Journal of Primary Health* M

Calma *et al.* (2018) reported the difficulties experienced by grey nomads in relation to accessing health services and medication and achieving continuity of care while travelling. Calma *et al.* (2018) and Stephens *et al.* (2018) conducted telephone interviews with eight and 14 participants with chronic disease and cancer respectively, and reported how these participants became experts in managing their health while travelling.

Discussion

Onyx and Leonard (2005) referred to the emergence of grey nomads in Australia as a phenomenon: a remarkable occurrence. Grey nomads became a topic of interest because of the aging population (ABS 2019) and the increasing number of retired people with the time and resources to travel the country (Holloway 2009). Australian grey nomads are a unique peripatetic group, many motivated by the desire for travel, adventure and freedom and actively avoiding structured activity. This contrasts North American 'snowbirds' and 'sunseekers', who travel to one destination where there are in-park recreational facilities and where they stay for prolonged periods (Onyx and Leonard 2005; Prideaux and McClymont 2006; Halcomb *et al.* 2017).

The grey nomad literature originates from a diverse range of academic fields: social sciences, media studies, psychology, marketing tourism and business, environmental science and health. Consequently, the reported perspectives on the grey nomad experience are broad, including identity, purpose, social capital, well-being and healthy aging, as well as health and illness management, translating and transcending daily living into a peripatetic lifestyle.

The studies included in this review fell primarily into two groups. Publications before 2011 were mainly concerned with a broad description of travelling people. While predominantly recruiting relatively smaller samples, these early studies focused on identifying the travelling population (White and White 2004; Onyx and Leonard 2005, 2007; Prideaux and McClymont 2006; Tate *et al.* 2006; Cridland 2008; Obst *et al.* 2008; Holloway 2009). Although small scale, these were the first studies from this population and they examined why grey nomads travelled. After 2011, health emerged as a specific consideration, from health and illness as social characteristics as part of healthy aging to a more medical view of people living with chronic disease and how they manage this while travelling (Halcomb *et al.* 2017; Calma *et al.* 2018; Stephens *et al.* 2018). Included studies were published in health or aging-related journals and were anticipated to inform the social trends of an aging population and early retirement (Onyx and Leonard 2007).

A defining characteristic of these participant groups was that they were predominantly older (i.e. >50 years). Other age groups were little described, and often excluded. Even in the most recent large survey, which focused on health (Halcomb *et al.* 2017) and did not apply age criteria, only 15.1% of recruited participants were aged <50 years. Although papers did not consistently report participants' demographic characteristics and recruitment criteria were not always clearly articulated, this population is clearly predominantly older in age. An important theme emerging from this literature is that of aging as a continuance of choice, activity and pursuit of interests. This contributes to the growing literature that challenges the stereotype of older people as increasingly inactive and passive with necessarily deteriorating health (Aronson 2020). Participants also talked of making new and often enduring friendships on the road. The social networks they established contrast with the picture of loneliness and isolation conventionally expected for this age group (von Soest *et al.* 2020). The travelling population clearly described their lives as active and engaged, further supporting the claim made by Onyx and Leonard (2007) that they are 'rewriting the script of aging', to continuing personal growth and social engagement rather than retreat and decline.

Despite the increasing proportion of women in the older population (ABS 2019), relatively few women are evident in this literature. Of the 3273 participants in the included studies, only 644 were identified as female (not all studies reported gender). Almost all women were travelling in heterosexual relationships (Onyx and Leonard 2005; Prideaux and McClymont 2006; Halcomb *et al.* 2017). Across all 14 publications, only two solo women were identified (Onyx and Leonard 2005; Holloway 2009). However, social media platforms, including Facebook, indicate many women are currently travelling Australia. At least eight Facebook closed groups are exclusively for women travelling domestically in self-contained vehicles, sharing their experiences and destinations with photographs and discussions.

Health and health planning

Ten of the 14 included publications reported on the travellers' health and their health planning. Most studies identified the elements of planning as having health checks before trips, carrying letters from their GP regarding their health status and needs, lists of current medications and a sufficient supply of prescriptions, medication and the necessary storage requirements (Tate *et al.* 2006; Cridland 2008; Holloway 2009; Hillman 2013; Calma *et al.* 2018). Some travellers planned their travel route to be at specific destinations to access relevant health care or stayed at destinations close to healthcare services (Cridland 2008; Hillman 2013; Stephens *et al.* 2018). Two studies whose participants were chosen because they were either living with chronic conditions (Calma *et al.* 2018) or were cancer survivors (Stephens *et al.* 2018) discussed, in detail, their planning and organisation for self-management of their condition while travelling. This contrasts the relatively less-prepared picture of the broader population sample from Fitzroy Crossing some 12 years earlier (Tate *et al.* 2006). Some had a plan for potential medical emergencies including communication devices such as UHF or CB radios, and notifying local homesteads on the route of more risky adventures (Onyx and Leonard 2005; Hillman 2013; Halcomb *et al.* 2017).

Most grey nomads have their care planned by healthcare professionals in metropolitan Australia, raising implications for both the education of urban healthcare providers on rural service availability and the integration of care delivery between metropolitan, regional, rural and remote areas. Health care that is planned in metropolitan areas may not be available in non-metropolitan locations. The care planned for travellers must be suitable for delivery at their various destinations (e.g. the availability of medications). The educational needs of both travellers and their healthcare providers as they relate to care planning for prolonged domestic travel should be clarified.

Only one study included health practitioners' views, reporting that travellers should carry and make available to clinicians information such as healthcare summaries, allergies, previous medical history and lists of active problems and medications, radiology and pathology results and hospital admissions (Tate *et al.* 2006). Tate *et al.* (2006) discuss grey nomads in terms of the burden they place on remote health infrastructure but without quantifying what this may entail. Clearly, the capacity of regional, rural and remote services to meet travellers' needs warrants review. Many but not all participants prepared for their trips in relation to their health by addressing items of the healthcare practitioners' wish list. A universal electronic medical record was suggested to address the availability of health information; this has yet to be fully achieved in Australia. Halcomb *et al.* (2017) and Calma *et al.* (2018) refer to the introduction of the voluntary national electronic health record system My Heath Record, but also acknowledge its limitations in terms of uptake, incomplete and potentially out-of-date data. These authors also suggest telehealth and telephone help lines as ways to enhance healthcare access for travellers. As long ago as 2009, Holloway (2009) recommended better policy resourcing and infrastructure to improve healthcare services in rural and remote Australia. It is not clear from this literature what improvements have occurred beyond the introduction of My Health Record as the limited health infrastructure in regional rural and remote Australia remains an issue (Australian Institute of Health and Welfare (AIHW) 2019). Tate *et al.* (2006), Holloway (2009) and, more recently, Raven (2016), Halcomb *et al.* (2017), Calma *et al.* (2018) and Stephens *et al.* (2018) all recognise and flag the topic as a priority for policy review and further research.

Health and healthcare experiences

Some participants accessed healthcare services without difficulty (Onyx and Leonard 2005; Obst *et al.* 2008; Hillman 2013; Calma *et al.* 2018). A few reported a lack of shared medical information and limited access to prescription medications at some pharmacies (Calma *et al.* 2018). Although most reported improved health, a small number terminated their trip because of health problems (Halcomb *et al.* 2017). The number of people visiting regional, rural and remote areas makes it imperative to better understand these travellers, particularly those on the road for longer periods and further from their home services. The implications of this travelling population for the provision of health services, policy, health infrastructure, education and workforce planning in rural and remote communities can only be surmised and research is urgently needed.

Limitations

The search strategy used 'grey nomad', 'traveller' and related terms, including their mode of travel, but may have missed literature if none of these specific words was used. The search was run on five health-related databases and Google Scholar, but searching reference lists identified some further studies, including some published in travel and tourism journals not indexed in health databases. These papers solely reported demographic characteristics of travellers but were excluded because it was not possible to differentiate holidaymakers from longer-term travellers. Nonetheless, it is possible that material may have been missed from tourism-related databases.

Conclusion

This review found only a small body of relevant literature, predominantly qualitative studies. Table 4 demonstrates the mixed quality of reporting in which the trustworthiness of the work was seldom addressed. It demonstrates how little is known about grey nomads, especially women travellers, and the health and other needs of this population.

In summary, research about grey nomads in the early 2000s explored their characteristics and experiences, including their health status and motivations to travel. Identified as primarily older and almost exclusively heterosexual couples, their patterns of chronic illnesses were similar to the age-matched general population, but their health was reported as improved by the less-stressful lifestyle. After 2011, fewer studies were published and the emphasis changed from the broader experience of grey nomads' lifestyle to travellers managing chronic illness. The older person demographic (i.e. those >50 years) remained predominant. No state or national statistics are available for grey nomad populations.

Where this was raised, a few studies reported participants' minimal use of healthcare services while travelling. Although the sole study to recruit healthcare practitioners, at a single remote site, argued that grey nomads adversely impacted local healthcare services, no detail was provided. This gap poses a substantial challenge for health policy and service development, as well as health resource allocation to non-metropolitan Australia. The significant number of people visiting regional, rural and remote areas makes it imperative to better understand these travellers, particularly those on the road for longer periods and further from their home services. The implications for policy and strategy, infrastructure and workforce planning and education and training for healthcare services in rural and remote communities can only be surmised, although the need for better policy and infrastructure to improve the provision of healthcare services has been argued. Discussion has been ongoing for many years, particularly in the community, about the limited health infrastructure in regional, rural and remote Australia (AIHW 2019). The information deficits revealed by the paucity of material available for inclusion in this review only serve to highlight this issue further, and research is desperately needed.

Conflicts of interest

The authors declare no conflicts of interest.

Acknowledgements

The authors thank Debra Jackson for early input into the review proposal. This research was supported by an Australian Government Research Training Program Scholarship.

References

Aronson L (2020) Health aging across the stages of old age. *Clinics in Geriatric Medicine*. doi:10.1016/j.cger.2020.06.001

Australian Bureau of Statistics (2013) Australian Health Survey: Updated Results, 2011–2012. Long-Term Health Conditions. Available at https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.003Chapter3002011-2012 [Verified 6 February 2021]

Australian Bureau of Statistics (2019) Twenty years of population change. Available at https://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument#:~:text=Over%20the%2020%20years%20between,1946%20and%201964)%20turn%2065 [Verified 6 February 2021]

Australian Institute of Health and Welfare (2019) Rural and remote health. Available at https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health [Verified 6 February 2021]

Brayley N, Obst PL (2010) The Australian Grey Nomads–are they who we think they are? Enhancing formative research through the quantitative assessment of psychological constructs. *Health promotion journal of Australia: official journal of Australian Association of Health Promotion Professionals* **21**, 138–142. doi:10.1071/HE10138

Calma KRB, Halcomb E, Stephens M (2018) An exploration of the experiences of Australian Grey Nomads travelling with chronic conditions. *Australian Journal of Primary Health* **24**, 183–188. doi:10.1071/PY17043

Cridland S (2008) An analysis of the winter movement of grey nomads to northern Australia: planning for increase senior visitation. PhD Thesis, James Cook University.

