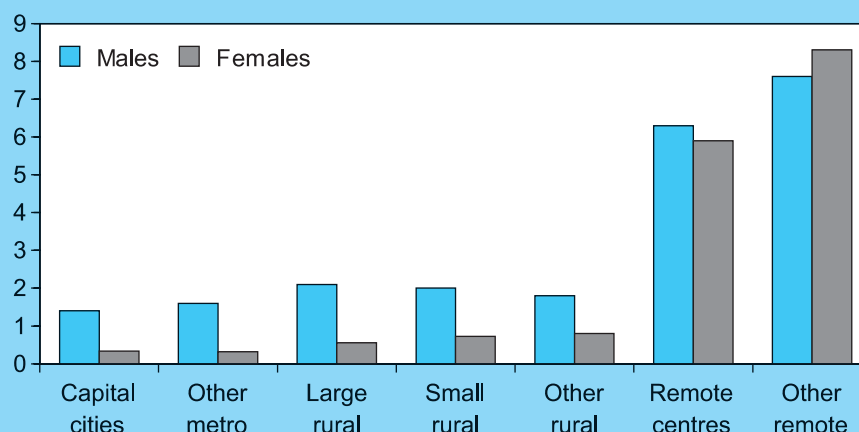


Hospital separation rates for homicide and injury purposely inflicted by other people, 1995–96

Separations per 1,000 population



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	1.4	*1.6	*2.1	*2.0	*1.8	*6.3	*7.6	1.8
Females	0.3	0.3	*0.6	*0.7	*0.8	*5.9	*8.3	0.6

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Records with length of stay greater than 364 days were eliminated from the analysis.
2. Causes of homicide and injury purposely inflicted by other persons are classified according to the ICD-9 external cause codes E960 to E969.

Source: AIHW National Morbidity Database.

Hospitalisation due to interpersonal violence

- Better data are available for fatalities from interpersonal violence than for non-fatal outcomes because some interpersonal violence goes unrecorded or may be attributed to other causes. As a result, it is likely that the hospitalisation rates from this cause of injury are underestimated (DHFS & AIHW 1998b).
- Males from the remote zone have three to five times higher rates of hospitalisation due to interpersonal violence than do males in metropolitan and rural zones. Rural hospital separation rates are double the metropolitan rates for females and around one-third higher for males.
- Females from the remote zone have seven to 25 times higher rates of hospitalisation due to interpersonal violence compared with females from other zones. However, the result is

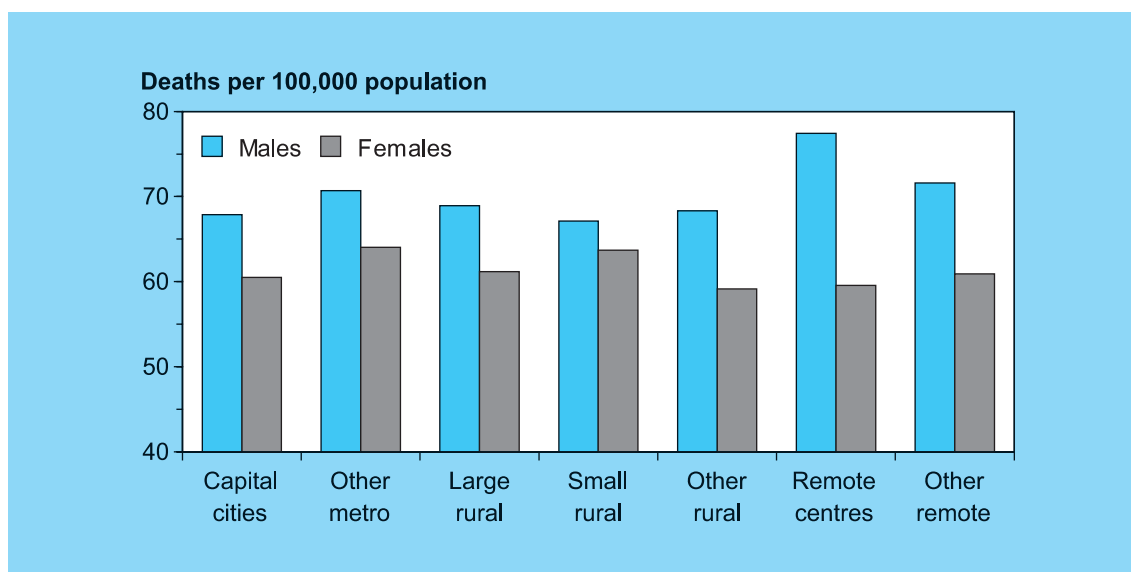
difficult to interpret because interpersonal violence against females in the non-Indigenous population is likely to be under-reported (Healthsharing Women 1994).

For more information, see:

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Injury prevention and control 1997. AIHW Cat. No. PHE 3. Canberra: DHFS & AIHW.

Healthsharing Women 1994. Women, health and the rural decline in Victoria. In Franklin MA, Short LM & Teather EK (eds.). Country women at the crossroads. Armidale: University of New England Press, 92–98.

Death rates for stroke, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	67.9	70.9	68.9	67.1	68.3	77.4	71.6	68.3
Females	60.5	64.0	61.2	63.7	59.2	59.6	61.0	60.9

Notes

1. Age-standardised to the Australian population at 30 June 1991.
 2. None of the rates is significantly different from 'capital cities' at the 5% level.
- Source: AIHW National Mortality Database.

Deaths from stroke

- For the period 1992–96, stroke accounted for 10% of all deaths in Australia. Risk factors for stroke include increasing age, high blood pressure, smoking, high serum cholesterol, obesity, lack of exercise and heavy alcohol intake.
- Some 25% of stroke victims die within the first month after stroke and a further 40% die within 1 year (Anderson et al. 1994).
- Death rates from stroke are similar across all regions for both males and females. The differences that are shown between remote, rural and metropolitan zones are not significantly different from those of 'capital cities' at the 5% level.
- Males have a higher rate of death from stroke compared with females across all zones. Males also have a higher incidence rate of stroke than females. This is supported by studies of

