The regional, rural, and remote experience in National Seniors Social Surveys

2025

National Seniors AUSTRALIA

Contents

Introduction

National Seniors Australia, or NSA, is a member based, not-for-profit research and advocacy organisation representing Australians aged 50+.

We receive funding from the Department of Health, Disability and Ageing to research older Australians via our National Seniors Social Survey (NSSS).

Every year the NSSS surveys thousands of older people on diverse topics relevant to lifestyle and wellbeing.

This report draws on data about older people in regional, rural, and remote locations from three iterations of the NSSS (2023, 2024, and 2025).

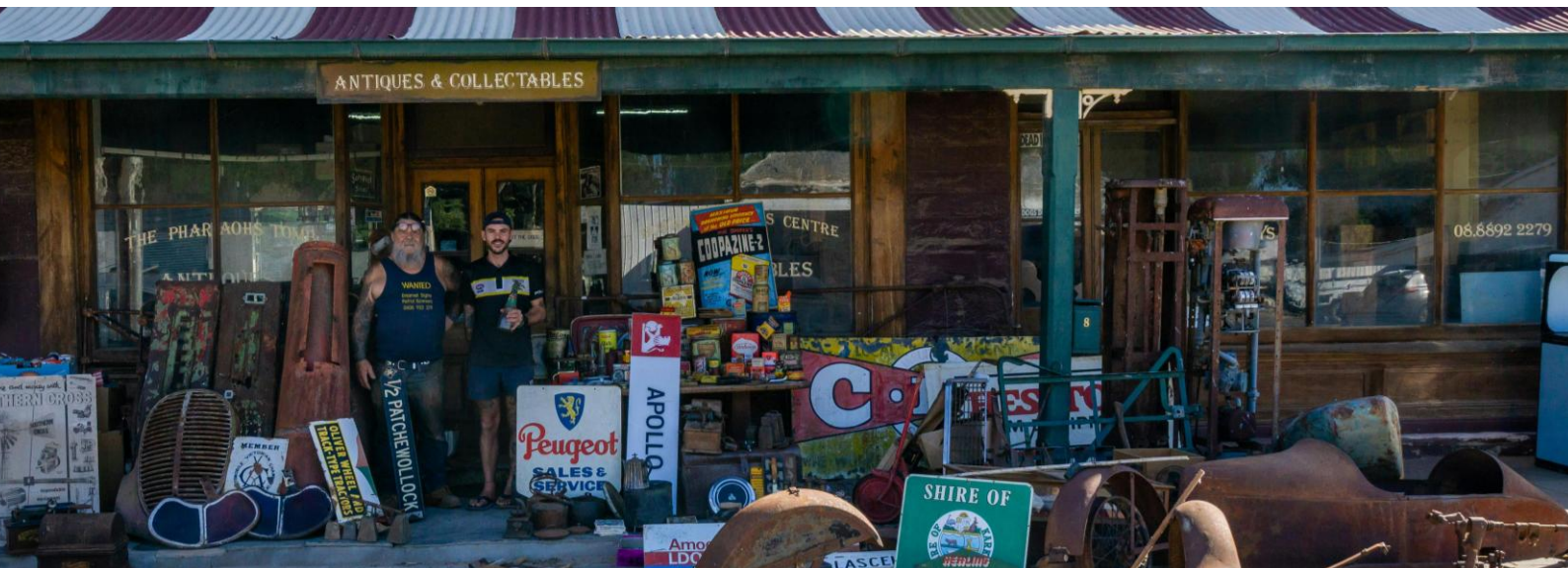
Representing the views and experiences of older people living in regional, rural, and remote locations is one of the intended outcomes of NSA's funding agreement with the Department of Health, Disability and Ageing.

The geographic isolation of these areas can impact on the experience of ageing because of poorer access to medical, healthcare, aged care, and lifestyle services compared to living in metro-based locations.

Every year in the NSSS we ask people if they live in a regional, rural or remote area. This report presents the demographic differences between regional, rural, and remote respondents and those living in metro areas over the last three surveys.

It also focuses on disparities between these groups in:

- healthcare access and affordability as assessed in 2023,
- private health cover, vaccination uptake, and connecting with people and places as assessed in 2024,
- and digital engagement as assessed in 2025.