Critical Appraisal Skills Programme (CASP) (2020) CASP Checklists. Available at http://casp-uk.net/casp-tools-checklists/ [Verified 6 February 2021]

Darley T, Lambert C, Ryan M (2017) Grey Nomads' caravanning use of social networking sites. *Information Technology & Tourism* **17**, 379–398. doi:10.1007/s40558-017-0091-6

DiCenso A, Guyatt G, Chiliska D (2005) 'Evidence-based nursing: a guide to clinical practice.' (Elsevier Mosby: St Louis, MO, USA)

Halcomb E, Stephens M, Smyth E, Meedya S, Tillott S (2017) The health and health preparation of long-term Australian travellers. *Australian Journal of Primary Health* **23**, 386–390. doi:10.1071/PY16138

Hillman W (2013) Grey Nomads travelling in Queensland, Australia: social and health needs. *Ageing and Society* **33**, 579–597. doi:10.1017/S0144686X12000116

Holloway DJ (2009) Grey nomads: retirement, leisure and travel in the Australian context. Edith Cowan University, Perth, WA, Australia.

Hsieh H-F, Shannon SE (2005) Three approaches to qualitative content analysis. *Qualitative Health Research* **15**, 1277–1288. doi:10.1177/1049732305276687

Mings RC (1997) Tracking Snowbirds in Australia: winter sun seekers in Far North Queensland. *Australian Geographical Studies* **35**, 168–182. doi:10.1111/1467-8470.00017

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009) Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Medicine* **6**, e1000097. doi:10.1371/journal.pmed.1000097

Obst PL, Brayley N, King MJ (2008) Grey Nomads: Road Safety Impacts and Risk Management Paper presented at the 2008 Australasian Road Safety Research, Policing and Education Conference, Adelaide South Australia, Australia.

Onyx J, Leonard R (2005) Australian grey nomads and American snowbirds: similarities and differences. *Journal of Tourism Studies* **16**, 61–68.

Onyx J, Leonard R (2007) The Grey Nomad phenomenon: changing the script of aging. *International Journal of Aging & Human Development* **64**, 381–398. doi:10.2190/G4N9-3627-3G7J-W454

Patterson I, Pegg S, Litster J (2011) Grey nomads on tour: a revolution in travel and tourism for older adults. *Tourism Analysis* **16**, 283–294. doi:10.3727/108354211X13110944387086

Prideaux B, McClymont H (2006) The Changing Profile of Caravanners in Australia. *International Journal of Tourism Research* **8**, 45–58. doi:10.1002/jtr.546

Raven M (2016) Health of grey nomads: on the move and under the health sector radar. *The Australian Journal of Rural Health* **24**, 182–187. doi:10.1111/ajr.12236

Stephens M, Halcomb E, Dewing J (2018) Living on: an exploration of healthful cancer survivorship among grey nomads. *Australian Journal of Cancer Nursing* **9**, 19–24.

Tate J, Mein J, Freeman H, Maguire G (2006) Grey nomads–health and health preparation of older travellers in remote Australia. *Australian Family Physician* **35**, 70–72.

von Soest T, Luhmann M, Hansen T, Gerstorf D (2020) Development of loneliness in midlife and old age: Its nature and correlates. *Journal of Personality and Social Psychology* **118**, 388–406. doi:10.1037/pspp0000219

White NR, White PB (2004) Travel as transition: identity and place. *Annals of Tourism Research* **31**, 200–218. doi:10.1016/j.annals.2003.10.005

Whittemore R, Knapfl K (2005) The integrative review: updated methodology. *Journal of Advanced Nursing* **52**, 546–553. doi:10.1111/j.1365-2648.2005.03621.x

Williams S (2017) Grey nomad numbers up. *The Sydney Morning Herald*. 24 February. Available at https://www.smh.com.au/national/nsw/grey-nomad-numbers-up-20170223-gujkdx.html [Verified 6 February 2021]

APPENDIX 4: WOMEN TRAVELLERS' INTRODUCTORY SCRIPT AND INTERVIEW QUESTIONS

Adapted from Holloway (2009) and Onyx and Leonard (2007)

Statement of Participant Information – Women travellers Group. Hi there, my name is Margaret Yates, I am a nurse and I work in a regional hospital in NSW. I am also a research student at University of Technology Sydney and a woman traveller. I am doing some research about women travellers. I have a special interest in women who travel by themselves or with other women. I would be delighted if you would participate in this study by being interviewed.

The information you provide will be treated with the greatest respect, confidence and security and your identity will remain confidential –my supervisors and I are the only people who will know you were interviewed.

I prefer to audio record our discussions because it's the best way to get an accurate picture of our conversation. The recording will be transcribed and then the audio will be destroyed. I can provide you with a copy of the transcription of your interview if you give me an email or postal address.

This study has been approved by the university's ethics committee. Part of that approval requires that you provide your consent to be interviewed. If you would like to join in can we decide on a time at your convenience and where you'd like to sit, and feel most comfortable? I will be providing something to drink and some cheese and crackers while we talk. The questions will include asking about you, why you are a woman traveller, and your experiences travelling, including health-related experiences.

Whether or not you take part is entirely up to you. If you decide to take part you can change your mind at any time, or opt not to answer any questions, and that will be OK.

(Questions asked:)

Demographic Details:

- Age
- Marital status
- Employment/Retired
- Ethnicity – where were you born? where were your parents born?
- Is English your first language
- Where is home?
- Are you travelling alone, with a friend, family or a partner?
- Do you have any children? If yes, any grandchildren?

On the Road

- What made you decide to be a woman traveller?
- How long have you been travelling on this trip and any previous trips?
- What do you enjoy the most about being a woman traveller?
- What have been some highlights of this trip or previous trips/ memorable places you've visited?
- Have you made any new friends?
- Have you had any difficult episodes? If so, can you tell me about them and what you did?

- Do you have any safety concerns?
- What is your main means of communication?
- What have you gained or what have learned from the experience of being a woman traveller?
- Is there anything else about being a woman traveller you would like to add?

Health Questions

- Did you have any health concerns before you started this trip? If yes can you tell me about them? How do you normally manage them?
- How do you manage them on the road; is it any different?
- How's your health now?
- What would you do if you had a health emergency, for example a heart attack?
- Do you know where the nearest health services are here?
- Have you needed to access any healthcare since you have been on the road? If yes can you describe what you needed?
- What was your experience of that care?
- Is there anything else about your health you'd like to talk about?

- Is there anything else about being a woman traveller that you'd like to talk about?

Thank you for your time.

APPENDIX 5: HUMAN RESEARCH ETHICS COMMITTEE APPROVALS

APPROVAL OF ORIGINAL PROPOSAL

From: Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>
Sent: Thursday, 5 March 2020 11:46 AM
To: Research Ethics <research.ethics@uts.edu.au>; Lin Perry <Lin.Perry@uts.edu.au>; Margaret Yates <Margaret.M.Yates@student.uts.edu.au>
Subject: HREC Approval Granted - ETH19-4565

Dear Applicant

Re: ETH19-4565 - "Older Women Who Travel Without Men Across Australia: Their Health and Social Wellbeing and Access to Healthcare"

Thank you for your response to the Committee's comments for your project. The Committee agreed that this application now meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application.

You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

Your approval number is UTS HREC REF NO. ETH19-4565.

Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat (Research.Ethics@uts.edu.au).
- The Principal Investigator will notify the UTS HREC of any event that requires a modification to the protocol or other project documents, and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.
- The Principal Investigator will report to the UTS HREC annually and notify the HREC when the project is completed at all sites. The Principal Investigator will notify the UTS HREC of any plan to extend the duration of the project past the approval period listed above through the progress report.

- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).
- The Principal Investigator will notify the UTS HREC of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please don't hesitate to contact the Ethics Secretariat and quote the ethics application number (e.g. ETH20-xxxx) in all correspondence.

Yours sincerely,
A/Prof Beata Bajorek
Chairperson
UTS Human Research Ethics Committee
C/- Research Office
University of Technology Sydney
E: Research.Ethics@uts.edu.au

Ref: E38

APPROVAL OF AMENDMENTS TO RESEARCH DESIGN IN RESPONSE TO TRAVEL RESTRICTIONS DUE TO COVID-19

From: Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>
Sent: Thursday, 11 June 2020 8:37 AM
To: Research Ethics <research.ethics@uts.edu.au>; Margaret Yates <Margaret.M.Yates@student.uts.edu.au>; Jenny Onyx <Jennifer.Onyx@uts.edu.au>; Lin Perry <Lin.Perry@uts.edu.au>; Tracy Levett-Jones <Tracy.Levett-Jones@uts.edu.au>
Subject: HREC Approval Granted - ETH19-4511

Dear Applicant

Re: ETH19-4511 - "Older Women Who Travel Without Men Across Australia: Their Health and Social Wellbeing and Access to Healthcare"

The UTS Human Research Ethics Expedited Review Committee reviewed your amendment application for your project and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that the Committee has approved your request to amend the protocol as follows:

Due to Covid19 travel and social distancing restrictions the original face to face recruitment strategy cannot be enacted. Additional recruitment and data collection strategies for the women travellers to include snowball sampling and telephone interviews. We will seek verbal consent but will use the Information statement and the consent form as the script, i.e. will read these documents to the potential participant. There is therefore no separate or different script for verbal rather than written consent.

This amendment is subject to the standard conditions outlined in your original letter of approval.

You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

To access this application, please click here, a copy of your application has also been attached to this email.

If you wish to make any further changes to your research, please contact the Research Ethics Secretariat on 02 9514 2478.

