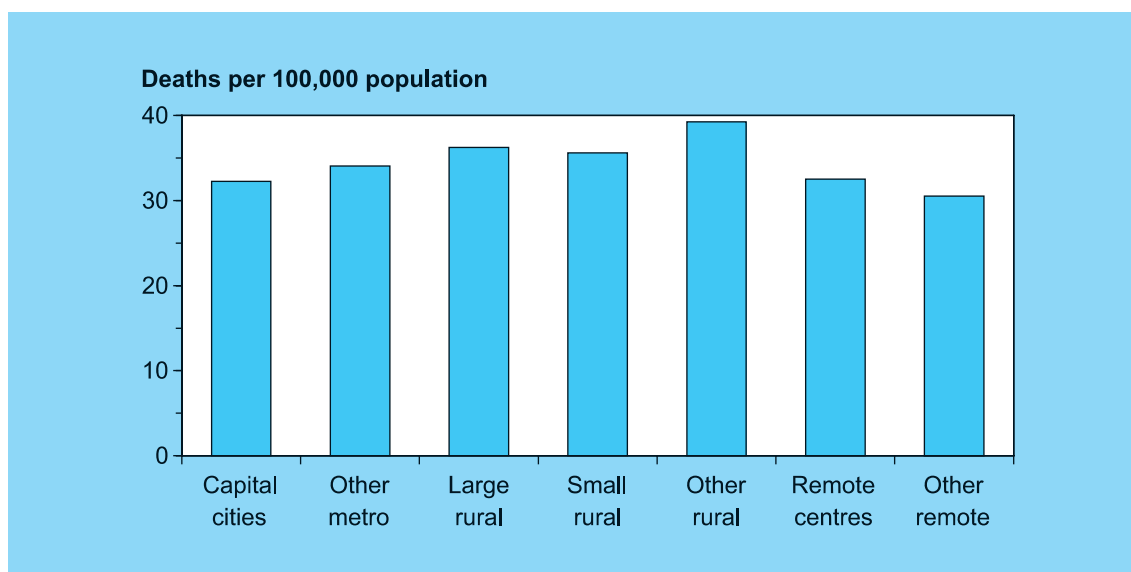


Prostate cancer

Death rates for prostate cancer, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	32.3	34.1	36.2	35.6	*39.2	32.5	30.5	34.0

* 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 prostate cancer

- Next to non-melanocytic skin cancer, prostate cancer is the most common cause of cancer in males. In 1996, 2,660 males died from prostate cancer (DHFS & AIHW 1998b). The 5-year survival rates for this cancer have been estimated to be 66% (DHFS & AIHW 1998b).
- Prostate cancer is a slow-growing cancer that occurs in over half of the male population over the age of 75. Many males who die of other conditions (e.g. cardiovascular diseases) are found at autopsy to have malignant cells in the prostate gland.
- Death rates from prostate cancer are similar across most RRMA groups but rates for 'other rural areas' are significantly higher than rates for 'capital cities'. In fact, males in 'other rural areas' have the highest death rate from prostate cancer. Males in the remote zone have similar or lower death rates compared with those in the metropolitan zone.
- Specific risk factors for this cancer are unclear. However, there is a strong association between advancing age and prostate cancer. Other possible risk factors may include high fat diet, large body mass, lack of physical activity and a family history of prostate cancer (NSW Public Health Division 1997).

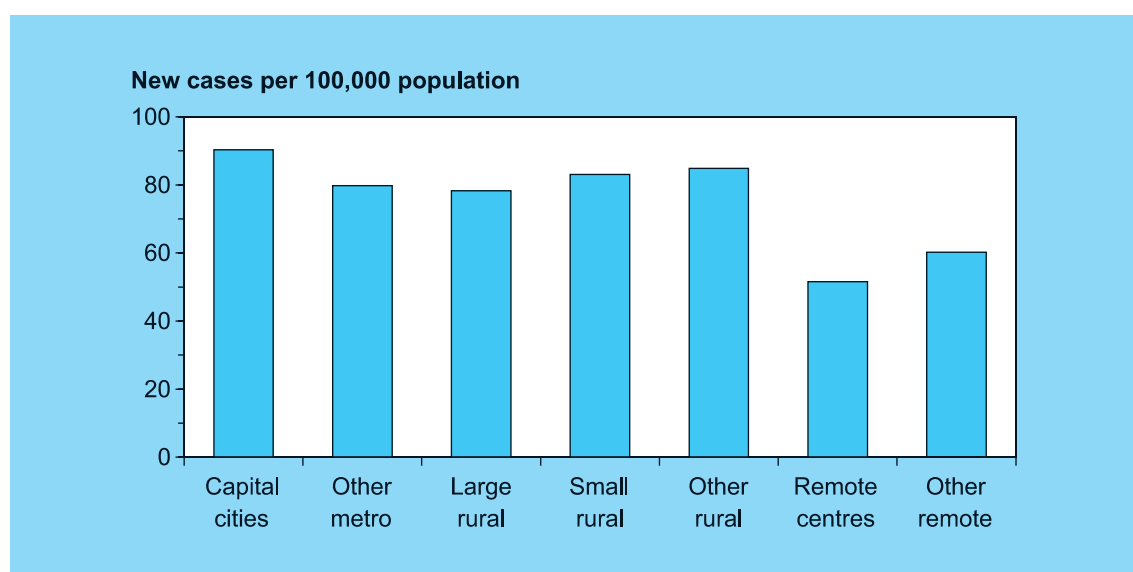
For more information, see:

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.

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.

New South Wales Public Health Division 1997. The health of the people of NSW. Report of the Chief Health Officer. Sydney: New South Wales Health Department.

Incidence of prostate cancer, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	90.3	79.8	78.3	83.1	84.9	*51.6	*60.2	86.7

* 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 prostate cancer

- Prostate cancer is the most commonly reported cancer in Australian males with 12,787 new cases diagnosed in 1994 (DHFS & AIHW 1998b). The highest incidence of prostate cancer occurs in males over the age of 60. This group accounts for 95% of detected prostate cancers (AIHW 1998a).
- The incidence of prostate cancer has risen rapidly since 1990 when prostate-specific antigen (PSA) testing and ultrasound techniques were introduced for detecting tumours in the prostate gland.
- Prostate cancer is a slow-growing cancer and males with tumours confined to the prostate are often asymptomatic. Patients that show symptoms will most likely have late-stage cancer that has spread beyond the prostate and is incurable (Coley et al. 1997). There is little evidence of mortality reduction as a result of screening for prostate cancer.
- While metropolitan and rural zones have similar rates, almost twice as much prostate cancer is recorded in these zones relative to

the remote zone. This is most likely to be a result of increased PSA screening by doctors in the metropolitan and rural zones.

