Australian Government
Australian Institute of
Health and Welfare

# Aboriginal and Torres Strait Islander

# Health Performance Framework
Summary report July 2023

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# Aboriginal and Torres Strait Islander Health Performance Framework - Summary report 2023

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The *Aboriginal and Torres Strait Islander Health Performance Framework summary report* summarises the latest information on how Indigenous Australians are faring, drawing from the Health Performance Framework (HPF) measures.

A pdf copy of the web report is available for download below (version released on 7 July 2023). Please check the online version for any available updates.

The July 2023 release incorporates updates from the following measures: 1.10 Kidney disease; 2.01 Housing; 2.05 Education outcomes for young people; 2.06 Educational participation and attainment of adults; 2.07 Employment; 2.08 Income; 2.12 Child protection; 3.02 Immunisation; 3.12 Aboriginal and Torres Strait Islander people in the health workforce; 3.13 Competent governance; 3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines; 3.21 Expenditure on Aboriginal and Torres Strait Islander health compared to need; and 3.22 Recruitment and retention of staff.

## Overview

In 2018, the burden of disease among Aboriginal and Torres Strait Islander people was 2.3 times that of non-Indigenous Australians. Among Indigenous Australians, mental and substance use disorders were the leading contributor to disease burden (24%).

Measures of health status, determinants of health, and health system performance drawn from the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) show mixed results. It is important to note that measures in the 3 tiers are interconnected, and understanding the reasons for progress (or lack thereof) in the health status and outcomes of Indigenous Australians may often be best understood by examining relevant measures in determinants of health and health system performance.

Analysis by the AIHW of ABS survey data indicates that about 34% of the total health gap between Indigenous and non-Indigenous Australians is due to social determinants, and 19% due to individual health risk factors (e.g. smoking). It is likely that differences in access to affordable and nearby health services explain a significant proportion of the health gap between the Indigenous and non-Indigenous populations. In many cases, Indigenous Australians have poorer access to health services than non-Indigenous Australians, for a range of reasons including barriers such as availability, cost and a lack of culturally appropriate health services. For Indigenous Australians to have better health outcomes, improvements in the health system are required.

For Indigenous Australians, cultural identity, family and kinship, country and caring for country, knowledge and beliefs, language and participation in cultural activities and access to traditional lands are also key determinants of health and wellbeing.

Across the HPF measures, there have been notable improvements in many areas – for example, increases in rates of Year 12 attainment, employment and home ownership, and decreases in rates of cardiovascular mortality, smoking, youth detention, and overcrowding.

However there has been little progress in other measures, and some have worsened. For example, there has been no significant change in the rate of avoidable mortality, and both adult imprisonment rates and suicide rates have increased.

| **Avoidable mortality** | **Perinatal and infant mortality** | **Kidney disease deaths** |
|---|---|---|
| Over the decade from 2010 to 2019, the rate of avoidable deaths among Indigenous Australians did not change significantly, nor did the gap between Indigenous and non-Indigenous Australians. | Between 2010 and 2019, there was no significant changes in perinatal death rates for babies born to Indigenous mothers, nor in Indigenous infant death rates. | Over the decade 2010 to 2019, the rate of death due to cardiovascular disease and kidney disease for Indigenous Australians decreased by 18% and 36%, respectively. |
| **Smoking** | **Employment** | **Year 12 attainment** |
| The proportion of Indigenous Australians aged 15 and over who smoke daily fell from 45% in 2008 to 37% in 2018–19.<br>Smoking accounted for 47% of the burden of disease due to respiratory disease, 37% of the burden of disease due to cancer and 34% of the burden due to cardiovascular disease in 2018. | For Indigenous Australians aged 25–64, the employment rate increased from 51% in 2006 to 56% in 2021.<br>The proportion of Indigenous Australians aged 25–64 who were employed increased with level of educational attainment, reaching 85% of those whose highest level of education was a bachelor's degree | From 2011 to 2021, the proportion of Indigenous Australians aged 20–24 who had completed year 12 or equivalent increased from 52% to 68%. The gap in attainment rates between and Indigenous and non-Indigenous Australians also decreased, from 34 to 23 percentage points. |
| **Youth justice supervision** | **Barriers to health care access** | **Health workforce** |
| Between 2011–12 to 2020–21, the rate of Indigenous young people aged 10–17 years under youth justice supervision fell from 186 to 117 per 10,000 population between 2011–12 to 2020–21, with a 30% decline in community supervision and a 25% decline in detention | In 2018–19, 3 in 10 Indigenous Australians who needed to go to a healthcare provider did not. Barriers included cost, and health services being unavailable, far away or with long waiting times. | Between 2011 and 2021, the rate of Indigenous Australians aged 15 and over employed in health-related occupations increased from 255 to 309 per 10,000.<br>In 2021, Indigenous Australians were employed in health-related occupations at about 60% the rate of non-Indigenous Australians (309 compared with 515 per 10,000) |

# 1. Introduction

The *Aboriginal and Torres Strait Islander Health Performance Framework summary report* provides the latest information on the health and welfare of Indigenous Australians, compiling key facts from the Health Performance Framework (HPF) measures.

In 2023, for the first time, the summary report has been released in a web report format to facilitate more regular updates. The previous summary report (published in PDF format in 2020) is available from Publications.

Since 2020, detailed HPF findings and data have been presented together on a dedicated website: indigenoushpf.gov.au. The website includes:

- comprehensive national and state and territory reporting
- supplementary data tables
- interactive data visualisations.

The measures also include sections on research and evaluations. These provide insights into aspects of health and service delivery that are not easily captured in administrative datasets, but can demonstrate characteristics of communities and services that are working well or need improvement.

In the future, feature articles will also be published on the Aboriginal and Torres Strait Islander Health Performance Framework website to further explore insights from key data and research, exploring particular topics across HPF measures. The first feature article *Key factors contributing to low birthweight among Aboriginal and Torres Strait Islander babies* was released in May 2022. This feature article examines birthweight among Aboriginal and Torres Strait Islander babies, with a focus on identifying factors contributing to low birthweight.

## Terminology

Aboriginal and Torres Strait Islander people are the Indigenous people of Australia. They are not one group, but comprise hundreds of groups that have their own distinct set of languages, histories and cultural traditions.

The term ‘Aboriginal and Torres Strait Islander people’ is preferred in AIHW publications when referring to the separate Indigenous peoples of Australia. In this report, the term ‘Indigenous Australians’ is used interchangeably with ‘Aboriginal and Torres Strait Islander people’.

See also Glossary.

## Interpretation of results

Some results are restricted to states and territories where information on Indigenous status is considered of sufficient quality. This is noted throughout the report.

Given the differences in the age structure between the Indigenous and non-Indigenous populations, age-standardised rates have been used in this report when comparing the two populations and when looking at change over time within the Indigenous Australian population. Where age-standardised rates have been used, this is stated in the relevant sections of the report.

Improvements in data quality and changes in Indigenous identification in several important datasets have a major bearing on the interpretation of the findings, and can impact the interpretation of changes in outcomes. This is particularly important for mortality data, the Census, and the population estimates derived from the Census that form the denominators for many of the statistics across datasets.

For more information, see Technical appendix.

# The Aboriginal and Torres Strait Islander Health Performance Framework

Since 2006, Aboriginal and Torres Strait Islander Health Performance Framework (HPF) reports have provided information about Indigenous Australians' health outcomes, key drivers of health and the performance of the health system.

The HPF was designed, in consultation with Aboriginal and Torres Strait Islander stakeholder groups, to promote accountability, inform policy and research, and foster informed debate about Indigenous Australians' health.

**The Aboriginal and Torres Strait Islander Health Performance Framework**

The HPF is made up of 68 measures across three levels, or *tiers:*

Tier 1: Health status and outcomes

Tier 2: Determinants of health

Tier 3: Health system performance

Each HPF measure represents a health-related concept that is explored in detail, using various indicators drawn from relevant data sources and research. It is important to note that measures in the 3 tiers are interconnected, and understanding the reasons for progress (or lack thereof) in the health status and outcomes of Indigenous Australians (Tier 1) may often be best understood by examining relevant measures in Tier 2 (determinants of health) and Tier 3 (performance of the health system).

The HPF illustrates change that has occurred for the measures, and draws implications for further improvement. It also explores differences within the Indigenous population by age, geography and other characteristics. This helps identify what is working well and how to better target policy and services to meet the needs of Indigenous Australians.

The HPF reporting process is overseen by a Steering Committee made up of Aboriginal and Torres Strait Islander representatives and other stakeholders. These include:

- an Aboriginal and Torres Strait Islander person as Chair
- the National Aboriginal Community Controlled Health Organisation
- a Torres Strait Islander representative
- the Australian Institute of Health and Welfare
- the National Indigenous Australians Agency
- the Australian Government Department of Health
- two state health departments
- epidemiologists.

The design of the HPF recognises that the health system and factors beyond the health sector contribute to health outcomes, and that achieving better health outcomes requires a whole-of-government approach, working in partnership with Aboriginal and Torres Strait Islander people (AHMAC 2006).

Information from HPF reporting has been used, in part, to monitor progress towards achieving Australian governments' Closing the Gap health targets and the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Department of Health 2019).

A key theme from the research is the importance of culturally competent service delivery, and the need to partner with and share decision-making with Aboriginal and Torres Strait Islander people in the design of services and programs that affect them.

While there are organisations across sectors that provide culturally competent services to Indigenous Australians, the HPF highlights the crucial role of Aboriginal Community Controlled Health Services. These services provide comprehensive, culturally appropriate and safe primary health care services for Indigenous Australians throughout their lives.

The HPF also highlights where mainstream services are not adequately meeting the needs of Indigenous Australians, or where there are service gaps.

The *Cultural safety in health care for Indigenous Australians: monitoring framework* aims to measure progress in achieving cultural safety in the Australian health system by bringing together data focusing on:

- culturally respectful health care services
- patient experience of health care among Indigenous Australians
- access to health care (AIHW 2019b).

## Future HPF developments

Recent and current policy developments will shape the HPF in the future.

In July 2020, the National Agreement on Closing the Gap was developed in partnership between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations. The National Agreement has been built around four Priority Reforms that will change the way governments work with Indigenous Australians. These reforms outline obligations for governments to work in partnership; share decision making; build the community-controlled sector; transform government organisations; and provide shared access to regional level data. Priority Reform 3 has implications for the way mainstream services need to transform to eliminate racism and deliver culturally safe services that are responsive to the needs of Indigenous Australians. This agreement provides a framework to address the entrenched inequality faced by Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians.

**The National Agreement on Closing the Gap, July 2020**

Closing the Gap is a government framework aiming to reduce disadvantage among Aboriginal and Torres Strait Islander people. In 2008, Australian governments first agreed to targets to 'close the gap' between Indigenous and non-Indigenous Australians in life expectancy, child mortality, education and employment. With four of the seven targets expiring unmet, a new approach was needed.

The National Agreement on Closing the Gap is a marked shift in the approach to the Closing the Gap framework. The agreement represents the culmination of a significant amount of work by the Joint Council on Closing the Gap in partnership between all Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations.

This is the first time an agreement designed to improve life outcomes for Aboriginal and Torres Strait Islander people has been developed with Aboriginal and Torres Strait Islander people. The agreement was launched on 30 July 2020 by former Prime Minister Scott Morrison, Minister for Indigenous Australians Ken Wyatt, and Pat Turner, the convenor of the Coalition of Peaks – a representative body of more than fifty Aboriginal and Torres Strait Islander community controlled peak organisations that have come together to partner with Australian governments on closing the gap.

The National Agreement is available at Closing the Gap. The Agreement has been built around four Priority Reforms:

- Priority reform 1 – Formal partnerships and shared decision making
- Priority reform 2 – Building the community-controlled sector
- Priority reform 3 – Transforming government organisations
- Priority reform 4 – Shared access to data and information at a regional level.

The Agreement also includes 17 socioeconomic outcomes and targets – see Table 1.1.

The Australian Institute of Health and Welfare (AIHW) Regional Insights for Indigenous Communities website will help improve access to regional data for Indigenous communities.

The National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (the Health Plan), provides a strong overarching policy framework for Aboriginal and Torres Strait Islander health and wellbeing and is the first national health document to address the health targets and priority reforms of the National Agreement on Closing the Gap. Data relevant to some of these targets are presented within the summary report. Assessment of progress against the targets by the Productivity Commission is available from the Closing the Gap Information Repository.

As reporting on the National Agreement on Closing the Gap targets and for the refreshed Health Plan progresses, the HPF will need to adapt. This might mean changing existing measures or adding other measures into the future.

### Table 1.1. National Agreement on Closing the Gap – socioeconomic outcomes and targets

| **Outcome** | **Target** |
|---|---|
| 1 Aboriginal and Torres Strait Islander people enjoy long and healthy lives. | Close the Gap in life expectancy within a generation, by 2031. |
| 2 Aboriginal and Torres Strait Islander children are born healthy and strong. | By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent. |
| 3 Aboriginal and Torres Strait Islander children are engaged in high-quality, culturally appropriate early childhood education in their early years. | By 2025, increase the proportion of Aboriginal and Torres Strait Islander children enrolled in Year Before Fulltime Schooling (YBFS) early childhood education to 95 per cent. |
| 4 Aboriginal and Torres Strait Islander children thrive in their early years. | By 2031, increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC) to 55 per cent. |
| 5 Aboriginal and Torres Strait Islander students achieve their full learning potential. | By 2031, increase the proportion of Aboriginal and Torres Strait Islander people (age 20–24) attaining year 12 or equivalent qualification to 96 per cent. |
| 6 Aboriginal and Torres Strait Islander students reach their full potential through further education pathways. | By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25–34 years who have completed a tertiary qualification (Certificate III and above) to 70 per cent. |
| 7 Aboriginal and Torres Strait Islander youth are engaged in employment or education. | By 2031, increase the proportion of Aboriginal and Torres Strait Islander youth (15–24 years) who are in employment, education or training to 67 per cent. |
| 8 Strong economic participation and development of Aboriginal and Torres Strait Islander people and communities. | By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25–64 who are employed to 62 per cent. |
| 9 Aboriginal and Torres Strait Islander people secure appropriate, affordable housing that is aligned with their priorities and need. | A: By 2031, increase the proportion of Aboriginal and Torres Strait Islander people living in appropriately sized (not overcrowded) housing to 88 per cent.<br>B: By 2031, all Aboriginal and Torres Strait Islander households: within discrete Aboriginal and Torres Strait Islander communities receive essential services that meet or exceed the relevant jurisdictional standard<br>in or near to a town receive essential services that meet or exceed the same standard as applies generally within the town (including if the household might be classified for other purposes as a part of a discrete settlement such as a ‘town camp’ or ‘town based reserve’) |
| 10 Aboriginal and Torres Strait Islander people are not overrepresented in the criminal justice system. | By 2031, reduce the rate of Aboriginal and Torres Strait Islander adults held in incarceration by at least 15 per cent. |
| 11 Aboriginal and Torres Strait Islander young people are not overrepresented in the criminal justice system. | By 2031, reduce the rate of Aboriginal and Torres Strait Islander young people (10–17 years) in detention by 30 per cent. |
| 12 Aboriginal and Torres Strait Islander children are not overrepresented in the child protection system. | By 2031, reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 per cent. |
| 13 Aboriginal and Torres Strait Islander families and households are safe. | By 2031, the rate of all forms of family violence and abuse against Aboriginal and Torres Strait Islander women and children is reduced by at least 50%, as progress towards zero. |
| 14 Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing. | Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero. |
| 15 Aboriginal and Torres Strait Islander people maintain a distinctive cultural, spiritual, physical and economic relationship with their land and waters. | A. By 2030, a 15 per cent increase in Australia’s landmass subject to Aboriginal and Torres Strait Islander people’s legal rights or interests.<br>B. By 2030, a 15 per cent increase in areas covered by Aboriginal and Torres Strait Islander people’s legal rights or interests in the sea. |
| 16 Aboriginal and Torres Strait Islander cultures and languages are strong, supported and flourishing. | By 2031, there is a sustained increase in number and strength of Aboriginal and Torres Strait Islander languages being spoken. |
| 17 Aboriginal and Torres Strait Islander people have access to information and services enabling participation in informed decision-making regarding their own lives. | Target 17: By 2026, Aboriginal and Torres Strait Islander people have equal levels of digital inclusion |

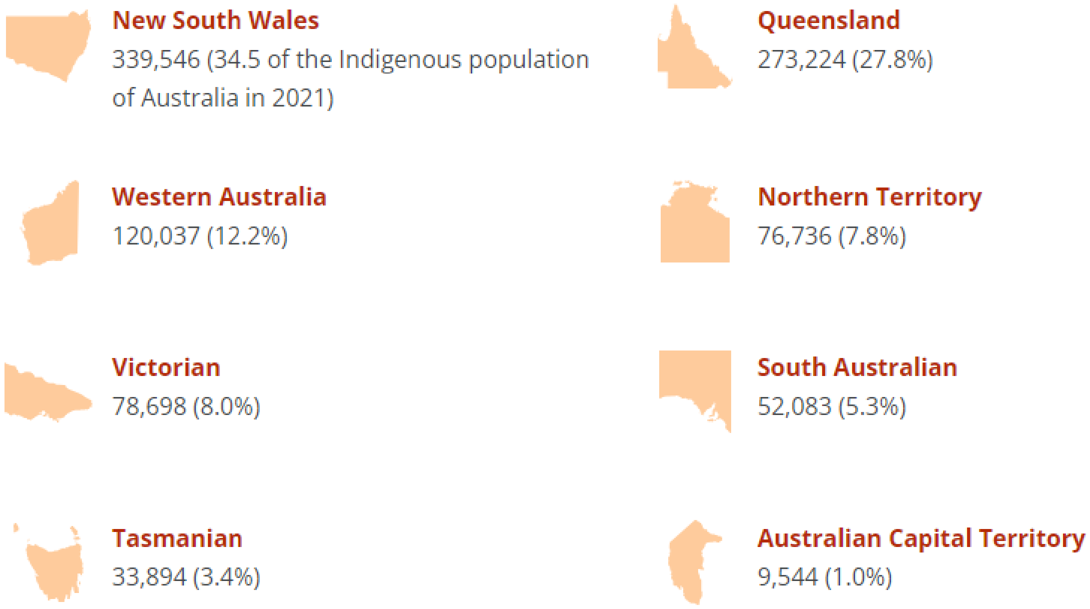
# Structure of this report

- Section 1 ‘Introduction’ presents the background to, and purpose of, the HPF.
- Section 2 ‘Demographic and social context’ presents an overview of the broader social and policy context to the health of Indigenous Australians.
- Section 3 ‘How Indigenous Australians are faring’ presents a summary of key findings from the 2023 Aboriginal and Torres Strait Islander HPF.
- Section 4 ‘Tier 1 – Health status and outcomes’ presents key findings from Tier 1 of the HPF.
- Section 5 ‘Tier 2 – Determinants of health’ presents key findings from Tier 2 of the HPF.
- Section 6 ‘Tier 3 – Health system performance’ presents key findings from Tier 3 of the HPF.
- Section 7 ‘For more information’ provides information about where to find more detailed data and related information (such as data source information).
- Section 8 'References' provides a list of references used in the Summary report.