In the meantime I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

A/Prof Beata Bajorek
Chairperson
UTS Human Research Ethics Committee

C/- Research Office
University of Technology Sydney
Research.Ethics@uts.edu.au | Website
PO Box 123 Broadway NSW 2007

Ref: E41

UTS CRICOS Provider Code: 00099F DISCLAIMER: This email message and any accompanying attachments may contain confidential information. If you are not the intended recipient, do not read, use, disseminate, distribute or copy this message or attachments. If you have received this message in error, please notify the sender immediately and delete this message. Any views expressed in this message are those of the individual sender, except where the sender expressly, and with authority, states them to be the views of the University of Technology Sydney. Before opening any attachments, please check them for viruses and defects. Think. Green. Do. Please consider the environment before printing this email.

APPENDIX 6: PARTICIPANT INFORMATION AND CONSENT FORMS: WOMEN TRAVELLERS

UTS UNIVERSITY OF TECHNOLOGY SYDNEY

PARTICIPANT INFORMATION SHEET FOR WOMEN

Women Who Travel Without Men Across Australia:
Their Health and Social Wellbeing and Access to Healthcare

UTS HREC ETH19-4565

WHO IS DOING THE RESEARCH?

My name is Margaret Yates and I am a student at UTS. My supervisors are:

Professor Tracy Levett-Jones: Tracy.Levett-Jones@uts.edu.au

Professor Lin Perry: Lin.Perry@uts.edu.au

Emeritus Professor Jenny Onyx: Jenny.Onyx@uts.edu.au

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about women who travel without men in regional, rural and remote areas of Australia; what their travelling experiences are, including their health and access to healthcare services while travelling

FUNDING

No funding has been provided for this study.

WHY HAVE I BEEN ASKED?

You have been invited to participate in this study because you are a woman traveller in a regional, rural or remote area of Australia.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate, I will invite you to participate in an approximately 1-hour semi-structured face to face interview or focus group. With your consent, these will be audio recorded and transcribed. The topics to be discussed will include your experiences on the road, your health and access to healthcare services. If you agree I may ask to photograph your rig (motorhome, caravan etc).

If you wish to receive a copy of the transcript of your interview / focus group, or a summary of the findings, you will need to supply an email address. To ensure your privacy, your email address will be deleted once you have acknowledged receipt of a copy of your transcript or the findings summary.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there are some risks/inconvenience, due to the time it takes for the interview or focus group, estimated at one hour.

If you experience any discomfort with the discussion content, you can stop the interview and withdraw from the study.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, nothing will happen. Saying no to participating in the study will in no way compromise or affect the relationship of the participant with the researchers or UTS.

If you wish to withdraw from the study during the interview or group discussion, you can do so without having to give a reason.

After the interview you will not be able to withdraw any information you provide as your information will not be able to be identified.

CONFIDENTIALITY

By signing the consent form you consent to the researcher collecting and using personal information about your experiences for the research project. All this information will be treated confidentially. The audio recordings will be secured under a password only known by the researcher and supervisors. You will not be able to be identified in any information collected Your information will only be used for the purpose of this research project.

We plan to discuss the results with health services involved in the study, and publish the results in relevant professional journals. In any publication, information will be provided in such a way that you cannot be identified.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my principal supervisor Professor Tracy Levett-Jones can help you with, please feel free to contact us at either email address Margaret.M.Yates@student.uts.edu.au or Tracy.Levett-Jones@uts.edu.au

You will be given a copy of this form to keep.

NOTE:

This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au], and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

CONSENT FORM

Women Who Travel Without Men Across Australia:

Their Health and Social Wellbeing and Access to Healthcare

UTS HREC ETH19-4565

I _____ agree to participate in the research project Women Who Travel Without Men Across Australia: Their Health and Social Wellbeing and Access to Healthcare (UTS HREC reference number ETH19-4565) being conducted by Margaret Yates of the University of Technology Sydney, Ultimo Sydney 2001, phone: 0405757025.

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers or the University of Technology Sydney.

I understand that I will be given a signed copy of this document to keep.

I agree to be:

☐ Audio recorded

☐ Photographed

I agree that the research data gathered from this project may be published in a form that does not identify me in any way

I am aware that I can contact Margaret Yates or Tracy Levett-Jones if I have any concerns about the research.

_____ ____/____/____

Name and Signature [participant] Date

_____ ____/____/____

Name and Signature [researcher or delegate] Date

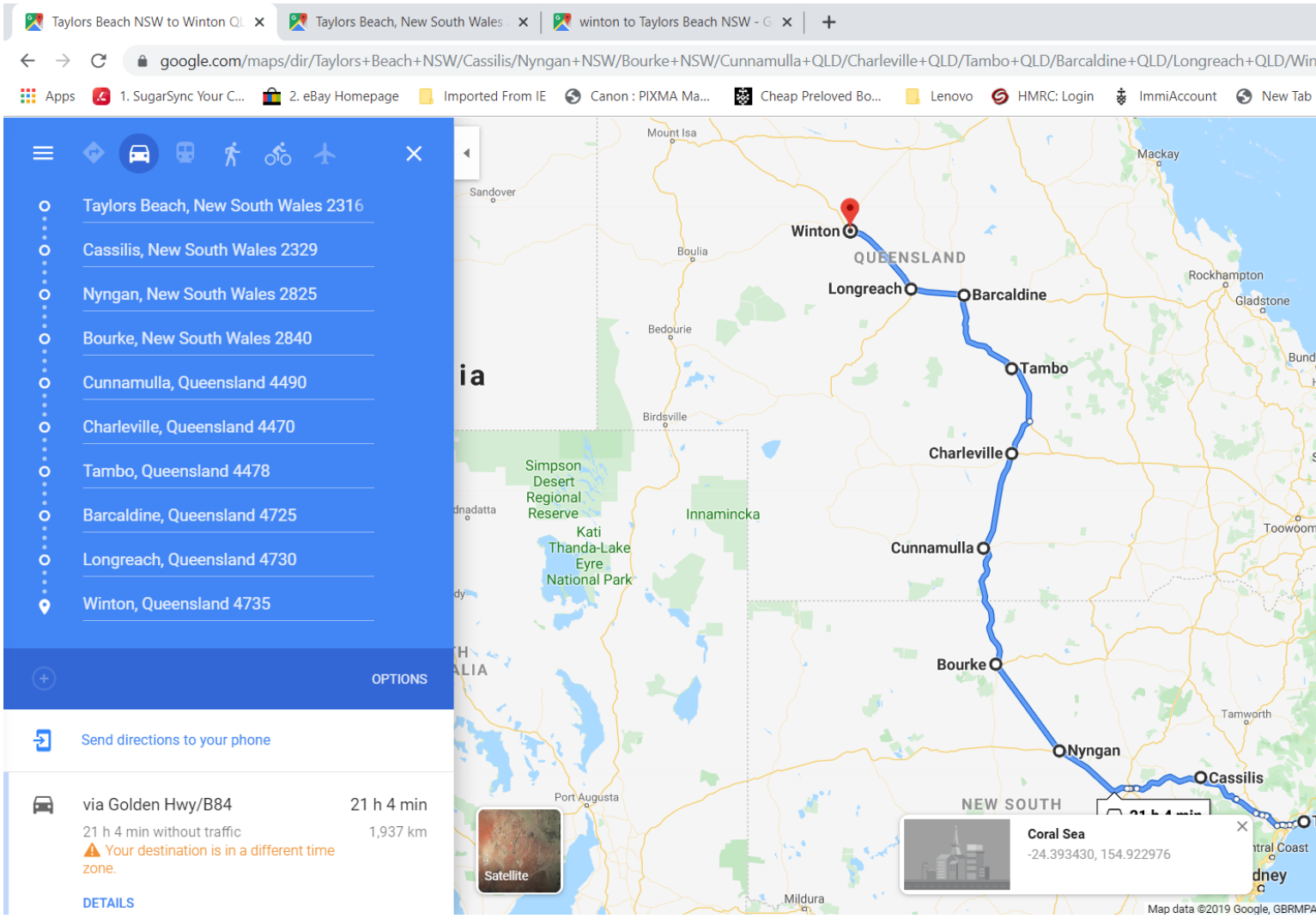
_____ ____/____/____

Name and Signature [witness*] Date

*** Witness to the consent process**

If the participant, or if their legally acceptable representative, is not able to read this document, this form must be witnessed by an independent person over the age of 18. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. By signing the consent form, the witness attests that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the participant (or representative) and that informed consent was freely given by the participant (or representative)

APPENDIX 7: FIRST PLANNED FIELD TRIP LOCATION MAP INCLUDING HEALTHCARE FACILITIES



HEALTHCARE FACILITIES ON FIELD TRIP ROUTE

NSW HEALTH SERVICES

Nyngan Multi-Purpose Service
15 Hoskins Street
Nyngan, NSW 2825
Phone 02 6835 1700 Fax: 02 6832 2015
A regional public hospital with an emergency department and fewer than 50 beds.
Hospital services include:
Emergency
Maintenance renal dialysis
Nursing home care

Bourke Multi-Purpose Service
26 Tarcoon Street
Bourke, NSW 2840
Phone 02 6870 8888
A regional public hospital with an emergency department and fewer than 50 beds.
Hospital services include:
Emergency
Maintenance renal dialysis
Nursing home care

QUEENSLAND HEALTH SERVICES

Cunnamulla Hospital
56 Wicks Street
Cunnamulla, QLD 4490
Phone: 07 46558100
The Cunnamulla Hospital is located in the regional town of Cunnamulla and is approximately 800 kilometres west of Brisbane in the Far South West planning region.
The number of available beds/bed alternatives at Cunnamulla Hospital is 20.
Services
Hospital
Accident & Emergency
General ward
Outpatients
X-ray
Pharmacy (hospital use only)
Wound management
General Medical Practice
Telehealth
Palliative care
Visiting Specialist
Flying Surgeon
Flying Obstetrician/Gynaecologist
Antenatal and postnatal services
Ophthalmologist

Optometrist
Community and Allied Health Services
Physiotherapy
Occupational therapy
Speech therapy
Social work
Podiatry
Dietetics and nutrition
Dentistry
Diabetes education
Early intervention parenting program
Mental health
Immunisation clinics
Child health
Cardiac nurse
Women's health
Aged care assessment
Drug and alcohol services
Indigenous health
Health promotion/prevention
Home and Community Care (HACC)
Frail aged
People with disabilities and carers
General Practitioners
There are two general practitioners (GP) who are responsible for care of inpatients and outpatients of the Hospital, with the majority of their time spent at the Primary Health Clinic (PHC), located off site in the CBD of town. The PHC is a collaboration of the hospital and health service's GP Clinic and the Cunnamulla Aboriginal Corporation for Health (CACH), and provides a variety of primary healthcare services to the wider community.