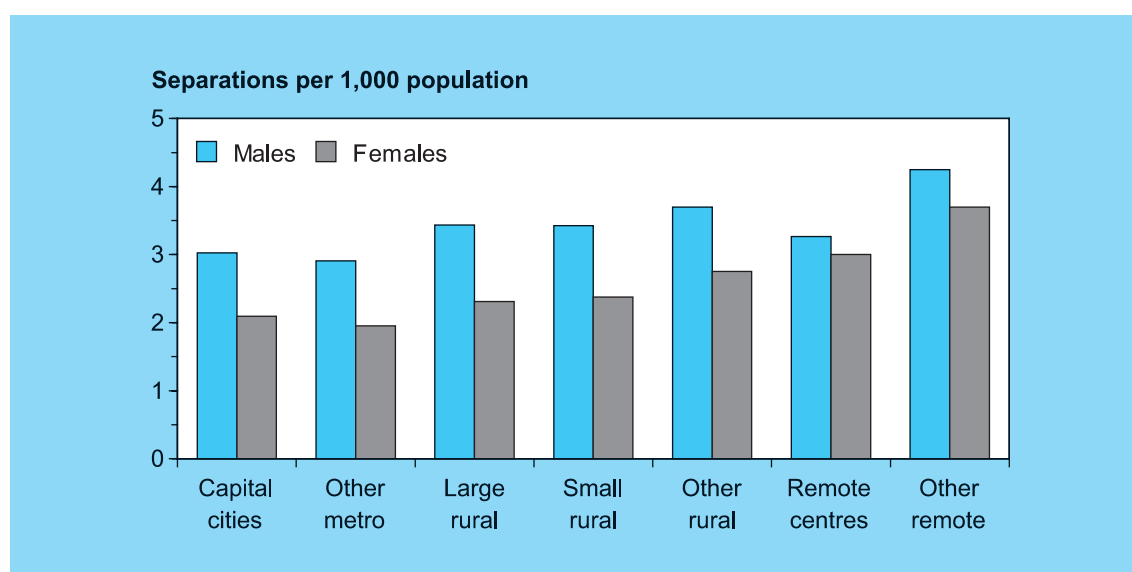
stroke incidence from Western Australia where age-adjusted rates were 132 per 100,000 for males and 77 per 100,000 for females (Anderson et al. 1993).

For more information, see:

Anderson C, Jamrozik K, Burvill P, Chakera T, Johnson G & Stewart-Wynne E 1993. Ascertaining the true incidence of stroke: experience from the Perth Community Stroke Study, 1989–1990. *Med J Aust* 158: 80–84.

Anderson C, Jamrozik K, Broadhurst R & Stewart-Wynne E 1994. Predicting survival among different subtypes of stroke: experience from the Perth Community Stroke Study, 1989–1990. *Stroke* 25: 1935–44.

Hospital separation rates for stroke, 1995–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	3.0	2.9	*3.4	*3.4	*3.7	3.3	*4.3	3.2
Females	2.1	2.0	*2.3	*2.4	*2.8	*3.0	*3.7	2.2

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Morbidity Database.

Hospitalisation due to stroke

- Hospitalisation rates from stroke are higher among males, as they are for death from stroke. This pattern is consistent across all seven RRMA categories.
- Unlike death rates, a clear pattern emerges for hospitalisation following stroke in the RRMA categories. Males and females from 'other remote areas' have the highest rate of hospitalisation due to stroke. The lowest rates are found in males and females in the metropolitan zone.
- The higher hospitalisation rates for stroke in rural and remote zones contrasts with the lack of significant differences between death rates in the metropolitan, rural and remote zones. The decision to hospitalise a patient for stroke may be based on factors such as the distance that he/she will have to travel to hospital

from home. Other considerations may include the availability of home-based nursing, nursing homes or community health services. Such services may be unavailable in remote communities, making hospitalisation the only option for long-term care of stroke victims.

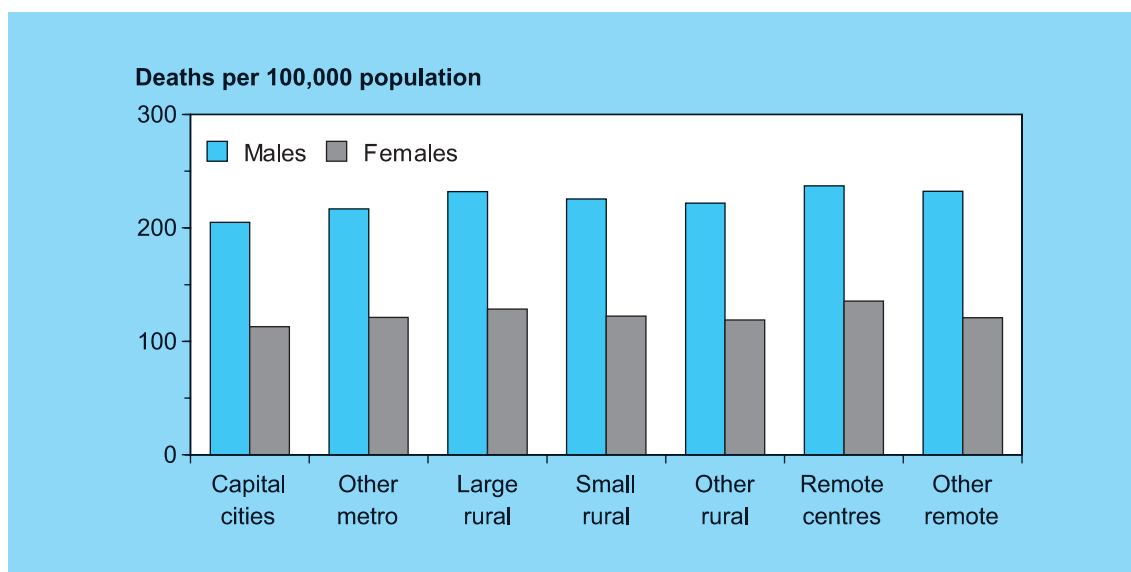
- As the average age of Australia's population increases, the incidence of stroke is also set to increase. An increase of 69% in the number of new stroke cases per year has been predicted by the year 2016 (NHMRC 1997).

For more information, see:

National Health and Medical Research Council 1997. Prevention of stroke. Clinical practice guidelines, December 1996. Canberra: AGPS.

Coronary heart disease

Death rates for coronary heart disease, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	205.0	216.7	*231.9	*225.6	*221.9	237.1	232.3	212.4
Females	113.0	*121.0	*128.6	*122.1	118.8	135.6	120.8	116.4

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Mortality Database.

Deaths from coronary heart disease

- Coronary heart disease is the most common form of cardiovascular disease and its cause is blockage of one or more of the coronary arteries that supply the heart with blood (Wise & Graham-Clarke 1994). The risk factors for coronary heart disease include being overweight or obese, having high serum cholesterol levels, smoking, high alcohol consumption and lack of regular exercise.
- Coronary heart disease is a major cause of mortality in Australia, accounting for 25% of all male deaths and 22% of all female deaths from 1992 to 1996. In 1996, 49,726 deaths were due to coronary heart disease alone.
- Death rates from coronary heart disease are higher in rural and remote zones compared with the metropolitan zone, for both sexes. The rates for the rural zone are significantly different from 'capital cities' at the 5% level.
- Across all zones, the male rate of death is twice that of the female rate. In general, cardiovascular disease is a greater health risk for males than for females. However, cardiovascular disease is still the leading cause of death in Australian females (Wise & Graham-Clarke 1994).

