

NCIS FACT SHEET

Injury deaths by residential remoteness area in Australia

127,854

injury deaths
2001-2017

7520

deaths per year
on average

60.9%

residents of major
cities

Remoteness areas divide Australia into five classes of remoteness based on a measure of relative access to services. The [Australian Bureau of Statistics](#) provides more information about remoteness areas.

The majority (72.2%) of Australia's population reside in major cities. The number of people living in major cities and regional areas increased between 2001 and 2017, while the number of residents in remote areas decreased (1). Those living in non-metropolitan areas have shorter life expectancies, higher levels of injury and less access to health services than their counterparts in major cities (2).

National overview

There were a total of 127,854 injury deaths reported to a coroner from 2001 to 2017. Almost two thirds (60.9%) of injury deaths were of residents of major cities of Australia. This is lower than the population distribution of persons residing in major cities (1).

The national rate of injury deaths per 100,000 across all remoteness areas increased slightly from 34.6 deaths per 100,000 in 2001 to 36.4 deaths per 100,000 in 2017.

The rate of injury deaths among residents of remote and very remote areas was consistently higher than that of major city and regional area residents (Figure 1).

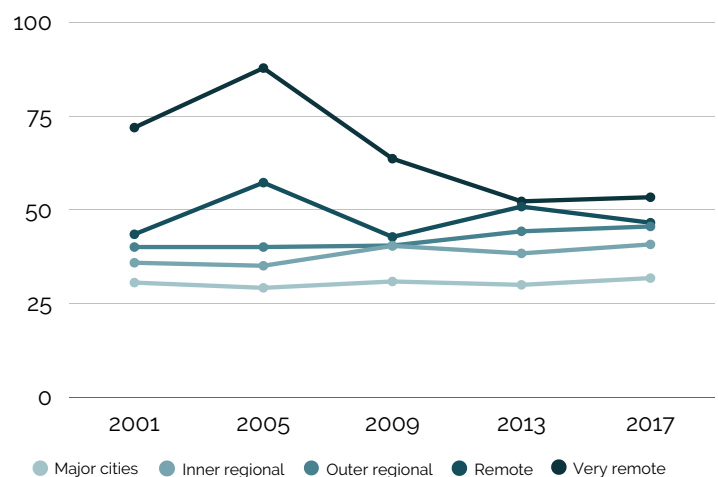


Figure 1. National rate of injury deaths per 100,000 by residential remoteness, 2001, 2005, 2009, 2013 and 2017

The highest rates of injury deaths per 100,000 residents in 2017 were recorded in very remote South Australia and Tasmania (79.8 and 78.9, respectively).

Major cities had lower rates of injury deaths in 2017. The lowest rates per 100,000 residents across major cities were in New South Wales (22.9) and the ACT (27.5). The highest rates among major city residents were in South Australia (49.3) and Western Australia (45.1), above the national average for major cities (31.8).

Age range and sex

Residents aged 65 years and over comprised the highest proportion of injury deaths in major cities (28.3%). All other age groups comprised between 10.3% and 16.9% of deaths. Deaths of regional residents were similarly distributed by age.

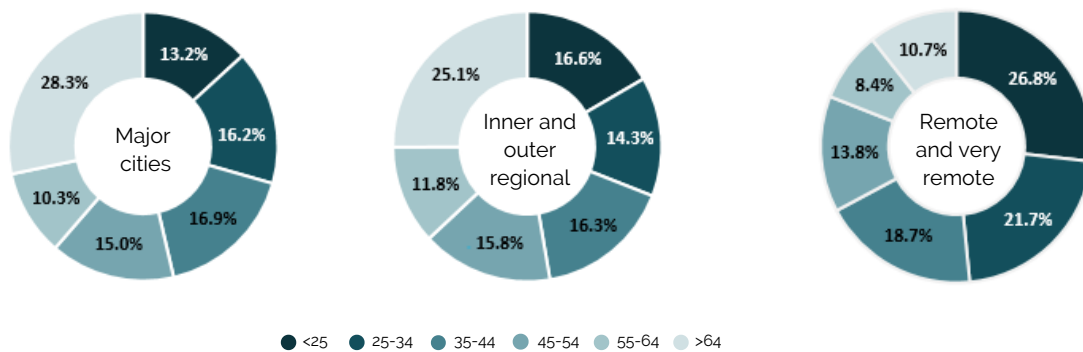


Figure 2. Proportion of injury deaths by age range and residential remoteness, 2001-2017