Longreach Hospital
Corner Jabiru and Plover Streets
LONGREACH QLD 4730.
Phone: 07 4658 4700
Longreach Hospital is the region's major healthcare facility offering 31-bed inpatient care.
Services
24-hour emergency department
Mental health
Pharmacy
Medical imaging
Elective surgery
Maternity
Dental

General Practitioner services are delivered through the Longreach Primary Care Clinic, lower floor of the Iningai Health Arcade, 109 Eagle Street, and Longreach.

Alpha Hospital and Multipurpose Health Service
1 Burns Street ALPHA QLD 4724
Phone: 70 4809 7000
Alpha Hospital and Multipurpose Health Service is a 10-bed, co-located general medical practice. The facility includes a five-bed flexible, residential aged care service and an ambulance service delivered in partnership with Queensland Ambulance Service.
Services
Emergency
Primary health
Allied health
Mental health

Blackwater Multipurpose Health Service
41 Mackenzie Street
Blackwater QLD 4717
Phone: 07 4980 1800
Services
24-hour Accident and Emergency services
Acute Inpatient medical services
Palliative Care
Emergency radiography services
Long Stay and Respite Residential Care
Outreach and visiting services
Child health nurse service including home visits and a day clinic
Mental health services - Outpatient
Women's health services - Outpatient
Podiatry - Outpatient
Physiotherapy – Outpatient
Speech Therapists - Outpatient
Occupational Therapists - Outpatient
Antenatal
Postnatal
Nutrition and Dietetics
Immunisation clinic

Charleville Hospital
72 King Street Charleville QLD 4470
Phone: 0746 505000
Charleville Hospital is located in the South West Hospital and Health Service (SWHHS). It is approximately 759 kilometres west of Brisbane. The hospital has 14 available acute beds including maternity
Services

Hospital
Accident & Emergency
General ward
Outpatients
X-ray
Pharmacy (hospital use only)
Wound management
General Medical Practice
Pathology Laboratory
Antenatal, birthing and postnatal services
Sonography
Telehealth
Palliative care
Visiting Specialist
Flying surgeon
Flying Obstetrician/Gynaecologist
Paediatrician
Community and Allied Health
Physiotherapy
Occupational therapy
Speech therapy
Social work
Podiatry
Dietetics and nutrition
Child protection
Dentistry
Diabetes education
Early intervention parenting program
Mental health – adult and child
Immunisation clinics
Child health
Cardiac nurse
Women's health
Aged care assessment
Drug and alcohol services
Indigenous health
Health promotion/prevention
Home and Community Care (HACC)
Frail aged
People with disabilities and carers

Tambo Primary Healthcare Centre
The Tambo Primary Healthcare Centre is a nurse-led emergency care and primary health service supported by a staffed Queensland Ambulance Service station.
Garden Street
TAMBO QLD 4478.
Phone: 07 4621 7100

Office hours: Monday – Friday 9.00 am - 12.00 pm & 2.00 pm - 5.00 pm

Winton Hospital and Multipurpose Health Service
Bloomfield Street
WINTON QLD 4735.
Phone:07 4657 2700
Winton Hospital and Multipurpose Health Service is a 16-bed, co-located general medical practice. The facility includes a six bed flexible, residential aged care service.
Services
Emergency
Inpatient
Primary health
Allied health.
General Practitioner services are delivered through the Winton Medical Practice, corner of Bloomfield and Oondooroo Streets, Winton.

Barcaldine Hospital and Multipurpose Health Service
Oak Street BARCALDINE QLD 4725
(access via the Capricorn Highway)
Barcaldine Hospital and Multipurpose Health Service is an 18-bed, co-located general medical practice offering a range of emergency, inpatient, primary health and allied health services, and a dental clinic. The facility includes a six bed flexible, residential aged care service and community care services.

APPENDIX 8: HEALTHCARE PROFESSIONALS INTEVIEW SCRIPT

Hi there, my name is Margaret Yates, I am a nurse and I work in a regional hospital in NSW. I am also a research student at University of Technology Sydney. I am doing research about travellers. I have a special interest in women who travel by themselves or with other women.

Very little research has been conducted about travellers and their impact on health services in rural and remote Australia. I would be delighted if you would participate in this study by being interviewed about your perspectives and observations on travellers, especially women travellers, and their use of health services. The questions I will be asking are about these travellers' use of local health services, what impact they have on the service's resources, and why they visit your services.

Any information you provide will be treated with the greatest respect, confidence and security and your identity will remain confidential –my supervisors and I are the only people who will know you were interviewed.

I prefer to audio record our discussions because it's the best way to get an accurate picture of our conversation. The recording will be transcribed and then the audio will be destroyed. I can provide you with a copy of the transcription of your interview if you give me an email or postal address.

This study has been approved by the university's ethics committee. Part of that approval depends on you providing written consent to be interviewed. Whether or not you take part is entirely up to you. If you decide to take part you can change your mind at any time, or opt not to answer any questions, and that will be OK.

(If consent obtained, proceed) If you're ready to start?

Draft Questions

- Do you record data on travellers' use of your health services? If so, how many travellers utilise your health service per year and when do they mostly turn up?
- If traveller numbers are not recorded, do you have an idea how often or how many travellers you would normally see in a day / week / month at your services or locally?
- What problems do they present with and what services do they seek and access?
- What time of the year are they evident?
- Do travellers in general impact on your healthcare services? On any health services locally in particular?
- Do women travelling either solo or with other women ever present for services? If so, what problems do they present with and what services do they seek and access?
- ▪ Do they have any particular impact on your services generally or what you provide for your community?
- Do women travellers have an impact on your local community, beyond the health services? If so, can you describe how? Any advantages? Disadvantages? Are there particular issues or problems?
- Do you have the resources to support these people? How do you manage (cope) with this?
- Are there any particular events or incidents involving women travellers locally that come to mind?
- ▪ Is there anything else about women travellers locally that you'd like to comment on?

Thank you for your time

APPENDIX 9: PARTICIPANT INFORMATION AND CONSENT FORMS: HEALTHCARE PROFESSIONALS

PARTICIPANT INFORMATION SHEET HealthCare Professionals

Women Who Travel Without Men Across Australia:
Their Health and Social Wellbeing and Access to Healthcare

UTS HREC ETH19-4565

WHO IS DOING THE RESEARCH?

My name is Margaret Yates and I am a student at UTS. My supervisors are:

Professor Tracy Levett-Jones: Tracy.Levett-Jones@uts.edu.au

Professor Lin Perry: Lin.Perry@uts.edu.au

Emeritus Professor Jenny Onyx: Jenny.Onyx@uts.edu.au

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about women who travel without men in regional, rural and remote areas of Australia; what their travelling experiences are, including their health and access to healthcare services while travelling

FUNDING

No funding has been provided for this study.

WHY HAVE I BEEN ASKED?

You have been invited to participate in this study because you are a healthcare professional working in a regional, rural or remote area health service.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate, I will invite you to participate in an approximately 1-hour semi-structured face to face interview/ focus group or telephone interview. With your agreement, these will be audio recorded and transcribed. The topic will be about your observations of travellers accessing local healthcare services.
If you wish to receive a copy of the transcript of your interview / focus group, or a summary of the findings, you will need to supply an email address. To ensure your privacy, your email address will be deleted once you have acknowledged receipt of a copy of your transcript or the findings summary.

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there are some risks/ inconvenience, due to the time it takes for the interview or focus group, estimated at one hour.

If you experience any discomfort with the discussion content, you can stop the interview and withdraw from the study.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, nothing will happen. Saying no to participating in the study will in no way compromise or affect the relationship of the participant with the researchers or UTS.

If you wish to withdraw from the study during the interview or group discussion, you can do so without having to give a reason.

After the interview you will not be able to withdraw any information you provide as your information will not be able to be identified.

CONFIDENTIALITY

By signing the consent form you consent to the researcher collecting and using personal information about your experiences for the research project. All this information will be treated confidentially. The audio recordings will be secured under a password only known by the researcher and supervisors. You will not be able to be identified in any information collected. Your information will only be used for the purpose of this research project.

We plan to discuss the results with health services involved in the study, and publish the results in relevant professional journals. In any publication, information will be provided in such a way that you cannot be identified.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my principal supervisor Professor Tracy Levett-Jones can help you with, please feel free to contact us at either email address Margaret.M.Yates@student.uts.edu.au or Tracy.Levett-Jones@uts.edu.au

You will be given a copy of this form to keep.

NOTE:

This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee [UTS HREC] guidelines. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au], and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

CONSENT FORM

Women Who Travel Without Men Across Australia:
Their Health and Social Wellbeing and Access to Healthcare

UTS HREC ETH19-4565

I _____ agree to participate in the research project Women Who Travel Without Men Across Australia: Their Health and Social Wellbeing and Access to Healthcare (UTS HREC reference number ETH19-4565) being conducted by Margaret Yates of the University of Technology Sydney, Ultimo Sydney 2001, phone: 0405757025.

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research as described in the Participant Information Sheet.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time without affecting my relationship with the researchers or the University of Technology Sydney.

I understand that I will be given a signed copy of this document to keep.

I agree to be:

☐ Audio recorded

I agree that the research data gathered from this project may be published in a form that does not identify me in any way

I am aware that I can contact Margaret Yates or Tracy Levett-Jones if I have any concerns about the research.

_____ ____/____/____

Name and Signature [participant] Date

_____ ____/____/____

Name and Signature [researcher or delegate] Date

_____ ____/____/____

Name and Signature [witness*] Date

*** Witness to the consent process**

If the participant, or if their legally acceptable representative, is not able to read this document, this form must be witnessed by an independent person over the age of 18. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. By signing the consent form, the witness attests that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the participant (or representative) and that informed consent was freely given by the participant (or representative)

APPENDIX 10: PERMISSION TO REPRODUCE THE PUBLICATION OF THE PHASE 1 MONTAGE FINDINGS

Article citation: Yates, M., Perry, L., Onyx, J., Levett-Jones, T. (2024) Women travelling solo or with other women across Australia: A montage of narratives. *Journal of Women and Ageing*, 12, 1-11. https://doi.org/10.1080/08952841.2024.2431412

From: Taylor & Francis Journal Permissions Support <taylorandfrancissupport@tandf.co.uk>
Sent: Monday, May 26, 2025 10:23:39 AM
To: Margaret Yates <margaret.m.yates@student.uts.edu.au>
Subject: wjwa20:Women travelling solo or with other women across Australia: A montage of narratives



Our Ref: wjwa/05193699

5/25/2025

Dear Requester,

Thank you for your correspondence requesting permission to reproduce content from a Taylor & Francis Group journal content in your thesis to be posted on your university's repository.