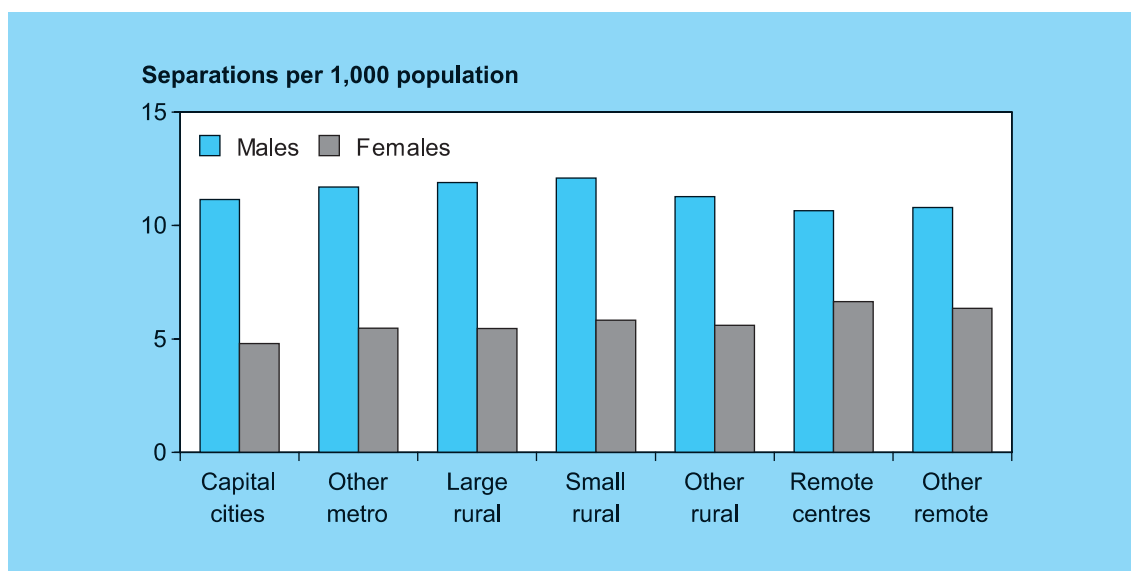
For more information, see:

Australian Bureau of Statistics 1997. Causes of death Australia, 1996. ABS Cat. No. 3303.0. Canberra: AGPS.

Australian Bureau of Statistics 1997. 1995 National Health Survey. Cardiovascular and related conditions Australia. ABS Cat. No. 4372.0. Canberra: AGPS.

Wise M & Graham-Clarke P 1994. Cardiovascular health in Australia. A review of current activities and future directions. Canberra: AGPS.

Hospital separation rates for coronary heart disease, 1995–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	11.1	11.7	*11.9	*12.1	11.3	10.7	10.8	11.3
Females	4.8	*5.5	*5.5	*5.8	*5.6	*6.7	*6.3	5.1

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Morbidity Database.

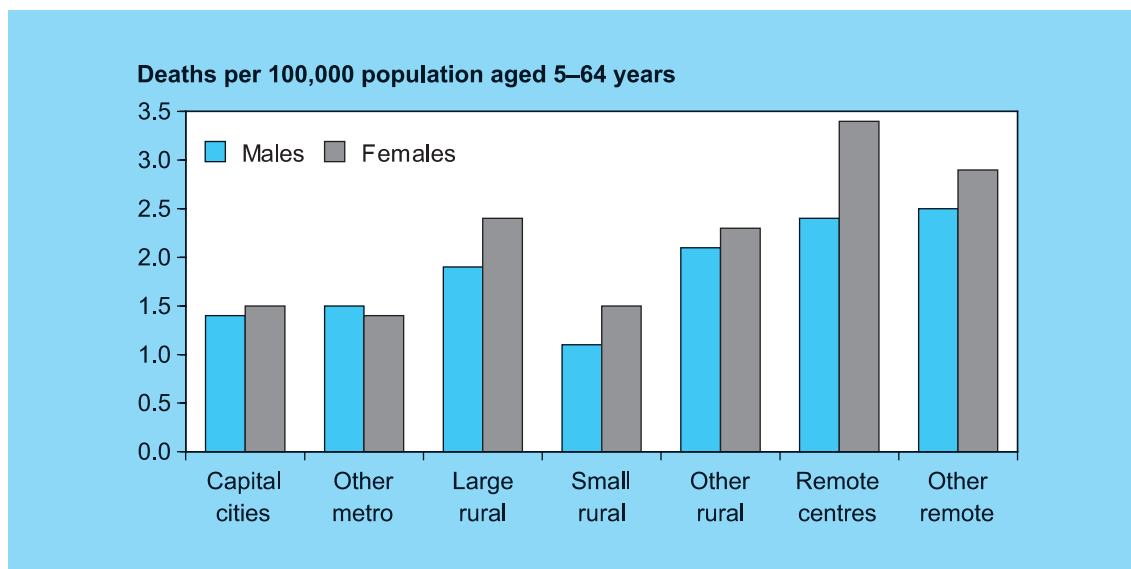
Hospitalisation due to coronary heart disease

- About 50% of all heart attack deaths occur before the victims reach hospital. However, once victims arrive at hospital, their chances of surviving improve substantially (Wise & Graham-Clarke 1994).
- The rates for hospital separations for coronary heart disease vary across the RRMA categories. The males living in 'large rural centres' and 'small rural centres' have significantly higher hospitalisation rates compared with those living in 'capital cities'. The rate for females living in 'capital cities' is significantly lower than the rates for all other RRMA categories.
- Females in the remote zone have slightly higher rates of hospital separations compared with females in other zones. Conversely, males in the remote zone have slightly lower rates of hospital separations compared with males from other zones. Males in the remote zone have higher death rates from coronary heart disease and their lower rate of hospitalisation may reflect fewer males surviving to be hospitalised in these zones. Another reason may be that males in the remote zone are at greater risk of premature death from injury, specifically road traffic accidents, than males in other zones. As a result, many may die from other causes before coronary heart disease can develop.
- Females have around half the hospital separation rate of males from the same zones. This reflects the lower risk of coronary heart disease for females relative to males also noted from the differences in death rates.

For more information, see:

Wise M & Graham-Clarke P 1994. Cardiovascular health in Australia. A review of current activities and future directions. Canberra: AGPS.

Death rates for asthma for persons aged 5–64 years, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	1.4	1.5	2.0	1.1	*2.1	2.4	2.5	1.6
Females	1.5	1.4	2.4	1.5	2.3	3.4	2.9	1.7

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Mortality Database.