Key to the graphics in this report

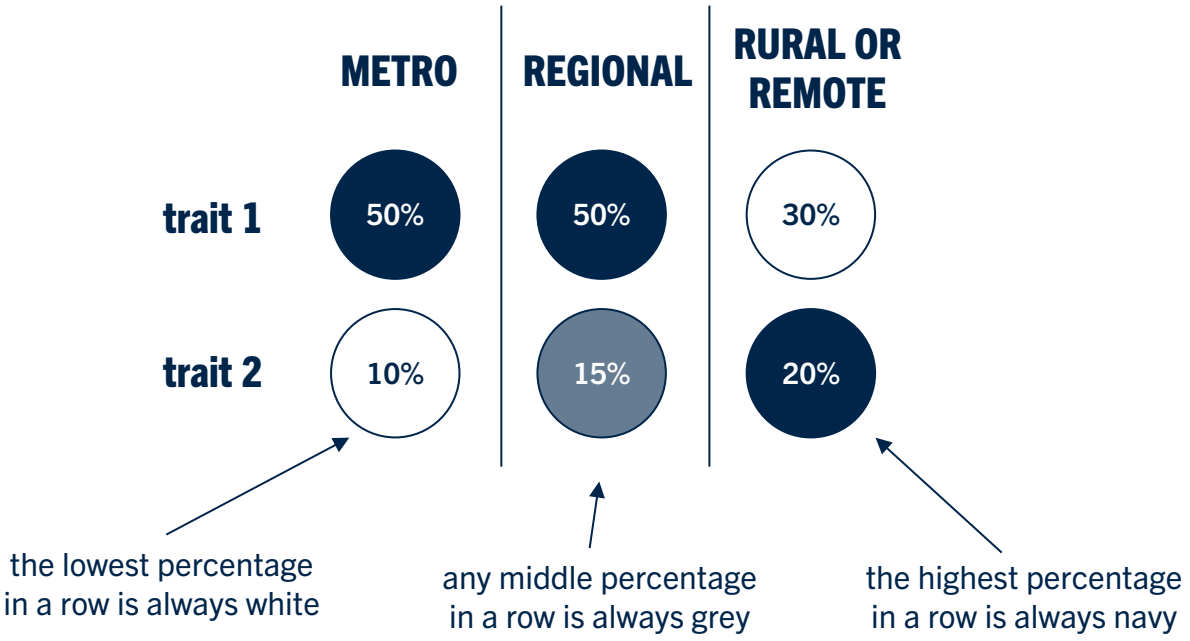
All graphical representations of data in this report highlight survey questions where outcomes differed significantly between rural/remote, regional and/or metro locations. So, if a difference is mentioned, it will be a statistically significant difference between the locations.

All but one of the comparisons are represented the same way throughout the report.

The location types are shown in three columns, always in the same order from metro on the left, through regional in the middle, to rural/remote on the right.

Traits of interest are listed in rows beneath the location headings. The percentage of respondents who correspond to the trait is shown in a coloured circle for each location. Reading across the row for each trait, the highest percentage is always coloured navy, the lowest is white, and any percentage in between is coloured grey.

This colour scheme shows at a glance which location type corresponds to the trait the most and which the least, irrespective of the actual numbers involved.



The percentages are based on overall numbers for each of the three surveys, as outlined below.

Total respondents for each location type

	METRO	REGIONAL	RURAL/REMOTE
NSSS-2023	3766 (66.2%)	1369 (24.1%)	551 (9.7%)
NSSS-2024	3393 (66.2%)	1291 (25.2%)	441 (8.6%)
NSSS-2025	3014 (60.7%)	1354 (27.3%)	600 (12.1%)

Demographic comparison

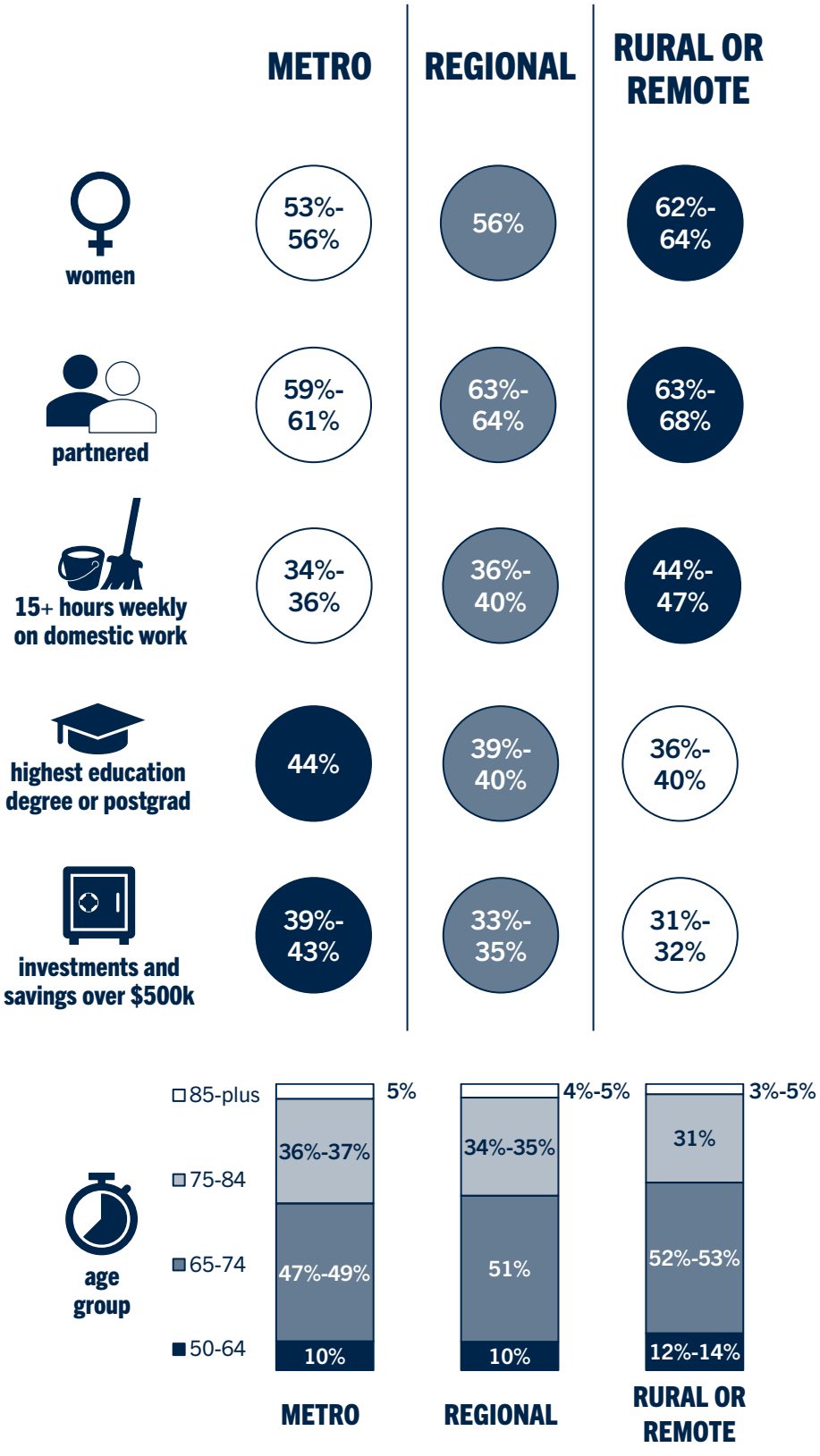
To characterise the regional, rural, and remote people who participated in the NSSS in 2023, 2024, and 2025, we compared them to metro respondents on eight key demographic traits.

