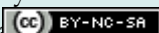


Regional health: trends in inequalities in health and wellbeing by remoteness, for New South Wales, Australia

February 2017

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1. Introduction

Urban and rural differences in service distribution, access, and health outcomes are challenges in many countries, with outcome indicators generally worse in rural and remote regions.^{1,2} In Australia, such differences or inequalities between 'the city and the bush' have been evident for many decades.^{3,4,5,2} As health services have been centralised in regional and metropolitan centres, the need to fund and deliver specific rural services to combat locational disadvantage has increased, resulting in a number of inventive rural outreach and mobile services, multipurpose centres with pooled funding, transport arrangements, training and incentives for rural health practitioners, and e-health services such as telemedicine.¹ However, despite the introduction of these initiatives, the health needs of many Australian communities are still not fully met, and substantial differences in health outcomes for rural and remote populations remain.^{6,5}

The paper was prepared from data supplied by State, Territory and Commonwealth Government agencies and published by PHIDU over a number of years in the Social Health Atlases. It will be updated from time to time, as new data become available.

2. Purpose

This paper examines some of these inequalities in health and wellbeing, by identifying trends over time in a number of indicators over the life course for New South Wales, by remoteness. The Remoteness Structure of the Australian Statistical Geography Standard (ASGS) identifies five Remoteness Area categories for Australia, ranging from Major Cities to Very Remote areas (see Section 3 for details of this remoteness classification).⁷ As at June 2015, 70.9% of the Australian population resided in Major Cities. By comparison, just 2.2% lived in Remote or Very Remote Australia. Geographically distant areas of Australia are disproportionately populated by Indigenous Australians, with 2015 estimates showing that almost half (44.8%) of all people in Very Remote areas and 17% in Remote areas were Indigenous, compared with just 3% Indigenous representation in the total population. The higher proportion of Indigenous Australians in remote area populations contributes substantially to, but does not completely account for, the generally poorer health of people living in remote areas.⁴

At June 2015, the estimated resident population of New South Wales was 7.6 million people, just under one third (32.0%) of Australia's population. The population of Greater Sydney was 4.9 million people, which represented almost two thirds (64.6%) of the total New South Wales population. Of those 2.7 million people living outside of Sydney, almost half (47%) resided in the coastal areas (at the SA4 level) of Newcastle and Lake Macquarie, Illawarra, Richmond - Tweed, Mid North Coast and Coffs Harbour - Grafton.

People in rural and remote (also referred to as Regional) New South Wales have worse health outcomes than those living in cities, across a range of indicators.⁸ They have a lower life expectancy by five to eight years, are more likely to die prematurely, report greater difficulties accessing health care, have higher potentially avoidable hospitalisations, and have a higher burden of chronic disease than other New South Wales residents.⁸ These health inequalities are largely preventable, as they are primarily the result of geographic isolation, greater socioeconomic disadvantage, lack of health care providers, lower levels of access to health services, fewer long-term employment opportunities, and greater exposure to injury risks.^{6,Error! Bookmark not defined.8}

3. Methods

3.1 Remoteness

The Australian Bureau of Statistics' (ABS) Australian Statistical Geography Standard-Remoteness Area (ASGS-RA) is a framework for statistical geography, which defines locations in terms of remoteness.^{9,7} Geographic remoteness is essentially a measure of a physical location's level of access to goods and services.¹⁰ Large population centres tend to have a greater range of goods and services available than small centres. Typically, a population centre is not likely to provide a full range of goods and services until its population reaches around 250,000 people.^{9,10}

The measures of remoteness used by the ABS are based on population estimates obtained from the Census of Population and Housing, conducted every five years. Remoteness measures are calculated using Accessibility/Remoteness Index of Australia (ARIA+) scores, which are based on the distance of geographic locations from the nearest population centre in various size ranges.⁹ The lower the ARIA+ score for a location, the better its level of access to goods and services.¹⁰

Box 1: Classification of Remoteness Areas in Australia⁷

The ABS Australian Statistical Geography Standard (ASGS) Remoteness Structure allocates areas to one of six Remoteness Areas depending on their distance from urban centres, where the population size of the urban centre is considered to govern the range and types of services available. Remoteness Areas used in this report cover the following five categories: Major Cities of Australia, Inner Regional Australia, Outer Regional Australia, Remote Australia and Very Remote Australia; the sixth Remoteness Area covers populations recorded as off-shore, migratory and shipping and is not of relevance to the data in this report.

The category Major Cities includes Australia's capital cities, with the exceptions of Hobart and Darwin, which are classified as Inner Regional and Outer Regional, respectively.

In this report older data, which precede the use of the ASGS, have been re-compiled to match the current (2011) Remoteness Areas published by the ABS.

Readers should note that the presentation of data by Remoteness Area is dependent on the recording of addresses in the various administrative data collections from which data in this report are drawn.

Indicators

Describing geographic variations in indicators of outcomes, and of inequalities in those outcomes, provides information which can be used to develop approaches and to support progress towards reducing such differences. The indicators selected for analysis in this paper are:

- women smoking during pregnancy;
- low birth weight babies;
- children aged less than 15 years living in jobless families;
- premature mortality; and
- bowel cancer screening participation.