# 2. Demographic and social context

According to national population estimates based on the 2016 Census, about 800,000 Australians identified as being Aboriginal and/or Torres Strait Islander in 2016 (ABS 2018b). Preliminary 2021 Census-based estimates indicate that there were 984,000 Aboriginal and Torres Strait Islander people in 2021 (ABS 2021). Final estimates for 2021 are expected to be released in August 2023, with time series data to be released in 2024.

Based on preliminary 2021 Census-based, about 3 in 5 (62%) Indigenous Australians lived in New South Wales and Queensland.



**New South Wales**
339,546 (34.5 of the Indigenous population of Australia in 2021)

**Queensland**
273,224 (27.8%)

**Western Australia**
120,037 (12.2%)

**Northern Territory**
76,736 (7.8%)

**Victorian**
78,698 (8.0%)

**South Australian**
52,083 (5.3%)

**Tasmanian**
33,894 (3.4%)

**Australian Capital Territory**
9,544 (1.0%)

The information by remoteness that follows is based on 2016 Census-based estimates, as estimates based on the 2021 Census are not yet available. This will be updated in late 2023, once estimates based on the 2021 Census are available.

Most Aboriginal and Torres Strait Islander people (around 3 in 5) lived in *Major cities* and *Inner regional* areas in 2016, 1 in 5 lived in *Outer regional* areas, and nearly 1 in 5 lived in *Remote* or *Very remote* areas.

Within remoteness areas, Indigenous Australians account for varying proportions of the total population, ranging from 2% in *Major cities* to 47% in *Very remote* areas in 2016 (Table 2.1).

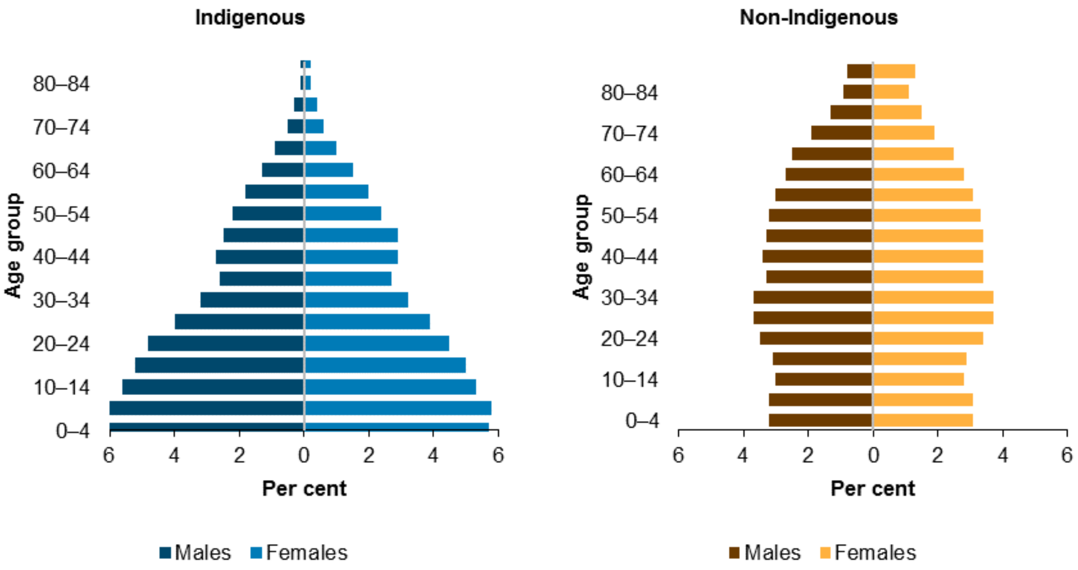
**Table 2.1 Indigenous population by remoteness area, 2016**

| Remoteness area | Number | Number as % of Indigenous population | Number as % of total population |
|---|---|---|---|
| Major cities | 298,430 | 37.4 | 1.7 |
| Inner regional | 189,414 | 23.7 | 4.4 |
| Outer regional | 161,792 | 20.3 | 7.9 |
| Remote | 53,507 | 6.7 | 18.2 |
| Very remote | 95,222 | 11.9 | 47.2 |

Source: HPF Table D2 – AIHW analysis of Australian Bureau of Statistics (ABS) population estimates based on 2016 Census

The Indigenous population is relatively young (Figure 2.1). In 2016, about 1 in 3 (34%) Indigenous Australians (274,300) were aged under 15, compared with fewer than 1 in 5 (18%) non-Indigenous Australians.

**Figure 2.1: Age structure of Indigenous and non-Indigenous populations, 2016**



Source: HPF Table D3 – AIHW analysis of ABS population estimates based on 2016 Census.

## Cultural and social determinants

There is evidence that cultural factors – country and caring for country, knowledge and beliefs, language, self-determination, family and kinship, and cultural expression – can be protective, and positively influence Aboriginal and Torres Strait Islander people's health and wellbeing (Bourke et al. 2018).

The Mayi Kuwayu Study of Aboriginal and Torres Strait Islander Wellbeing aims to provide more evidence of how culture is related to Aboriginal and Torres Strait Islander people's health and wellbeing (Australian National University 2020; Thurber et al 2022).

In contrast to cultural protective factors, racism or racial discrimination are associated with poorer physical and mental health (see, for example, Paradies et a. 2014; Priest et al. 2011. Colonisation is recognised as having a fundamental impact on disadvantage and health among Indigenous peoples worldwide, through social systems that maintain disparities (see, for example, Paradies et al. 2016; Paradies & Cunningham ).

Racism can be interpersonal (such as through exclusion, abuse, or stereotyping), or systemic (through policies, conditions, and practices).

Experiences of racism can have an impact on health through:

- reduced access to social resources, including employment, education, housing, health care, and other services
- psychological distress and increased likelihood of engaging in risk behaviours, such as substance use
- injury from assault (Paradies Yin & Cunningham 2012).

In 2017, the Australian Government released *My life my lead—opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: report on the national consultations*. These consultations provided an opportunity for Indigenous communities and leaders, governments, the non-government and private sectors to inform the refreshed National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (released in December 2021).

**My life my lead—report on the national consultations**

In 2017, the Australian Government released My life my lead—opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: report on the national consultations. Four main themes emerged from the consultations:

- Culture is central to the wellbeing of Aboriginal and Torres Strait Islander people, and needs to be an integral part of Aboriginal and Torres Strait Islander and mainstream services.
- Racism within health and other systems must be addressed to remove barriers and achieve better outcomes in health, education, and employment.
- The effects of trauma across generations of Aboriginal and Torres Strait Islander people must be acknowledged and addressed.
- Governments need to support long-term, coordinated, placed-based approaches that honour community priorities and embed participation (Department of Health 2017).

Health is also influenced by social determinants – the circumstances in which people grow, live, work, and age (Commission on Social Determinants of Health 2008) – and individual health risk factors. Income, employment, and education are key social determinants of health that account for a large part of the disparity in Indigenous and non-Indigenous health outcomes. Obesity and smoking are key health risk factors. Section 5 looks at these and other social determinants of health and risk factors.

## Recent events

During 2020, two major events with global effects occurred – the COVID-19 (coronavirus disease 2019) pandemic, and the Black Lives Matter protests that followed the death of George Floyd, a 46-year-old African American man, during a police arrest in the United States.

In Australia, there were concerns about the potential impact of COVID-19 on Aboriginal and Torres Strait Islander communities, particularly in remote areas. Black Lives Matter rallies in Australia protested against racism and deaths in police custody of Aboriginal and Torres Strait Islander people.

The pandemic and the protests have highlighted inequities in health and justice outcomes between Indigenous and non-Indigenous Australians. These events have also drawn attention to disparities in living conditions – including education, employment and housing – that are related to health and justice outcomes (Marmot et al. 2008; Pricewaterhouse Coopers 2017).

In Australia, 2020 also saw the signing of the National Agreement on Closing the Gap. This agreement is based on governments and Aboriginal and Torres Strait Islander people working in partnership and sharing decision-making to support better health and wellbeing outcomes among Indigenous Australians.

### COVID-19 among Indigenous Australians

During the first 18 months of the pandemic (January 2020 to June 2021), 171 cases of coronavirus disease 2019 (COVID-19) were confirmed among Aboriginal and Torres Strait Islander people (Indigenous Australians), representing less than 1% of all cases in Australia. Case numbers began increasing after this period, due to outbreaks of the Delta and then the Omicron variants.

By the end of 2021, the cumulative number of cases among Indigenous Australians was around 14,400 (AIHW 2022a).

In the subsequent Omicron wave, from 15 December 2021 to 23 October 2022, there have been 316,068 cases of COVID-19 notified for Indigenous Australians (3.5% of all cases in Australia) (Department of Health and Aged Care 2022).

Note that the accuracy of counts of COVID-19 cases has varied over the course of the pandemic, and there has also been variation in the proportion of cases of COVID-19 for which Indigenous status was missing: 3% of records when there were relatively few new cases in Australia; at least 19% between September and December 2021; just under half (49%) by mid-January 2022; and 20% by 10 April 2022

As at 23 October 2022, 279 deaths had been reported among Indigenous Australians, and 521 cases had been admitted to ICUs (Department of Health and Aged Care 2022) . The overall rate of severe disease (defined as ICU admission or death) for Indigenous Australians during the Delta wave (16 June to 14 December 2021) was 16.5 per 100,000, and rose to 76.3 per 100,000 by 23 October 2022 during the Omicron wave (Department of Health and Aged Care 2022). Based on surveillance data supplied by the Department of Health and Aged Care, the rate of severe disease during the Omicron wave to 3 July 2022 for Indigenous Australians was 1.4 times as high compared with non-Indigenous Australians (54.0 per 100,000 compared with 37.8 per 100,000 respectively).

For more information on the course of the pandemic among Indigenous Australians, including changes in the use of health services, see Australia’s Health 2022: Data insights.

The data presented in this summary report largely reflects the ‘pre-COVID’ situation. But the COVID-19 pandemic and response, and the Black Lives Matter protests, have highlighted recurring themes from Indigenous health policy and research in Australia over the past three decades, including:

- continuing health inequalities between Indigenous and non-Indigenous Australians
- broader social inequalities between Indigenous and non-Indigenous Australians in areas that can affect health, including housing, education, employment, income, and access to adequate health care and other goods and services
- how well the health system serves the needs of Indigenous Australians

- how governments can work in partnership and share decision-making with Aboriginal and Torres Strait Islander communities and leadership in identifying and responding to health priorities.

More recently, in 2023, Australia is experiencing high levels of inflation, with increased cost of living and higher interest rates impacting on housing costs and household disposable income (Reserve Bank of Australia 2023).

# 3. How Indigenous Australians are faring

In 2018, the burden of disease among Aboriginal and Torres Strait Islander people was 2.3 times that of non-Indigenous Australians. The leading contributors to burden for Indigenous Australians were, in order: mental and substance use disorders, injuries and chronic diseases such as cardiovascular disease, cancer, musculoskeletal conditions and respiratory disease. In general, people living in rural and remote areas are more likely to live with, and die prematurely from, a disease or injury. This is particularly relevant to Indigenous Australians as the proportion of the population who are Indigenous increases with remoteness, from 1.7% in *Major cities* to 47% in *Very remote* areas (2016 data).

Indigenous Australians have lower access to health services than non-Indigenous Australians, for a range of reasons including barriers such as cost and a lack of accessible or culturally appropriate health services. For Indigenous Australians to have better health outcomes, improvements in the health system and determinants beyond the health sector are required. A large part of the disparity in health outcomes between Indigenous Australians and non-Indigenous Australians is also explained by disparities in social determinants (in particular income, employment and education) – accounting for an estimated 34% of the total health gap between Indigenous and non-Indigenous Australians.

Measures of Indigenous Australians' health status and outcomes drawn from the HPF show mixed results over the most recent decade of data. Key selected findings are shown in below Figures, and described in the sections that follow.

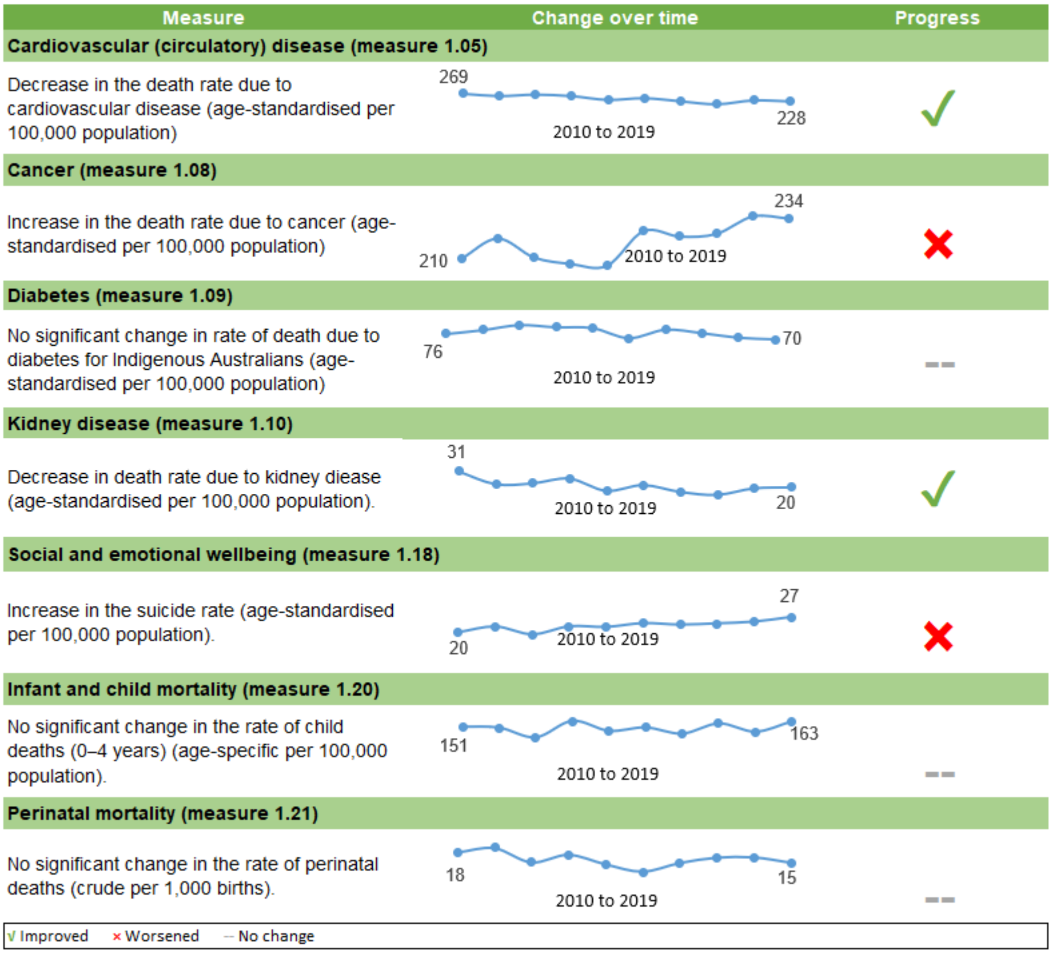
It is often difficult to establish the reasons behind improving or worsening health in a population, for several reasons:

- The factors that affect health are complex and are often inter-related.
- The relationship between health and health determinants can work in both directions – while education and employment can affect people's health, health can also affect people's ability to participate in schooling and work.
- Health is shaped throughout life – an adult's health is shaped by their life history, daily living conditions and health behaviours (Osborne et al. 2013).

However, measures across the HPF tiers can provide insights into changing health outcomes – for example, deaths from cardiovascular disease have decreased along with a decreased rate of smoking and increased rates of hospital procedures related to coronary heart disease.

Some key changes in health outcomes, determinants of health, and health system performance are shown in Figures 3.1, 3.2 and 3.3, respectively. Note that changes over time cannot be assessed for all measures, as trend data are not available in all cases. When assessing change over time, information from all data points in the series has been considered, rather than just the first and last points in the time trend. Linear regression (based on 'least squares' method) was used when assessing change over time for all trends shown in Figure 3.1 with more than 5 data points.

**Figure 3.1: Key changes in health status and outcomes for Indigenous Australians over time**

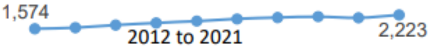
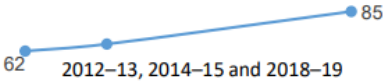


| Measure | Change over time | Progress |
|---|---|---|
| **Cardiovascular (circulatory) disease (measure 1.05)** | | |
| Decrease in the death rate due to cardiovascular disease (age-standardised per 100,000 population) | 269<br>228<br>2010 to 2019 | ✓ |
| **Cancer (measure 1.08)** | | |
| Increase in the death rate due to cancer (age-standardised per 100,000 population) | 234<br>210<br>2010 to 2019 | ✗ |
| **Diabetes (measure 1.09)** | | |
| No significant change in rate of death due to diabetes for Indigenous Australians (age-standardised per 100,000 population) | 76<br>70<br>2010 to 2019 | — |
| **Kidney disease (measure 1.10)** | | |
| Decrease in death rate due to kidney diease (age-standardised per 100,000 population). | 31<br>20<br>2010 to 2019 | ✓ |
| **Social and emotional wellbeing (measure 1.18)** | | |
| Increase in the suicide rate (age-standardised per 100,000 population). | 27<br>20<br>2010 to 2019 | ✗ |
| **Infant and child mortality (measure 1.20)** | | |
| No significant change in the rate of child deaths (0–4 years) (age-specific per 100,000 population). | 151<br>163<br>2010 to 2019 | — |
| **Perinatal mortality (measure 1.21)** | | |
| No significant change in the rate of perinatal deaths (crude per 1,000 births). | 18<br>15<br>2010 to 2019 | — |

√ Improved × Worsened – No change

Note: Mortality data are from New South Wales, Queensland, Western Australia, South Australia and Northern Territory combined.