We will be pleased to grant free permission on the condition that your acknowledgement must be included showing article title, author, full Journal title, and **© copyright # [year]**, reprinted by permission of Informa UK Limited, trading as Taylor & Taylor & Francis Group, http://www.tandfonline.com

This permission does not cover any third party copyrighted work which may appear in the article by permission. Please ensure you have checked all original source details for the rights holder and if need apply for permission from the original rightsholder.

Please note that this license **does not allow you to post our content on any other third-party websites.**

Please note permission does not provide access to our article, if you are affiliated to an institution and your institution holds a subscription to the content you are requesting you will be able to view the article free of charge, if your institution does not hold a subscription or you are not affiliated to an institution that has a subscription then you will need to

purchase this for your own personal use as we do not provide our articles free of charge for research.

Thank you for your interest in our Journal.

With best wishes,

Taylor & Francis Journal Permissions
Web: www.tandfonline.com
4 Park Square, Milton Park, Abingdon, OX14 4RN
(+44 (0)20 8052 0600

APPENDIX 11: PERMISSION TO REPRODUCE THE PUBLICATION OF THE PHASE 2 FINDINGS

Article citation: Yates, M., Perry, L., Onyx, J., Levett-Jones, T. (2022) 'Grey nomad' travellers' use of remote health services in Australia: a qualitative enquiry of hospital managers' perspectives. *BMC Health Services Research* **22,** 151 (2022). https://doi.org/10.1186/s12913-022-07580-8

BMC Health Services Research articles are published open access under a CC BY-NC-ND (Creative Commons Attribution Non-Commercial No Derivatives 4.0 International license) or CC BY (Creative Commons Attribution 4.0 International license) license. CC BY-NC-ND: The article can be shared for non-commercial purposes as long as the authors are credited. Permission is needed for commercial re-use or sharing adapted and derivative versions. CC BY: The article may be shared and adapted for any purpose, including commercially, so long as the authors are credited.

APPENDIX 12: PHASE 2 FINDINGS, CASE STUDY EXAMPLES

Case Example One: Caring for their community

HCP4: "…There was a man that was travelling on his own; we ended up looking after his dog for a week because he was actually quite unwell, he got sent off to Sydney so his caravan was kept here. And he had a little dog. He'd lost his wife in the last six months before he arrived here so he left his caravan here and we adopted the dog.

Researcher: Who looked after the dog?

HCP4: One of the nurses

Researcher: How long did she have the dog for?

HCP4: A week; the whole time he was away

Researcher: Where did you keep the caravan?

HCP4: Out the back of the hospital and, he was really worried because he had a port-a-loo and he said that it needed emptying, the maintenance man fixed all that up for him…."

Case Example Two: Travellers' impact on services

HCP2: "…We have had presentations here and lots of the presentations are around cardiac stuff, so we've had to fly them out. When we've had them it's always difficult because their poor wife is here, they're stuck lots of times, we've stored the caravans out the back under the cameras and we've allowed the partner to stay here in the hospital with them or they've slept in the car park around the back. Look yeah it's not an issue. It's the same as anybody sometimes you just work that bit harder when it is a grey nomad or anybody that comes here that doesn't come from here you take all those things into consideration maybe they've got an animal or they are going to be stuck out at, I know that one of the ones we had last year when the season was happening they were with a group of people and they got to town and they were actually on the start of their journey they got here and he had some cardiac issues so we had to fly him out. It was really traumatic for her because she couldn't drive. And so the others were leaving the next day and we just sort of helped, we got her on the flight which was good which is sometimes an advantage if we can get them on the Air Ambulance flight…."

Case Example Three: Unrealistic Expectations

HCP11: "…We do have quite a few come through and use our resources quite readily; not just women, men as well. The grey nomads in particular, and the expectation of what services can be delivered out this way is far higher than what is actually able to be serviced.

Researcher: What do they expect?

HCP11: I'll give you an example. We had a person come through here … who was on a trial study for cardiac myopathy. She was from Victoria and she needed to take it on a daily basis. She went to the pharmacist in town first and asked them to get it, the drug, and the pharmacist couldn't get it because it is off the approved medication list so the pharmacist directed her to us because we provide a small hospital pharmacy through our regional hub so we rang the largest facility pharmacy and the pharmacist just said that was above her pay grade as well so we went to the State-wide chief pharmacist and he said he'd look into it. Some trial drugs they can provide, others they can't, this one they couldn't. The actual pharmacy annual budget was around $16,000 at the time and the drug was $24,000; it was worth more so we said we just couldn't do it and the lady went off, "*My specialist said I can get this drug anywhere in Australia…*" and we explained that you probably can but you would have to pay and she said that's not what she had been told. We called her specialist and the specialist had no idea they were going to travel and there was no plan of care for what the person required observationally or medications. Our town is small isolated, the water, because of the high mineral content, reacts with some drugs including another one she was prescribed. This person had enough drugs to get her to the larger town further on that had a franchised pharmacy of the chain where she gets her trial drug dispensed. There were only two places in the whole of Queensland that had these franchises at that time that could access the drug through the trial. It became a logistical nightmare for us so now we set out on our hospital website, the five primary health centre websites the shire council's websites, that if you are a traveller coming into our shire make sure you have enough medication to last you.

Researcher: How many hours would you have been tied up you and your staff as well?

HCP11: What tied me up was the phone calls, finding the right person to talk to was probably the hardest but also the pharmacist, the expectations of those people we contacted with what we can provide including her specialist. He did not understand why she couldn't get the drug from us…"

Case Example Four: Expectations Met

Researcher: Where is your experience of grey nomads?

HCP12: "…mostly rural and remote out the "Back O' Bourke" I always call it and um where there's a single nurse post in Primary Healthcare Centres. They see the blue hospital sign and they'll come there because we often have Royal Flying Doctor Service [RFDS] flying in. For example, we had a couple of sick grey nomads come through and we have the RFDS fly in once a fortnight to do a day clinic but the rest of the time the nurse is dealing with whatever the presentations are. One grey nomad was in diabetic ketoacidosis, so somebody who had vomiting and diarrhoea, and they had a basal insulin pump on that wasn't working appropriately because they were sick and the pump was trying to measure what their glucose levels were and supply the appropriate insulin but realistically we had to remove the pump and we give them some education around needing the pump, measuring your own sugar levels and we had to put an IV in and give them some fluids….

[Another] one was a diabetic man as well and he had, first of all his wife found him unconscious in the caravan and when we went there, he was OK but then after that we took him to the hospital and he was flown out. But then he came back and he had an infection. He was a really bad diabetic. But he understood that and he said "yeah yeah I know all that but I'm going to travel before I die and I'm just going to do that"… And I guess because I have been working independently for such a long time I have a different attitude to a hospital because I have found with my nursing staff they have a totally different attitude about grey nomads "Oh that grey nomad he's forgotten what tablet he takes, they don't understand their diabetic regime, you know'', so I think it's hospital based perception of what a grey nomad looks like and you heard that opinion but in my opinion I find that they are a lot more educated than they used to be and I've seen them way back when, when they didn't even have a medication list, didn't even know what their medications were. Now they have a pretty good understanding of their illness and they can actually tell you about it. In a lot of cases clients have a better understanding about their health then we do because they have lived with it and our best defence is to listen to what they've got to say. And we are an ageing population so we are going to get more of them you know so it's inevitable that we will be faced with the challenges of ageing''.

Case Example Five: Traveller Preparation

And then it is challenging for the ladies left behind, when we fly out their partner and now they are left with, “I have a caravan, I don’t tow, I don’t drive”.

Researcher: You are still finding women saying that?

HCP9: Absolutely, so no preparation or forward thinking about what could happen or what would happen and how they would manage

Researcher: So do you take that on?

HCP9: We get in contact with Queensland Police Service. If we have to**,** we obviously help them make all the phone calls they do. So if they left their caravan somewhere we say, if you let the police know they’ll make sure they keep an eye on things. Because we don’t have after hours social work support. They visit once a week from [larger town] as an outreach. We take on the social work support as much as we can so we can support them.

REFERENCES

ABC News. (2024). *Broken Hill's Mundi Mundi Bash part of a boom in agritourism keeping graziers going*. https://www.abc.net.au/news/2024-08-13/broken-hill-mundi-mundi-festival-diversifying-tourism/104201896

Abelsen, B., Strasser, R., Heaney, D., Berggren, P., Sigurðsson, S., Brandstorp, H., Wakegijig, J., Forsling, N., Moody-Corbett, P., Akearok, G. H., Mason, A., Savage, C., & Nicoll, P. (2020). Plan, recruit, retain: a framework for local healthcare organizations to achieve a stable remote rural workforce. *Human resources for health*, *18*(1), 63-63. https://doi.org/10.1186/s12960-020-00502-x

Abigail, W., McCloud, C., de Bellis, A., Hagger, C., & Clark, R. (2016). Who's Maintaining the Health of Australia's Grey Nomads? *Journal of Aging and Physical Activity*, *24*, S73. https://doi.org/http://dx.doi.org/10.1123/japa.2016-0156

ABS. (2012). *4922.0 - Information Paper - A Statistical Definition of Homelessness, 2012*. (First Issue). Canberra Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4922.0Main%20Features32012?opendocument&tabname=Summary&prodno=4922.0&issue=2012&num=&view=

ABS. (2012). *4922.0 - Information Paper - A Statistical Definition of Homelessness, 2012*. Canberra Australian Bureau of Statistics Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4922.0Main%20Features32012?opendocument&tabname=Summary&prodno=4922.0&issue=2012&num=&view=

AHURI, A. H. U. R. I. (2022). *Why does Australia have a rental crisis, and what can be done about it?* https://www.ahuri.edu.au/research/brief/why-does-australia-have-rental-crisis-and-what-can-be-done-about-it

Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. *International Journal of Clinical Pharmacy*, *38*(3), 631-634. https://doi.org/10.1007/s11096-015-0222-0

Australian Bureau of Statistics. (2013). *Australian Health Survey: Updated Results, 2011-2012. Long-Term Health Conditions*. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.003Chapter3002011-2012

Australian Bureau of Statistics. (2018). *Changing patterns of mortality in Australia*. Canberra: Commonwealth of Australia Retrieved from https://www.abs.gov.au/statistics/health/causes-death/changing-patterns-mortality-australia/latest-release

Australian Bureau of Statistics. (2019). *Twenty years of population change*. Australian Bureau of Statistics. https://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument#:~:text=Over%20the%2020%20years%20between,1946%20and%201964)%20turn%2065.