They represent indicators for infant, child and adult health, avoidable health outcomes (premature mortality) and cancer screening. They are also indicators for which data are available that allow a comparison over time. A range of other indicators with similar characteristics are available online in the section, *Remoteness in Australia*, at <http://www.phidu.torrens.edu.au/social-health-atlases/graphs/remoteness-in-australia>.

Data are aggregated over a number of years for the majority of indicators to address the relatively small number of events for, e.g. low birth weight babies.

In this report, data are presented as percentages or age-standardised rates. Rate ratios show the ratio of the rate (i.e., the percentage or the standardised rate) in one area to that in another: in this report, it is the ratio of the Very Remote areas figure to the Major Cities figure which is used. More detailed data definitions, data sources and relevant notes are contained in Section 7.

The data are presented in charts; tables supporting the charts of smoking in pregnancy (Table 1) and low birthweight babies (Table 2) are in Section 9, rather than being interspersed throughout the document, as they are best presented in landscape mode.

Statistical significance

Statistical significance between rates over time was determined using two-tailed two-proportion z-tests. Statistical significance for rate ratios over time was determined by examining for overlapping confidence intervals of the rate ratios at the 95% and 99% confidence levels.

There may be large differences in rate ratios over time that are not statistically significant. In some cases this occurs because the small numbers of people in the Remote and Very Remote areas reduces the power of the statistical test.

Discussion of variations

In discussing the extent to which percentages or rates vary across the remoteness categories, the following terms are used:

- 'Notable', referring to a rate ratio from 1.10 to <1.20 (a difference of from 10% to <20%), or from 0.90 to <0.80 (a difference of from -10% to <-20%);
- 'Marked', referring to a rate ratio from 1.20 to <1.50 (a difference of from 20% to <50%), or from 0.80 to <0.50 (a difference of from -20% to <-50%);
- 'Substantial', referring to a rate ratio of 1.50 or above (a difference of 50% or more), or of 0.50 and below (a difference of greater than 50%).

Referencing

Data and commentary are referenced to the author(s) using Endnote; cross-references to previously referenced articles are also provided. Unreferenced statements are based on data published by PHIDU.

4. Findings

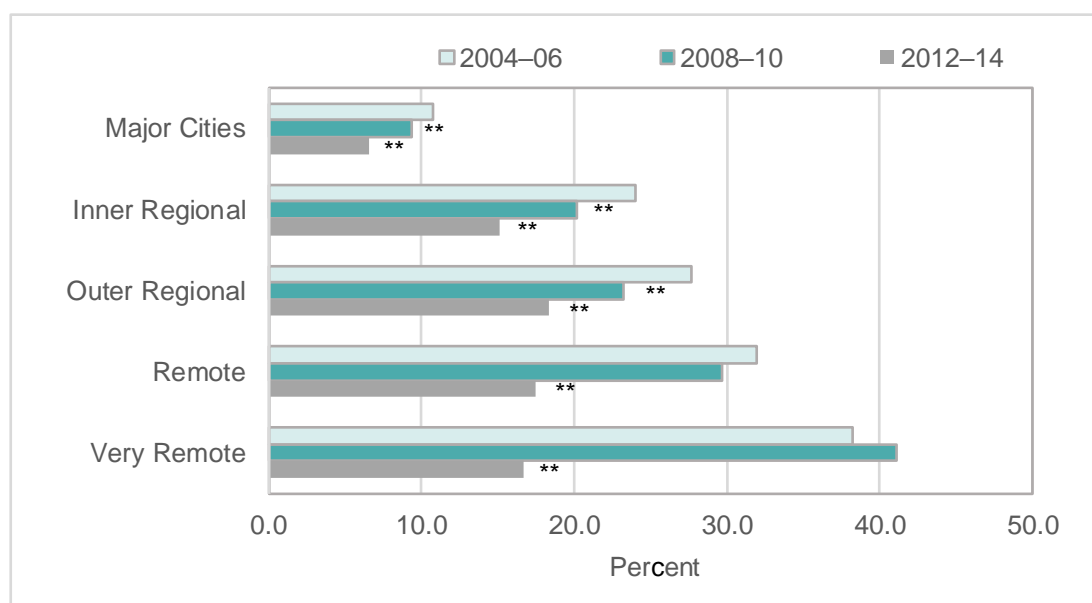
4.1 Women smoking during pregnancy

Maternal smoking during pregnancy is a major risk factor that can adversely affect infant health, increasing the likelihood of low birth weight, pre-term birth, fetal and neonatal death, and Sudden Infant Death Syndrome (SIDS).¹¹ In 2004–06, in New South Wales, one in seven women (14.2%) smoked during pregnancy, varying from 9.6% in Sydney to over twice that level (23.8%) in Regional New South Wales. By 2012–14 the rate of smoking among pregnant women in New South Wales had declined to one in twelve (8.4%), and in Sydney had declined by almost two thirds, to 5.8%; in Regional New South Wales the rate had dropped by over one third, to 14.8%.

Rates among Aboriginal and Torres Strait Islander women reporting that they smoked during pregnancy in 2004–06 were however, at 55.1%, over four times those of non-Indigenous women (whose rate was 13.0%, a rate ratio of 4.2). By 2012–14, although this rate had declined notably, to 47.2%, the gap compared with non-Indigenous women (with a smoking rate in pregnancy of 6.9%) had increased, to almost seven times (a rate ratio of 6.9).