Deaths from asthma

- Asthma is a chronic and debilitating disease that involves inflammation of the airways and results in wheezing, breathlessness, chest tightening and cough (Holgate 1997). It can cause death in the absence of medical intervention.
- The National Asthma Campaign (NAC) recommends the use of the age group 5–34 years for monitoring asthma deaths with the intention of preventing premature mortality. However, we report on a wider age group, 5–64 years, to provide a broad overview of asthma mortality in Australia.
- The remote zone has the highest death rates from asthma for both males and females. The rates are similar for the sexes in 'capital cities' and increase with remoteness to a similar extent. 'Small rural centres' are an exception to the higher rates in the rural zone as they have

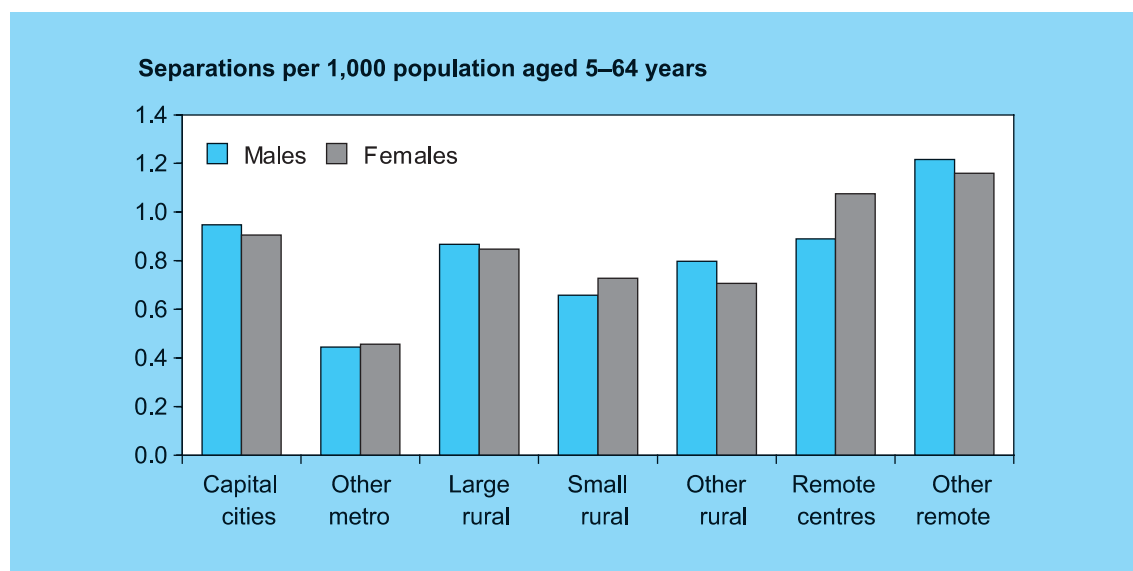
rates lower than that for males and females in 'capital cities'.

- The death rates from asthma among females are consistently higher than the male rates in all RRMA categories, except in 'other metropolitan centres'.
- People in rural and remote communities may not be monitoring their asthma to the same extent as people in the metropolitan zone with more direct access to health care. The result may be higher mortality from asthma in rural and remote zones compared with the metropolitan zone.

For more information, see:

Holgate ST 1997. Asthma: a dynamic disease of inflammation and repair. In Chadwick D & Cardew G (eds). The rising trends in asthma. Ciba Foundation Symposium 206. Chichester: John Wiley & Sons Ltd.

Hospital separation rates from asthma for persons aged 5–64 years, 1995–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	1.0	*0.4	0.9	*0.7	*0.8	0.9	1.2	0.9
Females	0.9	*0.5	0.9	*0.7	*0.7	1.1	*1.2	0.8

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Morbidity Database.

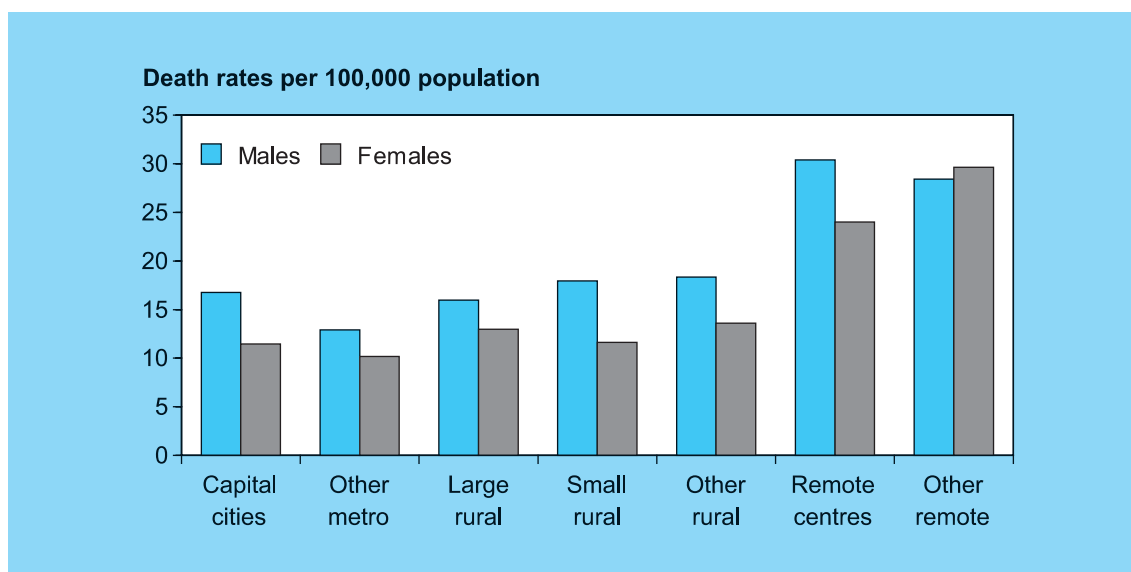
Hospital separations for asthma

- The prevalence of asthma, particularly in children and young adults, is increasing in Australia (Woolcock & Peat 1997). Risk factors for the development of asthma include being allergic to house dust mites, the mould *Alternaria*, or cats. Other risk factors are environmental tobacco smoke, diet and parental asthma (Woolcock & Peat 1997). Hospitalisation occurs for severe asthma attacks and asthma conditions that are not responding to the usual corticosteroid treatments.
- No clear RRMA pattern emerges for asthma hospitalisation, but interesting variation is noted in rates. Within the metropolitan zone, the hospitalisation rates in 'capital cities' are almost double the rates in 'other metropolitan centres'. The rates in 'small rural centres' and 'other rural areas' are also significantly lower than in 'capital cities'.
- Across all RRMA categories, there are no substantial differences between the male and female hospitalisation rates for asthma.
- Although the hospitalisation rates for asthma in the remote zone are higher than for other zones, interpreting hospitalisation for chronic conditions in the remote zone is difficult because individuals may be admitted to hospital if they have to travel long distances for follow-up treatment.

For more information, see:

Woolcock AJ & Peat JK 1997. Evidence for the increase in asthma world-wide. In Chadwick D & Cardew G (eds). *The rising trends in asthma*. Ciba Foundation Symposium 206. Chichester: John Wiley & Sons Ltd.

Death rates for diabetes, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	16.8	*12.9	16.0	18.0	18.3	30.4	*28.4	17.0
Females	11.5	10.2	13.0	11.6	*13.6	24.0	*29.7	12.1

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Mortality Database.