- The similar incidence rates in the metropolitan and rural zones are in contrast with the higher death rates in the rural zone.

For more information, see:

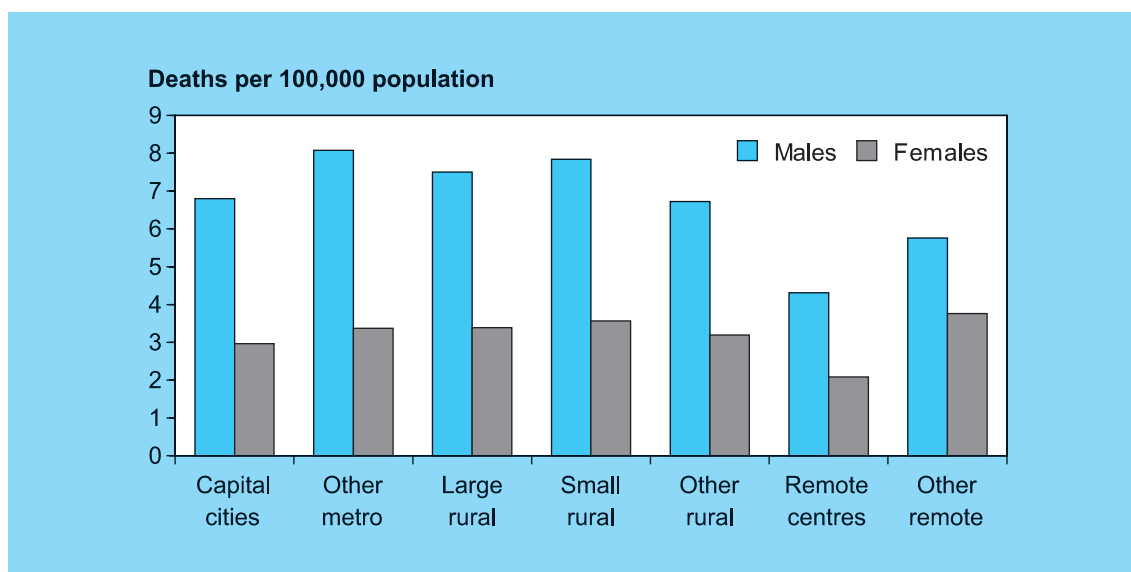
Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Coley CM, Barry MJ, Fleming C et al. 1997. Early detection of prostate cancer, part 2: estimating risks, benefits and costs. *Ann Int Med* 126: 468–79.

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.

Melanoma

Death rates for melanoma, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	6.8	8.1	7.5	7.8	6.7	4.3	5.8	7.0
Females	3.0	3.4	3.4	3.6	3.2	2.1	3.8	3.1

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.

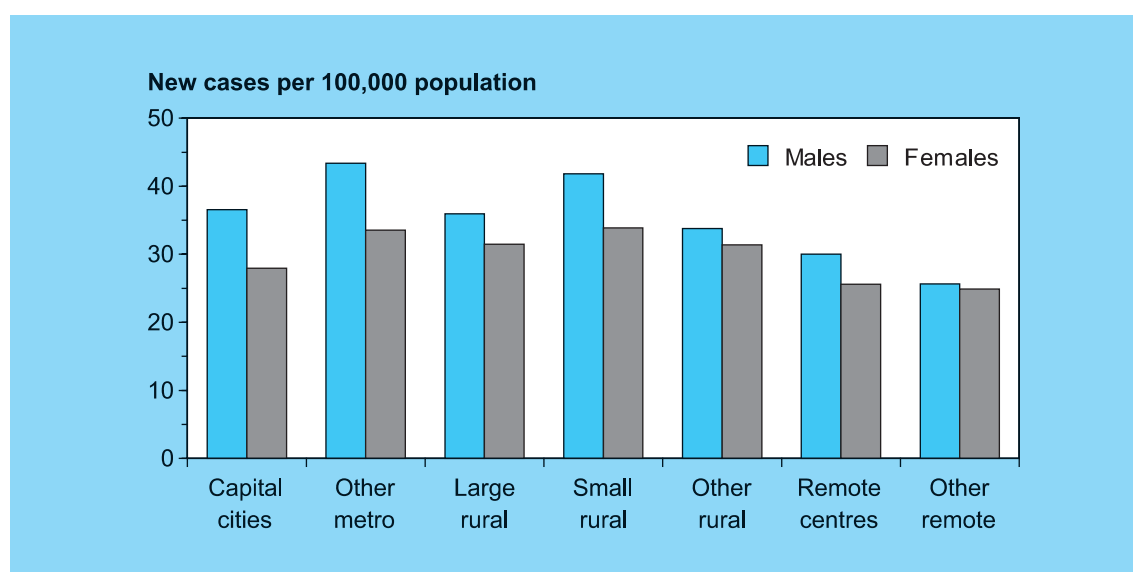
Deaths due to melanoma

- Melanomas are usually found on the skin but they can also occur on other parts of the body, notably in the eye and mucous membranes (Jelfs et al. 1996). For this report, melanoma refers only to melanoma of the skin. Melanoma, along with colorectal cancer, breast cancer and lung cancer, accounted for 47% of all registrable cancers in 1990 (Jelfs et al. 1996).
- Males have around twice the death rate for melanoma compared with females for all RRMA categories. Males from the remote zone have the lowest rate of death from melanoma compared to males from all other zones. However, these values are not significantly different from 'capital cities' at the 5% level.
- Females have similar death rates for melanoma across all RRMA categories, with females in 'remote centres' having the lowest rates. However, these differences are not significantly different from 'capital cities' at the 5% level.
- Risk factors for melanoma include fair skin, poor use of sun protection measures, and sun exposure under the age of 10 years. Survival rates for melanoma are good, as evidenced by the low death rate relative to the incidence rate.