These changes in the proportion of women in New South Wales who smoked during pregnancy are also evident across the Remoteness Areas, with declines of over one third in the rates in each of the remoteness categories; the largest declines were in the Very Remote and Remote areas, at 56.3% and 45.2%, respectively (Figure 1 and Table 1 – p. 15). It is notable that the relative declines between the first two periods were greatest in the Major Cities and Inner and Outer Regional areas, but between the later periods were greater in the Very Remote and Remote areas. All of the declines to 2012–14 are statistically significant.

Figure 1: Women smoking during pregnancy, by remoteness, New South Wales, 2004–2006, 2008–2010 and 2012–14



**Change to 2008–10 and to 2012–14 (both c.f. 2004–06) is statistically significant at the 99% confidence level

Source: Compiled by PHIDU based on data from the New South Wales Department of Health

The ratio between the proportion of New South Wales women smoking during pregnancy in the Very Remote and Major Cities areas increased over the first two periods under analysis, from three and a half times to nearly four and a half times, before declining to two and a half times in 2012–14 (rate ratios of 3.55, 4.39 and 2.54, respectively); in each case the difference statistically significant (Table 1 – p. 15).

The reduction of the smoking rate among pregnant women in all Remoteness Areas, and the narrowing of the gap between Very Remote and other areas would suggest that public health

campaigns and other preventive interventions to improve maternal health area are having an ongoing impact. However, the size of the gap and the stubbornly high rates among Aboriginal and Torres Strait Islander women remain as major concerns.

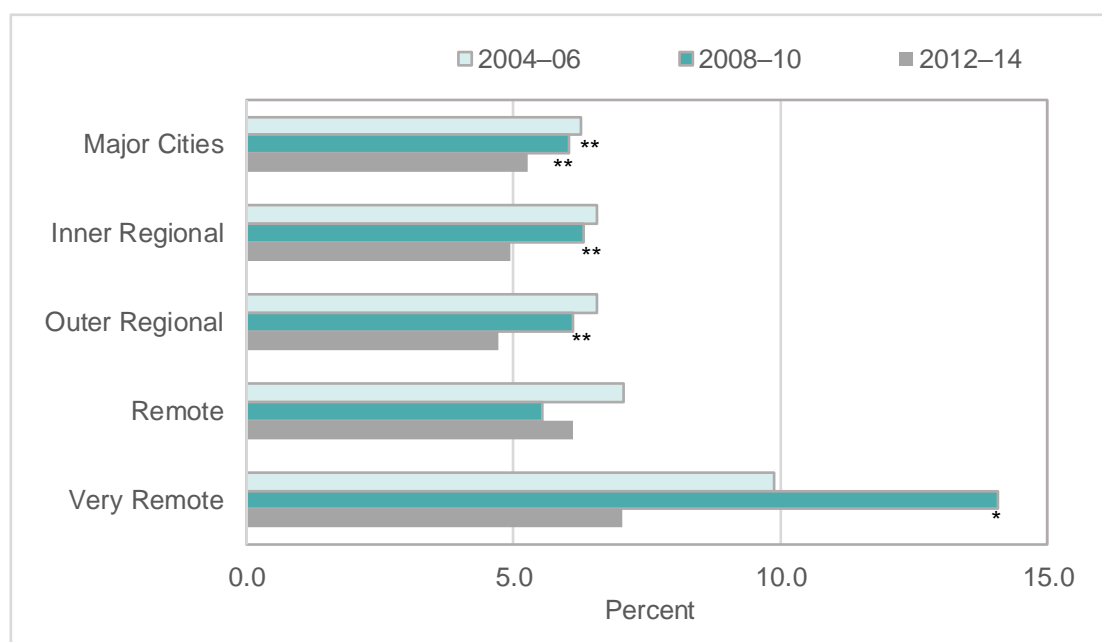
4.2 Low birth weight babies

Low birth weight is recognised to be associated with immediate and longer term consequences of ill-health. Immediate consequences include increased risk of hospitalisation and neonatal death. Over the longer term, low birthweight is considered a marker for chronic disease in adulthood, such as high blood pressure, coronary heart disease and type 2 diabetes.¹²

In Australia, over the period 2001–03, approximately 13% of babies born to Aboriginal and Torres Strait Islander women were of low birthweight, compared to 6% of babies born to non-Indigenous women.¹³ PHIDU does not yet have these data for Australia for 2012–14; however, over those years in New South Wales, the proportion of low birthweight babies for Aboriginal and Torres Strait Islander women was 10.3%, compared to 5.9% for non-Indigenous women.

Compared to the period 2004–06, the proportion of babies in New South Wales who had a low birth weight in 2012–14 was lower in all remoteness categories, with the largest decline (20.8%) in the Very Remote Areas, although this change was not statistically significant.

