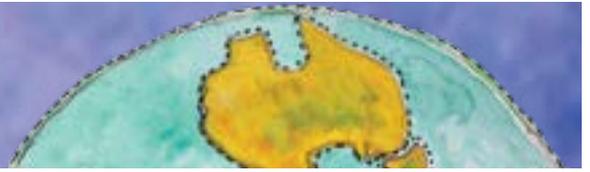


## 5.6 Health in regional and remote areas



In 2012, 30% of the Australian population lived in regional and remote areas, 18% in *Inner regional* areas, 9% in *Outer regional* areas, 1.4% in *Remote areas* and 0.9% in *Very remote* areas.

Australians in regional and remote areas tend to have shorter lives and higher rates of disease and injury than people in *Major cities*.

Poorer health outcomes in regional and remote areas may reflect a range of social and other factors that are detrimental to health. People living in more remote areas are often disadvantaged with regard to educational and employment opportunities, income, and access to goods and services. They may face more occupational and physical risks, for example, from farming or mining work and transport-related accidents, and experience higher rates of other risk factors associated with poorer health, such as tobacco smoking and alcohol misuse.

There are also higher proportions of Aboriginal and Torres Strait Islander people in *Remote* (16%) and *Very remote* (45%) areas than in *Major cities* (1%), and they have poorer health outcomes (see Chapter 7 'Remoteness and the health of Indigenous Australians').

The interactions between area of residence, social and other factors, and health outcomes are complex. For example, this snapshot presents some instances where the poorest health outcomes are for people living in *Inner Regional* areas (which include cities such as Wagga Wagga, Ballarat, Bundaberg and Hobart).

### Box 5.3

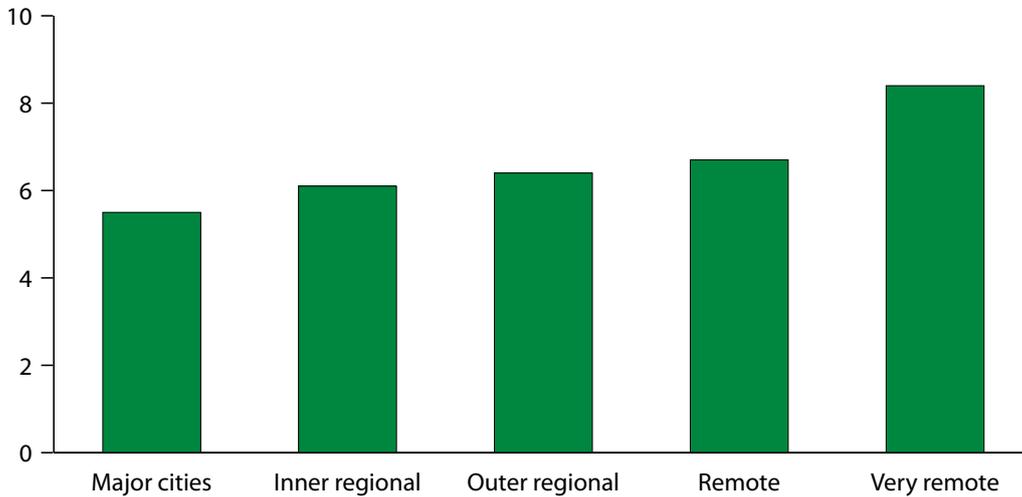
#### Defining regional and remote areas

This section uses the Australian Bureau of Statistics (ABS) Remoteness Area classification that allocates 1 of 5 categories to areas depending on their distance from urban centres, where the population of the urban centre is considered to influence the services available.

Regional and remote areas are compared with *Major cities* in most analyses. *Very remote* areas are excluded from some analyses where data are not available or of sufficient quality.