Six traits were significantly different and showed consistent patterns by location.

Compared to metro people, rural/remote people were more often younger, female, partnered, and doing more hours of domestic work. They less often had a degree or savings over $500k. Regional people fell in the middle on all these traits.

Self-rated health and home ownership were tested but did not differ significantly by location.

Note that age, binary gender, and domestic work only differed by location for the 2024 and 2025 surveys but not in 2023 (not significantly different by location that year or not asked about). These 2023 numbers are therefore not included in



Healthcare access and affordability

The 2023 NSSS featured a module about healthcare access and affordability.

Several questions asked respondents about their ability to access healthcare in a consistent and timely manner, while others asked about the impacts of costs.

Breaking down the data by location shows that for all but one of the measures, there were significant differences between rural/remote, regional, and metro respondents.

In all cases, greater proportions of rural/remote and/or regional people found healthcare inaccessible or unaffordable, compared to their metro counterparts. The graphics on this page and the next page show the proportions.

The only measure that was not significantly different was the proportion who took up the option to pay privately for surgery to avoid waiting. Differences by location were also apparent for this, but they were not statistically significant (not shown).

	METRO	REGIONAL	RURAL OR REMOTE
I always see the same GP	80%	77%	67%
I can generally see a GP the same day or within 1-2 days	43%	25%	25%
I could access a bulk billing GP practice this week relatively easily	44%	36%	39%
I go to a regular medical practice but see different GPs	17%	21%	30%
I generally have to wait a week or longer to see a GP	22%	38%	40%
I'm on an elective surgery waitlist now or was recently	14%	18%	24%
I have missed out on healthcare because of the cost, and it has negatively affected my health or wellbeing	18%	20%	26%

Costs that prevent access to healthcare

One NSSS-2023 question asked about the affordability of 10 common types of healthcare appointment or treatment.

For each, the question asked respondents whether the cost had affected their access in recent years.

They could select:

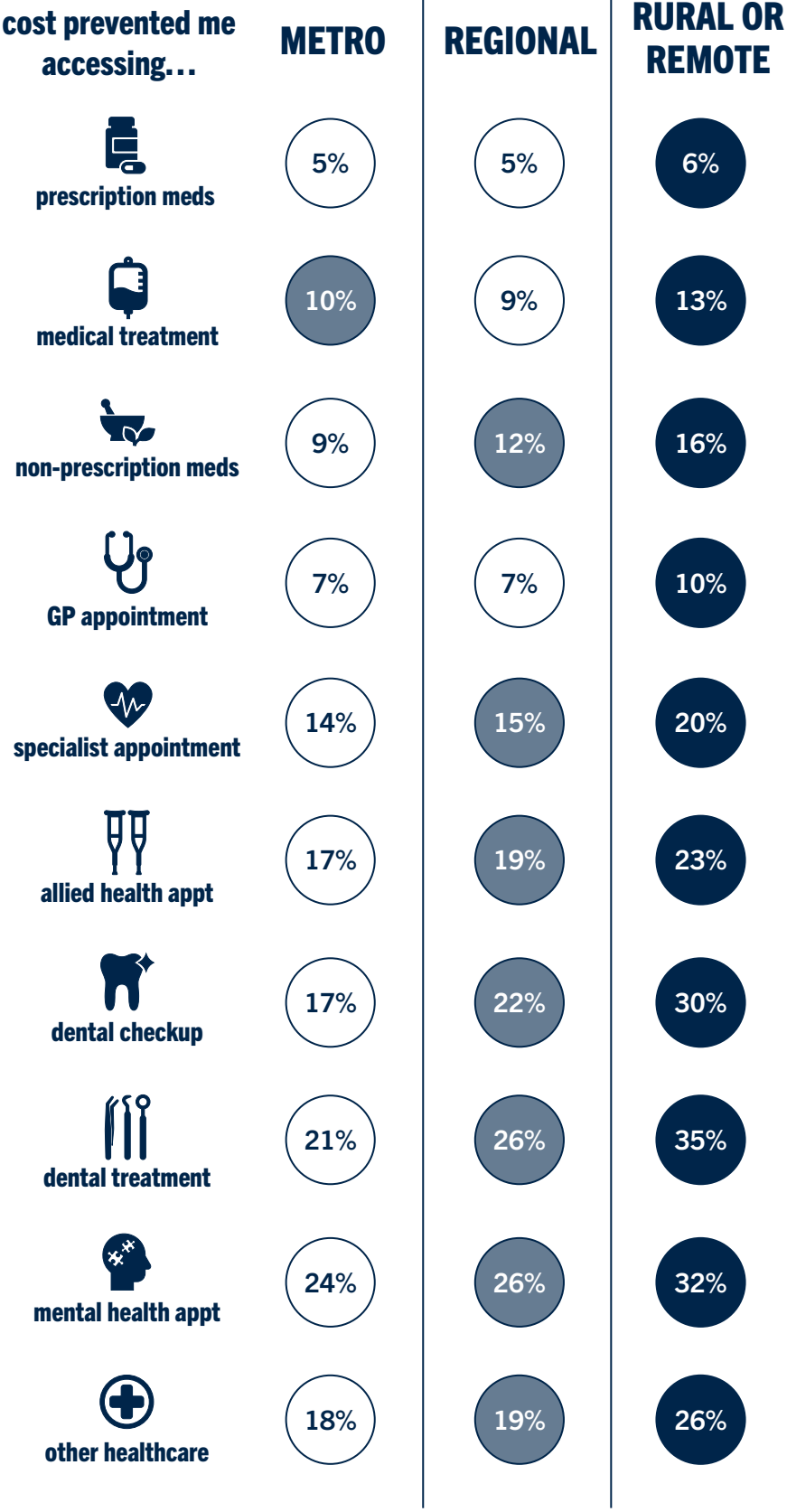
- Yes, the cost prevented me from accessing this.
- The cost made me hesitate about accessing it.
- No, the cost has not stopped me at all.
- Not applicable.

This graphic shows the percent who selected 'yes, the cost prevented me from accessing this' for each item.

For every item, a greater proportion of rural and remote respondents were impacted by cost compared to other respondents.

Regional people were also impacted more than metro respondents for most items.

'Not applicable' answers were excluded prior to calculations.



Private health insurance

The NSSS-2024 included a module on private health insurance (PHI).

Respondents were asked if they have it, how important it is to them to maintain it, and any cost-saving strategies they were considering in order to do so.

There were differences between locations for many of these questions.

Among those who did not have PHI at the time of the survey but did in the past, there were no differences between location categories.

There were also no location-based differences in the reasons people had dropped their PHI.

Among strategies to help maintain PHI, there were no differences for increasing hospital excess, dropping or reducing extras cover, and shopping around for a cheaper premium. The strategies that were significantly different are illustrated here.

	METRO	REGIONAL	RURAL OR REMOTE
don't have PHI	16%	24%	27%
have hospital cover only	8%	10%	11%
have hospital cover and extras	71%	62%	57%
importance of maintaining my PHI (among those who have it)	98%	96%	96%
don't need cost saving strategies to maintain my PHI	49%	45%	40%
nothing will help me maintain my PHI	22%	20%	12%
considering dropping level of hospital cover to maintain my PHI	11%	12%	18%
considering reducing spending on other living costs to maintain my PHI	20%	25%	28%

Vaccinations and COVID precautions

The NSSS-2024 asked respondents about their flu, shingles and COVID vaccinations and if they continue to take any COVID precautions.

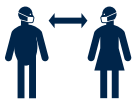
There were strong location-related differences in vaccination status for all three illnesses, with higher proportions of city-dwellers vaccinated.

Those who had not continued to get regular COVID boosters were asked why, but there were no location-based differences for any of the reasons given.

There were also no significant differences by location on whether people continued to take COVID precautions or not.

However, there were differences on three specific precautions taken, shown in the graphic.

Two other precautions – using hand sanitiser and doing a rapid antigen test if experiencing symptoms – yielded no significant location differences.