By contrast, residents aged under 25 years comprised the highest proportion of deaths in remote areas (26.8%), followed by persons aged 25-34 years and 35-44 years. Deaths of persons aged 65 years comprised 10.7% (3).

Males accounted for the majority of injury deaths across all areas. The proportion of male injury deaths increased with remoteness, with the exception of very remote areas (Figure 3).

Female injury deaths generally followed an inverse trend.

Remoteness area	Male (%)	Female (%)
Major cities	68.7	31.3
Inner regional	70.7	29.3
Outer regional	74.1	25.9
Remote	75.1	24.9
Very remote	73.1	26.9

Figure 3. Proportion of injury deaths by residential remoteness and sex, 2001-2017

Indigenous origin

Aboriginal and Torres Strait Islander persons who died due to injury were most likely to reside in remote and very remote areas (Figure 4).

This is consistent with the general population distribution of Aboriginal and Torres Strait Islander persons (4).

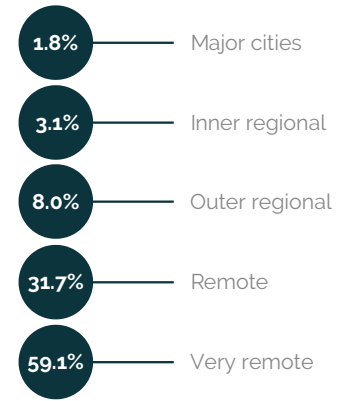


Figure 4. Proportion of indigenous deaths (where indigenous origin known) by residential remoteness, 2001-2017

Employment status

The proportion of injury deaths where the person was unemployed was higher in remote (27.1%) and very remote areas (36.7%), compared to major cities (17.6%).

By contrast, retirees and pensioners contributed to a higher proportion of injury deaths in major cities (33.5%) than in remote (14.4%) and very remote areas (8.7%).



Mechanism and intent type

Across all remoteness areas, the majority (56.1%) of injury deaths were unintentional and one third (33.8%) were due to intentional self-harm.

The most common mechanisms of injury across all areas were pharmaceutical drug toxicity, vehicle incidents and asphyxiation by hanging (Figure 5). Fall-related deaths decreased with residential remoteness from 15.4% in major cities to 3.6% in very remote areas.

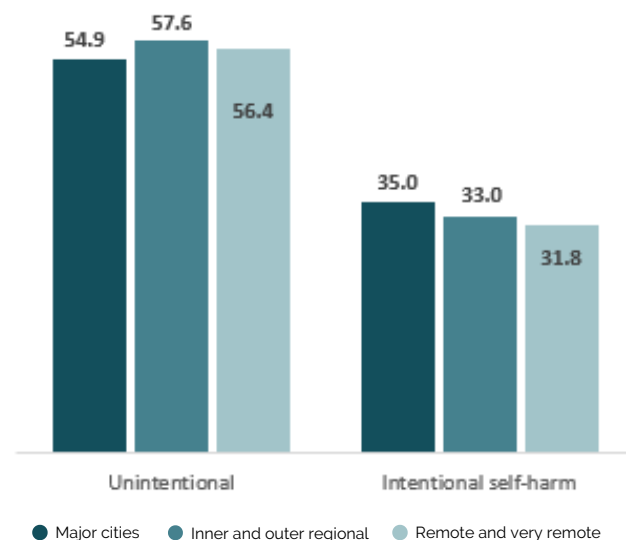


Figure 5. Proportion of most common intent types by residential remoteness, 2001-2017

Assault deaths were nearly three times more common among residents of very remote areas (9.0%) compared to major cities (3.3%)

Unintentional deaths

Vehicle incidents were the most common unintentional mechanism of injury across all areas. The highest proportions of vehicle incident deaths occurred among residents of very remote and remote areas (Figure 6).