Figure 2: Low birth weight babies, by remoteness, New South Wales, 2004–06, 2008–10 and 2012–14



*Change to 2008–10 (c.f. 2004–06) is statistically significant at the 95% confidence level

**Change to 2008–10 and to 2012–14 (both c.f. 2004–06) is statistically significant at the 99% confidence level

Source: Compiled by PHIDU based on data from the New South Wales Department of Health

From 2004–06 to 2008–10, the ratio between the proportion of low birth weight babies in Very Remote and Major Cities areas in New South Wales increased markedly (from 1.58 to 2.33, with both rate ratios of statistical significance), before dropping to 1.33 (not statistically significant) (Table 2 – p. 15).

These data suggest that public health campaigns and other preventive interventions to improve this aspect of maternal health are working relatively well in areas outside of the Major Cities, although the higher overall proportions for babies of Aboriginal and Torres Strait Islander women remain of concern.

4.3 Children living in jobless families

Families where no parent is employed ('jobless families') not only experience substantial economic disadvantage but may also have reduced social opportunities that affect their wellbeing and health.

Children who live without an employed parent may be at higher risk of experiencing financial hardship and other disadvantage in the short to medium term. They may not have a role model of employment to follow, and the joblessness of the parent(s) can mean that such children are more likely to have outcomes such as welfare dependency in the longer term.¹² In some families, the reason the parent is without a job may be to care for children or to undertake study to try to improve the future economic prospects of the household. However, most of the children living without an employed parent live in lone-parent households with limited resources.¹⁴

Opportunities for secure employment in areas outside of the Major cities are generally fewer as people living in rural areas do not have the range of employment and career options that are available in the larger urban centres and cities, levels of job security and future employment prospects are lower, and there are often poorer employment conditions than in urban areas.¹⁵ The need for agricultural workers has also decreased as farms have become larger and more mechanised.¹⁵ Poverty in rural and regional Australia is characterised by generally lower incomes of those living in these regions; reduced access to services such as health, education and transport; declining employment opportunities; and distance and isolation.¹⁹ For the significant proportion of Aboriginal and Torres Strait Islander people who live outside the Major Cities and for those living on income support, this is often exacerbated by cultural and language issues and the intergenerational impacts of colonisation, such as trauma, racism, discrimination and dislocation from country and culture.^{16, 17, 18, 19-21}

Compared to the period 2006, the proportion of New South Wales children aged less than 15 years living in families where no adult was employed in 2011 fell across all remoteness categories, except for the Very Remote areas, where it rose from 28.0% to 29.6%; however, only the increases in the first three remoteness categories were statistically significant (Table 3 and Figure 3).

Table 3: Children aged less than 15 years living in jobless families in New South Wales, by remoteness, 2006 and 2011

Remoteness category	Time period				Statistical significance of change
	2006		2011		
	Number	Per cent	Number	Per cent	
Major Cities	130,432	15.0	125,830	13.7	**
Inner Regional	44,461	17.7	42,111	16.9	**
Outer Regional	16,781	19.8	15,545	19.4	*
Remote	1,485	23.1	1,302	22.9	
Very Remote	499	28.0	461	29.6	
Rate Ratio#	..	1.87	..	2.16	..
Statistical significance	..	**	..	**	..

*Change from previous period is statistically significant at the 95% confidence level

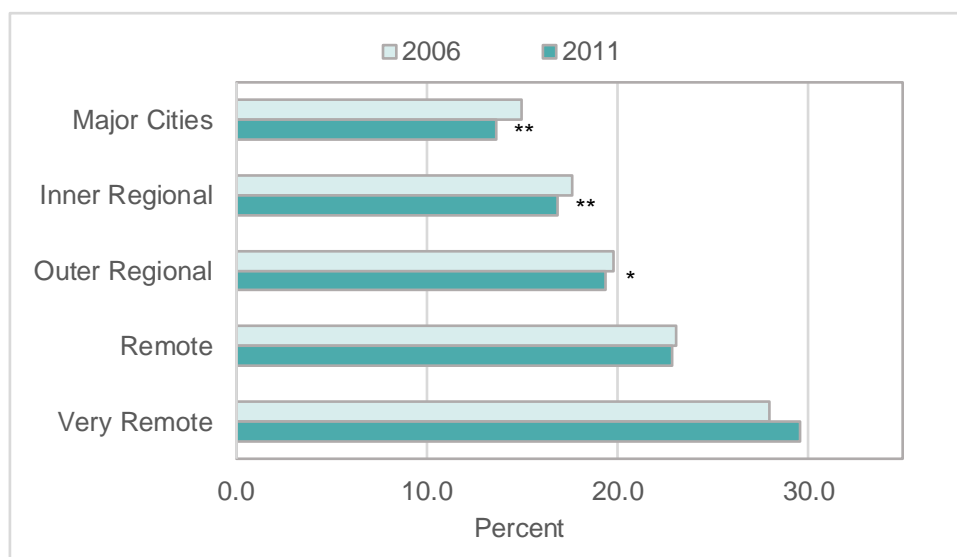
**Change from previous period is statistically significant at the 99% confidence level

#The rate ratio shows the ratio of the percentage in the Very Remote areas to the percentage in the Major Cities areas

Source: 2006 and 2011 data compiled by PHIDU based on data from the ABS Census, 2006 and 2011

The ratio between the proportion of these children in Very Remote and Major Cities areas increased, from 87% higher to just over twice as high (rate ratios of 1.87 and 2.16, respectively), indicating a widening of the gap, and worsening inequality; both of these differences is statistically significant (Table 3).