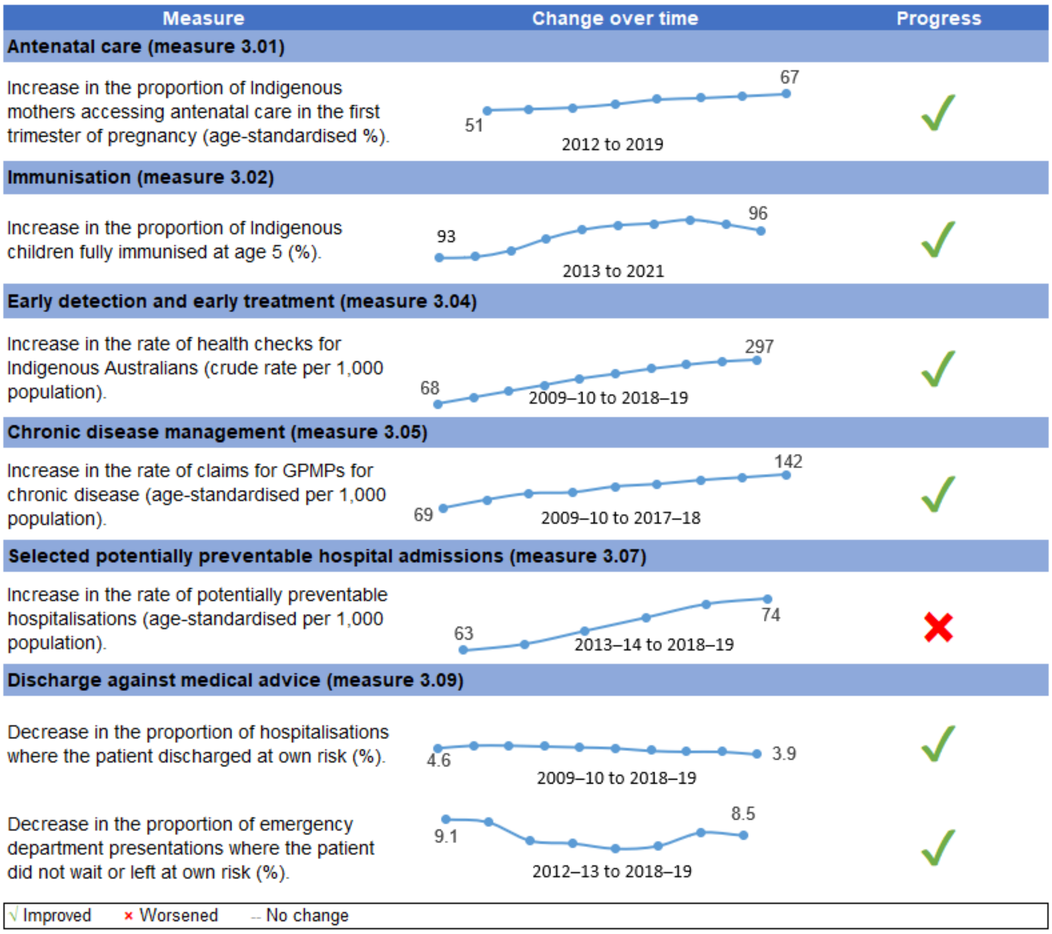
**Figure 3.2: Key changes in determinants of health for Indigenous Australians over time**

| Measure | Change over time | Progress |
|---|---|---|
| **Housing (measure 2.01)** | | |
| Increase in the proportion of Indigenous Australians living in appropriately sized housing (%). |  | ✓ |
| **Literacy and numeracy (measure 2.04)** | | |
| Increase in the proportion of Year 3 students achieving the national minimum standards in reading (%). |  | ✓ |
| **Education outcomes for young people (measure 2.05)** | | |
| Increase in the Year 7/8 to Year 12 retention rate (%). |  | ✓ |
| **Employment (measure 2.07)** | | |
| Increase in the employment-to-population rate among those aged 25-64 (%). |  | ✓ |
| **Contact with the criminal justice system (measure 2.11)** | | |
| Decrease in the youth detention rate for ages 10–17 (crude per 10,000 population). |  | ✓ |
| Increase in the adult imprisonment rate (age-standardised per 100,000 population). |  | ✗ |
| **Tobacco use (measure 2.15)** | | |
| Increase in the proportion of Indigenous Australians aged 15–17 who had never smoked (%). |  | ✓ |

√ Improved × Worsened -- No change

Note: In the employment data, people who participated in CDEP and received wages from their community were considered as employed in the 2011 Census. This changed in 2016 where people who participated in the CDP received income support payments directly from the Government and were not considered to be employed, unless they had another non-CDP job.

**Figure 3.3: Key changes in health system performance for Indigenous Australians over time**



| Measure | Change over time | Progress |
|---|---|---|
| **Antenatal care (measure 3.01)** | | |
| Increase in the proportion of Indigenous mothers accessing antenatal care in the first trimester of pregnancy (age-standardised %). | 51 – 67<br>2012 to 2019 | ✓ |
| **Immunisation (measure 3.02)** | | |
| Increase in the proportion of Indigenous children fully immunised at age 5 (%). | 93 – 96<br>2013 to 2021 | ✓ |
| **Early detection and early treatment (measure 3.04)** | | |
| Increase in the rate of health checks for Indigenous Australians (crude rate per 1,000 population). | 68 – 297<br>2009–10 to 2018–19 | ✓ |
| **Chronic disease management (measure 3.05)** | | |
| Increase in the rate of claims for GPMPs for chronic disease (age-standardised per 1,000 population). | 69 – 142<br>2009–10 to 2017–18 | ✓ |
| **Selected potentially preventable hospital admissions (measure 3.07)** | | |
| Increase in the rate of potentially preventable hospitalisations (age-standardised per 1,000 population). | 63 – 74<br>2013–14 to 2018–19 | ✗ |
| **Discharge against medical advice (measure 3.09)** | | |
| Decrease in the proportion of hospitalisations where the patient discharged at own risk (%). | 4.6 – 3.9<br>2009–10 to 2018–19 | ✓ |
| Decrease in the proportion of emergency department presentations where the patient did not wait or left at own risk (%). | 9.1 – 8.5<br>2012–13 to 2018–19 | ✓ |

√ Improved × Worsened -- No change

Note: Hospitalisation data are from New South Wales, Victoria, Queensland, Western Australia, South Australia and Northern Territory combined.

## Outcomes improved for a number of measures

Cardiovascular disease is the second leading cause of death among Aboriginal and Torres Strait Islander people. The age-standardised death rate due to cardiovascular disease decreased by 18% over the decade from 2010 to 2019 (though there was no significant change in the gap, due to a decrease in the rate for non-Indigenous Australians as well). The decline in deaths from cardiovascular disease coincided with reductions in smoking rates and an increase in hospitalisations for cardiovascular-related procedures.

Over the decade from 2010 to 2019, the age-standardised rate of death due to kidney disease declined by 36%.

Over the period from 2012 to 2021, the proportion of Indigenous Year 3 students meeting the national minimum standards for reading increased by 11% and the gap with non-Indigenous students narrowed by 33%. Over the same period the proportion of Indigenous students in Year 5 meeting the national minimum standards for numeracy increased by 13%.

Levels of educational attainment have improved over the decade. Between 2011 and 2021, the proportion of Indigenous Australians aged 20–24 who had completed Year 12 or equivalent increased from 52% to 68%, and the gap in attainment rates between Indigenous and non-Indigenous Australians aged 20–24 decreased from 34 to 23 percentage points. The relative difference (rate ratio) also decreased, from a Year 12 attainment rate that was 1.6 times as high for non-Indigenous Australians as Indigenous Australians to one that was 1.3 times as high. In 2021, 48% of Indigenous Australians aged 20–64 reported they either completed a non-school qualification at Certificate III or above or were studying for a non-school qualification at any level – an increase from 42% in 2016 and 35% in 2011.

Between 2011–12 and 2020–21, the rate of youth justice supervision for Indigenous young people (aged 10–17) declined from 186 to 117 per 10,000 population, a reduction of 29%.

In the decade from 2011–12 to 2020–21, the rate of Indigenous young people aged 10–17 in detention declined from 34 to 23 per 10,000 population, while the rate for non-Indigenous young people remained similar (from 1.6 to 1.3 per 10,000) and the gap declined from 32 to 22 per 10,000). Based on linear regression, the rate of Indigenous young people aged 10–17 in detention declined by 25% nationally between 2011–12 to 2020–21.

The proportion of Indigenous households who owned their home increased slightly over the last 3 Censuses - from 37% in 2011, to 40% in 2016, and 42% in 2021. The proportion of Indigenous Australians living in appropriately sized housing increased from 74.6% in 2011, to 78.9% in 2016, and 81.4% in 2021.

Between 2011 and 2021, the employment rate for Indigenous Australians aged 15–64 also increased from 46% in 2011, to 47% in 2016, and 52% in 2021.

Median household incomes of Indigenous Australians increased in real terms (that is, after adjusting for inflation) from $619 to $825 per week between 2011 and 2021. Other Australian households experienced a weekly increase in income of $998 to $1,141 over the same period.

The proportion of Indigenous Australians aged 15 and over who smoked daily fell from 45% in 2008 to 37% in 2018–19. The proportion of Indigenous Australians aged 15–17 who smoked fell from 22% to 13% between 2008 and 2018–19 and the proportion who had never smoked increased from 72% to 85% over the same period. The proportion of Indigenous women who smoked during pregnancy fell from 52% in 2009 to 44% in 2019.

In 2019, almost all (99.3%) Indigenous mothers attended antenatal care services at least once during pregnancy. Between 2012 and 2019, the proportion of Indigenous mothers who attended antenatal care in the first trimester of pregnancy increased by 18 percentage points from 50% in 2012 to 68% in 2019.

The rate of health assessments for Indigenous Australians increased fourfold between 2009–10 and 2018–19 from 68 checks per 1,000 population to 297 checks per 1,000.

Between 2006–2007 and 2010–2011, participation rates in BreastScreen Australia among Indigenous women aged 40 and above remained at around 18%. In the subsequent decade between 2010–2011 and 2018–2019, participation rates among Indigenous women aged 40 and above increased from 18% to 27%, before decreasing to 25% in 2019–2020, most likely due to the impact of the COVID-19 pandemic.

Between 2009–10 and 2017–18, the age-standardised rate of Medicare Benefit Schedule (MBS) claims for Indigenous Australians for chronic diseases management plans increased – from 55 to 125 per 1,000 for Team Care Arrangements (TCAs) and from 69 to 142 per 1,000 for GP Management Plans (GPMPs). In 2018, the rate for TCAs and GPMPs combined was 1.4 times the rate for non-Indigenous Australians (267 per 1,000 compared with 185 per 1,000).

The number of Commonwealth-funded Indigenous-specific primary health-care organisations increased from 108 in 1999–00 to 211 in 2021–22. Episodes of care delivered by these organisations increased from 1.2 million to 4.0 million and the number of health care workers in these organisations more than tripled from 2,300 to 8,800 over the same period.

In 2018–19, 92% of Indigenous Australians reported they had a usual place to go for health problems and advice. Those with a usual general practitioner or medical service reported higher rates of satisfaction with their health care experience than those without one.

The rate of general practitioner Medicare Items claimed by Aboriginal and Torres Strait Islander people increased by 42% between 2003–04 and 2017–18. Aboriginal and Torres Strait Islander people used GP services at rates that were slightly higher than those for non-Indigenous Australians (1.2 times) but do not reflect the higher level of need among Indigenous Australians.

Over the decade from 2009–10 to 2018–19, there was a 14% increase in the age-standardised proportion of hospitalisations for Indigenous Australians that included a hospital procedure.

Over the decade from 2009–10 to 2018–19, the age-standardised hospitalisations for Indigenous Australians where the patient was discharged from hospital at their own risk decreased from 4.4% to 3.8%. Similarly, the proportion of emergency department presentations where the patient left at their own risk or did not wait to be seen decreased from 9.1% to 8.5% for Indigenous Australians between 2011–12 and 2018–19.

## However, there has been little recent change for some measures

The proportion of Indigenous babies born with a low birthweight did not change significantly over the period from 2013 to 2019.

Over the decade from 2010 to 2019, the age-standardised rate of avoidable deaths among Indigenous Australians did not change significantly, nor was there a significant change in the absolute gap between Indigenous and non-Indigenous Australians.

From 2010 to 2019, there was no significant change in the age-standardised all-cause death rate for Indigenous Australians. However, the rate for non-Indigenous Australians declined by 8.6% and as a result the gap widened by 18% over this period.

Between 2010 and 2019, there was no significant changes in the death rates of perinatal, neonatal or stillbirth babies born to Indigenous women nor where there any significant reduction in the gap with babies born to non-Indigenous women.

In 2018–19, 31% of Indigenous adults reported high/very high levels of psychological distress, not significantly different from 2014–15 (33%). Those who had been removed from families or had relatives removed from families had a higher proportion of high/very high level of psychological distress (38%) compared with those who were not removed from their families (26%).

MBS claim rates for Indigenous patients accessing specialist providers were almost half the rate of non-Indigenous patients (598 per 1,000 and 1,070 per 1,000 population, respectively) in 2017–18. Over the period from 2009–10 to 2017–18 there was no significant change in the age-standardised rate of Medicare claims for specialist care among Indigenous Australians.

## Some measures have worsened

Cancer is currently the leading cause of death among Indigenous Australians (accounting for 23.4% of all deaths of Indigenous Australians) among Indigenous Australians. Between 2010 and 2019, the death rate for Indigenous Australians increased by 12% while the non-Indigenous rate decreased by 10%. This results in a widening of the absolute gap between Indigenous and non-Indigenous Australians. Indigenous Australians have lower cancer screening rates and are more likely to be diagnosed with cancer at more advanced stages resulting in lower cancer survival rates. Note that while there have been recent reductions in tobacco smoking, a risk factor for lung and other cancers, a time lag is expected before those improvements will result in measurable changes in cancer-related mortality.

In 2015–2019, the suicide rate for Indigenous Australians was 24 per 100,000 deaths and accounted for 5.5% of all Indigenous deaths. Over the decade from 2010 to 2019, the age-standardised rate of death due to suicide increased by 30% for Indigenous Australians. Similarly, over the period from 2009–10 to 2018–19 the hospitalisation rate of Indigenous Australians for Intentional self-harm increased by 63%.

Over the decade from 2009–10 to 2018–19, the age-standardised rate of hospitalisations due to assault for Indigenous Australians increased by 7.9%. This increase was driven by the 11% increase in hospitalisation rates due to assault for Indigenous females as the rate for Indigenous males remained unchanged over this period.

From 2012 to 2021, there was a 40% increase in the age-standardised imprisonment rate among Indigenous adults compared with an increase of 28% among non-Indigenous adults. As a result, the absolute gap between Indigenous and non-Indigenous Australians widened over this period.

# Tier 1 – Health status and outcomes

The original set of Closing the Gap targets included two health measures: life expectancy and child mortality (for example, see (Department of Prime Minister and Cabinet 2020).

The new Closing the Gap targets refer to life expectancy, healthy birthweight, and suicide (see Closing the Gap). As such, this section begins by presenting key findings on life expectancy, perinatal, infant and child mortality, and birthweight. The rest of the section focuses on leading causes of burden of disease and mortality, including suicide, among Aboriginal and Torres Strait Islander people.

## Life expectancy

In 2015–2017, life expectancy at birth was estimated to be 71.6 years for Indigenous males and 75.6 years for Indigenous females. The gap between Indigenous and non-Indigenous Australians was estimated to be 8.6 years for males and 7.8 years for females (Table 4.1). These life expectancy estimates for Australia are adjusted for age-specific rates of Indigenous identification ('age-adjusted') (ABS 2018a).

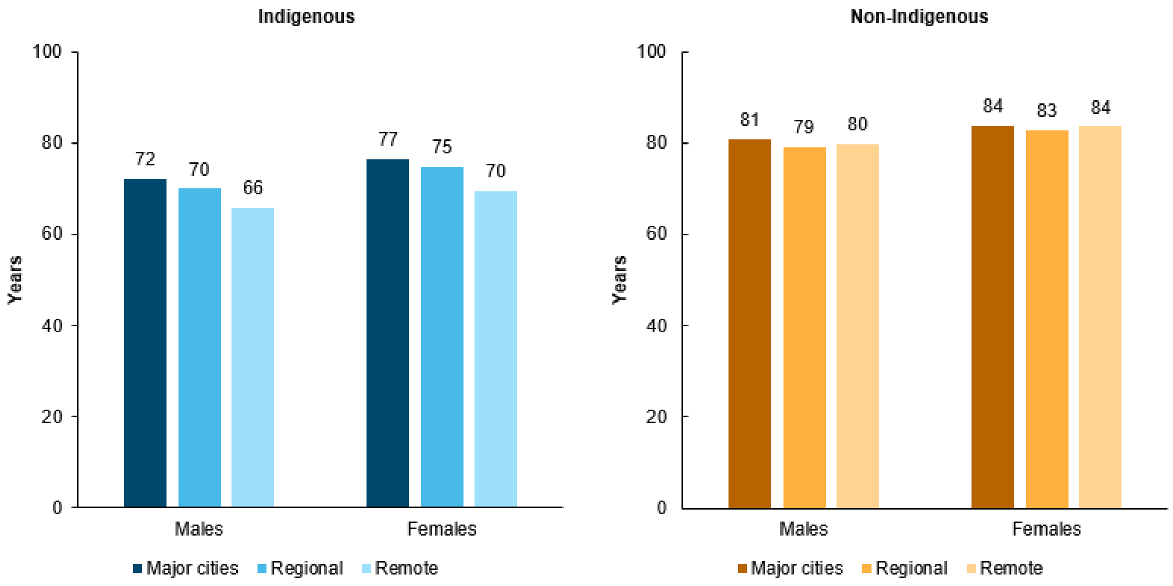
**Table 4.1: Life expectancy at birth (age-adjusted), by Indigenous status and sex, 2015–2017**

| | **Years** |
|---|---|
| Indigenous males | 71.6 |
| Non-Indigenous males | 80.2 |
| *Difference in years* | *8.6* |
| Indigenous females | 75.6 |
| Non-Indigenous females | 83.4 |
| *Difference in years* | *7.8* |

Source: Measure 1.19, Table D1.19.1 – Australian Bureau of Statistics 2018.

Life expectancy decreases as remoteness increases for Indigenous Australians, but not for non-Indigenous Australians. Indigenous males and females living in *Remote or Very remote* areas have a life expectancy 6–7 years lower than those in *Major cities* (Figure 4.1).

**Figure 4.1: Life expectancy at birth, by remoteness areas and sex, 2015–2017**



Notes

1. ‘Regional’ includes *Inner regional* and *Outer regional* areas, ‘Remote’ includes *Remote* and *Very remote* areas.

2. These estimates could not be age-adjusted, and so cannot be compared with estimates for Australia provided in Table 4.1.

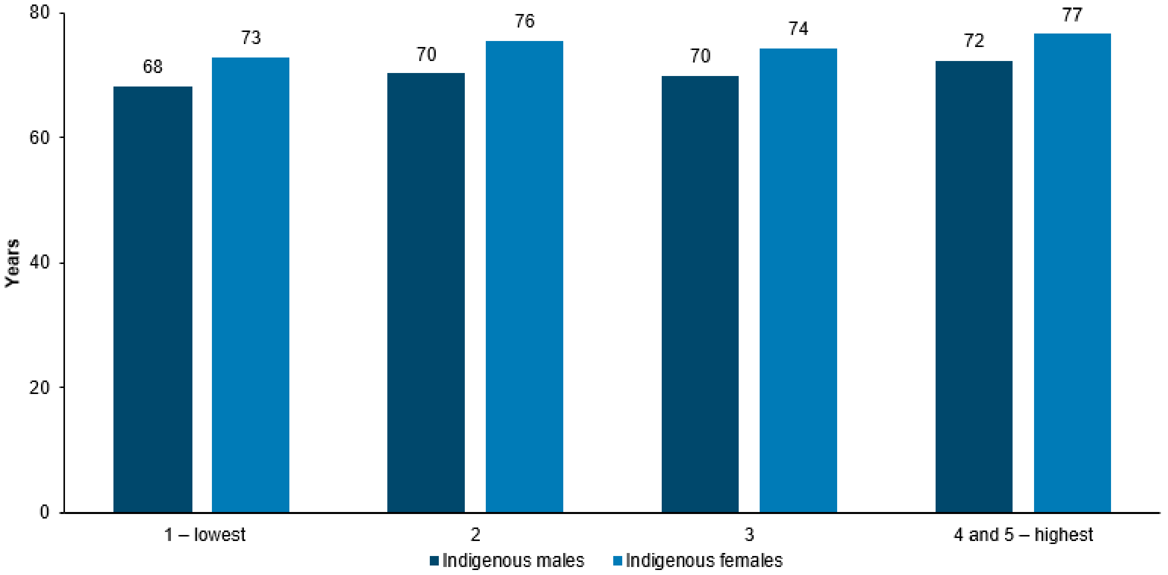
Source: Measure 1.19, Table D1.19.3 – Australian Bureau of Statistics 2018.