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.

Incidence of melanoma, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	36.6	*43.4	35.9	41.8	33.8	30.0	*25.7	36.6
Females	28.0	*33.5	31.5	*33.9	31.4	25.6	24.9	29.3

* 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 melanoma

- Melanoma is the fourth most common cause of cancer for males and the third most common cancer for females. Since the early 1980s, there has been a 66% increase in male melanoma incidence and a 26% increase in female melanoma incidence (DHFS & AIHW 1998b).
- The most common cancer in Australia is non-melanocytic skin cancer but cancer registries do not routinely collect incidence data for this cancer. Melanoma is a registerable cancer so good incidence data are available.
- Incidence of melanoma skin cancer is higher in metropolitan and rural zones than in the remote zone for both males and females. Males from 'other remote areas' have significantly lower rates of melanoma compared with males from 'capital cities'.
- These differences in incidence rates may be a reflection of the higher use of sun protection by both males and females in the remote zone

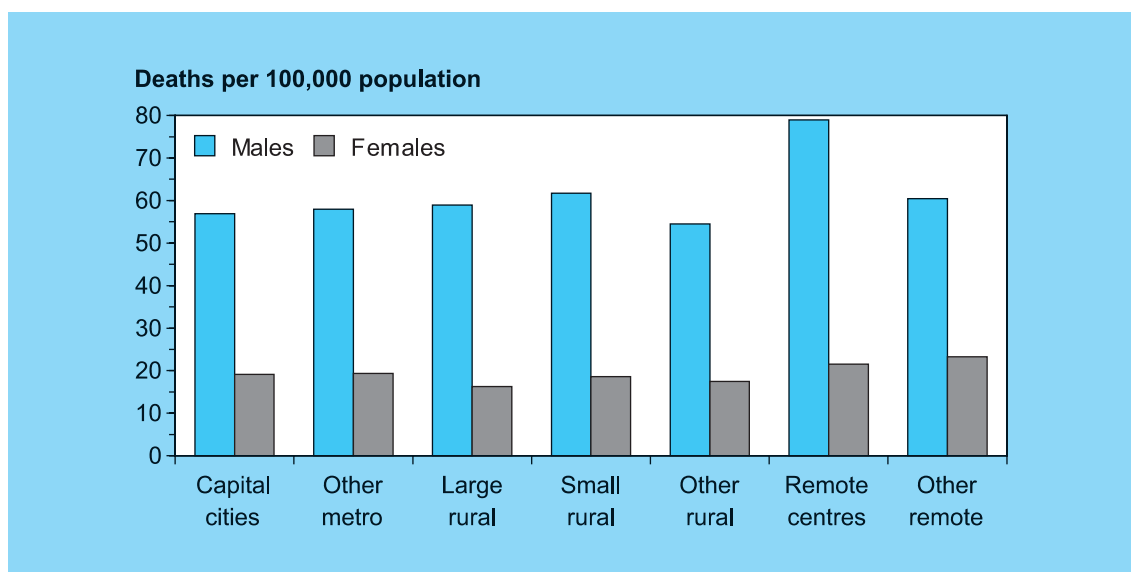
as measured by the 1995 National Health Survey. However, the lower incidence rates in the remote zone may also be due to less screening in those zones relative to the more urban areas. The relatively higher proportion of Indigenous people in the remote zone may provide another possible explanation for the lower incidence of melanoma. Indigenous people have negligible rates of melanoma as they are less susceptible to skin damage from the sun.

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.

Lung cancer

Death rates for lung cancer, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	56.9	58.0	58.9	61.7	54.5	78.9	60.4	57.3
Females	19.1	19.3	16.3	18.6	17.5	21.6	23.3	18.8

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 lung cancer

- Lung cancer is one of the most common causes of cancer deaths in males and the fourth most common cause of cancer death in females (DHFS & AIHW 1998b). In 1996, it accounted for 20% of all cancer deaths for both sexes combined.
- The death rate from lung cancer is almost three times higher for males than for females. This is a consistent pattern across all RRMA categories. Males from 'remote centres' have the highest death rate but this rate is not significantly different from that for males from 'capital cities'. Death rates for males are similar across metropolitan and rural zones.
- Females from the remote zone have the highest death rates for lung cancer. In contrast to the similarity between the rates for metropolitan and rural males, the rates for

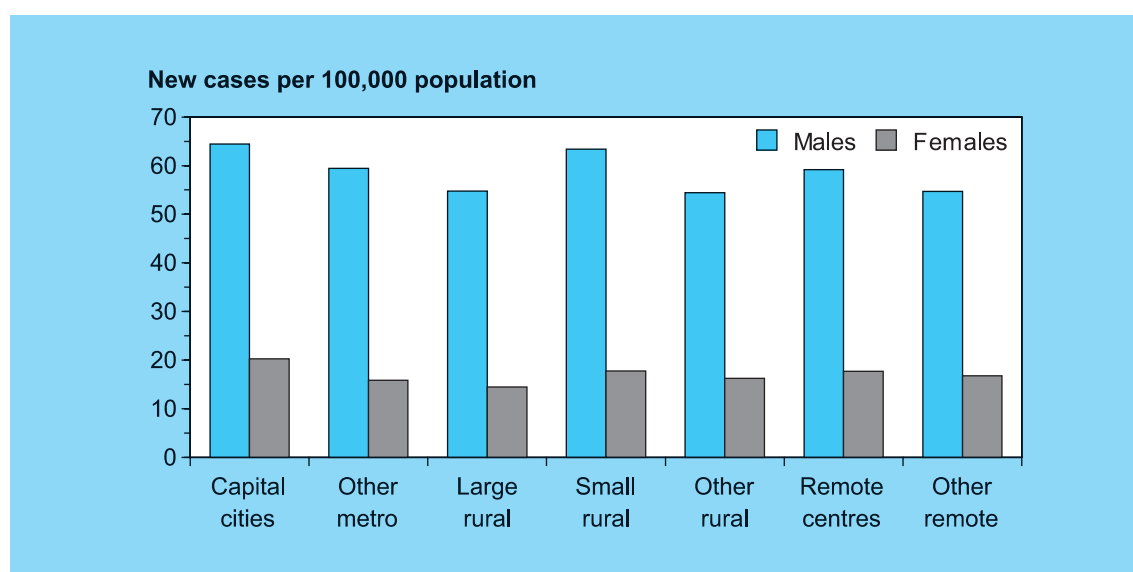
rural females are lower compared with the rates for metropolitan females.