	METRO	REGIONAL	RURAL OR REMOTE
get a flu vaccine annually	90%	87%	80%
vaccinated against shingles	67%	63%	49%
continue to get COVID boosters as they become available	82%	76%	67%
wear a mask in public places	17%	13%	13%
social distance	28%	32%	35%
avoid crowds	36%	39%	42%

Connecting with people and places

Several questions in the NSSS-2024 related to connecting with the world.

There were significant differences between locations in the responses given to a few of these.

One question asked respondents about the time they spent in nature.

It was asked within a module on actions to boost healthy ageing, and none of the other actions in the module differed by location.

A question about connections disrupted by the COVID pandemic also yielded location differences. Note that for this analysis we combined three of the original response options to create the measure 'my COVID-disrupted social connections are back' and excluded responses by those whose social connections had not been disrupted by COVID.

The survey also asked about barriers to getting out and about in one's local area, town or city, and five of the response options showed location differences.

	METRO	REGIONAL	RURAL OR REMOTE
I spend time in nature	39%	45%	54%
my COVID-disrupted social connections are back	89%	87%	85%
I haven't regained social connections disrupted by COVID	8%	8%	11%
I've made new social connections since COVID	3%	5%	5%
nothing stops me getting out and about	78%	77%	67%
FACE BARRIERS TO GETTING OUT AND ABOUT			
crowded streets	4%	2%	2%
heavy traffic	6%	4%	3%
inadequate pathways, shelter, or rest areas	5%	7%	12%
inadequate public transport	8%	11%	20%

Digital abilities and preferences

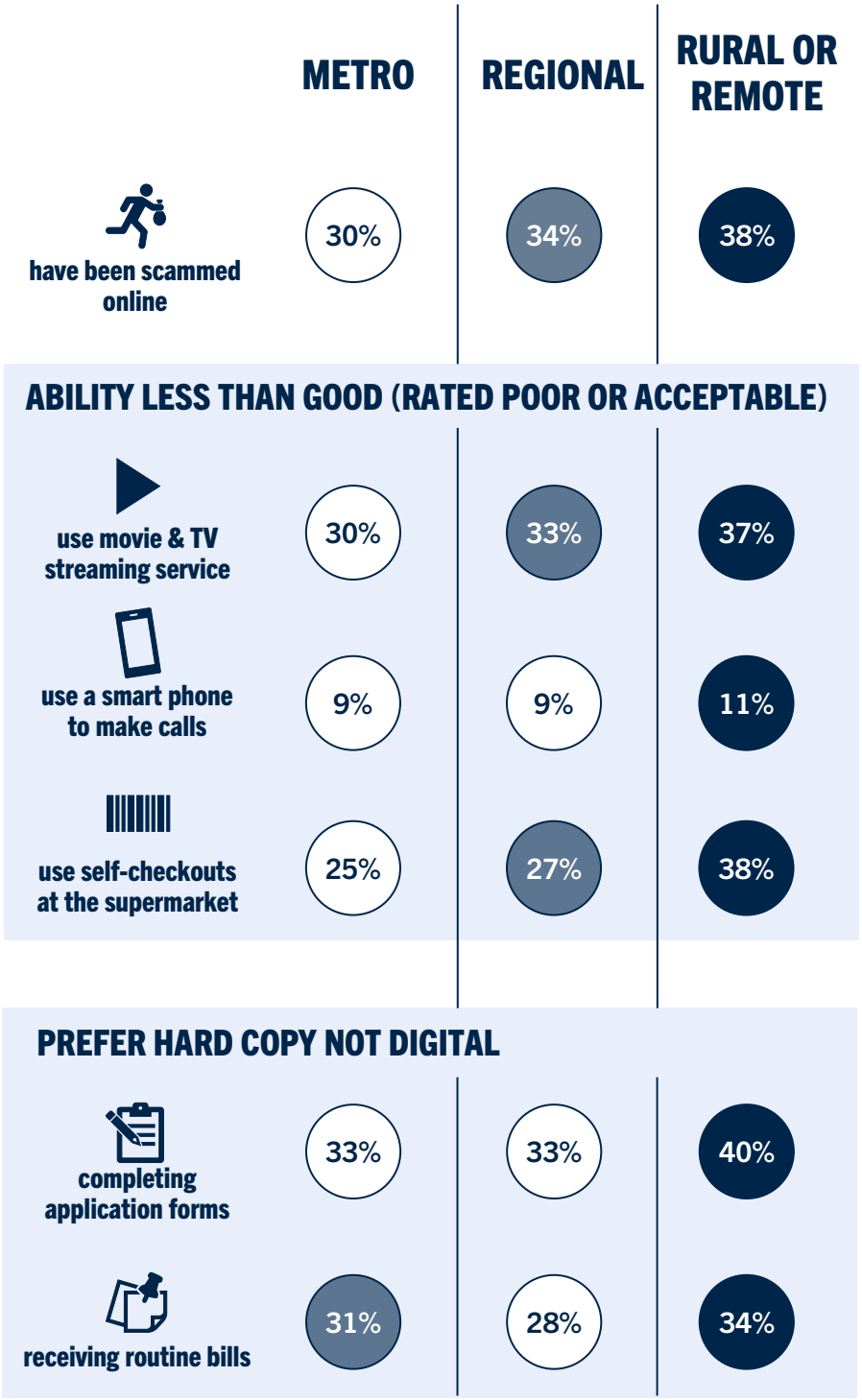
The 2025 iteration of the NSSS included a large module on respondents' experiences, abilities and preferences regarding digital technology.