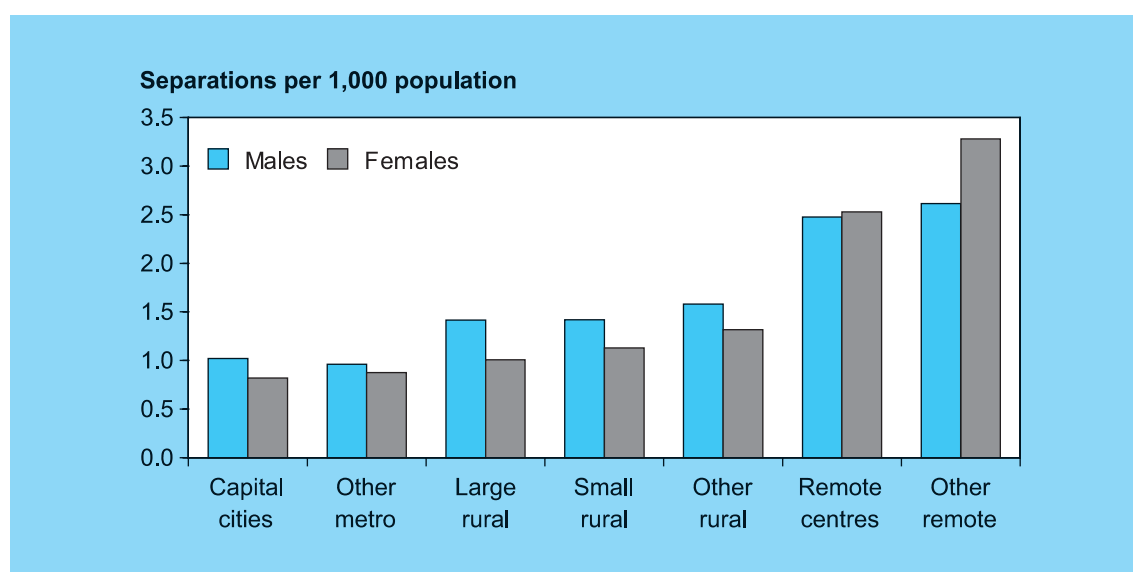
Deaths due to diabetes

- Diabetes results from the body's inability to properly metabolise glucose. The disease itself is not usually life-threatening but without proper medical supervision can lead to death.
- Diabetes is a risk factor for several diseases including cardiovascular disease and renal failure. These life-threatening diseases are often co-morbidities in people with diabetes and this makes ascertaining the cause of death difficult. Consequently, deaths from diabetes may be under-reported.
- Higher death rates are noted among males in comparison to females. This pattern is consistent across all RRMA categories except 'other remote areas'.
- Deaths from diabetes occur at higher rates in the remote zone than in the rural zone, which in turn have higher rates than those observed in the metropolitan zone. Males from 'other metropolitan centres' have significantly lower death rates compared with males from 'capital cities', whereas, males from 'other remote areas' have significantly higher death rates than males from 'capital cities'. In fact, males in the remote zone have almost twice the death rate from diabetes than males from the metropolitan zone and 'large rural centres'.
- Females from 'other rural areas' have significantly higher death rates from diabetes than females from 'capital cities'. Females in the remote zone have over twice the death rate from diabetes than females from the metropolitan and rural zones.
- The differential between those living in the remote zone and other zones could be influenced by a number of factors including access to and quality of health care services, availability of adequate management care plans and appropriate diets.

For more information, see:

McCarty J, Zimmet P, Dalton D, Segal L & Welborn T 1996. The rise and rise of diabetes in Australia. A review of statistical trends and costs. Canberra: Diabetes Australia.

Hospital separation rates for diabetes, 1995–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	1.0	1.0	*1.4	*1.4	*1.6	*2.5	*2.6	1.2
Females	0.8	0.9	*1.0	*1.1	*1.3	*2.5	*3.3	1.0

* Significantly different from 'capital cities' at the 5% level.

Note: Age-standardised to the Australian population at 30 June 1991.

Source: AIHW National Morbidity Database.

Hospital separations for diabetes

- Diabetes is a chronic condition that requires hospitalisation only in acute situations. Most people with diabetes manage their condition at diabetes clinics or with their general practitioners.
- Those living in the remote zone are hospitalised for diabetes at over twice the rate of their counterparts in the metropolitan zone. Males and females from the rural zone also have higher hospitalisation rates for diabetes. Rural males have rates 50% higher than those living in the metropolitan zone. Rural females have rates 25% higher than those living in the metropolitan zone.
- Females are hospitalised less often than males for diabetes. This pattern is consistent across all the RRMA categories except 'other remote areas'.
- The metabolic imbalance resulting from diabetes leads to a variety of complications, some of which require hospitalisation. In these

cases, diabetes is regarded as an associated rather than a principal diagnosis. Therefore, hospital separations resulting from diabetes are seriously underestimated.

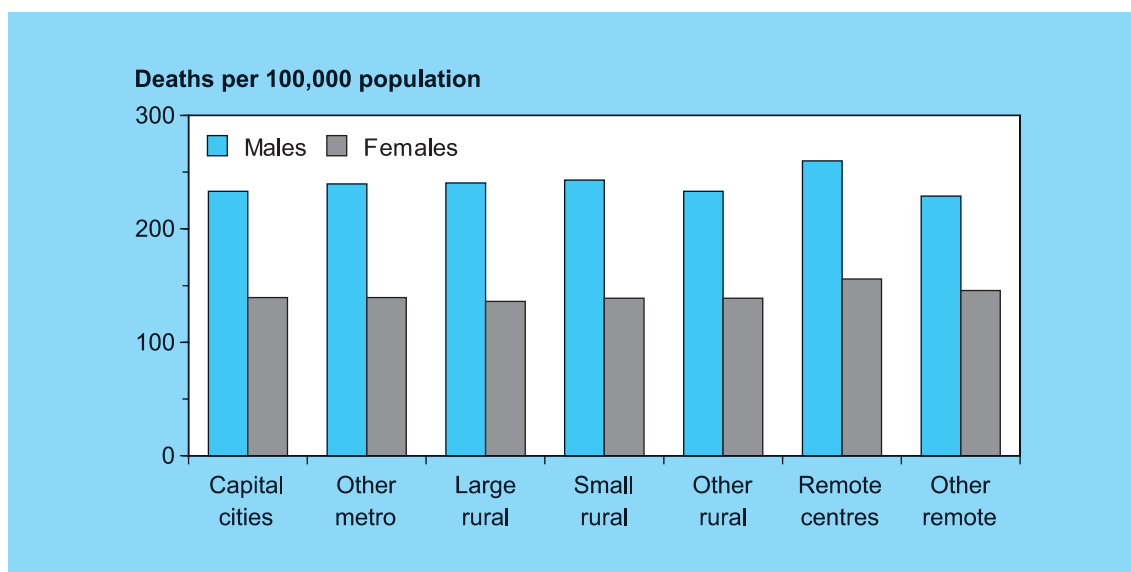
- Indigenous Australians have high prevalence rates of Type 2 (non-insulin-dependent) diabetes (AIHW & DHFS 1997). This may account for the higher hospital separation rates in the remote zone.