- Cigarette smoking or exposure to cigarette smoke causes cancer of the lungs (including the trachea and bronchus). Differences in death rates from lung cancer may reflect different attitudes to smoking in different communities.

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.

Incidence of lung cancer, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	64.4	59.4	*54.8	63.4	*54.4	59.2	54.7	61.7
Females	20.3	*15.9	*14.5	17.8	*16.3	17.7	16.8	18.8

* 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.

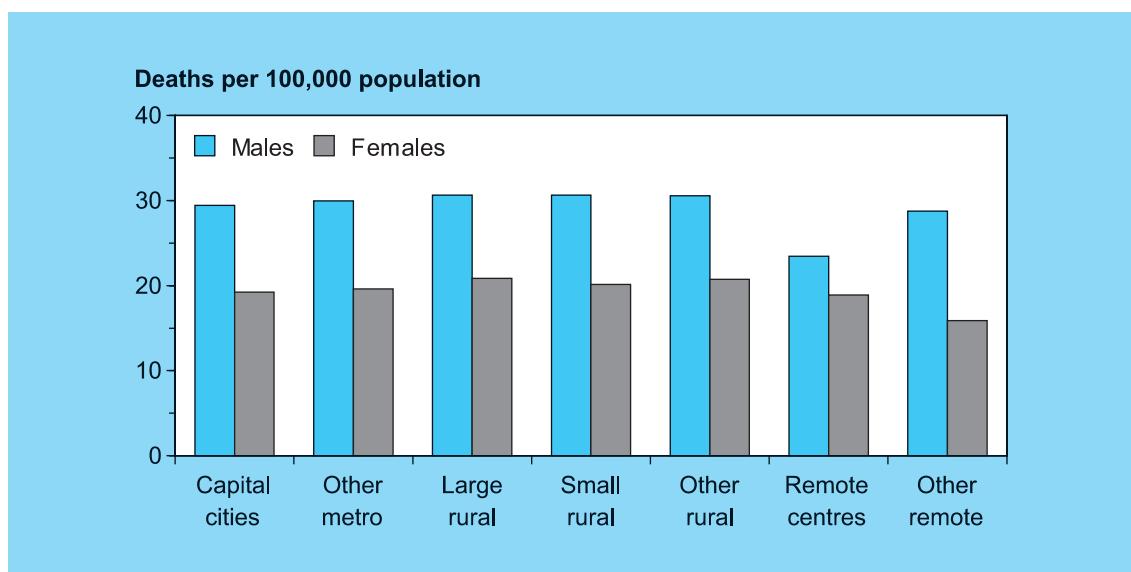
Incidence of lung cancer

- Since the early 1980s, there has been an 18% decrease in lung cancer incidence among males but a 23% increase in female lung cancer incidence (DHFS & AIHW 1998b). Projections show that the incidence of lung cancer for males will continue to decrease while the incidence for females will rise. Currently, lung cancer incidence and mortality are more than 3 times higher in males than in females.
- Tobacco smoking increases the risk of lung cancer and accounts for around 85% of new lung cancer cases (DHFS & AIHW 1998b).
- The incidence of lung cancer is similar across all areas for both males and females. Males and females in the remote zone have slightly lower incidence compared with males and females in the metropolitan zone but these rate differences are not significantly different from 'capital cities' at the 5% level.

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.

Death rates for colorectal cancer, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	29.4	30.0	30.6	30.6	30.6	23.5	28.8	29.7
Females	19.2	19.6	20.9	20.1	20.8	18.9	15.9	19.6

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 colorectal cancer

- Colorectal cancer is the second most common cause of cancer-related death (DHFS & AIHW 1998b; AHTAC 1997). The 5-year survival rates for this cancer are around 55% but early detection does result in better survival (DHFS & AIHW 1998b).
- Primary prevention of colorectal cancer includes avoiding possible risk factors such as high-fat, low-fibre diets. There is also evidence that mortality can be reduced through a program of screening for colorectal cancer using faecal occult blood tests (FOBT) (AHTAC 1997).
- Males have 50% higher death rates than females for this type of cancer. Death rates for males are similar in metropolitan, rural and remote zones. The lowest death rates from colorectal cancer are for males from the remote zone.
- Death rates for females are lowest in 'remote centres' and 'other remote areas' although these rates are not significantly different from those of females in 'capital cities'. The rates for females in the rural zone are similar to the rates for females in the metropolitan zone.

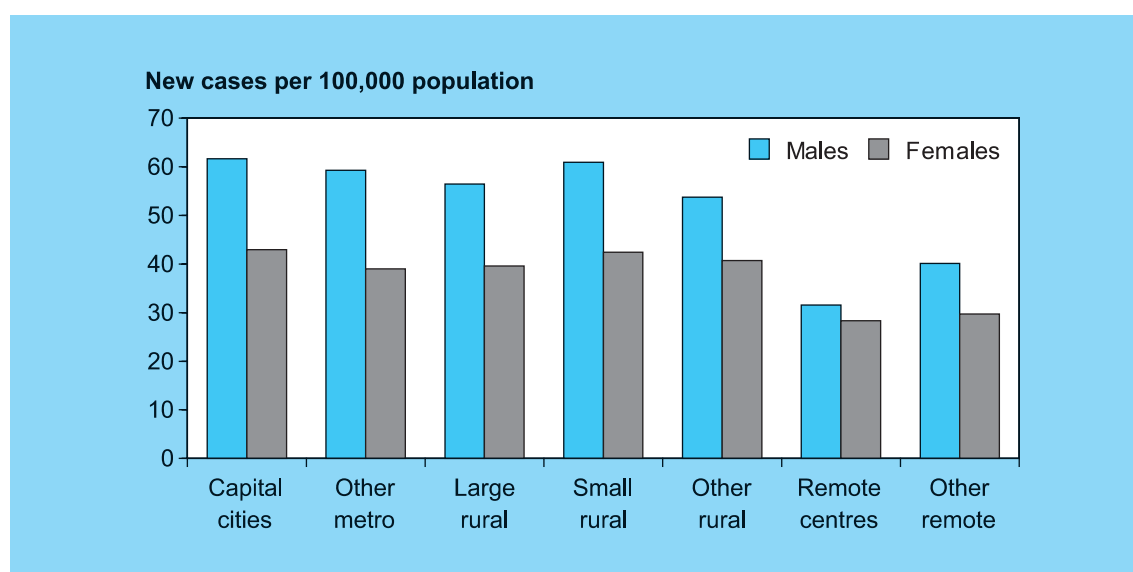
For more information, see:

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.