Some of the questions asked respondents to rate their abilities to use different technologies on a scale of excellent, good, acceptable, or poor.

Other questions asked about a range of activities and whether respondents preferred to perform them digitally or in hard copy.

This page shows the items in both for which there were significant location differences. There were no differences for eight other abilities questions and five other preference questions.

Respondents were also asked if they had ever been the victim of online fraud or an online scam where their money or identity had been stolen.



Impacts of the digital transition

The NSSS-2025 digital module also asked respondents to indicate their level of agreement with statements about the digital transition and its impact on their life.

Seven of the 14 items asked about showed significant location-based differences.

Respondents were required to indicate their agreement with each item on a 5-point Likert scale: strongly agree, somewhat agree, it depends, somewhat disagree, or strongly disagree.

The graphic shows the proportion who 'agreed' with each item, combining 'strongly agree' ratings and 'somewhat agree' ratings.

	METRO	REGIONAL	RURAL OR REMOTE
I feel frustrated using digital services	34%	36%	39%
mobile phone or internet costs hinder my use of digital services	24%	28%	36%
the digital transition has made me feel more isolated	31%	32%	38%
the move away from cash makes it harder to manage or access my money	47%	50%	57%
I like the convenience of cashless payments	55%	50%	45%
digital services make my life easier	62%	61%	56%
for some tasks I prefer to interact online rather than face to face or over the phone	46%	42%	39%

Summary and conclusions

Findings presented in this report show that on average, 36% of NSSS respondents said they live outside main metro areas, including approximately 10% living in rural or remote locations.

These proportions are similar to those in the general population where 40.6% live outside metro areas and 11% (aged over 65) live in outer regional and remote areas. NSSS respondents self-identified if they lived in a regional, rural or remote area so these proportions are not directly comparable with the outer regional/remote/very remote classification provided by the AIHW.

Disparities between metro and non-metro areas in the availability of health and aged care services are well documented, but this report presents geographical differences in additional outcomes that are relevant to older people's quality of life.

Demographic differences

Regional, rural and remote (RRR) NSSS respondents generally ranged younger than their metro counterparts and included a higher proportion of women. This contrasts with national population figures which show non-metro populations being older and having slightly higher proportions of men.

RRR respondents were also less likely to have a degree or higher education than respondents from metro areas, which accords with the general population pattern of lower education levels corresponding to remoteness level.

People living in rural and remote areas generally have lower incomes and pay higher prices for goods and services compared to city dwellers. The wealth disparity between non-metro and metro locations is reflected in the NSSS cohort with a lower proportion of RRR respondents having $500,000 or more in savings and investments (including super).

Healthcare access and cost

The inequitable provision of healthcare to people living in RRR areas is demonstrated clearly by the comparison of metro and RRR people's access to basic health services including the impact of cost.

Lower proportions of RRR dwellers than metro dwellers always saw the same GP, were able to see a GP within 2 days, and would have been able to access a bulk-billing GP within a week relatively easily.

On the latter measure, regional residents fared worse than rural and remote residents (36% vs 39%), in a break with one of the main patterns shown in this report. But both still fared worse than metro residents on this (44%).

RRR respondents were also more likely to see different GPs at their medical practice, to have to wait a week or longer to see a GP, to be on an elective surgery waitlist, and to be negatively impacted health-wise if cost prevented their access to healthcare.

A subset of questions presented respondents with ten specific types of healthcare and asked if cost had prevented them from accessing them. A larger proportion of rural and remote respondents said 'yes' for all ten types of healthcare we listed. This accords with other NSSS findings that higher proportions of people living in RRR areas experience severe cost of living impacts and also have lower rates of private health insurance as shown on page 8 of this report.

The difference was particularly marked for dental care, with the percentage of rural

and remote people missing checkups because of cost being 8% higher than the regional percentage (and 13% higher than metro), and the percentage missing dental treatment being 9% higher than the regional percentage (14% higher than metro).

Regional respondents also fared worse than metro respondents on seven of the healthcare types. On another two (prescription medications and GP appointments), the percentage missing out because of cost was equal between these locations. For the tenth item (medical treatment), a slightly higher percentage of metro residents (10%) went without because of cost compared to regional residents (9%).

Researchers and policy experts have long recognised the problem of geographically inequitable healthcare provision in Australia.

The Federal Government's National Strategy for the Care and Support Economy acknowledges the 'thin market' for healthcare in some regions, particularly outside of metro areas.

In the case of the large disparity in dental care access due to cost, there are other contributing factors at play. An important one is the lack of subsidy for dental care, outside of the very stretched public dental system.