### Socioeconomic disadvantage

Socioeconomic disadvantage refers to the social and economic position of an individual or population group. Measures of socioeconomic disadvantage capture people’s access to material and social resources, and their ability to participate in society, based on factors like occupation, education, income, employment, housing, family characteristics, health, access to transport, or internet connection (ABS 2018c).

Indigenous Australians living in the lowest socioeconomic areas have a life expectancy (not age-adjusted) that is about four years lower than those living in the highest socioeconomic areas (Figure 4.2).

**Figure 4.2: Life expectancy at birth, by socioeconomic area and sex, 2015–2017**



Note: Socieconomic area is based on the Index of Relative Socio-Economic Disadvantage (IRSD)

Source: Measure 1.19, Table D1.19.4 – Australian Bureau of Statistics 2018.

For further information, see:

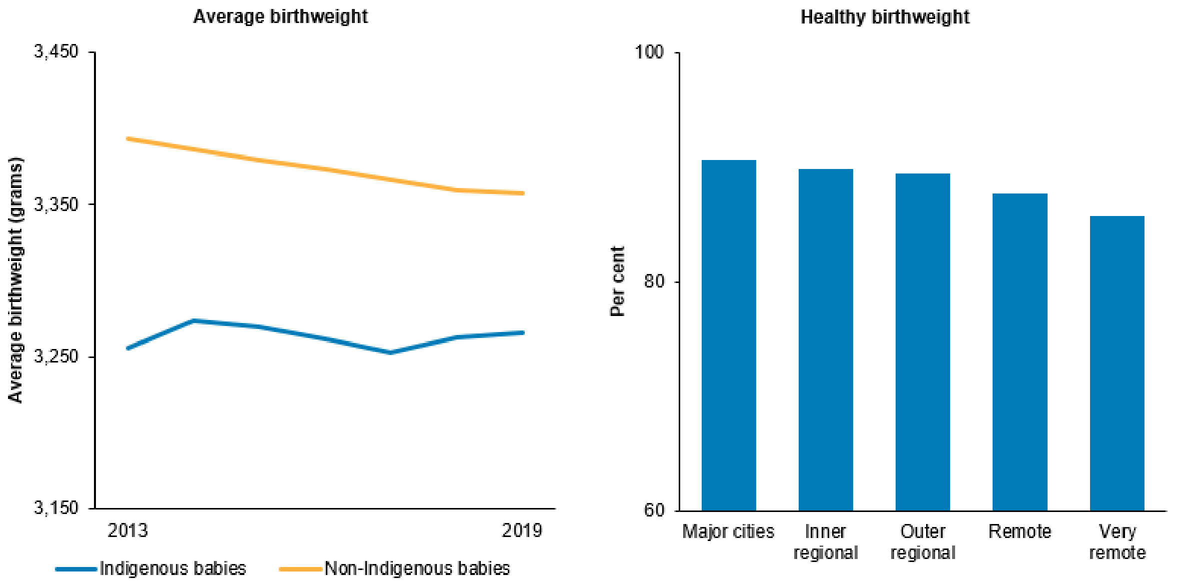
- 1.19 Life expectancy at birth

# Healthy birthweight

Having a healthy weight at birth provides children with a good start in life, while low birthweight infants are prone to ill-health in childhood and to chronic disease as adults (AIHW 2011). The importance of healthy birthweight is also reflected in the Closing the Gap Target 2 to increase the proportion of Indigenous babies with a healthy birthweight to 91 per cent by 2031 – see Target 2 in the Closing the Gap Information Repository.

In 2019, almost 9 in 10 (89.5%) Indigenous babies were born with a healthy birthweight. Over the period 2013 to 2019 the average birthweight among Indigenous babies has remained consistent (3,256 grams in 2013 and 3,265 grams in 2019). The proportion of Indigenous babies born with a healthy birthweight decreased with remoteness area from 91% in *Major cities* to 86% in *Very remote* Australia (Figure 4.3).

**Figure 4.3: Average birthweight babies (2013–2019) and proportion of babies born with a low birthweight by remoteness (2019)**



Source: Measure 1.01, Table D1.01.5 and D1.01.22 — AIHW analysis of the National Perinatal Data Collection.

Poor antenatal care and smoking during pregnancy are risk factors for low birthweight. Antenatal care is the professional health care provided to mothers during pregnancy, to ensure the best health outcomes for both mother and baby.

In 2019, Indigenous babies whose mothers attended antenatal care in the first trimester of pregnancy (14 weeks) were less likely to have a low birthweight compared with those who whose mother attended after the first trimester/did not attend (8.1% compared with 11.1%).

Over the period from 2009 to 2019, the proportion of Indigenous mothers who smoked during pregnancy decreased by 8 percentage points (from 52% to 44%). In 2019, 13.9% of Indigenous babies born to a mother who smoked had a low birthweight, compared with 5.7% born to a mother who did not smoke.

For further information, see:

- 1.01 Birthweight
- 2.21 Health Behaviours during pregnancy
- 3.01 Antenatal care
- HPF feature article Key factors contributing to low birthweight among Aboriginal and Torres Strait Islander babies

# Leading causes of disease burden and mortality

## Burden of disease

In 2018, Indigenous Australians lost 239,942 years due to premature death or living with disease or injury, which equates to around 289 DALY for every 1,000 Indigenous Australians

The rate of disease burden among Aboriginal and Torres Strait Islander people was more than double (2.3 times) that of non-Indigenous Australians in 2018. After adjusting for differences in population size and age structure:

- 400 years were lost to disease burden for every 1,000 Indigenous Australians
- 177 years were lost to disease burden for every 1,000 non-Indigenous Australians.

With regard to the fatal burden of disease among Indigenous Australians aged under 75, almost two-thirds (64%) was due to potentially avoidable deaths (AIHW 2023 forthcoming).

After adjusting for population growth and ageing, there was a 15% decline in total burden for Indigenous Australians from 2003 to 2018 – this decrease was driven by a 27% decline in fatal burden. Over the same period there was no substantial change in non-fatal burden.

These results come from *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018* (AIHW 2022d), the latest available burden of disease information for Indigenous and non-Indigenous Australians.

**What is the burden of disease and how is it measured?**

'Burden of disease' refers to the impact of disease and injury on a population. It is measured in 'disability adjusted life years' (DALY), which comprises:

- years lost from dying prematurely (YLL), also known as fatal disease burden.
- years lost due to living with disease or injury (YLD), also known as non-fatal disease burden.

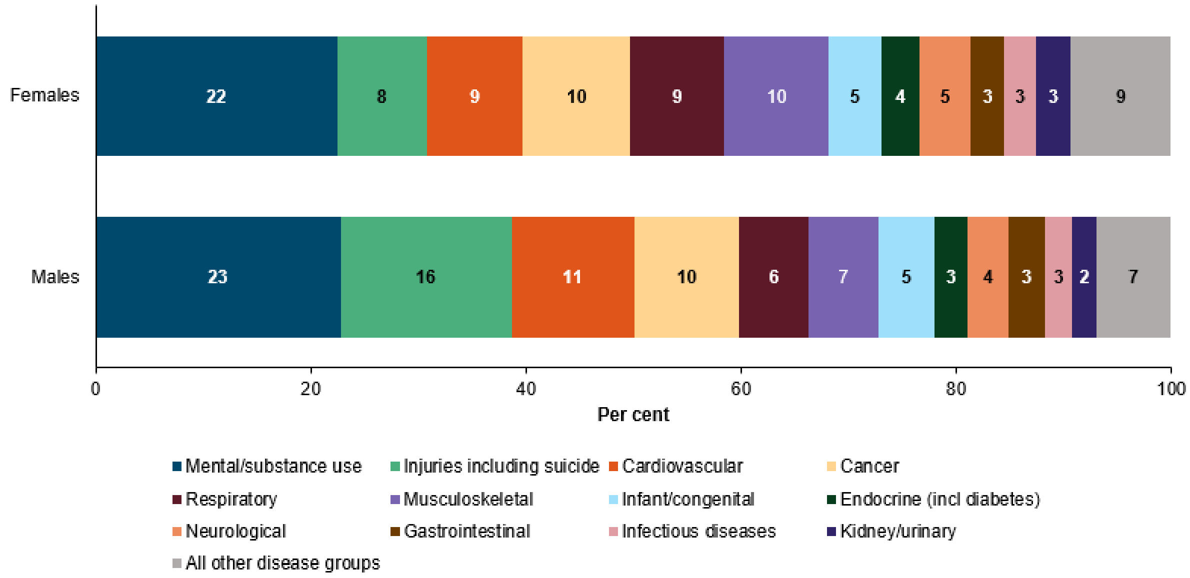
Among Indigenous Australians, 23% of total disease burden in 2018 was due to mental and substance use disorders (54,263 DALY). The other leading causes were:

- injuries (12% or 29,769)
- cardiovascular disease (10% or 24,612)
- cancer (9.9% or 23,742)
- musculoskeletal conditions (8.0% or 19,168) (Figure 4.4).

Indigenous Australians in *Very remote* (492 DALY per 1,000 population) and *Remote* (486 DALY per 1,000 population) areas experienced higher rates of total burden than those living in *Major cities* (393 DALY per 1,000 population). Mental & substance use disorders was the leading contributor to burden in all remoteness areas, ranging from 17% to 27% of total burden.

Indigenous Australians living in the most disadvantaged areas experienced more than 3 times the total burden of Indigenous Australians in the least disadvantaged areas (591 and 164 DALY per 1,000 population, respectively).

**Figure 4.4: Leading causes of disease burden among Indigenous Australians, by sex, 2018**



Source: adapted from Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018.

For further information, see:

- 1.02 Top reasons for hospitalisations
- 1.23 Leading causes of mortality

## Avoidable deaths

**Avoidable deaths**

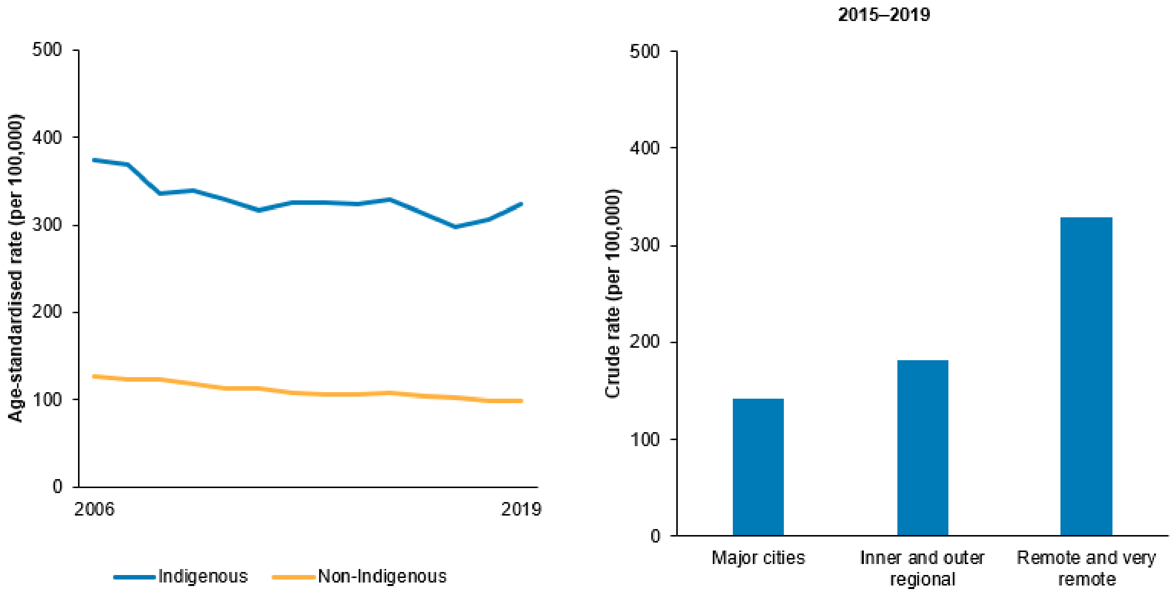
Avoidable deaths are premature deaths – among those aged under 75 – from health conditions and injuries that could be avoided with disease prevention and population health initiatives or access to timely and effective health care.

Avoidable deaths, as a measure, is often used as an indicator of the quality, effectiveness, and accessibility of the health system.

There were 7,400 avoidable deaths among Indigenous Australians over the 5-year period 2015–2019, accounting for 60% of all deaths of Indigenous Australians aged 0–74 (data from NSW, Qld, WA, SA and NT combined). The rate of avoidable deaths among Indigenous Australians was 208 deaths per 100,000 population, with a higher rate in more remote areas, ranging from 142 deaths per 100,000 population in *Major cities* to 329 deaths per 100,000 population in *Remote* and *Very remote* areas combined.

There were no significant changes in the rate of avoidable deaths over the decade from 2010 to 2019. Over a longer period, from 2006 to 2019, the age-standardised rate of avoidable deaths among Indigenous Australians declined from 374 to 323 per 100,000 population (Figure 4.5).

**Figure 4.5: Avoidable deaths by Indigenous status (age-standardised rate) (2006–2019), and remoteness area (crude rate) (2015–2019)**



Note: Data from NSW, Qld, WA, SA and NT combined.

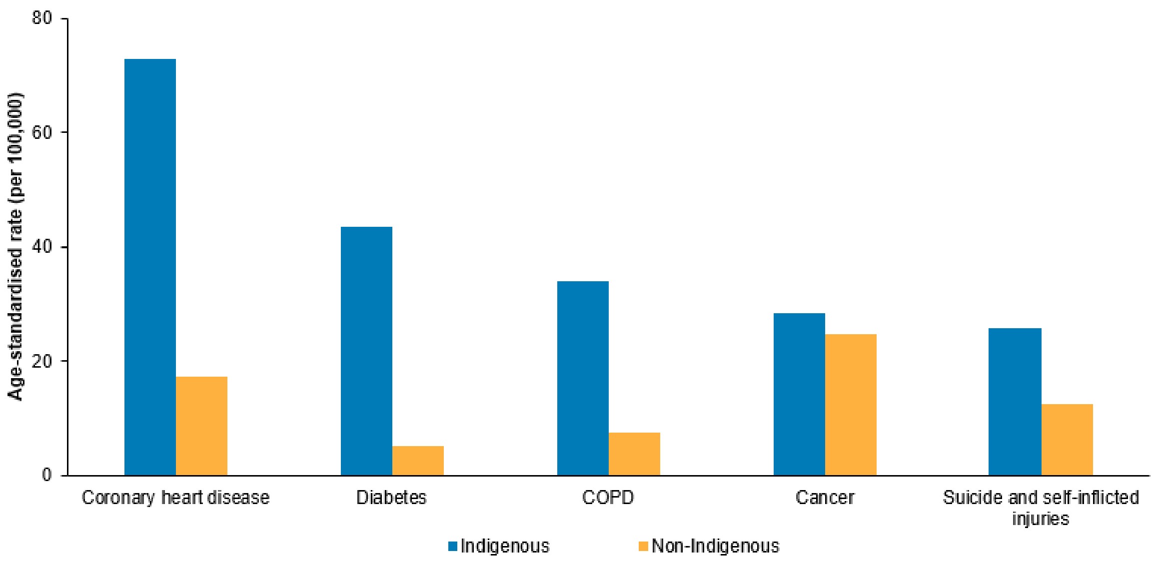
Sources: Measure 1.24, Table D1.24.2 and D1.24.6 – AIHW National Mortality Database.

In 2015–2019, the leading five causes of avoidable deaths among Indigenous Australians were:

- coronary heart disease (21%; 1,560 deaths)
- diabetes (12%; 868)
- suicide and self-inflicted injuries (11%; 843)
- chronic obstructive pulmonary disease (8.8%; 651)
- cancer (8.0%; 587).

The age-standardised death rate due to these leading causes was consistently higher for Indigenous Australians than non-Indigenous Australians with coronary heart disease (26% of the gap in avoidable mortality), diabetes (18% of the gap) and chronic obstructive pulmonary disease (13% of the gap) showing the largest differences (Figure 4.6).

**Figure 4.6: Rate of avoidable deaths, top 5 causes, by Indigenous status, 2015–2019 (age-standardised)**



Notes
1. Data from NSW, Qld, WA, SA and NT combined.
2. Data are shown for the top 5 causes of avoidable death for Indigenous Australians.
Source: Measure 1.24, Table D1.24.5 – AIHW and ABS analysis of National Hospital Mortality Database.

For further information, see:

- 1.24 Avoidable deaths

## Mortality rate and leading causes of death

In the 5-year period 2015–2019, there were 15,439 deaths of Indigenous Australians, corresponding to 430 deaths per 100,000 population. From 2006 to 2019, the age-standardised death rate for Indigenous Australians declined by 8.3%. However, over the most recent decade to 2019 there was no significant reduction in the age-standardised death rate among Indigenous Australians.

In 2015–2019, cancer (as a broad disease group) was the leading broad cause of death among Indigenous Australians accounting for 23% (3,612 deaths) of all deaths in this period. After cancer, the leading broad leading causes of death for Indigenous Australians were:

- cardiovascular disease (23%; 3,471 deaths)
- Injury and poisoning (15%; 2,240)
- respiratory disease (9.7%; 1,498)
- endocrine, nutritional and metabolic diseases (8.6%; 1,333)

Death rates for Indigenous males were higher than for Indigenous females across most leading causes, except for kidney diseases (6.5 compared with 9.1 per 100,000 population) and diabetes (29 compared with 34 per 100,000), where rates were higher for Indigenous females. Death rates from all the leading causes of death were higher for Indigenous Australians in remote than in non-remote areas.

The age-standardised death rate for endocrine, nutritional and metabolic diseases for Indigenous Australians was 3.7 times as high as for non-Indigenous Australians (86 compared with 23 deaths per 100,000 population).

For both injury and poisoning, and respiratory disease, were twice as high for Indigenous Australians compared with non-Indigenous Australians (79 compared with 40 per 100,000 population; and 106 compared with 52 per 100,000 population, respectively).

For chronic obstructive pulmonary disease, the age-standardised death rate for Indigenous Australians was almost 3 times as high as for non-Indigenous Australians (70 compared with 24 deaths per 100,000 population).