#### Health status

- Overall, death rates increase with increasing remoteness. In 2012, the age-standardised rate was highest in *Very remote* areas (8.4 per 1,000 population), followed by *Remote* (6.7), *Outer regional* (6.4), *Inner regional* (6.1) and *Major cities* (5.5) (Figure 5.11).
- In 2004–08, the age-standardised incidence rate of cancer was significantly higher in *Inner regional* areas (504 per 100,000 population) than in *Major cities* (480), *Outer regional* (495) and *Remote and very remote* (474) areas.
- In 2009, the age-standardised rate of disability among people aged under 65 was highest in *Inner regional* areas (at 15% compared with 14% in *Outer regional and remote* areas and 12% in *Major cities*) as was the rate of severe or profound core activity limitations (4.6% in *Inner regional* areas compared with 3.2% in *Outer regional and remote* areas and *Major cities*).

**Figure 5.11****Deaths per 1,000 population**

Note: Rates have been age-standardised to the 2001 Australian population.

Source: ABS 2013.

**Age-standardised death rates by remoteness area, 2012****Health behaviours and risk factors**

- In 2011–12, based on the Australian Health Survey (AHS), people in regional and remote areas (excluding *Very remote* areas and discrete Aboriginal and Torres Strait Islander communities) were more likely than their urban counterparts to:
  - be a daily smoker (*Outer regional and remote* 22% and *Inner regional* 18% compared with 15% in *Major cities*)
  - be overweight or obese (70% and 69% compared with 60%)
  - be insufficiently active (60% and 63% compared with 54%)
  - drink alcohol at levels that place them at risk of harm over their lifetime (24% and 21% compared with 19%) or at risk of an alcohol-related injury from a single occasion (52% and 47% compared with 43%)
  - have high blood cholesterol (37% and 38% compared with 31%).



## Health care

- In 2012, rates of employed GPs were higher in regional and remote areas than in *Major cities*. However, the overall rates of employed medical practitioners (including specialists) were lower. Whether there is adequate supply of medical practitioners to meet demand is difficult to determine because of the influence of factors such as varying health-seeking behaviours, professional scope of practice and health system efficiency across remoteness areas. For example, in 2010–11, despite there being more GPs in remote areas, there were about half the GP services provided per person in *Very remote* areas as in *Major cities* (Duckett et al. 2013).
- Participation in some cancer screening programs varies by remoteness areas—with breast cancer screening participation rates highest in *Outer regional* areas (58%) and lowest in *Very remote* areas (47%) in 2011–2012, and participation in bowel cancer screening generally decreasing with increasing remoteness (38% *Major cities*, 41% *Inner regional*, 40% *Outer regional*, 36% *Remote* and 27% *Very remote*) in 2011–12.
- People with end-stage kidney disease who live in isolated areas may need to travel long distances or relocate to receive treatment—57% of patients who lived in *Very remote* areas at the start of their treatment moved to less remote areas within 1 year.
- The proportion of people who go to hospital for conditions that are considered potentially preventable with timely and adequate non-hospital care is also higher outside *Major cities* (see Chapter 9 'Indicators of Australia's health').

### What is missing from the picture?

It can be difficult to assess the implications of remoteness on health due to the interactions between remoteness, socioeconomic disadvantage and the higher proportion of Indigenous Australians in many of these areas compared with *Major cities*. There are also gaps in the availability and coverage of health data in regional and remote areas, and gaps in information available at the local area level to guide better population health planning and to understand improvements in health.

### Where do I go for more information?

Information is presented by remoteness categories for a range of risk factors, health conditions and health care settings in various AIHW reports, including *Cardiovascular, diabetes and kidney disease: Australian facts 2014* (forthcoming), *Australia's welfare 2013*, *Cancer in Australia: an overview, 2012*, *Chronic kidney disease: regional variation in Australia*, *Australian hospital statistics 2011–12* and *Medical workforce 2012*. These reports are available for free download at [www.aihw.gov.au](http://www.aihw.gov.au). AHS results are available at [www.abs.gov.au](http://www.abs.gov.au).

### References

- ABS (Australian Bureau of Statistics) 2013. Deaths, Australia, 2012. ABS cat. no. 3302.0. Canberra: ABS.
- Duckett S, Bredon P & Ginnivan L 2013. Access all areas: new solutions for GP shortages in rural Australia. Melbourne: Grattan Institute.