In addition, the relative lack of demand for dental services in RRR locations because of lower populations and long distances for patients to travel is likely prohibitive to private practice there. AHPRA registrations for dental health practitioners markedly drop for the three most remote area types in the seven-category Modified Monash Model of remoteness. In some rural and remote areas, the majority of dental care is provided fly-in-fly-out by the Royal Flying Doctor Service (RFDS), which is inherently sporadic rather than continuously available. While the RFDS service is free, the potential cost of accessing dental care in between RFDS visits may contribute to explaining the geographic disparities in older people accessing dental care.

Private health insurance

Private Health Insurance (PHI) status may also partly explain the geographic differences in whether healthcare costs prevented care (though note the questions about PHI and healthcare cost impacts were asked in separate NSSSs conducted one year apart).

A substantially lower proportion of RRR respondents had PHI than metro respondents. RRR people were also substantially less likely to have both hospital cover and extras and were slightly more likely to have hospital cover only.

Almost everyone who had PHI put a high premium on keeping it, but the percentage was still slightly lower among RRR respondents (96% vs 98%).

RRR respondents were also more likely to need cost saving strategies to keep their PHI. However, they were less likely to say, 'nothing will help me maintain my PHI', which may indicate a smaller proportion in absolute dire straits re the affordability of PHI. This was particularly the case for rural and remote respondents (12% said nothing will help me, vs 20% of regional and 22% of metro).

Possibly balancing this out, a higher percentage of RRR respondents were considering dropping their level of hospital cover or reducing spending on other living costs in order to keep their PHI.

These plans should be of concern to governments as it may be contributing to the inequitable financial burden on people in RRR locations, who in general have much less access to the healthcare they need as the numbers in this report show.

Vaccinations and precautions

Older people living in RRR areas were less likely to be vaccinated against shingles, to receive an annual flu vaccine, and to continue getting COVID boosters as available. Rural and remote respondents were particularly behind with shingles and COVID boosters.

They were also slightly less likely to continue wearing a mask in public places to guard against COVID.

It may be that the rates of COVID and flu vaccination and mask wearing are lower in RRR locations because the lower density population itself reduces the risk of contracting these diseases, so the population sees less benefit to taking preventative measures.

The NSSS result showing a lower rate of shingles vaccination for older people in RRR communities aligns with population data. These lower vaccination rates are unlikely to be linked with vaccine affordability concerns given the shingles vaccine is free for people aged ≥65 (≥50 for Indigenous Australians). It could be argued that some of the metro vs RRR difference in vaccination rates in the NSSS is driven by the RRR cohort being slightly younger than their metro counterparts, and therefore not eligible for the free shingles vaccine. If so, the finding is driven by the rural and remote group only, given the proportions of respondents aged 50-64 was the same for metro and regional areas (10% for both).

Poorer access to GPs who are responsible for administering vaccines is more likely to account for the lower rates of vaccination in RRR areas. The cost of the appointment rather than the vaccine itself could also be an issue for RRR residents. As reported by NSSS respondents, wait times are longer to access a bulk-billing GP in RRR communities compared to metro areas.

Social connections

Maintaining connections with community and with others is integral to wellbeing in later life.

RRR dwellers were slightly less likely than their metro counterparts to have regained social connections lost during the COVID pandemic but slightly more likely to have made new connections.

They were more likely to indicate that there were barriers to them getting out and about, and more likely to be obstructed by inadequate public transport, pathways, shelter or rest areas. These patterns were particularly apparent for rural and remote respondents.

While in the cities crowding and traffic are more problematic for older people wanting to get out and about, in RRR places it is the lack of infrastructure and services.

Supporting infrastructure is especially important for older people given driving competency on average declines with age and mobility challenges increase. Ageing people therefore increasingly need public transport. They also need quality pathways for walking or for small vehicles such as mobility scooters, and the pathways need to be serviced by adequate rest areas, shade, and public toilets. This need was echoed in previous NSA research into communities as well as WHO guidelines for age-friendly communities.

In general, the lack of population density in RRR areas combined with geographically larger administrative areas can make it more difficult for councils and other levels of government to deliver the infrastructure and services needed. As the population ages this is only going to become more of a problem, and governments need to find creative ways to address it.

Digital engagement

When NSSS respondents were asked to rate their digital abilities across 11 different tasks, there were only location-based differences for three of them: using streaming services, making calls on a smart phone, and using self-serve checkouts. For these three items, higher proportions of RRR respondents rated their ability as less than good.

There were more location-based differences for the questions about the impact of the digital transition with higher proportions of RRR residents experiencing negative effects. Most notably, the cost of mobile phone and internet services limited access for a greater proportion of people in non-metro areas.

A larger proportion of people from RRR areas said they had been scammed online, and they were also more likely to want hard copies of documents for some tasks instead of completing the tasks digitally.

The complex reasons for these trends are yet to be fully understood by researchers. We conducted a brief qualitative analysis of around 120 survey comments that discussed digital technologies with respect to location types (NSA unpublished data from NSSS-2025). The results indicated that poor internet coverage and unreliable electricity supply were two important drawbacks of digital technologies in RRR areas.