Australian Bureau of Statistics. (2020). *1270.0.55.003 - Australian Statistical Geography Standard (ASGS): Volume 3 - Non ABS Structures, June 2020* https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1270.0.55.003Main+Features1June%202020?OpenDocument

Australian Bureau of Statistics. (2023). *Health conditions prevalence. Key findings on long-term health conditions and chronic conditions, and prevalence in Australia*. https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release

Australian Geographic Staff. (2016). *The most heroic Aussie female adventurers*. https://www.australiangeographic.com.au/australian-geographic-adventure/adventure/2017/10/the-most-heroic-aussie-female-adventurers/

Australian Government Department of Health and Aged Care. (2016). *National Strategic Framework for Rural and Remote Health*. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.health.gov.au/sites/default/files/documents/2020/10/national-strategic-framework-for-rural-and-remote-health.pdf

Australian Health Ministers Advisory Councils. (1999). *Healthy Horizons: a Framework for Improving the Health of Rural and Remote Australians. 1999-2003.* https://www.ruralhealth.org.au/sites/default/files/healthy-horizons/healthy%20horizons%2C%201999-2003.pdf

Australian Health Ministers Advisory Councils. (2002). *Healthy Horizons: a Framework for Improving the Health of Rural and Remote Australians. Outlook 2003-2007.* https://www.ruralhealth.org.au/sites/default/files/healthy-horizons/healthy%20horizons%20outlook%202003-2007.pdf

Australian Human Rights Commission. (2013). *Fact or fiction? Stereotypes of older Australians*. https://humanrights.gov.au/sites/default/files/document/publication/Fact%20or%20Fiction_2013_WebVersion_FINAL_0.pdf

Australian Institute of Health and Welfare. (2021). *Homelessness and homelessness services*. https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services

Australian Institute of Health and Welfare. (2022). *Rural and Remote Health*. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health#Access

Australian Institute of Health and Welfare. (2023). *Rural and remote health*. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

Australian Institute of Health and Welfare. (2024a). *Health workforce*. https://www.aihw.gov.au/reports/workforce/health-workforce

Australian Institute of Health and Welfare. (2024b). *Older Australians*. Australian Government. https://www.aihw.gov.au/reports/older-people/older-australians/contents/summary

Australian Museum. (2021). *Linda Beilharz OAM Trailblazers: Australia's 50 Greatest Explorers*. Australian Museum Retrieved from https://australian.museum/about/history/exhibitions/trailblazers/linda-beilharz-oam/

Australian Trade & Investment Commission, & Tourism Research Australia. (2023). *National Visitor Survey results 2023*. https://www.tra.gov.au/en/domestic/domestic-tourism-results/domestic-tourism-results-march-2023#ref5

Australian Trade & Investment Commission, & Tourism Research Australia. (2025). *Domestic tourism trends*. https://www.tra.gov.au/en/domestic/domestic-tourism-trends

Beaumont, C. (2017). What Do Women Want? Housewives' Associations, Activism and Changing Representations of Women in the 1950s. *Women's history review*, *26*(1), 147-162. https://doi.org/10.1080/09612025.2015.1123029

Birdsville Race Club. (2025). *Birdsville Races*. https://birdsvilleraces.com/the-races/#about

BITRE, B. o. I. T. R. E. (2022). *Road Trauma Australia 2021: statistical summary* https://www.bitre.gov.au/sites/default/files/documents/road_trauma_2021.pdf

Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal*, *19*(4), 426-432. https://doi.org/10.1108/QMR-06-2016-0053

Boneham, M., & Sixsmith, J. (2006). The voices of older women in a disadvantaged community: Issues of health and social capital. *Social science & medicine (1982)*, *62*(2), 269-279. https://doi.org/10.1016/j.socscimed.2005.06.003

Bowling, A. (1997). *Research Methods in Health*. Open University Press.

Bozzaro, C., Boldt, J., & Schweda, M. (2018). Are older people a vulnerable group? Philosophical and bioethical perspectives on ageing and vulnerability. *Bioethics*, *32*(4), 233-239. https://doi.org/https://doi.org/10.1111/bioe.12440

Bradford, N. K., Caffery, L. J., & Smith, A. C. (2016). Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. *Rural and Remote Health*, *16*(4), 3808-3808. https://doi.org/10.22605/RRH3808

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brayley, N., & Obst, P. L. (2010). The Australian Grey Nomads--are they who we think they are? Enhancing formative research through the quantitative assessment of psychological constructs [Article]. *Health Promotion Journal of Australia*, *21*(2), 138-142.

Broomhill, R., & Sharp, R. (2005). The Changing Male Breadwinner Model in Australia: a New Gender Order? *Labour & industry (Brisbane, Qld.)*, *16*(1), 103-127. https://doi.org/10.1080/10301763.2005.10722033

Bureau of Infrastructure and Transport Research Economics. (2024). *Road Vehicles, Australia January 2023 (Re-issue)*. R. D. Department of Infrastructure Transport, Communications and the Arts Commonwealth of Australia https://www.bitre.gov.au/sites/default/files/documents/BITRE-Road-Vehicles-Australia-January-2023-Re-Issue

Burns, A., & Leonard, R. (2005). Chapters of Our Lives: Life Narratives of Midlife and Older Australian Women. *Sex Roles: A Journal of Research*, *52*(5-6), 269-277. https://doi.org/10.1007/s11199-005-2671-8

Butler, R. N. (1969). Age-Ism: Another Form of Bigotry. *The Gerontologist*, *9*(4_Part_1), 243-246. https://doi.org/10.1093/geront/9.4_Part_1.243

Butler, R. N. (2009). Combating ageism. *International Psychogeriatrics*, *21*(2), 211. https://doi.org/https://doi.org/10.1017/S104161020800731X

Byles, J., Powers, J., Chojenta, C., & Warner-Smith, P. (2006). Older women in Australia: ageing in urban, rural and remote environments. *Australasian Journal on Ageing*, *25*(3), 151-157. https://doi.org/10.1111/j.1741-6612.2006.00171.x

Calma, K. R. B., Halcomb, E., & Stephens, M. (2018). An exploration of the experiences of Australian Grey Nomads travelling with chronic conditions. *Australian Journal of Primary Health*, *24*(2), 183-188. https://doi.org/10.1071/PY17043Research

Caravan Industry Association of Australia. (2019). *New figures reveal domestic caravan and camping trips increase in popularity*. https://www.caravanindustry.com.au/new-figures-reveal-domestic-caravan-and-camping-trips-increase-in-popularity

Caravan Industry Association of Australia. (2021). *Caravan Industry Supports National Road Safety Week as "Grey Nomads" begin to head north*. https://www.caravanindustry.com.au/caravan-industry-supports-national-road-safety-week-as-grey-nomads-begin-to-head-north

Cecil, V., Pendry, L. F., Salvatore, J., Mycroft, H., & Kurz, T. (2022). Gendered ageism and gray hair: must older women choose between feeling authentic and looking competent? *Journal of Women & Aging*, *34*(2), 210-225. https://doi.org/10.1080/08952841.2021.1899744

Chang, E.-S., Kannoth, S., Levy, S., Wang, S.-Y., Lee, J., & Levy, B. (2020). Global reach of ageism on older persons' health: A systematic review. *PLOS One*, *15*(1), e0220857. https://doi.org/https://doi.org/10.1371/journal.pone.0220857

Chase, S. E. (2011). Narrative Inquiry Still a Field in the Making In N. K. Densin, Lincoln, Y.S (Ed.), *The Sage Handbook of Qualitative Research* (4 ed., pp. 421-434). Sage.

Chimowitz, H., & Ruege, A. (2023). *The costs and harms of homelessness*. https://community.solutions/research-posts/the-costs-and-harms-of-homelessness/

Chrisler, J. C., Barney, A., & Palatino, B. (2016). Ageism can be Hazardous to Women's Health: Ageism, Sexism, and Stereotypes of Older Women in the Healthcare System [https://doi.org/10.1111/josi.12157]. *Journal of Social Issues*, *72*(1), 86-104. https://doi.org/https://doi.org/10.1111/josi.12157

Commonwealth of Australia. (2021). *Stronger Rural Health Strategy*. Canberra: Commonwealth of Australia

Cox, K. (2022). *Driving around Australia: Tips and advice for doing 'The Big Lap' around the country*. https://www.traveller.com.au/driving-around-australia-tips-and-advice-for-doing-the-big-lap-around-the-country-h1ug9m

Cridland, S. (2008). *An analysis of the winter movement of grey nomads to northern Australia: planning for increase senior visitation* James Cook University].

Cuddy, A. J. C., Norton, M. I., & Fiske, S. T. (2016). Corrigendum to "This Old Stereotype: The Pervasiveness and Persistence of the Elderly Stereotype". *Journal of Social Issues*, *72*(3), 614-614. https://doi.org/https://doi.org/10.1111/josi.12185

Darab, S., & Hartman, Y. (2013). Understanding Single Older Women's Invisibility in Housing Issues in Australia. *Housing, theory, and society*, *30*(4), 348-367. https://doi.org/10.1080/14036096.2012.746944

Darley, T., Lambert, C., Ryan, M. (2017). Grey Nomads' caravanning use of social networking sites. *Information Technology & Tourism*, *4*, 379–398.

De Bellis, A., Hill, P., Abigail, W., Giles, J., & McCloud, C. (2020). Grey nomads with diabetes: The experience of rural and remote diabetes educators in South Australia. *Australian Journal of Primary Health*, *26*(4), 300-305. https://doi.org/https://dx.doi.org/10.1071/PY19164

De Bellis, A., McCloud, C., Abigail, W., Hill, P., Giles, J., Apolloni, M., & Gregoric, C. (2023). Understanding the planning and preparation for diabetes self-management of grey nomads when travelling in rural and remote Australia: An exploratory survey. *Australasian Journal on Ageing*, *42*(2), 401-408. https://doi.org/https://dx.doi.org/10.1111/ajag.13150

De Bellis, A., McCloud, C., Giles, J., Apolloni, M., Abigail, W., Hill, P., & McClory, L. (2021). Grey nomads with diabetes self-management on the road – a scoping review. *Rural and Remote Health 21*(3), 6517. https://doi.org/https://doi.org/10.22605/RRH6517

Denmark, F. L., & Zarbiv, T. (2016). Living Life to the Fullest: A Perspective on Positive Aging. *Women & Therapy*, *39*(3-4), 315-321. https://doi.org/10.1080/02703149.2016.1116864

Denzin, N., & Lincoln, Y. (2000). *Handbook of Qualitative Research* (2 ed.). Sage Publications Inc.