Figure 3: Children living in jobless families in New South Wales, by remoteness, 2006 and 2011



*Change from previous period is statistically significant at the 95% confidence level

**Change from previous period is statistically significant at the 99% confidence level

Source: 2006 and 2011 data compiled by PHIDU based on data from the ABS Census, 2006 and 2011

4.4 Premature mortality

Deaths before 75 years of age are described as 'premature'. The upper age limit reflects current life expectancy of around 80 years in developed countries such as Australia.¹⁹ Malignant neoplasms (cancer), diseases of the circulatory system and the combined external causes of accidents, poisonings and violence are the main causes of premature death for Australians. Persons most likely to die prematurely include Aboriginal and Torres Strait Islander people, those earning low incomes, those who are unemployed, and residents of rural and remote areas.²⁰

Premature mortality has economic and social costs. These include a decline in the size of the labour force, leading to lost productivity and economic output, as well as the loss of skills and experience.²¹

Social implications involve the emotional trauma experienced by family and friends due to the death of their family member, as well as the loss of social support and potential financial insecurity.

In New South Wales, the overall premature mortality rate fell by 19.3% from an age-standardised rate of 296.0 deaths per 100,000 population in 1997–2001, to 238.9 deaths per 100,000 population in 2010–14; this is a notable fall over this 13-year period.

In addition, the premature mortality rate in 2010–14 was lower across all remoteness categories than in the period 1997–2001; note that these reductions were statistically significant, other than for that in the Very Remote areas (Table 4).

However, the ratio of the premature mortality rate in the Very Remote compared to the Major Cities areas increased, from just over twice as high in 1997–2001 to nearly two and a half times higher in 2010–14 (rate ratios of 2.12 and 2.41, respectively), indicating a widening of the gap, and worsening inequality; both of these differences were statistically significant (Table 4 and Figure 4).

Table 4: Premature mortality in New South Wales, by remoteness, 1997–2001 and 2010–14

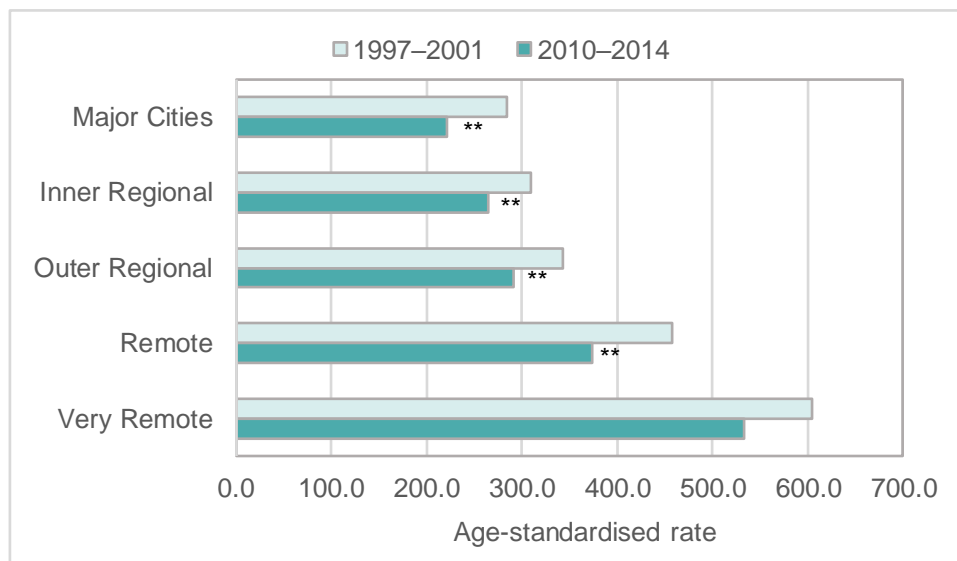
Remoteness category	Time period				Statistical significance of change
	1997–2001		2010–14		
	Number	Rate	Number	Rate	
Major Cities	62,373	284.9	53,823	221.3	**
Inner Regional	20,721	309.4	20,552	265.3	**
Outer Regional	8,229	342.4	7,425	291.0	**
Remote	782	458.1	597	373.1	**
Very Remote	262	604.0	214	533.4	
Rate Ratio#	..	2.12	..	2.41	..
Statistical significance	..	**	..	**	..

**Change from previous period/ difference between Very Remote and Major Cities areas is statistically significant at the 99% confidence level

#The rate ratio shows the ratio of the rate in the Very Remote areas to the rate in the Major Cities areas

Source: 1997 to 2001 data compiled by PHIDU from deaths data supplied by the ABS on behalf of the State and Territory Registrars of Births, Deaths and Marriages for 1997 to 2001; and the ABS Estimated Resident Population, 30 June 1997 to 2001; 2010 to 2014 data compiled by PHIDU from deaths data based on the 2010 to 2014 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry, on behalf of the Registries of Births, Deaths and Marriages and the National Coronal Information System; and the ABS Estimated Resident Population, 30 June 2010 to 30 June 2014

Figure 4: Premature mortality in New South Wales, by remoteness, 1997–2001 and 2010–14