For more information, see:

Australian Institute of Health and Welfare & Commonwealth Department of Health and Family Services 1997. First report on National Health Priority Areas 1996. AIHW Cat. No. PHE 1. Canberra: AIHW & DHFS.
Colaguirri S, Colaguirri R & Ward J 1998. National diabetes strategy and implementation plan. Canberra: Diabetes Australia.

All cancer

Death rates for all cancers, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	233.1	239.6	240.4	243.1	233.2	260.0	228.9	234.8
Females	139.4	139.4	136.1	138.9	139.0	155.8	145.8	139.3

Notes

1. Age-standardised to the Australian population at 30 June 1991.
 2. None of the rates is significantly different from 'capital cities' at the 5% level.
- Source: AIHW National Mortality Database.

Deaths due to cancer

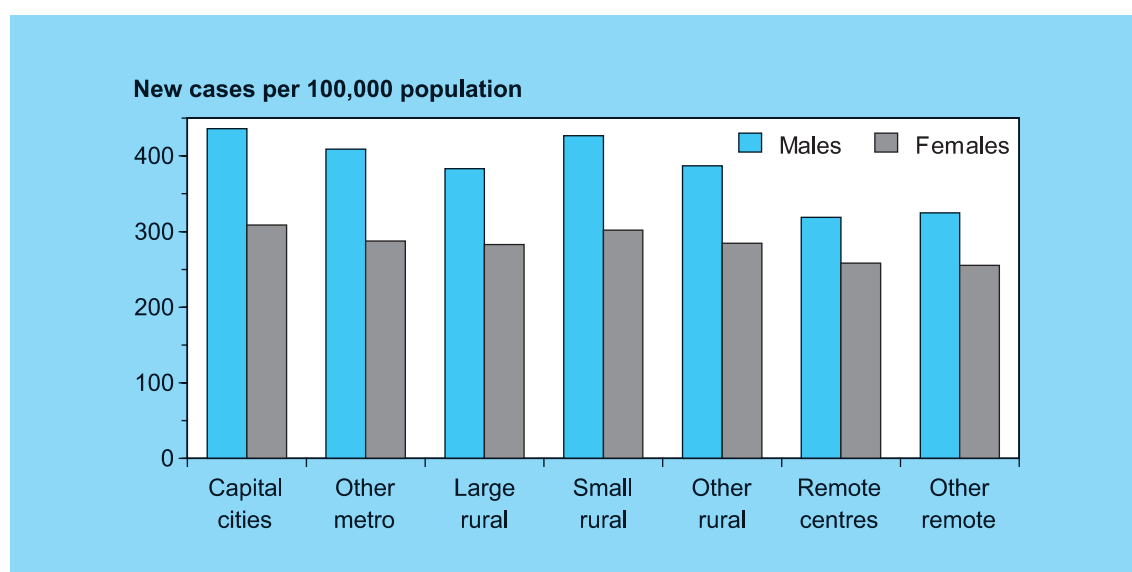
- Cancer is the leading cause of death in Australia. It is a varied group of diseases that are caused by the growth and spread of abnormal cells that are not regulated by normal cellular mechanisms. These cells can invade and destroy body tissue and spread to other organs (DHFS & AIHW 1998b). Each type of cancer has its own mechanisms for development and growth.
- In general, cancer occurs more commonly in males than in females, with one out of three males developing cancer compared with one out of four females (DHFS & AIHW 1998b). Males have a higher rate of death for every major cancer, except for cancers of the breast, gallbladder and thyroid (Jelfs et al. 1996).
- For all cancers combined, the death rate for males is higher than for females across all RRMA categories. Cancer death rates are highest for males and females from 'remote centres', although these rates are not significantly different from those of males and

females from 'capital cities' at the 5% level. Cancer death rates for females are similar for all zones except for the remote zone, where death rates are around 10% higher than other zones.

For more information, see:

Jelfs P, Coates M, Giles G et al. 1996. Cancer in Australia 1989–1990 (with projections to 1995). AIHW Cancer Series No. 5. Canberra: AIHW. Australian Institute of Health and Welfare & Australasian Association of Cancer Registries 1998. Cancer in Australia 1991–1994 (with projections to 1999). Cancer Series No. 7. AIHW Cat. No. CAN 2. Canberra: AIHW. Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat No. PHE 4. Canberra: DHFS & AIHW.

Cancer incidence, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	436.2	409.2	383.2	426.7	*387.1	*319.0	*324.6	419.8
Females	308.6	287.6	282.9	301.8	284.6	258.4	*255.4	300.6

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Data for Queensland were unavailable for 1992–94 at the time of analysis and are excluded.
3. Some Victorian data may be incorrect for place of residence at diagnosis.

Source: AIHW National Cancer Statistics Clearing House.

Incidence of cancers

- Cancer is a notifiable disease in all States and Territories. As a result, it is one disease for which almost complete incidence data is available. Cancer incidence increases with age and 55% of all cancers occur in those aged over 65 years of age. Better diagnosis of cancer has led to an increase in the incidence of cancer reported in recent years. Projections of new cancer cases in Australia have been estimated at 76,000 cases per annum by 1999 (DHFS & AIHW 1998b).
- For the period 1986–1994, there was a higher incidence of cancers in the metropolitan zone than in either the rural or remote zone. An exception was 'small rural centres', which had cancer incidence rates similar to those of 'capital cities' and higher than those for 'other metropolitan centres'. The higher incidence in the metropolitan zone may reflect better availability of diagnostic facilities. Males have a higher incidence of cancer than do females.

This is true for all RRMA categories. The lowest levels of cancer incidence are for males and females in 'remote centres' and 'other remote areas'. This is in contrast to the death rates for cancer, which are highest for males and females in 'remote centres'.