By comparison, pharmaceutical drug toxicity accounted for a smaller proportion of unintentional deaths in regional and remote areas.

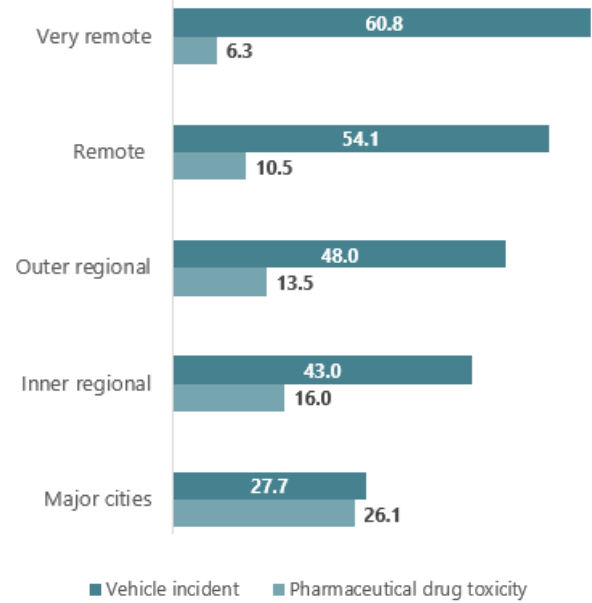


Figure 6. Proportion of unintentional vehicle incident and pharmaceutical drug toxicity deaths by residential remoteness, 2001-2017

Intentional self-harm deaths

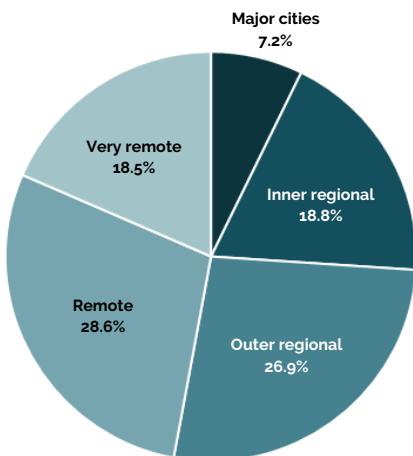


Figure 7. Proportion of firearm-related deaths by residential remoteness, 2001-2017

Among residents of remote and very remote areas, the highest proportion of self-harm deaths were due to hanging (77.1%). By comparison, hanging deaths accounted for under half (47.2%) of self-harm deaths among residents of major cities.

Firearm-related self-harm deaths were most common among residents of remote and outer regional areas (Figure 7).

1. Australian Bureau of Statistics 2020, [Regional Population Growth, Australia](#)
2. Australian Institute of Health and Welfare 2019, [Rural & remote health](#)
3. Note the age groupings are not equally distributed. Caution should be applied when comparing specific age groups
4. Australian Bureau of Statistics 2018, [Estimates of Aboriginal and Torres Strait Islander Australians, June 2016](#)

The data presented in this fact sheet was extracted from the National Coronial Information System (NCIS) in August 2020. The dataset extracted contained every fatality of a person with an Australian residential address that was reported to an Australian coroner from 1 January 2001 to 31 December 2017. Cases were included where the coronial investigation had concluded and the case was closed on the NCIS. Population data was sourced from the Australian Bureau of Statistics. Visit the NCIS website for information on [data sources and limitations](#). To request a comprehensive data report, contact the NCIS or visit www.ncis.org.au.

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