**Change from previous period is statistically significant at the 99% confidence level

Source: 1997 to 2001 data compiled by PHIDU from deaths data supplied by the ABS on behalf of the State and Territory Registrars of Births, Deaths and Marriages for 1997 to 2001; and the ABS Estimated Resident Population, 30 June 1997 to 2001; 2010 to 2014 data compiled by PHIDU from deaths data based on the 2010 to 2014 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry, on behalf of the Registries of Births, Deaths and Marriages and the National Coronal Information System; and the ABS Estimated Resident Population, 30 June 2010 to 30 June 2014

4.5 Participation in the National Bowel Cancer Screening Program

Colorectal cancer (CRC), also known as bowel cancer, is one of the commonest forms of cancer in Australia, with around 80 Australians dying each week from the disease. Bowel cancer can be treated successfully if detected in its early stages, but currently fewer than 40 per cent of bowel cancers are detected early. Screening has been shown in randomised trials to reduce the incidence of and mortality from CRC.^{22,23}

The National Bowel Cancer Screening Program (NBCSP) has operated since 2006, and aims to reduce the morbidity and mortality from bowel cancer by actively recruiting and screening the target population for early detection or prevention of the disease.²⁴ The NBCSP uses a one-time immunochemical faecal occult blood test (FOBT) for people aged 50, 55 and 65 years. The second phase of the National Bowel Cancer Screening Program (NBCSP) commenced on 1 July 2008 and offered testing to people turning 50 years of age between January 2008 and December 2010, and those turning 55 or 65 between July 2008 and December 2010. Ongoing funding has meant the program has continued to operate, expanding to include those turning 60 years of age from 2013 and those turning 70 years of age from 2015. In 2017–18, the program will introduce biennial screening, which, once fully implemented, will be offered to all Australians aged between 50 and 74 years, as per the recommendations by the National Health and Medical Research Council for two-yearly screening.²⁵ The NBCSP has been phased in gradually to help ensure that health services, such as colonoscopy and treatment options, are able to meet any increased demand.²⁴

In addition to the NBCSP, a variety of FOBT kits are available in Australia to screen for bowel cancer either available over the counter from pharmacies, through medical practitioners, or through other programs such as BowelScreen Australia, an education and screening initiative run by The Pharmacy Guild of Australia, and BowelCare, a community service project of various Rotary clubs and districts. The data contained within this report only represent participation within the NBCSP implemented by the Australian Government in partnership with the state and territory governments, not the programs operating within the community and described above.

Aboriginal and Torres Strait Islander participants, participants who live in regional and remote locations, and participants who live in areas of lower socioeconomic status, continue to have higher rates of positive screening results, yet lower rates of follow-up colonoscopies than other participants.²⁶

In 2010, one third (33.2%) of Sydney residents invited to participate in the NBCSP did so, compared with a higher proportion (37.4%) in Regional New South Wales. Participation in 2012/13 was lower, at 29.4% and 32.5%, respectively. The lower rate of participation may be a consequence of the pause in the program between January and June 2011 leading to uncertainty over program continuation and reduced participant confidence.²⁵ The NBCSP recommenced gradually from 1 July 2011 following the Australian Government's decision in the 2011–12 Budget to make the program ongoing.

Participation in 2012/13 was also lower in all remoteness categories, with all of the reductions being of statistical significance (Table 5).

At the same time, the ratios for participation in the Very Remote compared to the Major Cities areas worsened between 2010 and 2012/13 (rate ratios of 0.82 and 0.57, respectively), indicating a widening of the inequality gap; and both of these differences was statistically significant (Table 5 and Figure 5).

Table 5: NBCSP participation in New South Wales, by remoteness, 2010 and 2012/13

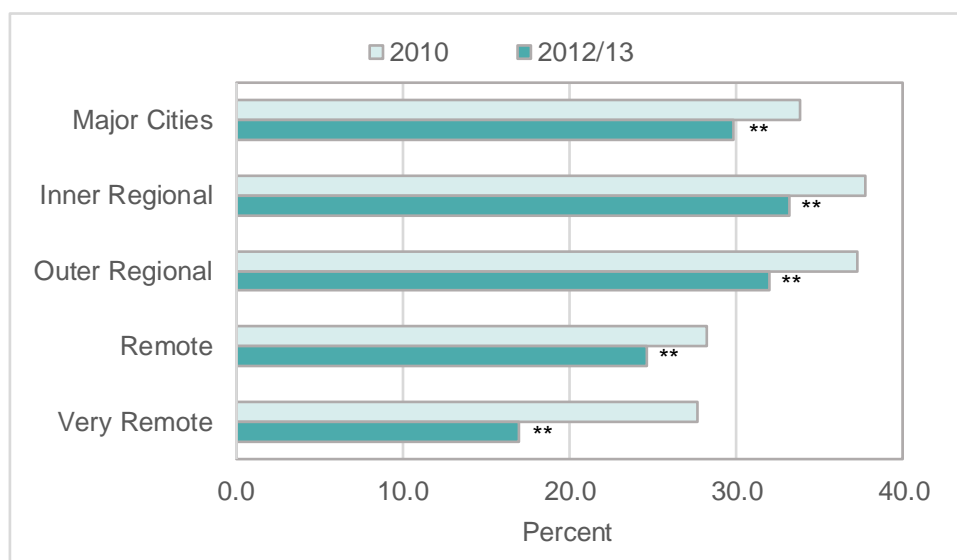
Remoteness category	Time period				Statistical significance of change
	2010		20012/13		
	Number	Per cent	Number	Per cent	
Major Cities	85,230	33.8	63,020	29.8	**
Inner Regional	31,191	37.7	21,000	33.2	**
Outer Regional	9,912	37.3	6,585	31.9	**
Remote	575	28.2	360	24.6	**
Very Remote	90	27.6	76	17.0	**
Rate Ratio#	..	0.82	..	0.57	..
Statistical significance	..	**	..	**	..