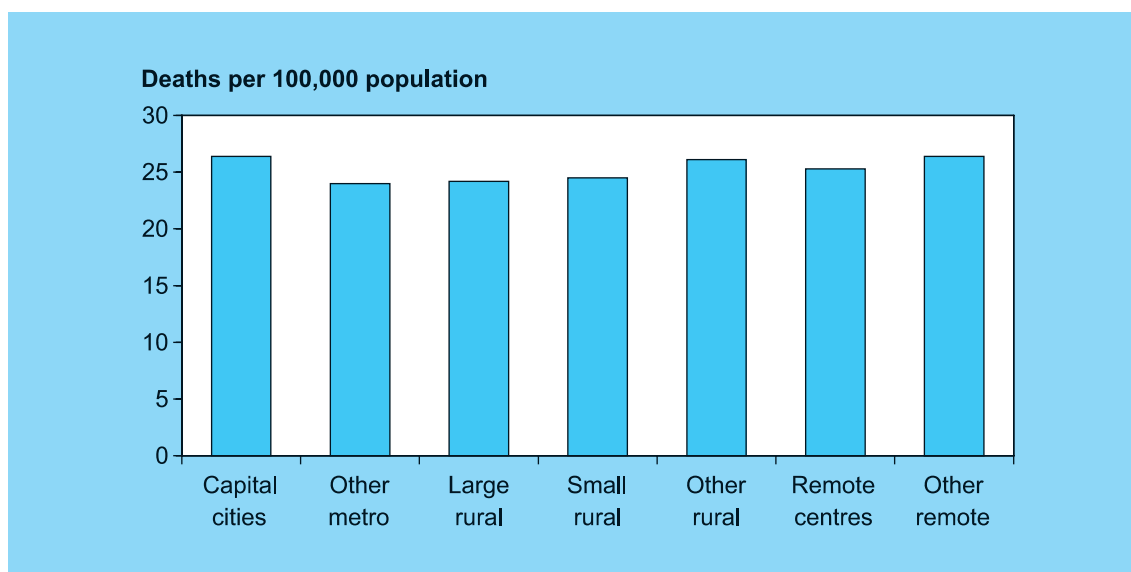
For more information, see:

Australian Institute of Health and Welfare & Australasian Association of Cancer Registries 1998. *Cancer in Australia 1991–1994 (with projections to 1999)*. Cancer Series No. 7. AIHW Cat. No. CAN 2. Canberra: AIHW.

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. *National Health Priority Areas report. Cancer control 1997*. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

Breast cancer

Death rates for breast cancer in women, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Females	26.4	24.0	24.2	24.5	26.1	25.3	26.4	25.9

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. None of the rates is significantly different from 'capital cities' at the 5% level.

Source: AIHW National Mortality Database.

Deaths from breast cancer

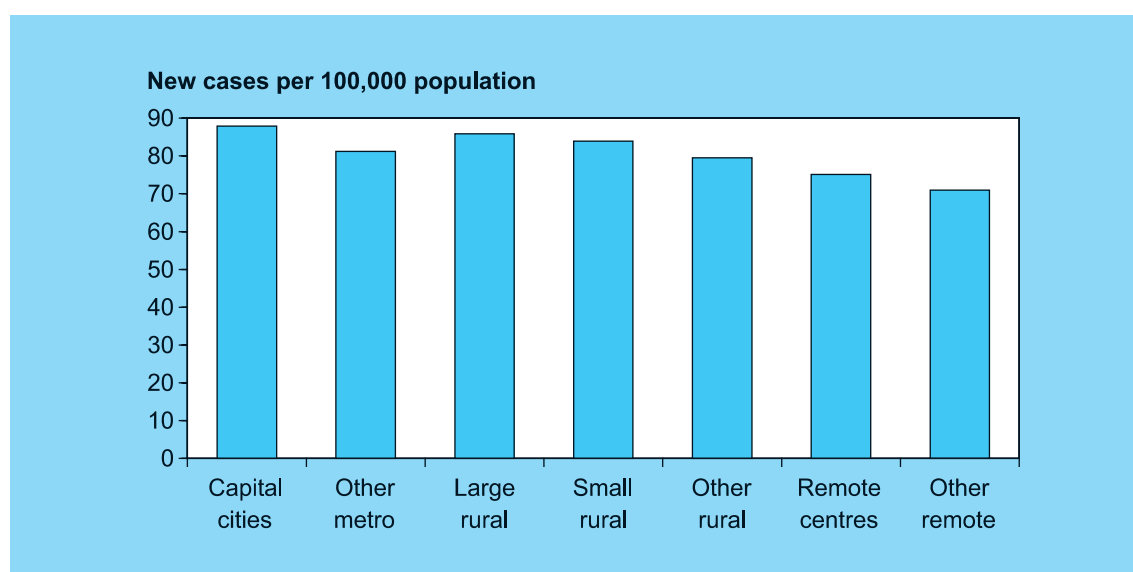
- Breast cancer is the most common cancer diagnosed in females in Australia apart from non-melanocytic skin cancers. It is also the most common cause of cancer-related death in Australian females. Over 2,500 females die from breast cancer yearly (DHFS & AIHW 1998b). The risk factors for breast cancer include age and family history of the disease.
- Prevention of mortality from breast cancer is currently achievable by early detection (via mammography) and early treatment. The 5-year relative survival rate for females with localised disease is 90% (Kricker & Jelfs 1996). Increased survival in recent years is a result of screening techniques such as mammography and breast examination by a doctor and advances in treatment.
- BreastScreen Australia provides free 2-yearly mammographic screening to females over the age of 40. The target group is females aged 50–69 years but females aged 40–49 years and over 70 years are also able to participate (DHFS & AIHW 1998b).
- RRMA category does not appear to be a factor in mortality from breast cancer, with death rates similar in all regions.

For more information, see:

Kricker A & Jelfs P 1996. Breast cancer in Australian women 1921–1994. AIHW Cancer Series No. 6. Canberra: AIHW.

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

Incidence of breast cancer in females, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Females	88.0	81.2	85.9	83.9	79.5	75.1	71.0	85.5

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. None of the rates is significantly different from 'capital cities' at the 5% level.
3. Queensland data included.
4. Some Victorian data may be incorrect for place of residence at diagnosis.

Source: AIHW National Cancer Statistics Clearing House.

Incidence of breast cancer

- In 1994, there were 9,694 new cases of breast cancer registered in Australia (DHFS & AIHW 1998b). Breast cancer incidence has increased by 5.7% per year from 1990 to 1994 for females of all ages. For females aged 50–74 years the increase in incidence has been higher, 8.3% per year (DHFS & AIHW 1998b). It has been estimated that 1 in 14 females will develop breast cancer if they live to 75 years of age (Kricker & Jelfs 1996).
- Incidence of breast cancer is highest in females from 'capital cities' and lowest in females from 'other remote areas'. This is in contrast to the death rates for females from these two areas, which are similar.
- The differences in incidence rates between rural and remote zones and 'capital cities' are not significantly different at the 5% level. However, the lower rates in the remote zone

could be a result of differences in availability of and access to screening programs between the zones. Screening for breast cancer involves mammography and/or breast examination by a doctor. Mammography detects about 30% of all breast cancers (DHFS & AIHW 1998b).