Department of Health and Aged Care. (2023). *Royal Flying Doctor Service program*. Australian Government https://www.health.gov.au/our-work/rfds

Dialsingh, I. (2008). Face to face interviewing. In: Encyclopedia of Survey Research Methods. In. https://methods.sagepub.com/ency/edvol/encyclopedia-of-survey-research-methods/chpt/facetoface-interviewing

DiCenso, A., Guyatt, G., & Chiliska, D. (2005). *Evidence-based nursing: A Guide to Clinical Practice*. Elsevier Mosby.

Diehl, M., Smyer, M. A., & Mehrotra, C. M. (2020). Optimizing Aging: A Call for a New Narrative. *American Psychologist*, *75*(4), 577-589. https://doi.org/10.1037/amp0000598

Dougherty, E. N., Dorr, N., & Pulice, R. T. (2016). Assisting Older Women in Combatting Ageist Stereotypes and Improving Attitudes Toward Aging. *Women & Therapy*, *39*(1-2), 12-34. https://doi.org/10.1080/02703149.2016.1116308

Emerson, R. W. (2015). Convenience Sampling, Random Sampling, and Snowball Sampling: How Does Sampling Affect the Validity of Research? *Journal of visual impairment & blindness*, *109*(2), 164-168. https://doi.org/10.1177/0145482X1510900215

Fessenden, M. (2025). *Nellie Bly's Record-Breaking Trip Around the World Was, to Her Surprise, A Race* (Smithsonian magazine, Issue. https://www.smithsonianmag.com/smart-news/nellie-blys-record-breaking-trip-around-world-was-to-her-surprise-race-180957910/

Fiske, S. T., Cuddy, A. J. C., Glick, P., & Xu, J. (2002). A Model of (Often Mixed) Stereotype Content: Competence and Warmth Respectively Follow From Perceived Status and Competition. *Journal of personality and social psychology*, *82*(6), 878-902. https://doi.org/10.1037/0022-3514.82.6.878

Government of Western Australia. (2025). *Climate Change in WA*. https://www.wa.gov.au/organisation/department-of-water-and-environmental-regulation/climate-change-wa

Grey Nomad administration. (2023). *The Grey Nomads*. https://www.thegreynomads.com.au/

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?:An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59-82. https://doi.org/10.1177/1525822x05279903

Gullette, M. M. (2017). Ending Ageism, or How Not to Shoot Old People. 2. How (Not) to Shoot Old People. In (pp. 22-53). Rutgers University Press. https://doi.org/doi:10.36019/9780813589312-003

Halcomb E, Stephens M, Smyth, E., Meedya, S., & Tillott, S. (2017). The health and health preparation of long-term Australian travellers. *Australian Journal of Primary Health*, *23*, 386-390.

Halcomb, E., & Andrew, S. (2005). Triangulation as a method for contemporary nursing research. *Nurse Researcher*, *13*(2), 71-82. https://doi.org/10.7748/nr2005.10.13.2.71.c5969

Halcomb, E., Stephens, M., Smyth, E., Meedya, S., & Tillott, S. (2017). The health and health preparation of long-term Australian travellers. *Australian Journal of Primary Health*, *23*, 386-390.

Hammersley, M. A., Paul. (2019). *Ethnography Principles in Practice* (Fourth ed.). Routledge.

Hewitt, J., Smeeth, L., Chaturvedi, N., Bulpitt, C. J., & Fletcher, A. E. (2011). Self management and patient understanding of diabetes in the older person. *Diabetic Medicine*, *28*(1), 117-122. https://doi.org/https://doi.org/10.1111/j.1464-5491.2010.03142.x

Hillman, W. (2013). Grey Nomads travelling in Queensland, Australia: social and health needs. *Ageing & Society*, *33*(4), 579-597. https://doi.org/10.1017/S0144686X12000116

Holloway, D. (2007). See Australia and Die: Shifting Discourses About Gray Nomads. *Tourism Culture & Communication*, *7*(3), 161-168. https://doi.org/10.3727/109830407782212475

Holloway, D. (2009). *Grey Nomads: Retirement, leisure and travel in the Australian context* Edith Cowan Universtiy]. Perth.

Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, *15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Jordan, F., & Gibson, H. (2005). "We're not stupid ... but we'll not stay home either": Experiences of solo women travellers. *Tourism Review International*, *9*(2), 195-211. https://doi.org/10.3727/154427205774791663

Jovchelovitch, S., & Bauer, M. (2000). *Narrative interviewing [online].* http://eprints.lse.ac.uk/2633

Kennedy, F., Bathurst, R., & Carroll, B. (2015). Montage:A Method for Developing Leadership Practice. *Advances in Developing Human Resources*, *17*(3), 307-320. https://doi.org/10.1177/1523422315587896

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of Qualitative Descriptive Studies: A Systematic Review. *Research in Nursing & Health*, *40*(1), 23-42. https://doi.org/https://doi.org/10.1002/nur.21768

Korstjens, I., & Moser, A. (2018). Series: Practical Guidance to Qualitative Research. Part 4 Trustworthiness and Publishing *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/https://DOI.org/10.1080/13814788.2017.1375092

Lake, M. (2013). Women's and gender history in Australia: A Transformative Practice. *Journal of Women's History*, *25*(4), 190-211,369.

Leahy, C. P. (2019). From the Little Wife to the Supermom? Maternographies of Feminism and Mothering in Australia since 1945. *Feminist Studies*, *45*(1), 100-128,264.

Lemish, D., & Muhlbauer, V. (2012). “Can't have it all”: Representations of older women in popular culture. *Women & Therapy*, *35*(3-4), 165-180. https://doi.org/10.1080/02703149.2012.684541

Leonard, R., & Burns, A. (2001). Models of the Life-Span for an Ageing Society. In J. Morss, N. Stephenson, & v. R. H. (Eds.), *Theoretical Issues in Psychology* (pp. 265-273). Springer Science + Business Media.

Lewis-Beck, M., Bryman, A., & Futing Liao, T. (2004). Semi-structured interview. In: The SAGE Encyclopedia of Social Science Research Methods. In. https://methods.sagepub.com/ency/edvol/the-sage-encyclopedia-of-social-science-research-methods/chpt/semistructured-interview#_

Lumivero. (2017). *NVivo (Version 12)* In www.lumivero.com

Mackenbach, J. P. P., Stirbu, I. M., Roskam, A.-J. R. M., Schaap, M. M. M., Menvielle, G. P., Leinsalu, M. P., & Kunst, A. E. P. (2008). Socioeconomic Inequalities in Health in 22 European Countries. *The New England Journal of Medicine*, *358*(23), 2468-2481. https://doi.org/https://doi.org/10.1056/NEJMsa0707519

Mansfeld, Y., & Ginosar, O. (1994). Determinants of locals' perceptions and attitudes towards tourism development in their locality. *Geoforum*, *25*(2), 227-248. https://doi.org/https://doi.org/10.1016/0016-7185(94)90018-3

MBS Review Advisory Committee. (2024). *Telehealth Post-Implementation Review Final Report*. https://www.health.gov.au/sites/default/files/2024-06/mbs-review-advisory-committee-telehealth-post-implementation-review-final-report.pdf

McFayden, J., & Rankin, J. (2016). The role of gatekeepers in research: Learning from reflexivity and reflection. *Journal of Nursing and Health Care*, *4*(1), 82-88. https://doi.org/Doi: 10.5176/2345-718X_4.1.135

Murphy, J. (2002). Breadwinning: Accounts Of Work And Family Life In The 1950s. *Labour and Industry*, *12*(3), 59-75. https://doi.org/10.1080/10301763.2002.10722024

Music Festivals Australia. (2024). *Broken Hill Mundi Mundi Bash*. https://musicfestivalsaustralia.com/events-calendar/rockin-the-plains

National Rural Health Alliance. (2023). *Evidence base for additional rural health investment in Australia*. https://www.ruralhealth.org.au/document/evidence-base-additional-investment-rural-health-australia

National Rural Health Alliance Inc. (2008). *Improving the rural and remote health workforce. A submission to the Department of Health and Ageing related to the audit of the rural and remote health workforce* https://ruralhealth.org.au/sites/default/files/submissions/sub-08-02-08.pdf

Nelson, T. D. (2016). Promoting healthy aging by confronting ageism. *American Psychologist*, *71*(4), 276-282. https://doi.org/10.1037/a0040221 (Aging in America: Perspectives From Psychological Science)

Nicholson, L. (2010). Feminism in "Waves": Useful Metaphor or Not? *New Politics*, *12*(4), 34-39.

Northern Territory Government information and services. (2023). https://nt.gov.au/search?query=Towing+a+caravan

NSW Government. (2023a). *Towing a Trailer or Caravan*. https://www.nsw.gov.au/driving-boating-and-transport/roads-safety-and-rules/vehicle-safety-and-compliance/towing-a-carava

NSW Government. (2023b). *Virtual care (telehealth) in Far West and Western NSW*. NSW Government. https://www.nsw.gov.au/health/fwlhd/services/virtual-care

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for Reporting Qualitative Research: A Synthesis of Recommendations. *Academic Medicine*, *89*(9), 1245-1251. https://doi.org/10.1097/acm.0000000000000388

Obst, P., Brayley, N., & King, M. (2008, 10-12 Nov 2008). *Grey Nomads: Road Safety Impacts and Risk Management* 2008 Australasian Road Safety Research, Policing and Education Conference, Adelaide South Australia.

Officer, A., & de la Fuente-Núñez, V. (2018). A global campaign to combat ageism. *Bulletin of the World Health Organization*, *96*(4), 295-296. https://doi.org/10.2471/BLT.17.202424

Onyx, J., & Leonard, R. (2005). Australian grey nomads and American snowbirds: similarities and differences. *The Journal of Tourism Studies*, *16*, 61-68.