**Change from previous period is statistically significant at the 99% confidence level

#The rate ratio shows the ratio of the percentage in the Very Remote areas to the percentage in the Major Cities areas

Source: Data compiled by PHIDU based on data provided by the Department of Health from the National Bowel Cancer Screening Program, 2010 and 2012/13

Figure 5: NBCSP participation in New South Wales, by remoteness, 2010 and 2012/13



**Change from previous period is statistically significant at the 99% confidence level

Source: Data compiled by PHIDU based on data provided by the Department of Health from the National Bowel Cancer Screening Program, 2010 and 2012/13

In 2012/13, as remoteness increased, and participation in the NBCSP decreased, so the proportion of participants with a positive FOBT increased (Figure 6). PHIDU does not have these data for 2010.

The difference in percentages in the Very Remote and Major Cities areas, as shown by the rate ratio of 1.58, is not statistically significant (Table 6).

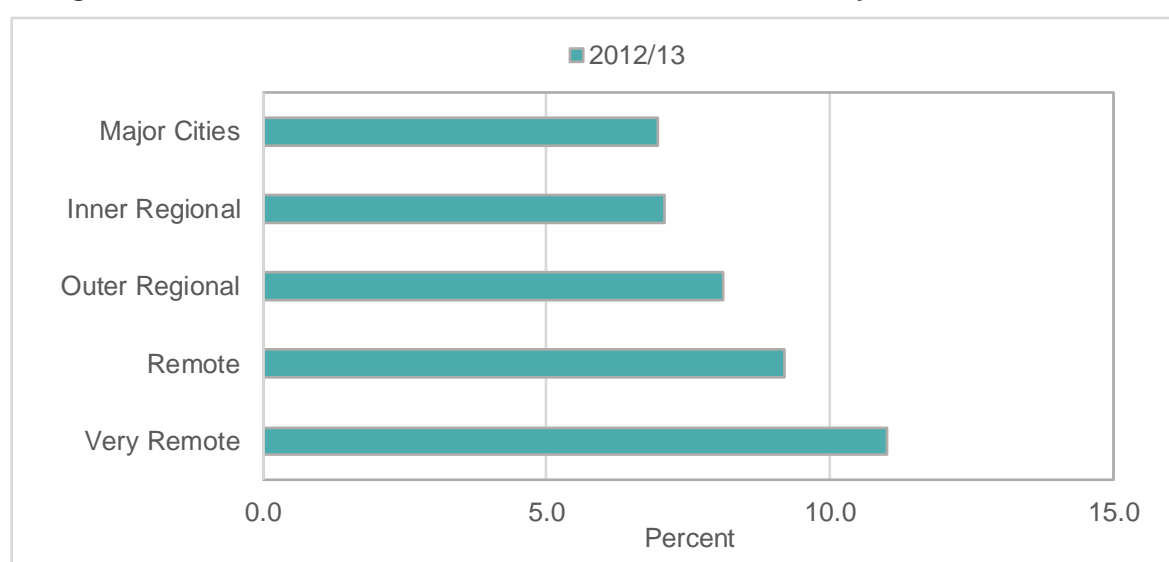
Table 6: FOBT results under the NBCSP in New South Wales, by remoteness, 2012/13

Remoteness category	Time period				Statistical significance of change
	2010		20012/13		
	Number	Per cent	Number	Per cent	
Major Cities	n.a.	..	4,398	7.0	..
Inner Regional	n.a.	..	1,489	7.1	..
Outer Regional	n.a.	..	534	8.1	..
Remote	n.a.	..	33	9.2	..
Very Remote	n.a.	..	8	11.0	..
Rate Ratio#	..	..	..	1.58	..
Statistical significance	..	..	..		..

#The rate ratio shows the ratio of the percentage in the Very Remote areas to the percentage in the Major Cities areas

Source: Data compiled by PHIDU based on data provided by the Department of Health from the National Bowel Cancer Screening Program, 2010 and 2012/13

Figure 6: FOBT results under the NBCSP in New South Wales, by remoteness, 2012/13



Source: Data compiled by PHIDU based on data provided by the Department of Health from the National Bowel Cancer Screening Program, 2012/13

5. Conclusion

For a number of health-related outcomes there is a gradient evident across remoteness categories, with populations living in the most remote areas of New South Wales having the poorest health and wellbeing compared to those living in Major Cities. While there have been some improvements in absolute differences over time, in some instances there is evidence of worsening relative inequality, as shown by the gap between those who are the best off and those who are the worst off.