The National Rural Health Alliance highlighted the issues of digital affordability and access outside metro areas in their submission to a review of regional telecommunications in 2021. Adopting new technologies can be challenging in later life but for older people in RRR locations, these challenges are compounded by not having the same opportunities to engage with digital services as people in metro areas. To some extent this may also explain the higher proportion of RRR respondents who experienced online scams. It is difficult to be aware of online risks without the opportunity to be digitally savvy.

Conclusions

This report was prepared for the Commonwealth Department of Health, Disability and Ageing to illustrate the geographic distribution of the average NSSS sample in terms of metro versus non-metro areas and to highlight some current issues facing older people in RRR locations of Australia.

For the most part, responses to the NSSS by people who said they lived in RRR areas demonstrate consistency with population-wide trends in terms of structural disadvantage faced by these communities. In particular, they speak to the unaffordability of healthcare and digital services, both of which are essential for older people's wellbeing and quality of life.

The report also highlights the well-established need for better access to healthcare services in RRR areas, especially dental services.

Finally, work is needed to address geographic inequalities in terms of infrastructure and services such as better public transport and quality pathways so older people living anywhere in Australia can engage fully in their communities.

Methods

Survey ethics and recruitment

The information in this report comes from the iterations of the National Seniors Social Survey (NSSS) conducted in February-March 2023, 2024, and 2025.

The surveys received ethics approval from Bellberry Ltd prior to implementation (approval numbers 2022-12-1325, 2023-11-1424, and 2023-11-1424-A-1).

Anyone aged 50 or older who resided in Australia at the time of the survey was welcome to participate in the NSSS.

When inviting people to participate, we always strive for greater inclusivity and maximising participation, rather than numerical representativeness. For this reason, we use comprehensive demographics to describe each survey's sample, enabling readers to compare the sample to national trends if desired.

Identifying regional, rural and remote participants

Representing the views and experiences of older people living in regional, rural and remote (RRR) locations is one of the intended outcomes of NSA's funding agreement with the Department of Health, Disability and Ageing (DHDA) (Activity ID 4-KSB3JM6).

The way living location was identified differed between the NSSS-2023/2024 and the NSSS-2025.

The NSSS-2023 and 2024 asked respondents to identify if they belonged to one or more diversity groups, which included living in a regional, rural, or remote location. Those who did not tick any of the regional, rural, or remote options were assumed to live in a metro location.

The NSSS-2025 asked respondents to select the single option that best described the location they lived in, out of metro, outer metropolitan, regional centre, rural, or remote.

Data analysis and report production

For analysis, the rural and remote categories were combined due to very small numbers of people saying they lived remotely.

For the NSSS-2025 data, metro and outer metropolitan categories were also combined (as 'metro') to simplify the comparison.

The software package Stata v18 was used for all quantitative analysis. Statistical tests took the form of chi-square analysis. P-values $<.05$ were considered significant.

The graphics generally use an example trait to simplify communication. For example, the analysis for hours spent on household work compared locations using four different categories (<5 hrs, 5-14 hrs, 15-29 hrs, 30+ hrs). But the location pattern (i.e. rural/remote people did more than regional and they did more than metro) was apparent using the single trait of '15+ hrs', so this was used to avoid unnecessary clutter.

Methods (continued)

Selecting questions to analyse and reasons for exclusions

Questions to re-analyse for this report were all selected from the full set of questions in the three NSSS iterations noted above.

An overview of each survey's results was presented to the DHDA soon after each survey closed. These overview documents provide a summary of all modules, questions and quantitative results and are therefore useful documents for showing the context for the data analysed in this report.

Click on the hyperlinked years to view the overview documents:

- NSSS-2023
- NSSS-2024
- NSSS-2025.

To select which data to re-analyse, the major point we considered was whether the survey module's topic was relevant to healthy or happy ageing. If it was not, we did not re-analyse the data.

The only modules included were those of interest to the DHDA, not those sponsored by a commercial partner or included in the NSSS for internal use.

We also set aside any questions for which we had previously published a breakdown by location. Most notably this included a 'cost of living' module in 2023.

Some modules which did yield one or more statistically significant differences by location were excluded from this report if the results were not meaningful from an advocacy or policy perspective.

For example, only one question from the 2024 dementia module showed differences according to location, but the effect was small, and the question did not speak to issues of inequity or disadvantage. This result was therefore omitted from the report.

The head office of National Seniors Australia is located in Brisbane/Meanjin but we represent older people from across this great continent.

We acknowledge the traditional custodians of the land and waters in which we operate, the Turrbul People, and all other First Nations, Aboriginal, and Torres Strait Islander people.

We honour and value their continuing cultures, contributions, and connections to Country, and pay our respects to Elders, past and present.

We extend our warmest thanks to the thousands of older people who participated in the 2023, 2024 and 2025 National Seniors Social Surveys, who so generously gave their time, thoughts and personal information. Without them this report would not be possible.

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