Onyx, J., & Leonard, R. (2007). The Grey Nomad phenomenon: Changing the script of aging. *The International Journal of Aging & Human Development*, *64*(4), 381-398. http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2007-07082-004&site=ehost-live

Onyx, J., & Wexler, C. (2017). A review of aging literature: looking for more than decline. *Arts and Humanities Open Access Journal*, *1*(4), 122-123.

Page, M. J., Moher, D., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., . . . McKenzie, J. E. (2021). PRISMA 2020 explanation and elaboration: updated guidance and exemplars for reporting systematic reviews. *BMJ*, *372*, n160. https://doi.org/10.1136/bmj.n160

Parsell, C., Kuskoff, E., & Reddel, T. (2025). *Australia's Housing Crisis: How did we get here and where to now?* https://stories.uq.edu.au/contact-magazine/2023/australias-housing-crisis-how-did-we-get-here-where-to-now/index.html

Patterson, I., Pegg, S., Litster, J. (2011). Grey Nomads on Tour: A Revolution in Travel and Tourism for Older Adults. *Tourism Analysis*, *16*(3), 283-294. https://doi.org/ https://doi.org/10.3727/108354211X13110944387086

Pelto, P. J. (2016). *Applied Ethnography Guidelines for Field Research*. Routledge

Pfau-Effinger, B. (2004). Socio-historical paths of the male breadwinner model - an explanation of cross-national differences. *The British journal of sociology*, *55*(3), 377-399. https://doi.org/10.1111/j.1468-4446.2004.00025.x

Price, M., & Dunning, K. (2019). Social Scripts for Inclusive Excursions. *Agora*, *54*(2), 44-48.

Prideaux, B., & McClymont, H. (2006). The Changing Profile of Caravanners in Australia. *Internation Journal of Tourism Research*, *8*, 45-58.

Pung, J. M., Yung, R., Khoo-Lattimore, C., & Del Chiappa, G. (2020). Transformative travel experiences and gender: a double duoethnography approach. *Current issues in tourism*, *23*(5), 538-558. https://doi.org/10.1080/13683500.2019.1635091

Queensland Government. (1995-2023). *Towing vehicles and trailers*. https://www.qld.gov.au/transport/vehicle-safety/towing/towing-vehicles-and-trailers

Raven, M. (2016). Health of grey nomads: On the move and under the health sector radar [Review]. *Australian Journal of Rural Health*, *24*(3), 182-187.

Riegel, B., Jaarsma, T., & Strömberg, A. (2012). A Middle-Range Theory of Self-Care of Chronic Illness. *Advances in Nursing Science*, *35*(3), 194-204. https://doi.org/10.1097/ANS.0b013e318261b1ba

Roper, M., & Shapira, J. (2000). *Ethnography in Nursing Research*. Sage Publications Inc.

Royal Flying Doctor Service. (2023). *Royal Flying Doctor Service*. https://www.flyingdoctor.org.au/about-the-rfds/

Russell, D. J., Zhao, Y., Guthridge, S., Ramjan, M., Jones, M. P., Humphreys, J. S., & Wakerman, J. (2017). Patterns of resident health workforce turnover and retention in remote communities of the Northern Territory of Australia, 2013-2015. *Human resources for health*, *15*(1), 52-52. https://doi.org/10.1186/s12960-017-0229-9

Sadler, E., Wolfe, C. D., & McKevitt, C. (2014). Lay and health care professional understandings of self-management: A systematic review and narrative synthesis. *SAGE Open Medicine*, *2*, 2050312114544493. https://doi.org/10.1177/2050312114544493

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health 33*(1), 77-84. https://doi.org/https://doi.org/10.1002/nur.20362

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Schuster, J. (2017). Why the personal remained political: comparing second and third wave perspectives on everyday feminism. *Social Movement Studies*, *16*(6), 647-659. https://doi.org/10.1080/14742837.2017.1285223

Siebelt, L., Jackson, C., McFadden, A., Dyson, L., & Atkin, K. (2017). Use of UK health services by Gypsies, Roma, and Travellers: triangulation of two mixed methods studies. *The Lancet (British edition)*, *390*, S81-S81. https://doi.org/10.1016/S0140-6736(17)33016-7

Smart Trucking. (2023). *Australian Road Trains – Kings of the Road in the Outback of Australia*. https://www.smart-trucking.com/australian-road-trains/

Smith, D., & Ruston, A. (2013). 'If you feel that nobody wants you you'll withdraw into your own': Gypsies/Travellers, networks and healthcare utilisation. *Sociology of Health & Illness*, *35*(8), 1196-1210. https://doi.org/10.1111/1467-9566.12029

Song, M., & Kong, E. H. (2015). Older adults' definitions of health: A metasynthesis. *International journal of nursing studies*, *52*(6), 1097-1106. https://doi.org/https://doi.org/10.1016/j.ijnurstu.2015.02.001

Sophie Matterson. (2023). *A camel odyssey complete*. https://www.australiangeographic.com.au/society/society-expeditions/2023/05/a-camel-odyssey-complete/

South Australian Government. (2023). https://www.sa.gov.au/search?collection=sagov-web-search&query=Towing+a+caravan&x=3&y=12

Šprocha, B., & Bleha, B. (2021). Mortality, Health Status and Self-Perception of Health in Slovak Roma Communities. *Social indicators research*, *153*(3), 1065-1086. https://doi.org/10.1007/s11205-020-02533-2

State of Queensland. (2024). *Queensland Future Climate*. https://longpaddock.qld.gov.au/qld-future-climate/regional-sum/

Stephens, M., Halcomb, E., & Dewing, J. (2018). Living on: an exploration of healthful cancer survivorship among grey nomads. *Australian Journal of Cancer Nursing*, *9*(1), 19-24.

Summers, A. (2016). *Damned Whores and God's Police*. NewSouth.

Tate, J., Mein, J., Freeman, H., & Maguire, G. (2006). Grey nomads--health and health preparation of older travellers in remote Australia. *Australian Family Physician*, *35*(1/2), 70-72.

The Birdsville Race Club. (2025). *An event unlike any other*. https://birdsvilleraces.com/

Tong, R. (2007). Feminist thought in transition: Never a dull moment. *The Social Science Journal*, *44*(1), 23-39. https://doi.org/10.1016/j.soscij.2006.12.003

Tourism Australia. (2023). *Come and say g'day*. Tourisim Australia. https://www.australia.com/en

Tourism Australia. (2024). *Welcome to Tourism Australia's Corporate Site*. https://www.tourism.australia.com/en

Tourism Research Australia. (2019). *TRA Case Study: Caravan Industry Association of Australia*. Retrieved 10.08.2019 from https://www.tra.gov.au/Data-and-Research/Case-studies/case-studies

Tourism Research Australia. (2025). *Caravan and camping data*. Australian Trade and Investment Commission. https://www.tra.gov.au/en/domestic/caravan-and-camping-data

TRA. (2023). *Caravan and Camping Data*. Australian Government, Australian Trade and Investment Commission. https://www.tra.gov.au/Domestic/monthly-snapshot

Trappe, H., Pollmann-Schult, M., & Schmitt, C. (2015). The Rise and Decline of the Male Breadwinner Model: Institutional Underpinnings and Future Expectations. *European sociological review*, *31*(2), 230-242. https://doi.org/10.1093/esr/jcv015

Victorian Government. (2023). https://www.vicroads.vic.gov.au/searchresultpage?collection=vicroads-web&query=Towing%20a%20caravan

WA Government. (2021). *Caravan towing safety information*. https://www.wa.gov.au/government/publications/caravan-towing-safety-information-give-caradamn-reference-checklist

Webb, C. (1993). Feminist research: definitions, methodology, methods and evaluation. *Journal of advanced nursing*, *18*(3), 416-423. https://doi.org/10.1046/j.1365-2648.1993.18030416.x

Webb, C., Doggett, S., & Russell, R. (2013). *Arthropod Pests of Public Health significance in Australia* Commonwealth of Australia https://www.health.gov.au/sites/default/files/documents/2022/07/enhealth-guidance-arthropod-pests-of-public-health-significance-in-australia.pdf

White, N. R., & White, P. B. (2004). Travel as transition: Identity and Place. *Annals of tourism research*, *31*(1), 200-218. https://doi.org/https://doi.org/10.1016/j.annals.2003.10.005

Whittemore, R., & Knapfl, K. (2005). The integrative review: updated methodology. *Journal of advanced nursing*, *52*(5), 546-553. https://doi.org/https://doi.org/10.1111/j.1365-2648.2005.03621.x

WHO. (2015). *World Report on Ageing and Health*. https://www.who.int/publications/i/item/9789241565042

WHO. (2025). *Ageism*. https://www.who.int/health-topics/ageism#tab=tab_1

Williams, S. (2017, 24 February). Grey nomad numbers up. *The Sydney Morning Herald*. https://www.smh.com.au/national/nsw/grey-nomad-numbers-up-20170223-gujkdx.html

Wilson, S., & Hannam, K. (2017). The frictions of slow tourism mobilities: conceptualising campervan travel. *Annals of tourism research*, *67*, 2536-2566. http://sure.sunderland.ac.uk/id/eprint/8561/

Wolcott, H. F. (2005). *The Art of Fieldwork* (Second ed.). AltaMira Press.

Wolcott, H. F. (2010). *Ethnography Lessons A Primer*. Left Coast Press Inc. .

Wood, L., & Villiers, R. (2024). Leave no-one behind: reducing health disparities for women experiencing homelessness in Australia. *Medical Journal of Australia*, *221*(7), 354-356. https://doi.org/https://doi.org/10.5694/mja2.52430

World Health Organisation. (2022). *Aging and Health*. WHO. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

Yates, M., & Perry, L. (2019, 21-23 August 2019). *Travelling as grey nomads: What does this mean for their health and health care access?* The National Nursing Forum Nursing Now-Power of Policy, Hobart, Tasmania, Australia.

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2021). Exploring the 'grey nomad' travelling population of Australia and its health: an integrative literature review. *Australian Journal of Primary Health*, *27* (3), 163-177. https://doi.org/https://doi.org/10.1071/PY20023

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2022). 'Grey nomad' travellers' use of remote health services in Australia: a qualitative enquiry of hospital managers' perspectives. *BMC Health Services Research*, *22*(1). https://doi.org/https://dx.doi.org/10.1186/s12913-022-07580-8

Yates, M., Perry, L., Onyx, J., & Levett-Jones, T. (2024). Women travelling solo or with other women across Australia: A montage of narratives. *Journal of Women & Aging*. https://doi.org/https://doi.org/10.1080/08952841.2024.2431412