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 Health Technology Advisory Committee (AHTAC) 1997. Colorectal cancer screening. Canberra: Commonwealth Department of Health and Family Services.

Incidence of colorectal cancer, 1986–94



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	61.7	59.3	56.4	60.9	*53.8	*31.6	*40.1	59.3
Females	42.9	39.0	39.6	42.4	40.7	28.3	*29.7	41.8

* 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 colorectal cancer

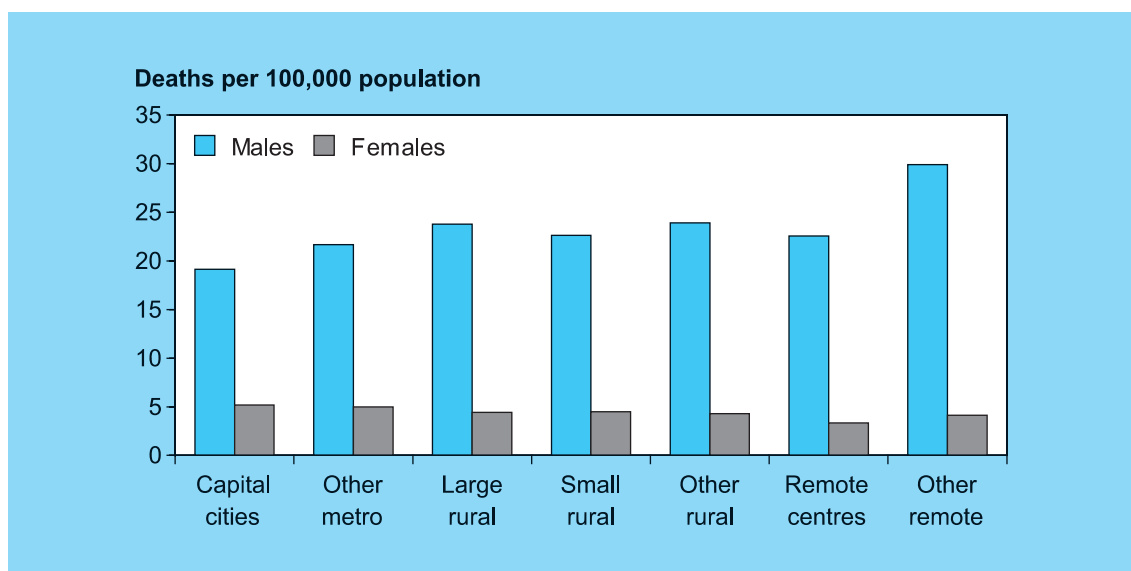
- For males and females combined, colorectal cancer is the second most common registered cancer. Since the early 1980s, both incidence and mortality rates have been relatively stable (DHFS & AIHW 1998b).
- Incidence of colorectal cancer is similar in metropolitan and rural zones and lower in the remote zone for both males and females. This may reflect increased use of screening techniques for colorectal cancers in metropolitan and rural zones relative to the remote zone. It could also reflect differences in diet, a risk factor, between the different zones.
- Colorectal cancer incidence is much higher for males than for females across all zones. This result is consistent with the death rate from colorectal cancer which is 50% higher for males than for females.

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.

Suicide

Death rates for suicide and self-inflicted injury, 1992–96



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	19.2	21.7	*23.8	22.6	*23.9	22.6	*29.9	20.7
Females	5.2	5.0	4.4	4.5	4.3	3.3	4.1	4.9

* 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 suicide

- Suicide rates in Australia have remained fairly constant during the twentieth century (AIHW 1998a). However, there has been an increase in suicide by young adult males over the past 30 years. In 1996, there were 2,393 suicide deaths, accounting for 32% of all injury deaths in Australia (AIHW 1998a).
- Death from suicide is often underrecorded with only an estimated one-half of male suicides and three-quarters of female suicides officially recorded (O'Donnell & Farmer 1995). Risk factors for suicide include low socioeconomic status and unemployment, divorce or separation, and in-patient psychiatric diagnosis (Ellis & Collings 1997). Alcohol abuse is another factor that is related to suicide. A study of suicide in Western Australia found that one-third of people who had committed suicide had alcohol in their blood (Hayward et al. 1992).
- Youth suicide is a growing problem in Australia. This is highlighted by the fact that Australia and New Zealand are the only Western countries in which youth suicide rates are higher than the total suicide rates (Ellis & Collings 1997). Risk factors for youth suicide are depression, past attempt at suicide, substance abuse, conduct abuse, family history of discord, exposure to suicide, child abuse and academic failure (Dudley et al. 1997). Other factors thought to be involved in the decision to suicide include: youth unemployment, media depictions of suicide, availability of lethal methods (e.g. firearms) and problems with access to and use of psychiatric services (Dudley et al. 1997).
- The death rate from suicide is five times higher for males than for females in all areas. Young males are more likely to use firearms, hanging or motor vehicle exhaust as the means of committing suicide, whereas females are most likely to use drug overdose or poisons to commit suicide (DHFS 1997b).

- The highest male suicide rates are for males in 'large rural centres', and 'other remote areas'. The rates for these zones are significantly higher than the rates for males from 'capital cities'. In contrast to the picture for males, death rates for females are highest in the metropolitan zone and the lowest in the remote zone.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Commonwealth Department of Health and Family Services 1997. Youth suicide in Australia: a background monograph. Canberra: AGPS.