For further information, see:

- 1.22 All-cause age-standardised death rates
- 1.23 Leading causes of mortality

## Perinatal, infant, and child mortality

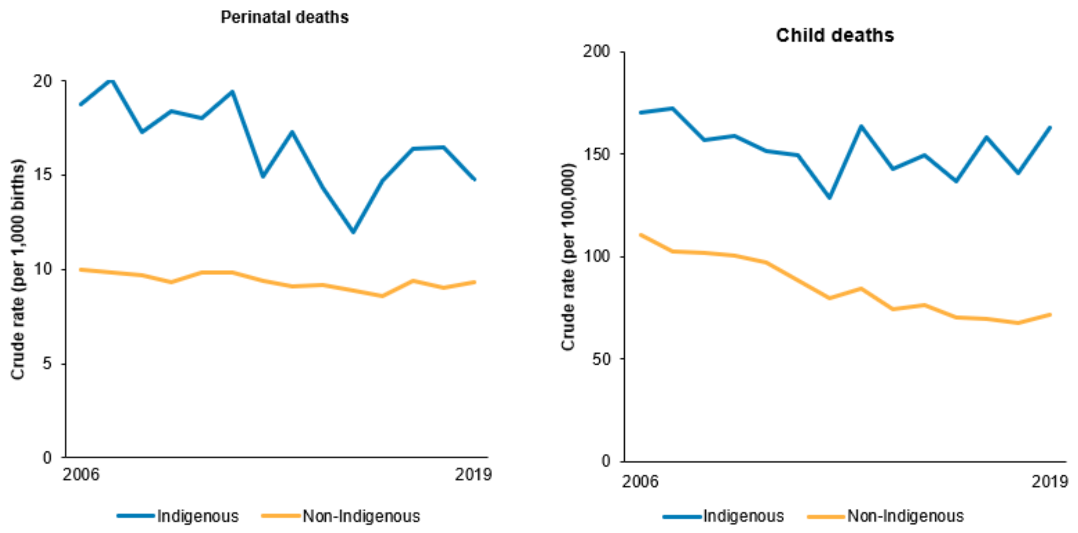
Perinatal deaths include stillbirths (deaths prior to or during labour and/or birth) and neonatal deaths (within 28 days following birth).

Over the decade from 2010 to 2019, there were no significant changes in the rates of perinatal, neonatal or stillbirth deaths among babies born to Indigenous women (Figure 4.5).

Over a longer period, from 2006 to 2019, the perinatal death rate for babies born to Indigenous women declined by 25% from 19 to 15 per 1,000 births. This was predominatly driven by the significant declines (by 38% from 7.2 to 4.4 per 1,000 births) in the neonatal death rate as the rate of stillbirth deaths has not changed significantly over this period.

Similarly, death rates of Indigenous infants (aged under 1) did not change significantly over the decade from 2010 to 2019, though there was a decline over the longer period between 2006 and 2019 (by 34%, from 9.4 to 5.8 per 1,000 live births). The death rate among Indigenous children (aged 0–4) did not change significantly in either analysis period (Figure 4.7).

**Figure 4.7: Rate of perinatal and child deaths, 2006–2019**



Note: Child deaths data from NSW, Qld, WA, SA and NT combined. Child deaths includes children aged 0–4.

Sources: Measure 1.21, Table D1.21.2 – AIHW analysis of the National Perinatal Data collection; and Measure 1.20, Table D1.20.3 – AIHW National Mortality Database.

Note that data pertaining to perinatal deaths are from the AIHW's National Perinatal Mortality Data Collection (NPMDC). These data sourced are from midwives and other birth attendants, who collect information from mothers, perinatal administrative and clinical record systems. This differs to the source used for reporting on infant and child deaths (the National Mortality Database), which is based on death registrations. The two collections are not directly comparable.

For further information, see:

- 1.20 Infant and child mortality
- 1.21 Perinatal mortality

## Mental health and social and emotional wellbeing

**Where to find help and support**

This page presents material that some people may find distressing. If this material raises any issues for you, these services can help:

- **13YARN:** 13 92 76
- **Lifeline** 13 11 14
- **Beyond Blue** 1300 22 4636
- **The National Indigenous Postvention Service** 1800 805 801

Crisis support services can be reached 24 hours a day, 7 days a week.

The broad disease group that is the leading cause of disease burden for Aboriginal and Torres Strait Islander people is mental and substance use disorders, including depressive disorders, bipolar disorder, anxiety disorders, schizophrenia and alcohol and drug use disorders.

Most of the disease burden from mental and substance use disorders is non-fatal – that is, it is due to years spent living with illness.

Maintaining high levels of social and emotional wellbeing is now a focus of the National Agreement on Closing the Gap, with a target for significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero – see Target 14 in the Closing the Gap Information Repository.

The National Aboriginal and Torres Strait Islander Health Plan 2021-2031, released in December 2021, provides a strong overarching policy framework to ensure the formal partnership and shared decision making between the Australian Government and Indigenous communities. The Health Plan covers a range of health services including mental health, and social and emotional wellbeing.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (Commonwealth of Australia 2017a) and the Fifth National Mental Health and Suicide Prevention Plan (Commonwealth of Australia 2017b) are important components of the national response to Aboriginal and Torres Strait Islander health.

While intentional self-harm and suicidal behaviour are classified as injuries for burden of disease analysis, in the HPF they are reported under measure 1.18 Social and emotional wellbeing. Some information on intentional self-harm and deaths by suicide is presented in this section and in the following section on injury.

Almost 1 in 3 Indigenous adults (31%) had high to very high levels of psychological distress in 2018–19 (age-standardised), a similar proportion to 2014–15. In comparison, 13% of non-Indigenous adults had high levels of psychological distress. Those who had been removed from families or had relatives removed from families had a higher proportion with high or very high levels of psychological distress (38%) compared to those who were not removed from their families (26%).

In 2014–15, 68% of Indigenous Australians aged 15 and above (303,300) reported that in the previous year they had experienced one or more specified personal stressors – that is, events with the potential to adversely affect their health or wellbeing, such as serious illness or the death of a family member or friend (see Table 4.2 for most common personal stressors).

**Table 4.2: Most common personal stressors, Indigenous Australians aged 15 and over, by remoteness area, 2014–15**

| Sources of stress | Non-remote | | Remote | |
|---|---|---|---|---|
| Death of a family member or close friend | 89,100 | 26% | 33,400 | 35% |
| Not able to get a job | 63,500 | 18% | 18,200 | 19% |
| Serious illness | 45,100 | 13% | 8,600 | 8.9% |
| Mental illness | 40,200 | 12% | 5,500 | 5.7% |
| Overcrowding at home | 20,100 | 5.8% | 9,000 | 9.3% |
| Alcohol-related problems | 20,500 | 5.9% | 8,600 | 8.9% |

Note: Proportion of all Indigenous Australians aged 15 and over, more than one response could be given.

Source: Measure 1.18, Table D1.18.4 – AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Social Survey 2014–15.

**COVID-19 and mental health of Indigenous Australians**

The COVID-19 pandemic is a high risk to Indigenous Australians' physical and social and emotional wellbeing (Victorian Government et al. 2020). Specific concerns have included: lack of accessible, culturally appropriate and culturally safe mental health services; challenges faced by the Indigenous Australian allied health workforce, including those living with high-risk individuals; inequalities within the health system that may affect access to care, particularly in the move to digital and telehealth; and loss of remote community services including fly in fly out mental health care.

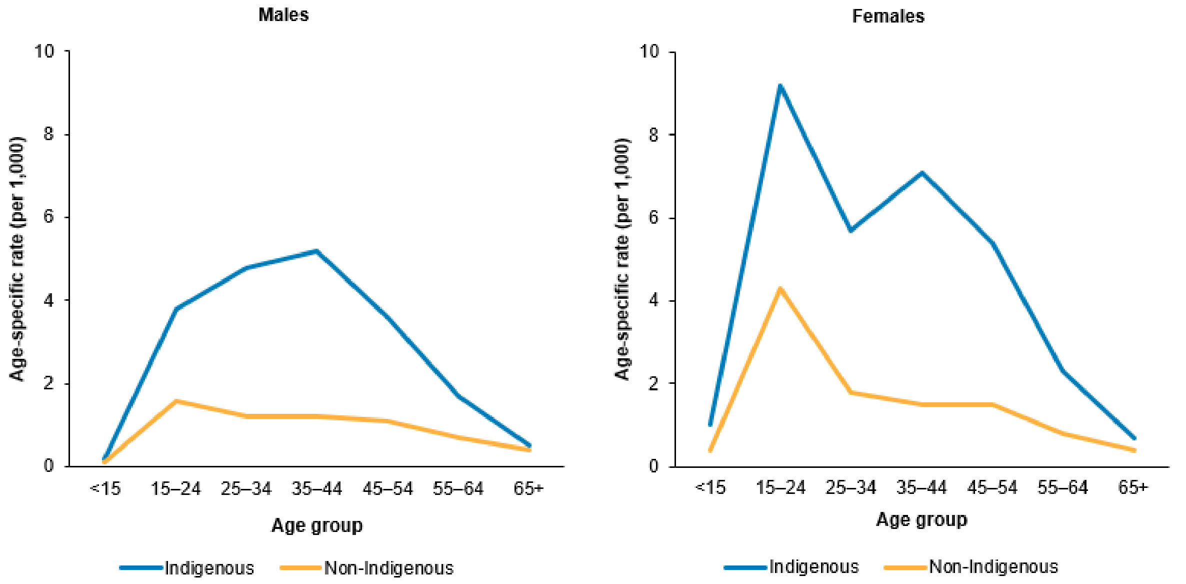
The impact of lockdowns was particularly acute for Indigenous Australians who are deeply interconnected with family and community members, and where caring responsibilities may have been disrupted. There were heightened effects on those in, or with connections to, remote communities, where isolation was greater and freedom of movement more restricted; those who cannot access waterways, songlines and country; and those who cannot attend to cultural and sorry business. Research on the impacts of COVID-19 and the associated restrictions on Stolen Generations survivors found they had an increased and heightened sense of isolation and loneliness, significant disconnection from family, community, culture and country, and declines in their mental health and wellbeing (Aboriginal and Torres Strait Islander Healing Foundation 2021).

## Intentional self-harm and suicide

Between July 2017 and June 2019, 5,829 Aboriginal and Torres Strait Islander people were hospitalised due to intentional self-harm (0.9% of all hospitalisations of Indigenous Australians, excluding dialysis). This corresponds to a rate of 3.5 hospitalisations per 1,000 population for Indigenous Australians.

After adjusting for differences between the age structures of the two populations, Indigenous Australians were hospitalised for intentional self-harm at nearly 3 times the rate of non-Indigenous Australians (3.6 and 1.2 per 1,000 population, respectively). The greatest absolute difference in rates between Indigenous and non-Indigenous Australians were among those in the age groups of 15–24 (rate difference of 3.5), 25–34 (3.8) and 35–45 (4.8) (Figure 4.8).

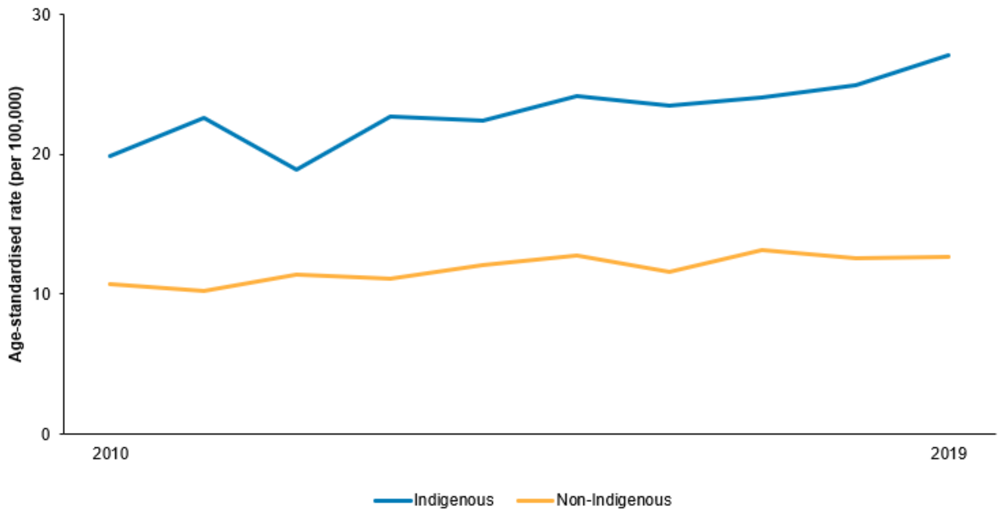
**Figure 4.8: Rate of hospitalisations due to intentional self-harm, by Indigenous status and age, July 2017 to June 2019**



Source: Measure 1.18, Table D1.18.27 – AIHW analysis of National Hospital Morbidity Database.

In 2015–2019, 847 Indigenous Australians died from intentional self-harm (suicide), a rate of 24 suicide deaths per 100,000 population. Suicide accounted for approximately 5.5% of total deaths among Indigenous Australians. The age-standardised suicide rate for Indigenous Australians increased by 30% over the decade from 2010 to 2019, with the rate also increasing for non-Indigenous Australians (by 24%) (data from NSW, Qld, WA, SA and NT combined) (Figure 4.9). This corresponded to a significant widening (by 40%) of the gap between Indigenous and non-Indigenous Australians.

**Figure 4.9: Suicide rates, by Indigenous status (age-standardised), 2010–2019**

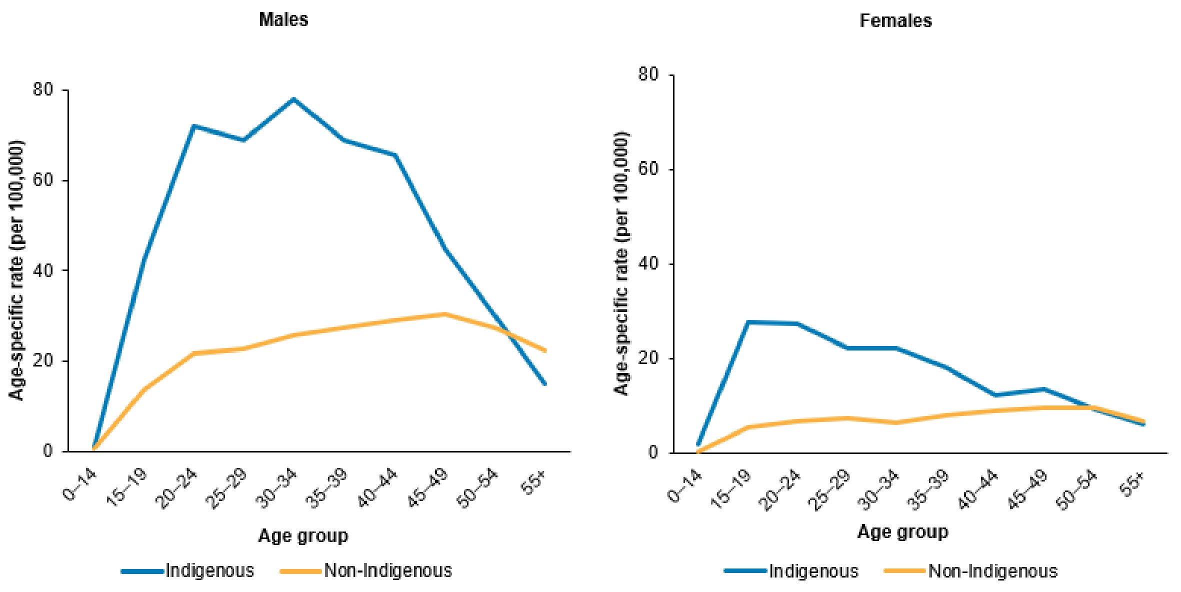


Note: Data from NSW, Qld, WA, SA and NT combined.

Source: Measure 1.18, Table D1.18.26 – AIHW National Mortality Database.

The death rate due to suicide was highest for Indigenous males aged 30–34 (78 per 100,000) and for Indigenous females aged 15–19 (28 per 100,000) in 2015–2019 (data from NSW, Qld, WA, SA and NT combined). Among non-Indigenous Australians, the suicide death rate was highest for males aged 45–49 (31 per 100,000) and females aged 45–49 and 50–54 (both 9.7 per 100,000) (Figure 4.10). The overall rate of deaths from suicide for Indigenous Australians was 2 times the rate of non-Indigenous Australians.

**Figure 4.10: Suicide rates, by age group and sex, 2015–2019**



Note: Data from NSW, Qld, WA, SA and NT combined.

Source: Measure 1.18, Table D1.18.22 – AIHW and ABS National Mortality Database.

For further information, see:

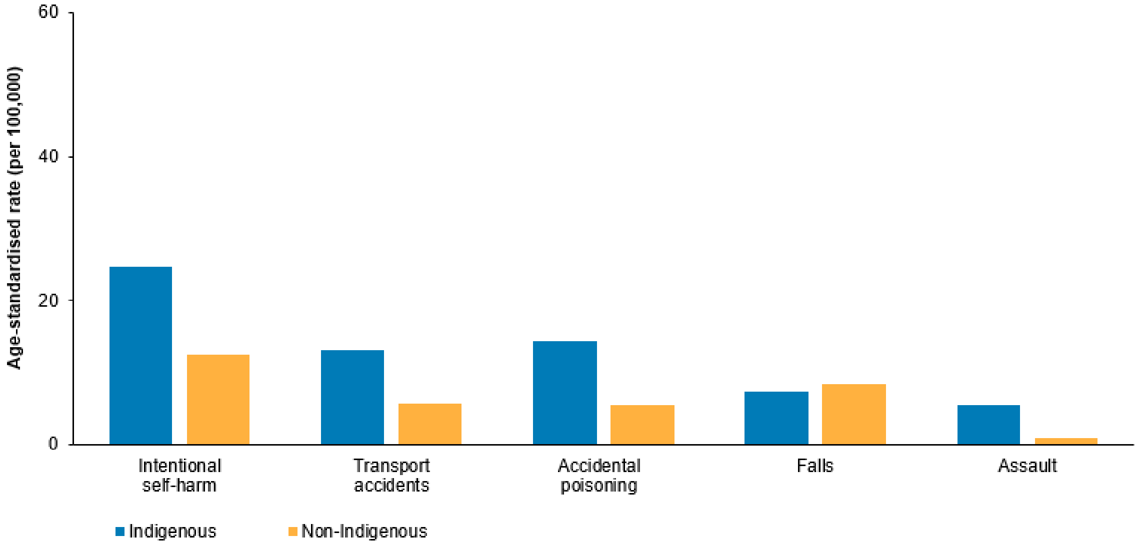
- 1.18 Social and emotional wellbeing
- 3.10 Access to mental health services

# Injury and poisoning

Injury and poisoning is the second leading cause of disease burden and third leading cause of death among Aboriginal and Torres Strait Islander people. It accounted for 15% (2,240) of deaths in 2015–2019.

The rate of death due to injury and poisoning among Indigenous Australians was 62 deaths per 100,000 population, with a rate 2.1 times as high for Indigenous males as females (84 compared with 40 per 100,000). After adjusting for differences in the age structure of the Indigenous and non-Indigenous populations, there are large disparities between the two populations in the rates of underlying cause of death per 100,000 from all causes of injury and poisoning except for falls (Figure 4.11).