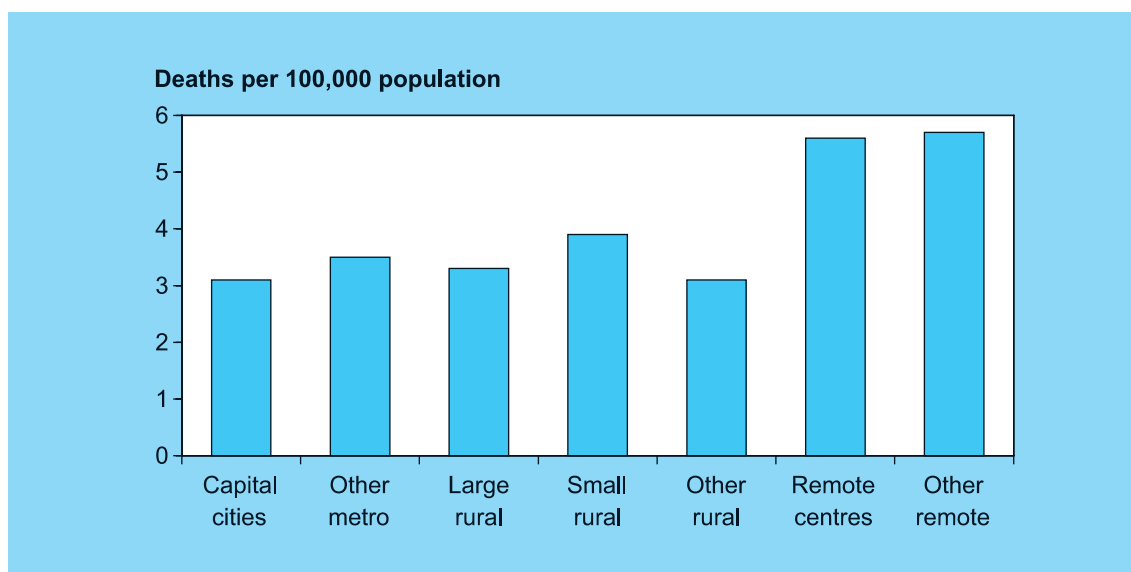
For more information, see:

Kricker A & Jelfs P 1996. Breast cancer in Australian women 1921–1994. AIHW Cancer Series No. 6. Canberra: AIHW.

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

Cervical cancer

Death rates for cervical cancer, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Females	3.1	3.5	3.3	3.9	3.1	5.6	5.7	3.3

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. None of the rates is significantly different from 'capital cities' at the 5% level.

Source: AIHW National Mortality Database.

Deaths from cervical cancer

- Cervical cancer is the eighth most common type of cancer in Australian females (AIHW & DHFS 1997). In 1994, 1,121 new cases of the disease were reported (DHFS & AIHW 1998b). Mortality from cervical cancer has continued to decline with the introduction and widespread use of the Papanicolaou (Pap) smear test. Pap smear tests are effective for identifying pre-cancerous abnormalities. The early stages of the disease are easy to treat, and prevent the occurrence of cancer.
- Females from the remote zone have higher death rates for cervical cancer than females from all other zones. Females from metropolitan and rural zones have similar death rates for cervical cancer. None of the rates for rural and remote zones is significantly different from 'capital cities' at the 5% level.
- Lack of screening tests in the remote zone may result in greater mortality from cervical cancer if the disease is diagnosed at a later stage. However, most States and Territories have

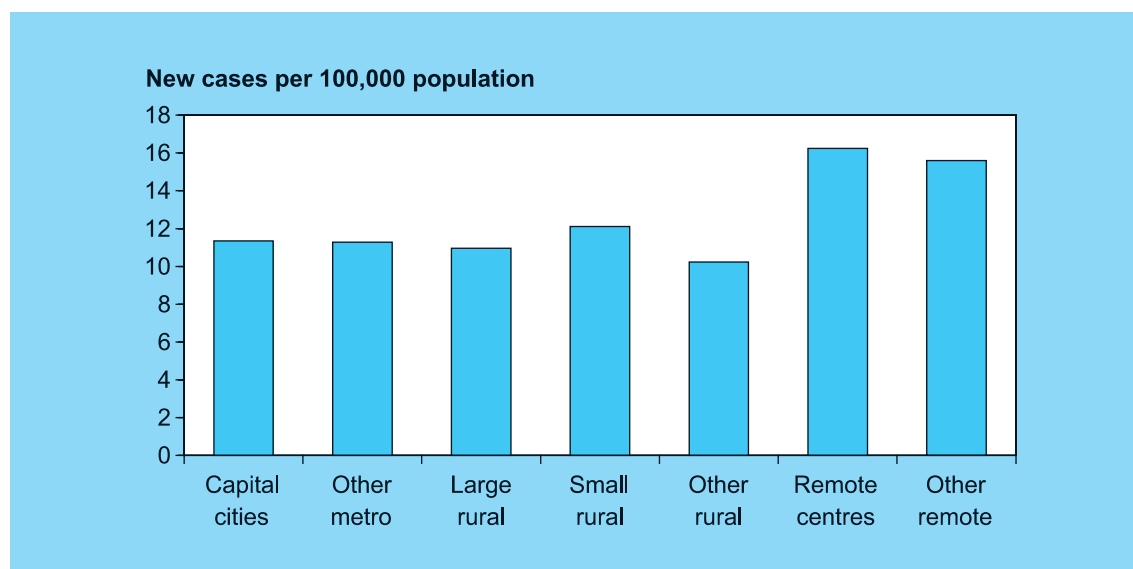
strategies in place to increase participation in screening programs (DHFS & AIHW 1998b). Despite these efforts, non-English-speaking and Indigenous females still have low rates of cervical cancer screening (DHFS & AIHW 1998b). This is a likely explanation for the eight times higher death rates from cervical cancer experienced by Indigenous females, compared with non-Indigenous females (Anderson et al. 1996).

For more information, see:

Anderson P, Bhatia K & Cunningham J 1996. Occasional paper: mortality of Indigenous Australians. ABS Cat. No. 3315.0, AIHW Cat. No. IHW 1. Canberra: AGPS.

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

Incidence of cervical cancer, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Females	11.3	11.3	11.0	12.1	10.2	16.2	15.6	11.3

Notes

- 1 Age-standardised to the Australian population at 30 June 1991.
- 2 Data for Queensland were unavailable for 1992–94 at the time of analysis and are excluded.
- 3 None of the rates is significantly different from 'capital cities' at the 5% level.
- 4 Some Victorian data may be incorrect for place of residence at diagnosis.

Source: AIHW National Cancer Statistics Clearing House.

Incidence of cervical cancer

- The incidence of cervical cancer continues to fall in Australia largely as a result of the use of Pap smear tests for early detection of the cancer. The projected incidence for 1999 is 10.4 cases per 100,000 females (DHFS & AIHW 1998b). Cancer of the cervix is related to infection by the human papilloma virus (HPV) (DHFS & AIHW 1998b). Other risk factors include multiple sex partners, young age at first intercourse, smoking and low socio-economic status.
- The lowest incidence of cervical cancer is found in 'other rural areas'. Females in the metropolitan zone, 'large rural centres' and 'small rural centres' all have a similar incidence of cervical cancer.
- The incidence of cervical cancer is highest in the remote zone. Indigenous females have a higher incidence of cervical cancer than non-Indigenous females (d'Espaignet et al. 1996) and this may be reflected in the higher rates for the remote zone.

For more information, see:

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

d'Espaignet E, Measey M, Condon J et al. 1996. Cancer in the Northern Territory 1987–1993. Darwin: Northern Territory Health Services.