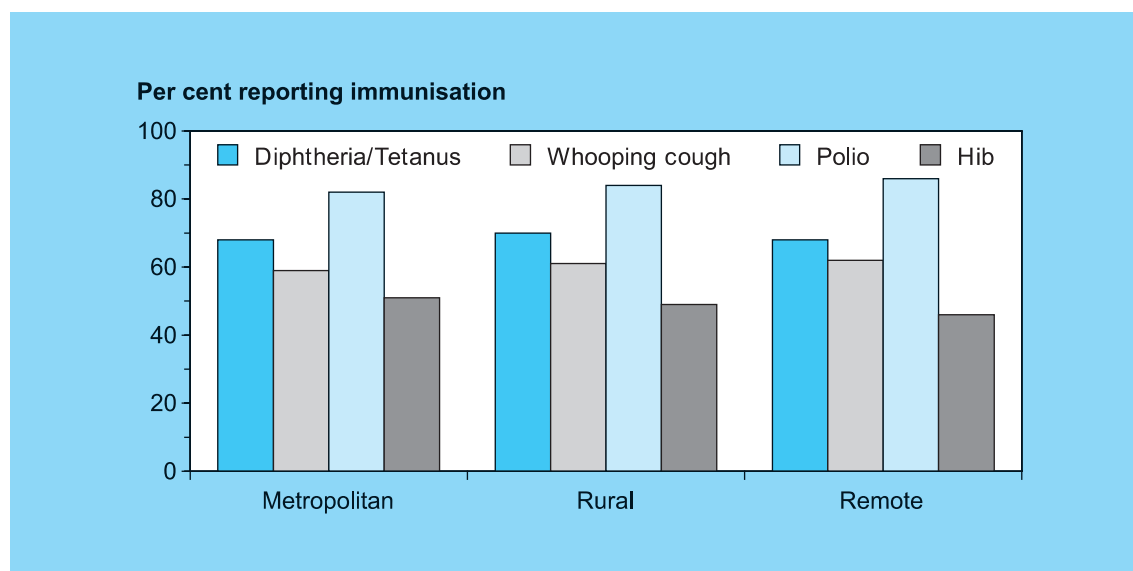
Dudley M, Kelk N, Florio T et al. 1997. Suicide among young rural Australians 1964-1993: a comparison with metropolitan trends. *Soc Psychiatry Psychiatr Epidemiol* 32: 251-60.

Ellis PM & Collings SCD 1997. Mental health in New Zealand from a public health perspective. Wellington: Ministry of Health.

Hayward L, Zubrick SR & Silburn S 1992. Blood alcohol levels in suicide cases. *J Epidemiol Community Health* 46: 256-60.

O'Donnell I & Farmer R 1995. The limitations of official suicide statistics. *Br J Psychiatry* 166: 458-61.

Proportion of children aged 0–6 years immunised for vaccine-preventable diseases, 1995



Disease	Metropolitan	Rural	Remote	Total
Diphtheria/Tetanus	68	70	68	69
Whooping cough	59	61	62	60
Polio	82	84	86	83
Hib	51	49	46	50

Notes

1. Table shows percentage of children fully immunised with reference to the current (1994) NHMRC Standard Childhood Vaccination Schedules.

2. The survey sample size was too small to allow the full seven-category RRMA breakdown.

Source: 1995 ABS Children's Immunisation and Health Screening Survey.

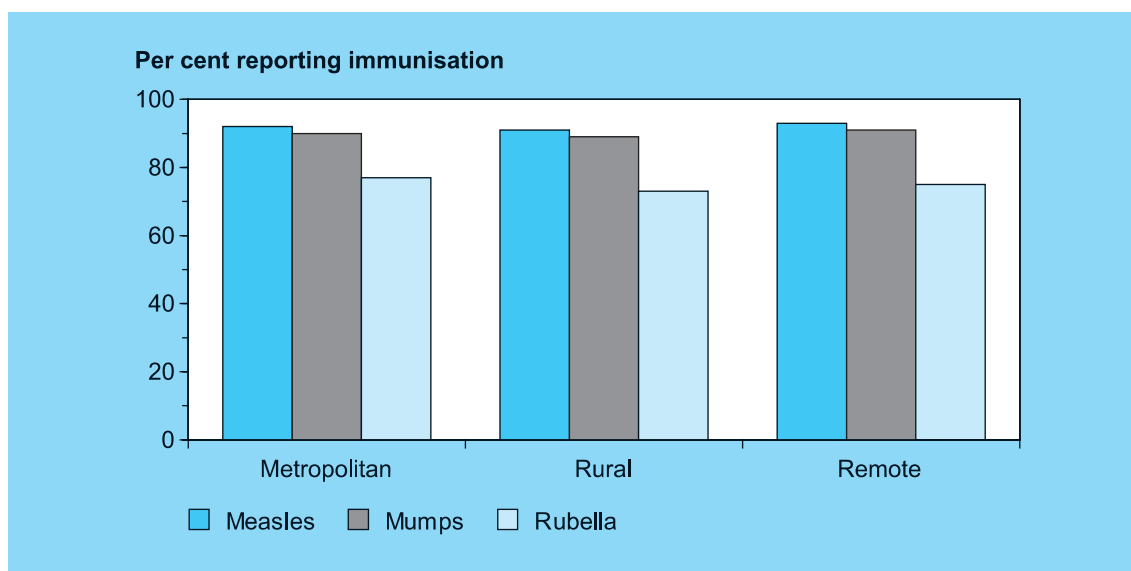
Immunisation against vaccine-preventable diseases

- Immunisation against vaccine-preventable diseases is an important public health measure aimed at reducing sickness and death from childhood diseases. In order to prevent transmission of a highly infectious disease, 92% to 95% of the population must have immunity to the disease (AIHW 1998a). The percentages vaccinated for diphtheria/tetanus, whooping cough, polio and *Haemophilus influenzae* type b (Hib) are too low to provide full immunity to the Australian population.
- Metropolitan, rural and remote zones all report similar proportions vaccinated for diphtheria/tetanus, whooping cough, polio and Hib.
- A high percentage of children from all areas are vaccinated against polio. In contrast, only 50% of children from all areas report a vaccination against Hib. Hib was added to the vaccination schedule for the first time in April 1993 and rates of vaccination are expected to increase in the future.
- Vaccination rates for diphtheria/tetanus, whooping cough and Hib are considerably lower than for the other communicable diseases across all areas. These are the vaccines that require multiple doses for complete immunisation. To be fully immunised according to the NHMRC Standard Childhood Vaccination Schedules, a child needs to receive vaccination at least five times, at 2, 4, 6, 18 and 60 months of age.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Proportion of children over one year of age vaccinated for measles, mumps and rubella, 1995



Disease	Metropolitan	Rural	Remote	Total
Measles	92	91	93	92
Mumps	90	89	91	90
Rubella	77	73	75	76

Notes

1. Table shows percentage of children fully immunised with reference to the current (1994) NHMRC Standard Childhood Vaccination Schedules.
 2. The survey sample size was too small to allow the full seven-category RRMA breakdown.
- Source: 1995 ABS Children's Immunisation and Health Screening Survey.