**Figure 4.11: Rate of injury and poisoning deaths, top 5 causes, by Indigenous status, 2015–2019**



Notes

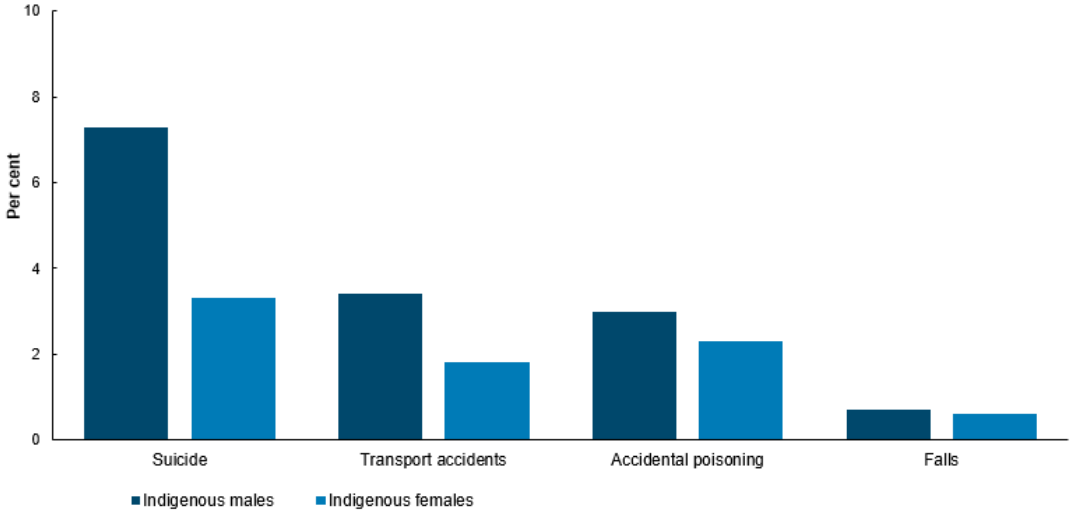
1. Data from NSW, Qld, WA, SA and NT combined.

2. Data are shown for the top 5 causes of injury and poisoning death for Indigenous Australians.

Source: Measure 1.03, Table D1.03.1 – AIHW National Mortality Database.

Among Indigenous Australians, the most common underlying causes of deaths from injury and poisoning in 2015–2019 were suicides (847 deaths; 38% of all injury and poisoning deaths), transport accidents (417 deaths; 19%), accidental poisoning (413 deaths; 18%), assault (174 deaths; 7.8%) and falls (101 deaths; 4.5%). Suicide and transport accidents accounted for a higher proportion of injury and poisoning deaths for Indigenous males, while accidental poisoning, assault and falls accounted for a higher proportion of injury and poisoning deaths for Indigenous females (Figure 4.12).

**Figure 4.12: Leading causes of death due to injury and poisoning, as a proportion of total deaths, for Indigenous males and females, 2015–2019**

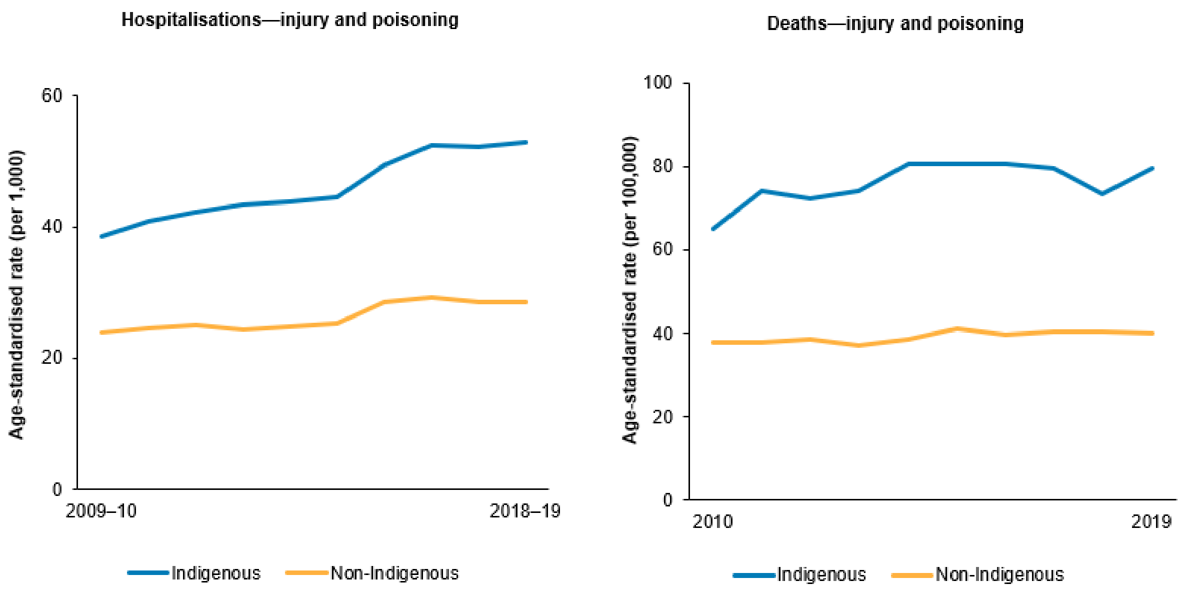


Note: Data from NSW, Qld, WA, SA and NT combined.

Source: Measure 1.03, Table D1.03.1 – AIHW National Mortality Database.

In 2017–19, injury and poisoning was the most common broad cause of hospitalisation for Indigenous Australians (excluding dialysis). Between 2009–10 and 2018–19, the age-standardised hospitalisation rate due to injury and poisoning increased by 34%. The age-standardised death rate due to injury and poisoning among Indigenous Australians increased by 14% between 2010 and 2019 (Figure 4.13).

**Figure 4.13: Rate of injury and poisoning hospitalisations (2009–10 to 2018–19) and deaths (2010–2019), by Indigenous status, (age-standardised)**



Notes

1. Data on hospitalisations from NSW, Vic, Qld, WA, SA and NT combined.

2. Data on deaths from NSW, Qld, WA, SA and NT combined.

Sources: Measure 1.03, Table D1.03.5 – AIHW analysis of National Hospital Morbidity Database; and Measure 1.23, Table D1.23.19 – AIHW National Mortality Database.

For further information, see:

- Injury and poisoning

# Cancer

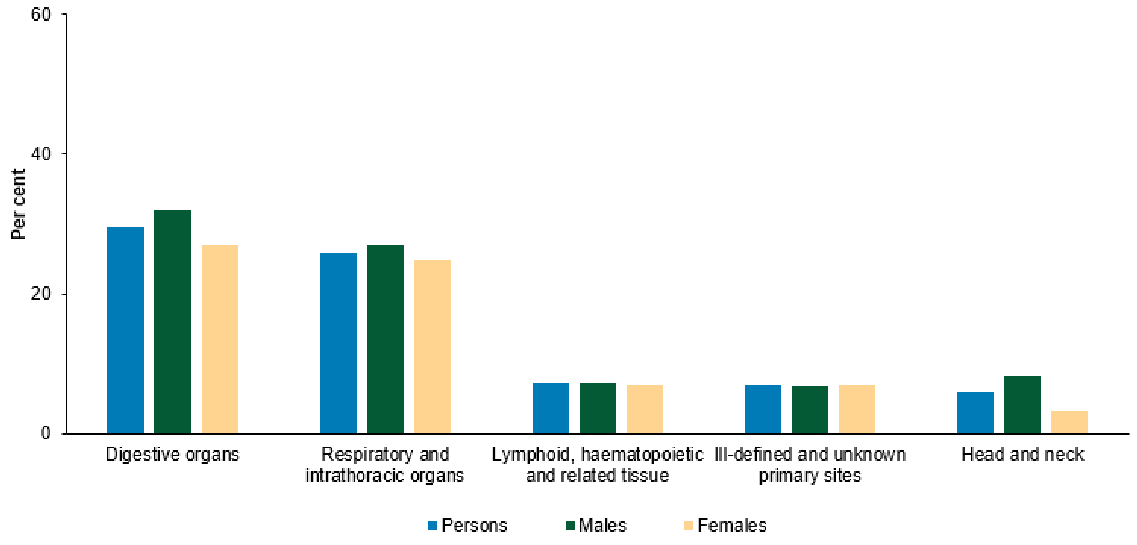
In 2018, cancer and other neoplasms accounted for 10% of the total disease burden among Indigenous Australians, and in the 5-year period 2015–2019 was the leading broad cause of death. Smoking is a risk factor for many types of cancer – in 2018, tobacco smoking accounted for around two-fifths of the cancer burden (39%).

In 2015–2019, 3,612 Indigenous Australians died from cancer and other neoplasms (23.4% of all deaths), the vast majority of which were caused by cancer (that is, malignant neoplasms). Cancer accounted for 23.1% of all deaths, with a rate of 99 cancer deaths per 100,000 population.

For Indigenous Australians, the most common broad types of cancer deaths were:

- cancers of digestive organs (including liver cancer), accounting for 30% of cancer deaths
- cancers of respiratory organs (including lungs), 26% of cancer deaths (Figure 4.14).

**Figure 4.14: Leading causes of cancer and other neoplasm deaths among Indigenous Australians, 2015–2019 (proportion of total cancer and other neoplasm deaths)**



Note: Data from NSW, Qld, WA, SA and NT combined.

Source: Measure 1.23, Table D1.23.12 – AIHW and ABS analysis of National Mortality Database.

For Indigenous Australians living in non-remote areas, the death rate due to cancer was 90 per 100,000 population, compared with 126 per 100,000 in remote areas.

There are several national cancer screening programs available free of charge for Australians to reduce the risk of death through early detection of cancer when treatment is likely to be more effective. However, Indigenous Australians have lower rates of participation in breast and bowel cancer screening programs than non-Indigenous Australians (Table 4.3).

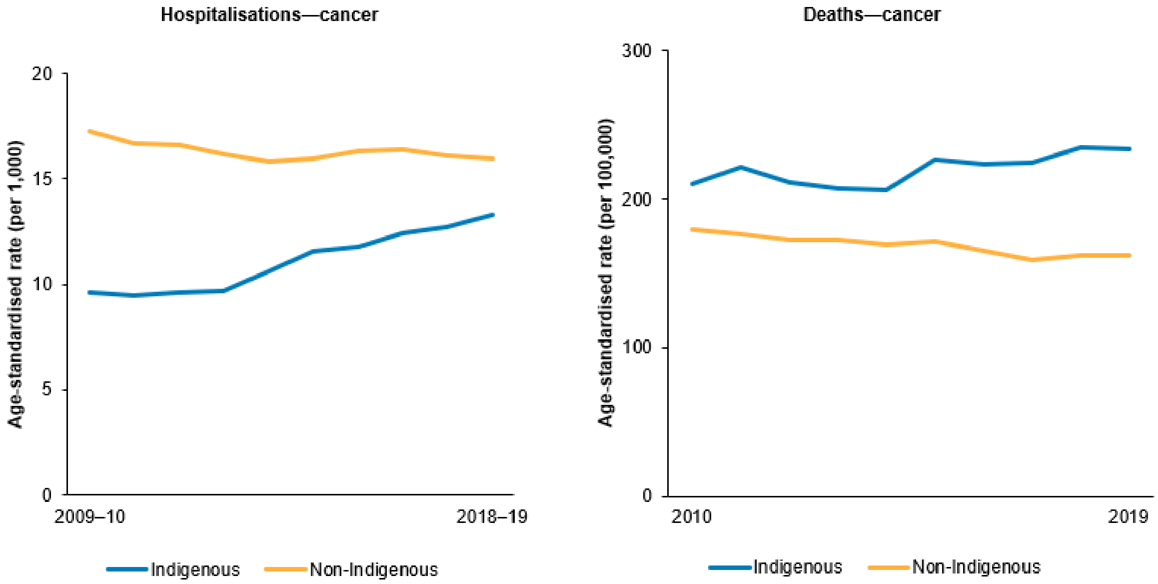
**Table 4.3: Participation in cancer screening programs**

| | Indigenous | Non-Indigenous |
|---|---|---|
| | Per cent | |
| Women aged 50–74 screened for breast cancer – age-standardised, 2019–20 | 36 | 50 |
| People aged 50–74 participating in National Bowel Screening Program, 2019–2020(a) | 35 | 46 |
| People aged 50–74 having follow up colonoscopy, where appropriate, 2017– 2018 | 51 | 62 |

(a) Given the limitations in the data available to estimate Indigenous Australians’ participation in the NBCSP, caution should be used when interpreting these data (see Appendix F of AIHW 2021b).

Sources: Measure 3.04, Table D3.04.9 – AIHW analysis of BreastScreen Australia data; National Bowel Cancer Screening Program: monitoring report 2021.

**Figure 4.15: Rate of cancer hospitalisations (2009–10 to 2018–19) and deaths (2010–2019), by Indigenous status (age-standardised)**



Notes

1. Data on hospitalisations from NSW, Vic, Qld, WA, SA and NT combined.

2. Data on deaths from NSW, Qld, WA, SA and NT combined.

Sources: Measure 1.08, Table D1.08.15 — AIHW analysis of National Hospital Morbidity Database; and Measure 1.23, Table D1.23.20 — AIHW National Mortality Database.

For many people, cancer diagnosis will lead to multiple hospitalisations for treatment and recovery. Between July 2017 and June 2019, there were 11,970 hospitalisations with a principal diagnosis of cancer for Indigenous Australians, equivalent to hospitalisation rate of 7.2 per 1,000 populations. Indigenous males had a higher hospitalisation rate than Indigenous females, at 7.9 and 6.5 per 1,000 population, respectively.

Over the decade between 2009–10 and 2018–19, the age-standardised rate of hospitalisation with a principal diagnosis of cancer among Indigenous Australians increased by 47% from 9.6 to 13 per 1,000 population (data from NSW, Vic, Qld, WA, SA and NT combined). Among Indigenous Australians, age-standardised death rates from cancer increased by 12% between 2010 and 2019 (data from NSW, Qld, WA, SA and NT combined).

For further information, see:

- 1.08 Cancer
- 3.04 Early detection and early treatment

# Cardiovascular disease

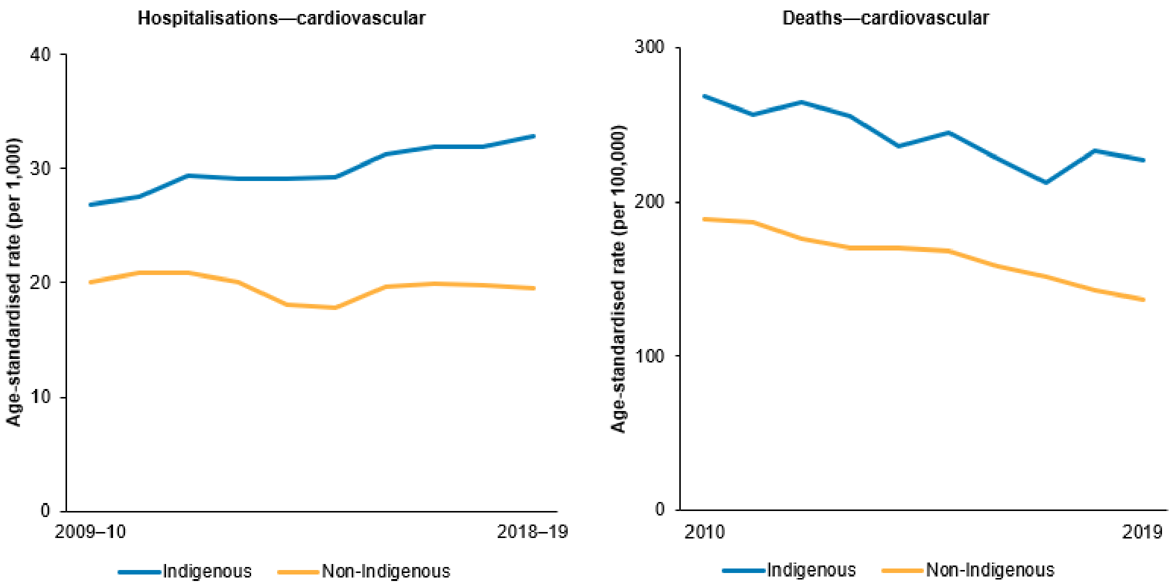
Cardiovascular disease is a disease of the circulatory system, namely the heart (cardio) or blood vessels (vascular). This includes heart attack, angina, stroke and peripheral arterial disease. It is the second leading cause of death among Aboriginal and Torres Strait Islander people, accounting for 23% of deaths (3,471) in 2015–2019 (data from NSW, Qld, WA, SA and NT combined).

In 2018–19, an estimated 16% (122,100) of Indigenous Australians aged 2 and over had a cardiovascular condition, based on self-reported data from the 2018–19 National Aboriginal and Torres Strait Islander Health survey.

The age-standardised rate of hospitalisations from cardiovascular diseases among Indigenous Australians increased by 21% over the decade to 2018–19 (Figure 4.16). Between 2006–07 and 2018–19, the age-standardised proportion of hospitalisations of Indigenous adults involving procedures for coronary heart disease increased from 35% to 66%. These were procedures such as angiography (X-ray imaging of blood vessels) and coronary revascularisation (including, for example, procedures to dilate blood vessels and heart bypass surgery).

The age-standardised death rate from cardiovascular diseases among Indigenous Australians decreased by 18% over the decade 2010 to 2019 (Figure 4.16). There was also a decline in the death rate from cardiovascular diseases among non-Indigenous Australians, with no significant change in the gap.

**Figure 4.16: Rate of cardiovascular disease hospitalisations (2009–10 to 2018–19) and deaths (2010–2019), by Indigenous status (age-standardised)**



Notes

1. Data on hospitalisations from NSW, Vic, Qld, WA, SA and NT combined.

2. Data on deaths from NSW, Qld, WA, SA and NT combined.

Sources: Measure 1.05, Table D1.05.11 – AIHW analysis of National Hospital Morbidity Database; and Measure 1.23, Table D1.23.18 – AIHW National Mortality Database.

For further information, see:

- 1.05 Cardiovascular disease

# Respiratory diseases

Chronic respiratory diseases, such as asthma and chronic obstructive pulmonary disease, make a large contribution to disease burden among Indigenous Australians.

In 2015–2019, 1,498 Indigenous Australians died from respiratory diseases (10% of all deaths), corresponding to 42 deaths per 100,000 population, making this the fourth leading cause of death (data from NSW, Qld, WA, SA and NT combined). Most of these deaths were from chronic obstructive pulmonary disease (COPD) (63% of all respiratory disease deaths), pneumonia and influenza (17%), and asthma (5%).

In 2018–19, almost 1 in 3 Indigenous Australians (29% or 238,000) had a long-term respiratory disease (lasting 6 months or more), based on self-reported survey data.

Indigenous Australians living in non-remote areas (32%) reported a higher rate of respiratory disease than those in remote areas (15%). The most commonly reported respiratory conditions for Indigenous Australians were asthma (16%), chronic sinusitis (7.4%) and COPD (3.4%).

After adjusting for differences in the age structure between the two populations, Indigenous Australians were 2.2 times as likely to report COPD (5% and 2%, respectively) and 1.6 times as likely to report asthma as non-Indigenous Australians (18% and 11%, respectively).