It has been argued that relative measures are better for assessing progress in reducing inequalities because, in the context of overall health improvement, narrowing relative measures necessarily imply narrowing absolute measures when health is improving relatively faster among the people who are worse off.²⁷³⁰ The need to continue to improve health and wellbeing outcomes for those Australians who live in the nation's most remote areas remains an imperative if such inequalities are to be reduced.

6. Data notes, sources and definitions

Symbols used

n.a. not available

.. not applicable.

Smoking in pregnancy

The data comprise the women who reported that they smoked during a pregnancy, expressed as a proportion of the number of pregnancies. Note that the data may include women who were pregnant more than once during each time period (3 years).

Data compiled by PHIDU based on data from the New South Wales Department of Health.

Low birth weight babies

The data comprise the babies (live born) weighing less than 2500 grams at birth (data over 3 years), expressed as a proportion of the number of all live births.

Data compiled by PHIDU based on data from the New South Wales Department of Health.

Children aged less than 15 years living in jobless families

The data presented are the number of children aged less than 15 years living in families in which no parent is employed, expressed as a proportion of all children aged less than 15 years of age.

Data compiled by PHIDU based on the ABS Census 2006 and 2011 (unpublished) data.

Premature mortality

The data presented are the average annual indirectly age-standardised rates per 100,000 population (aged 0 to 74 years), based on the Australian standard.

1997 to 2001 data compiled by PHIDU from deaths data supplied by the ABS on behalf of the State and Territory Registrars of Births, Deaths and Marriages for 1997 to 2001; and the ABS Estimated Resident Population, 30 June 1997 to 2001.

2010 to 2014 data compiled by PHIDU from deaths data based on the 2010 to 2014 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System; and the ABS Estimated Resident Population, 30 June 2010 to 30 June 2014.

Participation in the NBCSP

The term participation is used to refer to participation in the screening test. Hence, the participation rate is the proportion of the eligible population invited who returned a completed Faecal Occult Blood Test (FOBT) kit for analysis.²⁹

Data compiled by PHIDU based on data provided by the Department of Health from the National Bowel Cancer Screening Program, 2010 and 2012/13.

FOBT results

The outcome indicator presented is referred to as a 'positive test result'; a positive FOBT result indicates that blood has been found in the sample provided.

Data compiled by PHIDU based on data provided by the Department of Health from the National Bowel Cancer Screening Program, 2010 and 2012/13.

7. Data quality statements (as available at 14 July 2016)

Smoking in pregnancy and low birth weight babies

<http://meteor.aihw.gov.au/content/index.phtml/itemId/624809>

Mortality data

<http://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3303.0Quality%20Declaration02013?opendocument&tabname=Notes&prodno=3303.0&issue=2013&num=&view>

National Bowel Cancer Screening Program

<http://www.aihw.gov.au/publication-detail/?id=60129549725>: see page 40

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8. Data tables

Table 1: Women smoking during pregnancy, by remoteness, New South Wales, 2004–06, 2008–10 and 2012–14

Remoteness Area	Time period						Statistical significance of	
	2004–06		2008–10		2012–14		change from 2004–06 to	
	Number	Per cent	Number	Per cent	Number	Per cent	2008–10	2012–14
Major Cities	21,726	10.8	20,451	9.4	14,730	6.6	**	**
Inner Regional	10,571	24.0	9,232	20.2	6,235	15.1	**	**
Outer Regional	4,195	27.7	3,503	23.2	2,282	18.4	**	**
Remote	447	31.9	362	29.7	144	17.5		**
Very Remote	143	38.2	159	41.1	29	16.7		**
Rate Ratio#	..	3.55	..	4.39	..	2.54	..	..
Statistical significance**	..	**	..	**	..	**	..	..

**Change from previous period/ difference between Very Remote and Major Cities areas is statistically significant at the 99% confidence level

#The rate ratio shows the ratio of the percentage in the Very Remote areas to the percentage in the Major Cities areas

Source: Data compiled by PHIDU based on data from the New South Wales Department of Health

Table 2: Low birth weight babies, by remoteness, New South Wales, 2004–06, 2008–10 and 2012–14

Remoteness Area	Time period						Statistical significance of	
	2004–06		2008–10		2012–14		change from 2004–06 to	
	Number	Per cent	Number	Per cent	Number	Per cent	2008–10	2012–14
Major Cities	12,820	6.3	13,407	6.0	11,783	5.3	**	**
Inner Regional	2,933	6.6	2,927	6.3	2,101	4.9		**
Outer Regional	1,006	6.6	931	6.1	610	4.7		**
Remote	99	7.1	68	5.5	64	6.1		
Very Remote	36	9.9	56	14.1	22	7.0	*	
Rate Ratio#	..	1.58	..	2.33	..	1.33	..	..
Statistical significance**	..	**	..	**	..		..	..

*Change from previous period is statistically significant at the 95% confidence level

**Change from previous period/ difference between Very Remote and Major Cities areas is statistically significant at the 99% confidence level

#The rate ratio shows the ratio of the percentage in the Very Remote areas to the percentage in the Major Cities areas

Source: Data compiled by PHIDU based on data from the New South Wales Department of Health

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