Vaccination for measles, mumps and rubella

- Vaccinations for measles, mumps and rubella are given with a combined measles, mumps and rubella (MMR) vaccine to children at 12 months of age (AIHW 1998a; NHMRC 1996). However, Indigenous children in the Northern Territory are vaccinated at 9 months of age (NHMRC 1996). A second dose is recommended at 10-16 years of age. Rubella requires re-vaccination and is particularly recommended for females of child-bearing age because rubella can cause blindness, deafness and congenital heart abnormalities in the fetuses of infected mothers.
- More than 90% of children over the age of 1 year are vaccinated against measles and mumps. A lower rate of vaccination is evident for rubella, with only around 75% of children fully vaccinated. The lower percentage of rubella vaccinations compared with the rates for measles and mumps is partly explained by

fewer males being fully immunised than females, reflecting a perception that rubella vaccination is required only for females (ABS 1998c).

- Immunisation rates for measles, mumps and rubella are similar across metropolitan, rural and remote zones.

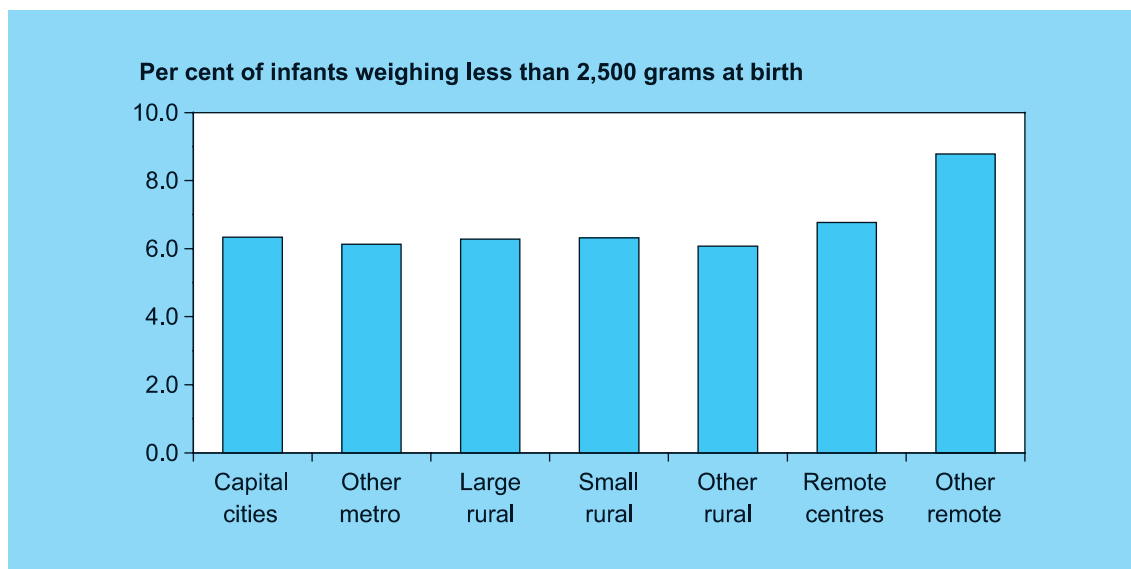
For more information, see:

Australian Bureau of Statistics 1998. Children's immunisation Australia, April 1995. ABS Cat. No. 4352.0. Canberra: AGPS.

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

National Health and Medical Research Council 1996. Measles. Guidelines for control of outbreaks in Australia. Canberra: AGPS.

Proportion of infants weighing less than 2,500 grams at birth, 1991–95



Indicator	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Per cent low-birthweight	6.3	6.1	6.3	6.3	6.1	6.8	8.8	6.4

Source: AIHW National Perinatal Statistics Unit.

Low-birthweight

- Low-birthweight is an important indicator of infant health status and may result in poor health outcomes later in life. Low-birthweight infants are more likely to die or suffer illness compared with those of normal birthweight (Day et al. 1997). Low-birthweight is related to risk factors such as lack of prenatal care and inadequate maternal nutrition.
- In 1995, there were 16,571 infants of low-birthweight born in Australia (Day et al. 1997). Low-birthweight is more common in Indigenous babies, with 11.8% of Indigenous newborns in 1995 weighing less than 2,500 grams (Day et al. 1997).
- 'Other remote areas' have the highest proportion of low-birthweight babies. The relatively higher proportion of Indigenous babies in remote areas may explain this result because Indigenous Australians have twice