**Chronic respiratory diseases**

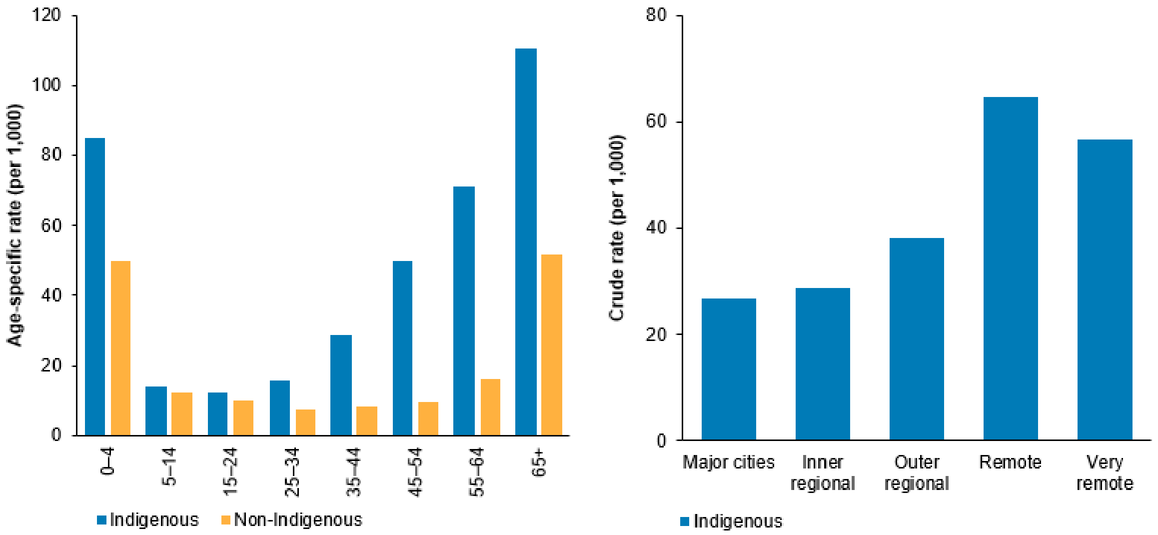
Chronic respiratory diseases are long-lasting with persistent effects.

- Chronic obstructive pulmonary *disease* is a serious long-term lung disorder that limits airflow in the lungs. It includes emphysema and bronchitis, and is not fully reversible, even with treatment.
- Asthma is chronic inflammation of the airways, causing wheezing, breathlessness, and chest tightness. Asthma can usually be managed through appropriate treatment.

The hospitalisation rate for respiratory diseases for Indigenous Australians was highest for those aged 65 years and over (110 per 1,000), followed by those aged 0–4 years (85 per 1,000) between July 2017 and June 2019. The rate of hospitalisations due to respiratory diseases was higher among Indigenous Australians living in *Remote* and *Very remote* areas than among those in non-remote areas (Figure 4.17).

Across all age groups, the hospitalisation rate for respiratory diseases was higher for Indigenous Australians than for non-Indigenous Australians. After adjusting for differences in the age structure between the two populations, the hospitalisation rate of Indigenous Australians for respiratory diseases was 2.4 times the rate for non-Indigenous Australians.

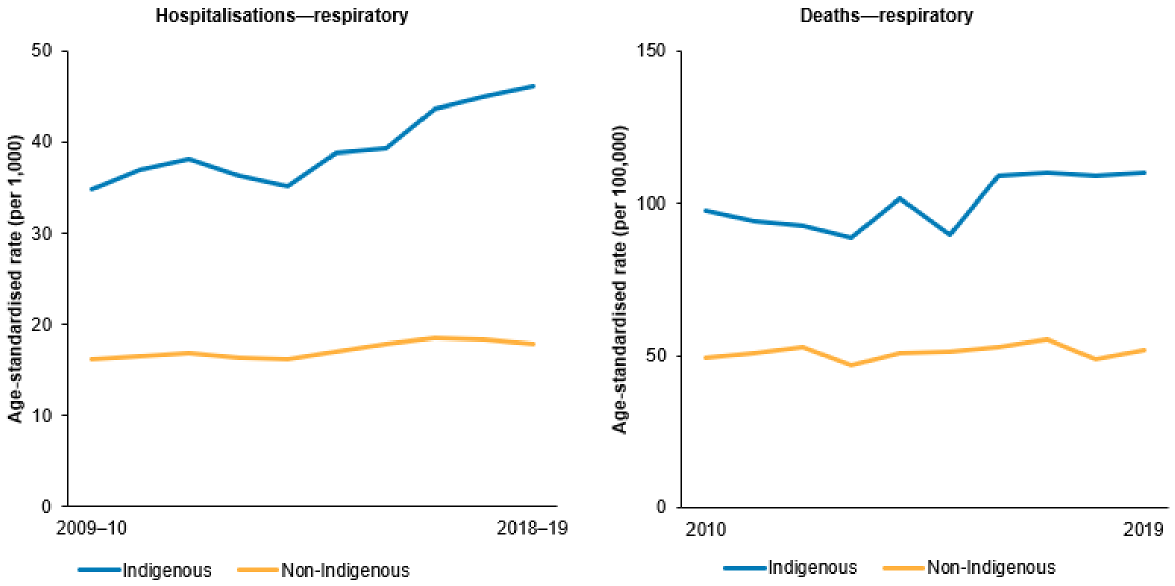
**Figure 4.17: Rate of hospitalisations due to respiratory disease by Indigenous status and age group, and for Indigenous Australians by remoteness, July 2017 to June 2019**



Sources: Measure 1.04, Table D1.04.6—ABS and AIHW analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and National Health Survey 2017–18; and Measure 1.04, Table D1.04.9 – AIHW analysis of National Hospital Morbidity Database.

Age-standardised rates of hospitalisation from respiratory disease among Indigenous Australians increased over the decade to 2018–19, but the age-standardised rate of deaths from respiratory disease changed little over a similar period (2010–2019) (Figure 4.18).

**Figure 4.18: Rate of hospitalisations (2009–10 to 2018–19) and deaths (2010–2019) due to respiratory disease, by Indigenous status (age-standardised)**



Notes

1. Data on hospitalisations from NSW, Vic, Qld, WA, SA and NT combined.

2. Data on deaths from NSW, Qld, WA, SA and NT combined.

Sources: Measure 1.04, Table D1.04.11— AIHW analysis of National Hospital Morbidity Database; and Measure 1.23, Table D1.23.21 — AIHW National Mortality Database.

For further information, see:

- [1.04 Respiratory disease](#)
- [3.02 Immunisation](#)

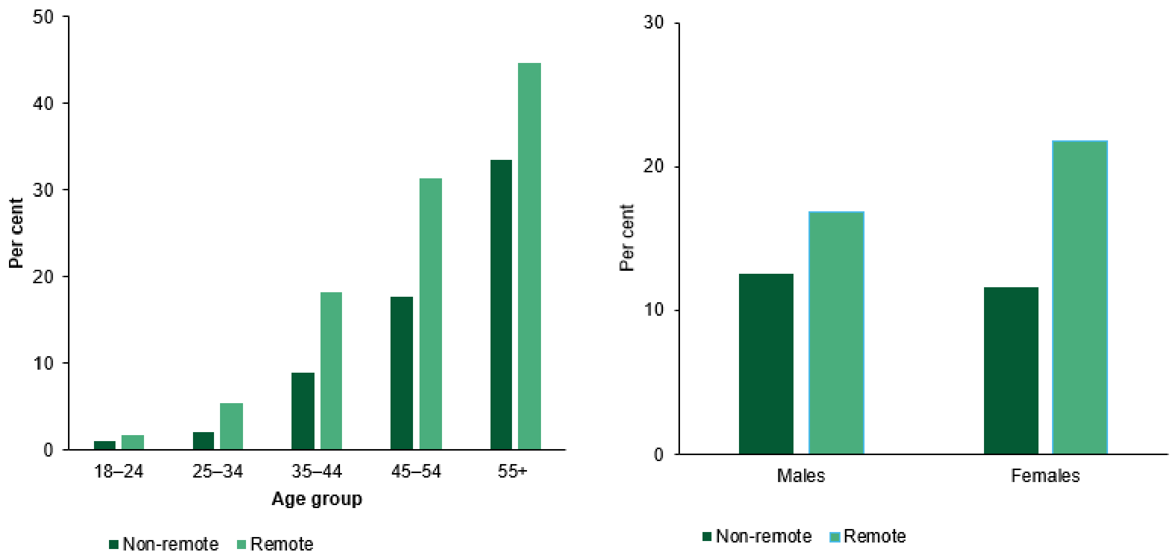
# Diabetes

Diabetes is a chronic condition that can cause serious health complications. Some types of diabetes can be prevented through a healthy lifestyle – getting enough exercise, having a healthy diet, and not smoking. Diabetes is a risk factor for cardiovascular disease, and can lead to kidney damage. Often, people have all three of these conditions (AIHW 2015a).

In 2018–19, about 13% of Indigenous adults reported having diabetes or high sugar level (65,300). Based on age-standardised rates, in 2018–19, Indigenous adults were 2.8 times as likely to report having diabetes or high sugar levels as non-Indigenous adults (17% compared with 6.1%).

The prevalence of diabetes/high sugar levels increases with age, and is higher among Indigenous Australians in remote areas than in non-remote areas (Figure 4.19).

**Figure 4.19: Diabetes/high sugar levels among Indigenous Australians, by remoteness, 2018–19**



Source: Measure 1.09, Table D1.09.2 – ABS 2018–19 National Aboriginal and Torres Strait Islander Health Survey; Table D1.09.14 – AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19.

In the 5-year period 2015–2019, 7.3% (1,124) of total deaths of Indigenous Australians were due to diabetes. The proportion of total deaths due to diabetes was higher for Indigenous females (608 deaths or 8.7% of all Indigenous female deaths) than Indigenous males (516 or 6.1%).

Between July 2017 and June 2019, there were 7,664 Indigenous Australians hospitalised with a principal diagnosis of diabetes, corresponding to a rate of 4.6 hospitalisations per 1,000 population. Based on age-standardised rates, Indigenous Australians were hospitalised due to diabetes at a rate nearly 4 times that for rate of non-Indigenous Australians (6.1 compared with 1.8 per 1,000 population).

Over the decade from 2010 to 2019, the age-standardised death rate from diabetes for Indigenous Australians did not change significantly. There was also no significant change in the age-standardised rate of deaths due to diabetes among non-Indigenous Australians. However, death rates from diabetes remain relatively high for Indigenous Australians compared with non-Indigenous Australians, with Indigenous Australians dying from diabetes at about 4.7 times the rate (age-standardised) of non-Indigenous Australians in the period 2015–2019 (data from NSW, Qld, WA, SA and NT combined).

For further information, see:

- 1.09 Diabetes

# Kidney disease

While chronic kidney disease is often detected too late to be reversible, it can be prevented by a healthy lifestyle, or treated if detected early.

Between July 2017 and June 2019, care involving dialysis was the leading cause of hospitalisation among Indigenous Australians, accounting for 44% (474,745) of all hospitalisations. Excluding dialysis, there were 6,710 hospitalisations for Indigenous Australians due to chronic kidney disease.

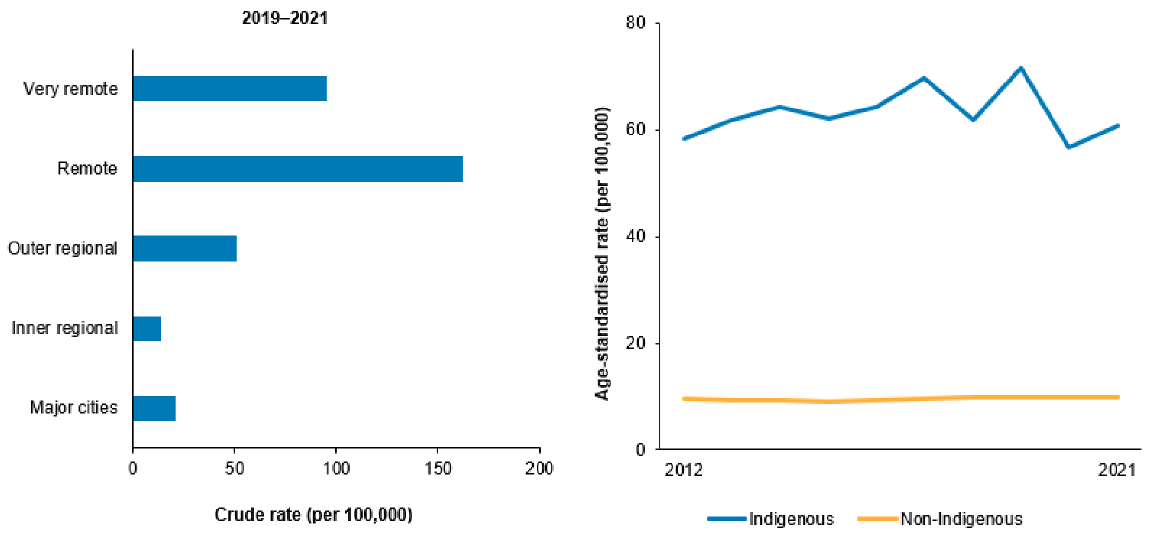
Patients with kidney failure, also known as end-stage kidney disease, require either a kidney transplant or dialysis to maintain the functions normally performed by the kidneys. These treatments are collectively known as ‘kidney replacement therapy’.

In the three-year period 2019–2021, 1,063 Indigenous Australians began kidney replacement therapy for kidney failure. This corresponds to an incidence rate of 41 new cases of kidney failure with replacement therapy for every 100,000 Indigenous Australians.

In 2019–2021, among Indigenous Australians who began receiving kidney replacement therapy, the most common type of primary kidney disease was diabetic kidney disease (also known as diabetic nephropathy) – experienced by 71% (753) of the new 1,063 Indigenous kidney replacement therapy patients. This was followed by glomerulonephritis (77 or 7.2%) and hypertension (61 or 5.7%).

The incidence of kidney failure with replacement therapy was 6 times as high for Indigenous Australians as for non-Indigenous Australians (63 compared with 10 per 100,000 population, based on age-standardised rates). Between 2012 and 2021, the age-standardised incidence rate for kidney failure with replacement therapy did not change significantly for Indigenous Australians. For non-Indigenous Australians, there was a 7.8% increase in age-standardised incidence rate for kidney failure with replacement therapy, which was mainly driven by the increases among non-Indigenous males (10% increase over the period) (Figure 4.20).

**Figure 4.20: Incidence of kidney failure with replacement therapy among Indigenous Australians by remoteness area (crude rates, 2019–2021), and by Indigenous status over time (age-standardised rates, 2012 to 2021)**



Sources: Measure 1.10, Table D1.10.13 and Table D1.10.12 – AIHW analysis of Australia and New Zealand Dialysis and Transplant Registry data.

As at 31 December 2021, a total 2,569 Indigenous Australians with kidney failure were receiving kidney replacement therapy, a prevalence rate of 289 per 100,000 population. Most Indigenous patients with kidney failure (85% or 2,170 patients) were receiving dialysis, while 15% (or 398 patients) had received a kidney transplant. In comparison, about half (49%; 12,063 of 24,774 patients) of non-Indigenous patients received a kidney transplant.

In the 6-year period 2016–2021, 1,381 Indigenous Australians were reliant on dialysis to manage their kidney failure at the time of their death, based on underlying cause of death. The primary cause of death in over one-third (466 deaths or 34%) of these cases was cardiovascular diseases, a further one-fifth (307 deaths or 22%) was due to withdrawal from dialysis and 12% (161 deaths) was due to infections. Among Indigenous Australians who had received a transplant to manage their kidney failure, there were 49 deaths in 2016–2021 - the leading cause of these deaths was cardiovascular disease (13 deaths or 27%), followed by cancer (7 deaths or 14%), infections, and withdrawal (both 6 deaths or 12%).

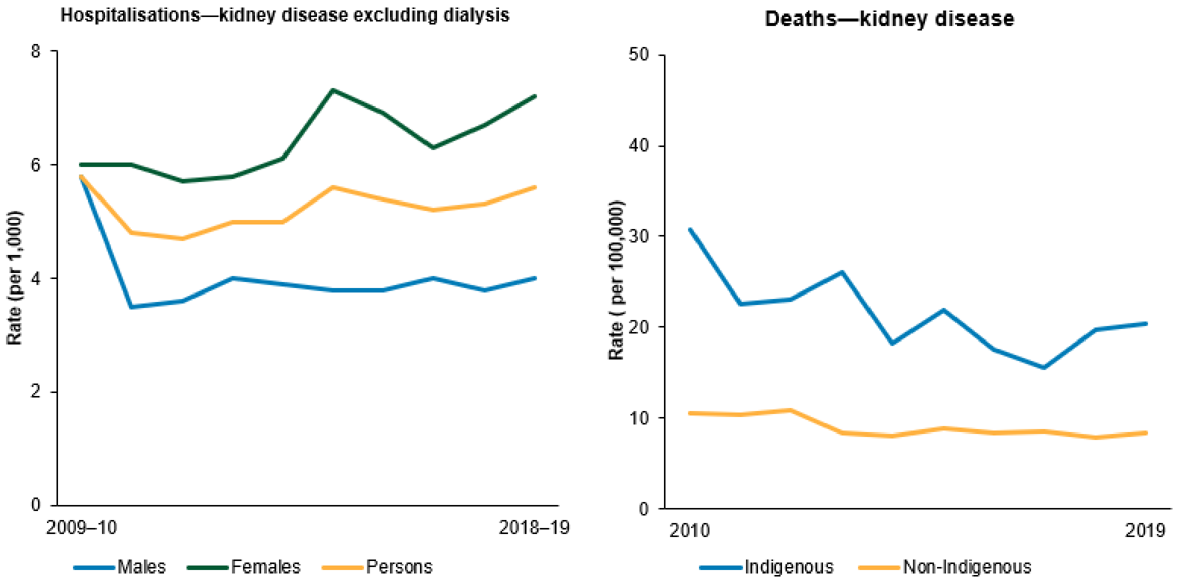
Kidney diseases were the 10th leading cause of death of Indigenous Australians (1.8% of deaths of Indigenous Australians). Indigenous females accounted for 58% of deaths due to kidney disease among Indigenous Australians.

Over the decade between 2010 and 2019, the age-standardised death rate from kidney disease among Indigenous Australians decreased by 36%. However, there was no significant reduction in the gap between Indigenous and non-Indigenous Australians over this period (data from NSW, Qld, WA, SA and NT combined) (Figure 4.21).

Over the decade from 2009–10 to 2018–19, the age-standardised hospitalisation rate for a principal diagnosis of chronic kidney disease increased by 6% for Indigenous Australians. This trend was driven by the increases for Indigenous females (22%) as the rate among Indigenous males declined (16%) (Figure 4.21).

Kidney disease is more likely to be recorded as an additional diagnosis on hospitalisation administrative record or recorded on death certificates as an associated cause compared with other diseases. The above estimations of the impact of kidney disease were based on the principal diagnosis of hospitalisation or underlying cause of death; therefore, will likely underestimate the true extent of chronic kidney disease among Indigenous Australians.

**Figure 4.21: Rates of hospitalisations (2009–10 to 2018–19) and deaths (2010–2019) due to kidney disease, by Indigenous status and sex (age-standardised)**



Notes

1. Data on hospitalisations from NSW, Vic, Qld, WA, SA and NT combined.

2. Data on deaths from NSW, Qld, WA, SA and NT combined.

Sources: Measure 1.10, Table D1.10.20 – AIHW analysis of National Hospital Morbidity Database; and Measure 1.10, Table D1.23.23 – AIHW National Mortality Database.