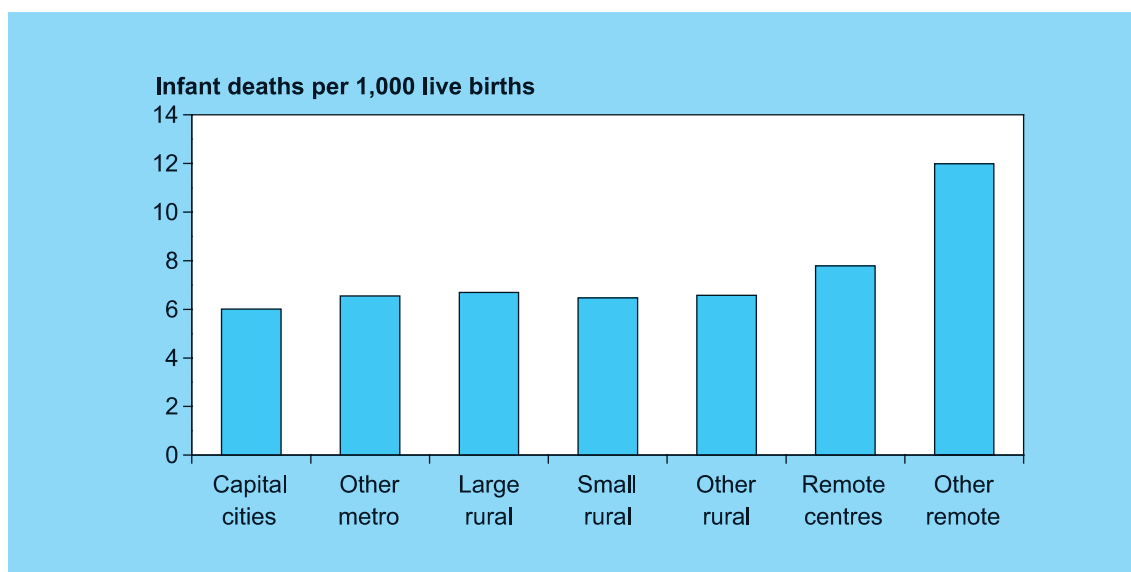
the rate of low-birthweight infants compared with non-Indigenous Australians. Females living in the remote zone may not have the same access to prenatal care as females living in metropolitan and rural zones.

- All other areas have similar proportions of low-birthweight infants.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.
Day P, Lancaster P & Huang J 1997. Australia's mothers and babies 1995. Perinatal Statistics Series No. 6. Sydney: AIHW National Perinatal Statistics Unit.

Infant mortality rates per 1,000 live births, 1991–95



Indicator	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Infant mortality per 1,000 live births	6.0	6.6	6.7	6.5	6.6	7.8	12.0	6.3

Source: AIHW National Mortality Database.

Infant mortality

- Infant mortality is a traditional indicator of the health of a population. In the last two decades, infant mortality has declined dramatically in Australia. In 1996 the rate was 5.9 deaths per 1,000 live births (AIHW 1998a).
- Three main causes of infant mortality accounted for 76% of all infant deaths from 1980 to 1995. These are congenital anomalies, sudden infant death syndrome (SIDs), and perinatal conditions such as low birth-weight.
- Infants from 'other remote areas' have twice the mortality rates of other areas. This may be partially explained by the high proportion of Indigenous infants in this area of Australia.
- 'Remote centres' have slightly higher infant mortality rates than other regions but considerably lower rates than 'other remote

areas'. The lowest infant mortality rates are found in 'capital cities'.

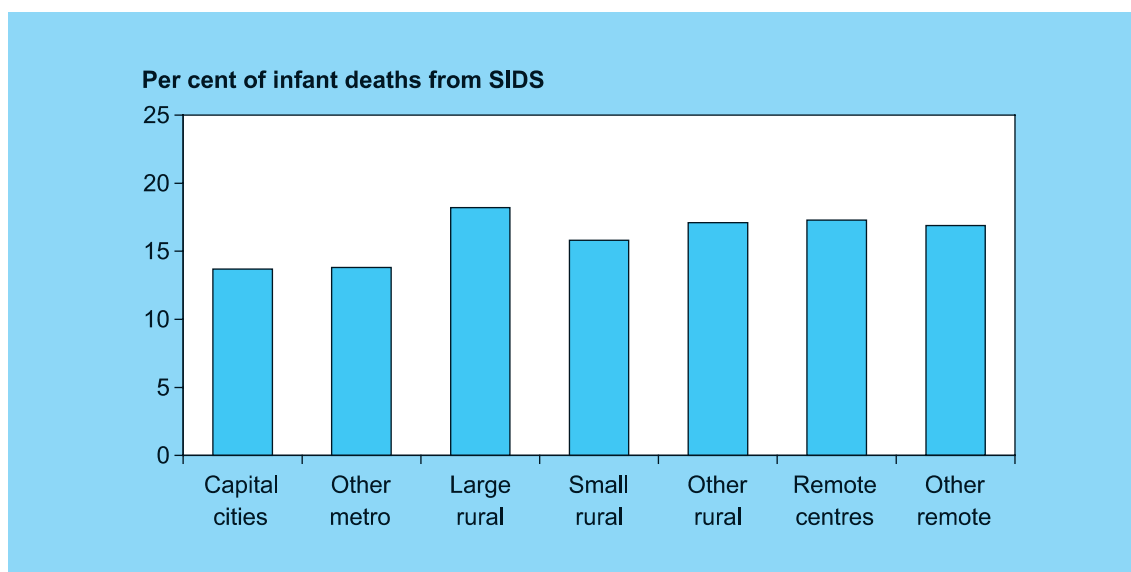
For more information, see:

Australian Institute of Health and Welfare 1998. *Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare*. Canberra: AIHW.

Australian Bureau of Statistics 1998. *Causes of infant and child deaths in Australia 1982-1996*. ABS Cat. No. 4398.0. Canberra: AGPS.

Mathers CD 1995. *Health differentials among Australian children*. Australian Institute of Health and Welfare: Health Monitoring Series No. 3. Canberra: AGPS.

Proportion of infant deaths from SIDS, 1992–96



Indicator	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Per cent of infant deaths from SIDS	13.7	13.8	18.2	15.8	17.1	17.3	16.9	14.8

Source: AIHW National Mortality Database.

SIDS deaths

- Sudden infant death syndrome (SIDS) is one of the leading causes of death in infants in Australia. SIDS accounted for 14% of infant deaths in 1996 with a higher death rate for males than for females (AIHW 1998a).
- A decline in SIDS deaths since 1990 is attributed to the success of a national campaign, Reducing the Risks of SIDS. This campaign highlighted risk factors including sleeping posture, feeding practices and exposure of infants to passive smoking.
- Rural and remote zones have substantially higher rates of deaths due to SIDS than the metropolitan zone over the 5-year period 1992–96. The greater proportion of Indigenous infant deaths in the remote zone may explain the higher rate for SIDS in this zone. However,

caution must be used when interpreting these results because only a small number of infant deaths each year are attributable to SIDS. As a result, the differences between populations may not reflect actual differences in SIDS death rates between areas.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.
 Australian Bureau of Statistics, 1998. Causes of infant and child deaths in Australia 1982–1996. ABS Cat. No. 4398.0. Canberra: AGPS.