For further information, see:

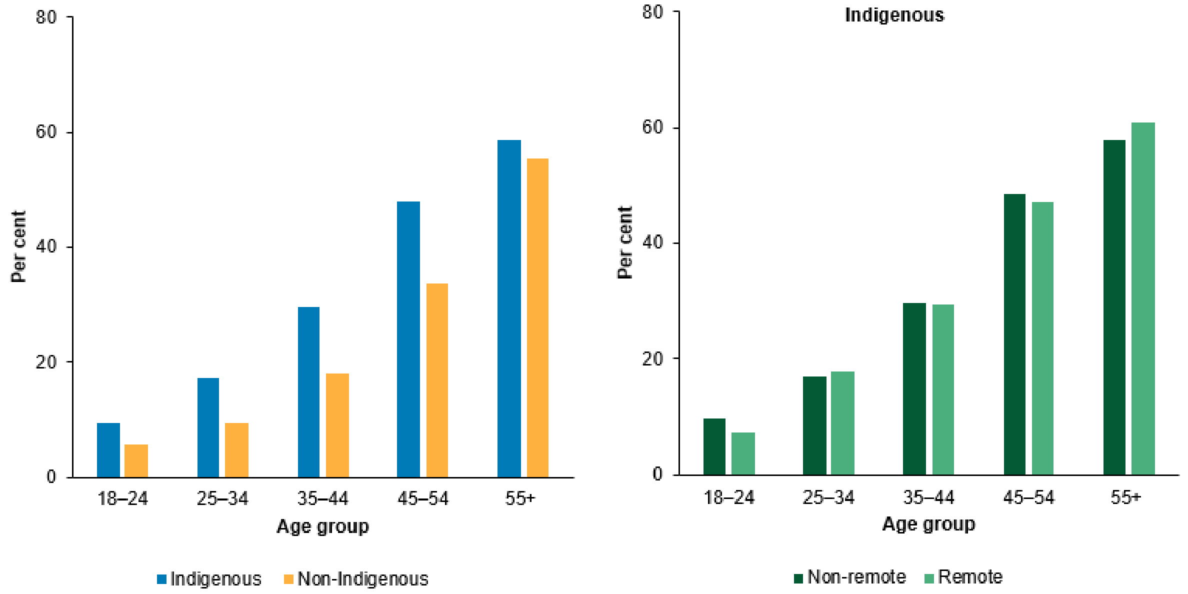
- 1.10 Kidney disease

# High blood pressure

High blood pressure is a leading risk factor for cardiovascular diseases, including coronary heart disease, which is the leading cause of avoidable deaths among Indigenous Australians (AIHW 2022d).

In 2018–19, almost 1 in 3 (31%) Indigenous adults (151,000) had high blood pressure (based on both measured and self-reported data). The prevalence of high blood pressure increased with age for both Indigenous and non-Indigenous adults. The greatest difference in age-standardised rate of high blood pressure between Indigenous and non-Indigenous Australians was found among those in the 25–34 age group, with the rate for Indigenous Australians nearly twice as high as non-Indigenous Australians. Rates of high blood pressure are similar among Indigenous Australians in non-remote and remote areas (Figure 4.22).

**Figure 4.22: High blood pressure prevalence, by Indigenous status and remoteness, 2017–19**



Source: Measure 1.07, Table D1.07.7 – AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19 and National Health Survey 2017–18.

### Many people with high blood pressure do not know they have the condition

People with high blood pressure may not know they have the condition–often there are no symptoms.

The 2018–19 National Aboriginal and Torres Strait Islander Health Survey asked participants whether they had been told they had high blood pressure by a doctor or nurse, and their blood pressure was measured.

Of the Indigenous adults with *measured* high blood pressure (140/90 mmHg or greater):

- 25% (an estimated 28,400) had already been told they had high blood pressure by a health professional.
- 75% (83,600) had not been told they had high blood pressure by a health professional.

For further information, see:

- 1.07 High blood pressure

# Tier 2 – Determinants of health

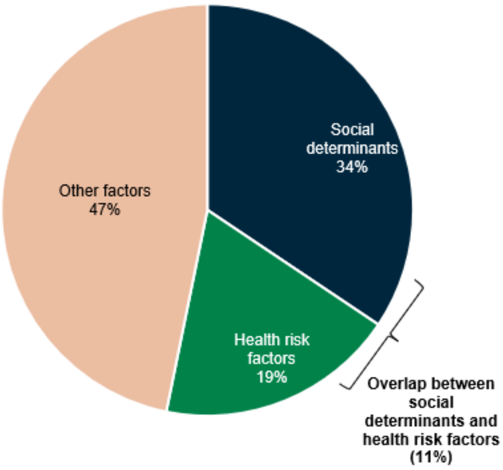
Health is influenced by social determinants and individual health risk factors. Social determinants of health refer to the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces such as economics, social policies, and politics (Commission on Social Determinants of Health 2008).

Using both the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) (for data for Indigenous Australians) and 2011–12 Australian Health Survey (AHS) (for data for non-Indigenous Australians), the level of good health among Indigenous and non-Indigenous Australians were measured. Aligning with the World Health Organization's view of good health, which is a state of complete physical, mental and social well-being, several components were assessed. That included a combination of self-assessed physical health, self-reported long-term health conditions (morbidity score) and emotional wellbeing based on self-reported level of distress (emotional distress score), the key factors that contributed to a large part of the health gap between Indigenous and non-Indigenous Australians were identified (AIHW 2018):

- Socioeconomic factors (social determinants) explained 34% of the total health gap between Indigenous and non-Indigenous Australians. The leading social determinants that accounted for the health gap include household income (explained 14% of the total health gap) and employment and hours worked (12%) (Figure 5.1).
- Individual health risk factors explained 19% of the total health gap between Indigenous and non-Indigenous Australians. The leading health risk factors that accounted for the health gap were smoking (10% of the total health gap) and overweight or obesity (7.2%).

It is likely that differences in access to affordable and nearby health services explain a significant proportion of the health gap between the Indigenous and non-Indigenous populations. Health service accessibility could not be quantified in the analysis because comparable measures of access to services were not available in the two surveys used.

**Figure 5.1: Health gap between Indigenous and non-Indigenous Australians explained by social determinants and health risk factors, 2011–13 (%)**



Source: AIHW analyses of ABS 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey; ABS 2011–12 Australian Health Survey (adapted from Australia's Health 2018; Table S7.6.2).

# Education

A person's educational qualifications can influence their health status and health outcomes. Higher levels of education can lead to:

- greater health literacy (a person's ability to find, understand, and apply health information), which can have a direct impact on a person's health,
- better prospects for employment and income, which can help people access good quality housing, healthy food, and health care services.

Health also influences education. Poor health through life, and health conditions like vision and hearing impairment, especially in childhood, can disrupt a person's schooling and affect their ability to learn (Department of Prime Minister and Cabinet 2020).

The importance of education is also reflected in 4 Closing the Gap targets: increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC) to 55 per cent by 2031 (Target 4); increase the proportion of Aboriginal and Torres Strait Islander people (age 20-24) attaining year 12 or equivalent qualification to 96 per cent by 2031 (Target 5); increase the proportion of Aboriginal and Torres Strait Islander people aged 25-34 years who have completed a tertiary qualification (Certificate III and above) to 70 per cent by 2031 (Target 6); and increase the proportion of Aboriginal and Torres Strait Islander youth (15-24 years) who are in employment, education or training to 67 per cent by 2031 (Target 7). See Targets 4, 5, 6 and 7 in the Closing the Gap Information Repository.

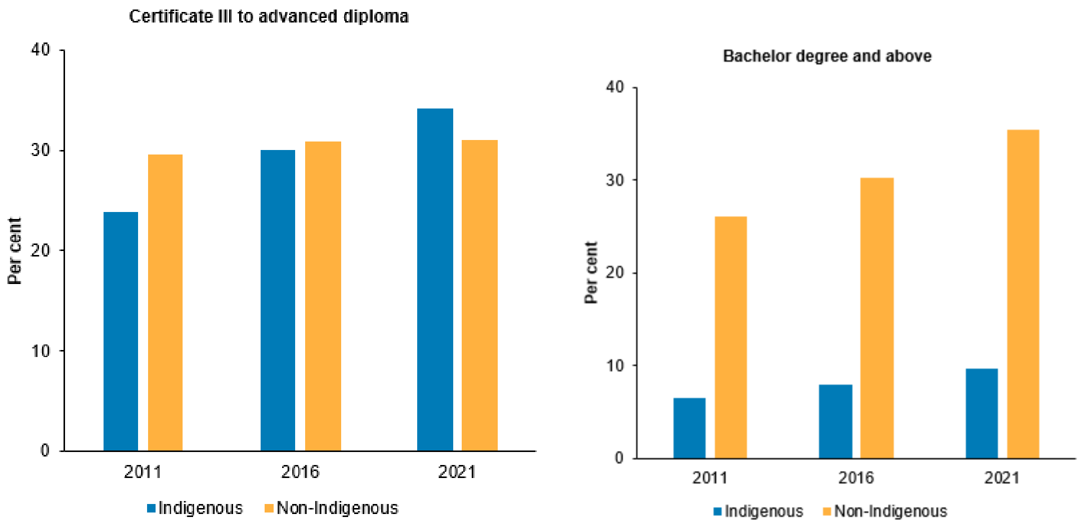
Over the past decade from 2012 to 2021:

- the proportion of Indigenous school students in Year 5 who were at or above the national minimum standards increased for numeracy (13%) and spelling (9.9%). Likewise, the proportion of Indigenous students at or above the national minimum standards increased for Year 7 in spelling (5.7%) and Year 3 in reading (11%).
- the proportion of Indigenous students staying in school from the first year of secondary school (Year 7 in most states and territories, and Year 8 in South Australia) to Year 12 increased by 7.9 percentage points to 59%.

Between 2011 and 2021, rates of highest education or training level completed have also improved significantly.

- The proportion of Indigenous young adults aged 20–24 who had completed Year 12 qualification or equivalent, or attained a non-school qualification at Certificate III level or above increased from 52% to 68%.
- The proportion of Indigenous adults aged 20–64 who had either completed a non-school qualification at Certificate III or above or were studying for a non-school qualification at any level increased from 35% to 48%, mainly due to increased attainment of certificate III or advanced diploma qualifications.
  - The proportion of Indigenous adults aged 20–64 whose highest educational qualification was a certificate III or advanced diploma increased from 24% to 34%
  - The proportion of Indigenous adults aged 20–64 whose highest educational qualification was a Bachelor Degree or above increased from 6.6% to 9.8% (Figure 5.2).

**Figure 5.2: Attainment of post-school qualifications among Australians aged 20–64, by Indigenous status, 2011 to 2021 (per cent of population)**



Source: Measure 2.06, Table D2.06.13. AIHW analysis of ABS Census of Population and Housing 2021 (ABS 2022a) .

Educational attainment among Indigenous Australians was highest in *Major cities*. In the 2021 Census, among Indigenous Australians:

- the proportion aged 20–24 with a Year 12 or a non-school qualification at Certificate III level or above was 76% (23,400 people) in *Major cities*, compared with 42% (2,500) in *Very remote* areas.
- the proportion aged 20–64 who had completed a Certificate III to Advanced diploma was 37% (60,800 people) in *Major cities*, compared with 16% (6,100) in *Very remote* areas.
- the proportion aged 20–64 who had completed a Bachelor Degree or above was 14% (22,800) in *Major cities*, compared with 2.2% (830) in *Very remote* areas.

Educational achievement for all students decreases with increasing remoteness, and this disparity is more significant for Indigenous than non-Indigenous students.

For further information, see:

- 2.04 Literacy and numeracy
- 2.05 Education outcomes for young people
- 2.06 Educational participation and attainment of adults

# Employment

### COVID-19 and employment data

The COVID-19 pandemic has had a substantial impact on employment (see also Australia's Welfare: employment and unemployment).

In 2021, the Census was held on 10 August, during which most states and territories in Australia were under restrictions due to the COVID-19 pandemic. COVID-19 restrictions affected people's labour force status, working hours, and attendance at their usual workplace (ABS 2022b). For example, in 2021, 6.5% of employed people worked 0 hours, the highest ever recorded (with 4.1% in the 2011 Census being the second highest).

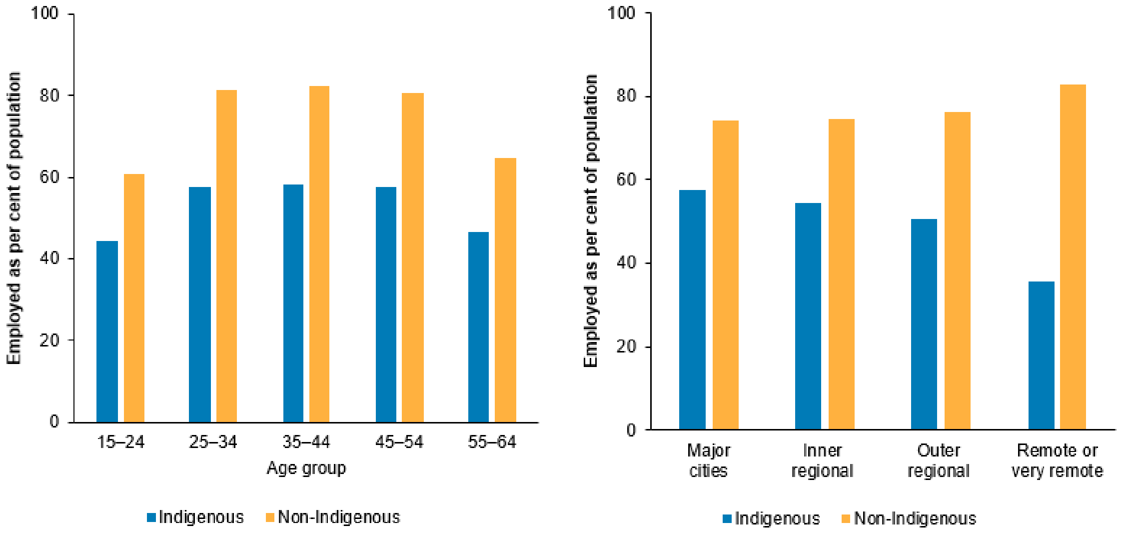
There were instructions on the Census website and online form to guide people in how to respond to questions on employment while in lockdown (ABS 2022c). If the person was employed in the last four weeks prior to lockdown, but was unable to work in the last week due to lockdown, they were instructed to select 'Yes, but absent on holidays, on paid leave, on strike or temporarily stood down'. However, complexities in interpretation of employment during lockdown may have affected how people responded to questions about their labour force status.

The employment rate – the number of employed people as a proportion of the population – remains much lower among Indigenous Australians than non-Indigenous Australians. Education attainment is associated with employment outcomes, with people who have completed tertiary level education generally having better employment opportunities than those who have not completed further education after leaving school (National Skills Commission 2021). Two of the Closing the Gap targets relate to employment: increase the proportion of Aboriginal and Torres Strait Islander youth (15-24 years) who are in employment, education or training to 67 per cent by 2031 (Target 7), and increasing the proportion of Aboriginal and Torres Strait Islander people aged 25–64 who are employed to 62 per cent by 2031 (Target 8) – see Targets 7 and 8 in the Closing the Gap Information Repository.

In the 2021 Census, 52% (253,600) of Indigenous Australians aged 15–64 were employed. The employment rate was generally lower in more remote areas (Figure 5.3). In 2021, the employment rate for Indigenous Australians at working age was highest in Major cities at 58% and the lowest in Very remote areas at 32%.

Indigenous Australians aged 15–64 had a lower employment rate than non-Indigenous Australians (52% compared with 75%), and this was true across all age groups (Figure 5.3). The employment gap was higher for Indigenous Australians living in more remote areas (Figure 5.3).

**Figure 5.3: Employment rate (people aged 15–64), by Indigenous status, 2021**



Sources: Measure 2.07, Table D2.07.3Cen and Table D2.07.6 AIHW analysis of ABS Census of Population and Housing 2021 (ABS 2022a)..

For Indigenous Australians aged 25–64 (the target age group for the employment Closing the Gap target), the employment rate increased from 51% to 56% between 2016 and 2021, and the gap between Indigenous and non-Indigenous employment rates reduced from 24.7 to 22.0 percentage points.

The proportion of Indigenous Australians aged 25–64 who were employed increased with each level of educational attainment: 85% of those whose highest level of education was a bachelor’s degree were employed; 72% of those with a Certificate III or IV level qualification; 45% of those with a secondary education at Year 10 to 12 level; and 24% of those with lower levels of qualification (Table 5.1).

**Table 5.1: Employment rate for Indigenous Australians aged 25–64, by highest level of educational attainment and remoteness, 2021**

| | Bachelor Degree Level or higher | Advanced Diploma and Diploma Level | Certificate III and IV Level | Year 10 to 12 | Certificate I & II Level | Year 9 or below/no education attainment | Total |
|---|---|---|---|---|---|---|---|
| **Major cities** | 86 | 76 | 72 | 52 | 30 | 28 | 62 |
| **Inner regional** | 84 | 76 | 73 | 48 | 32 | 28 | 58 |
| **Outer regional** | 84 | 76 | 73 | 45 | 34 | 25 | 54 |
| **Remote** | 85 | 80 | 75 | 37 | 46 | 20 | 46 |
| **Very Remote** | 82 | 78 | 64 | 30 | 48 | 17 | 35 |
| **Australia** | 85 | 76 | 72 | 45 | 34 | 24 | **56** |

Note: Total includes people for whom educational attainment was inadequately described or not stated.

Source: Measure 2.07, Table D2.07.22. AIHW analysis of ABS Census of Population and Housing 2021 (ABS 2021).

Indigenous Australians aged 25–64 who reported having any of a selected list of 10 long-term health condition had a lower employment rate than those with no long-term conditions (ranging from 17% to 53% for those with a long-term health condition, compared with 65% for those without), whereas those who needed assistance with core activities was 14% compared with 62% among those who did not need assistance.

For many Indigenous Australians, there is a conflict between family responsibilities and finding and keeping a job (Venn & Biddle 2018). A recent study found that education, disability, and having spent time in prison were the most important factors underlying labour force participation (Dinku & Hunt 2021).

Nearly 2 in 5 (38%) Indigenous Australians in remote areas who were unemployed in 2014–15 reported a lack of any jobs as a barrier to finding work, compared with 1 in 5 (22%) unemployed Indigenous Australians in non-remote areas. Among Indigenous Australians in non-remote areas who were unemployed, 1 in 3 (33%) reported not having a driver's licence as a barrier to finding work (Table 5.2).

**Table 5.2: Top 5 difficulties finding work, unemployed Indigenous Australians aged 15–64, 2014–15**

| Remote | Non-remote |
|---|---|
| No jobs in local area or line of work 44% (5,700) | No jobs in local area or line of work 38% (15,500) |
| No jobs at all 38% (4,900) | Don't have driver's licence 33% (13,500) |
| Transport problems/distance 27% (3,500) | Transport problems/distance 33% (13,300) |
| Insufficient education, training, skills 22% (2,800) | Insufficient education, training, skills 32% (13,000) |
| Don't have driver's licence 19% (2,400) | No jobs at all 22% (8,800) |

Source: Measure 2.07, Table D2.07.10 – AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Social Survey 2014–15.

For further information, see:

- 2.07 Employment

# Income

An adequate income is fundamental to being able to live a healthy life – it gives a person greater access to nutritious food, better housing, and health and other services, as well as a greater ability for social participation (World Health Organization 2017).

**Equivalised household income:** Household incomes are adjusted to facilitate the comparison of income levels between households of different size and composition, reflecting the requirement of a larger household to need a higher level of income to achieve the same standard of living as a smaller household.

**Income quintiles:** Household incomes are ordered from lowest to highest income, and then divided into five equal-sized groups, or quintiles. The lowest income group is the 1st quintile, and the highest is the 5th quintile. Equivalised household income quintile boundaries are calculated for the total population.

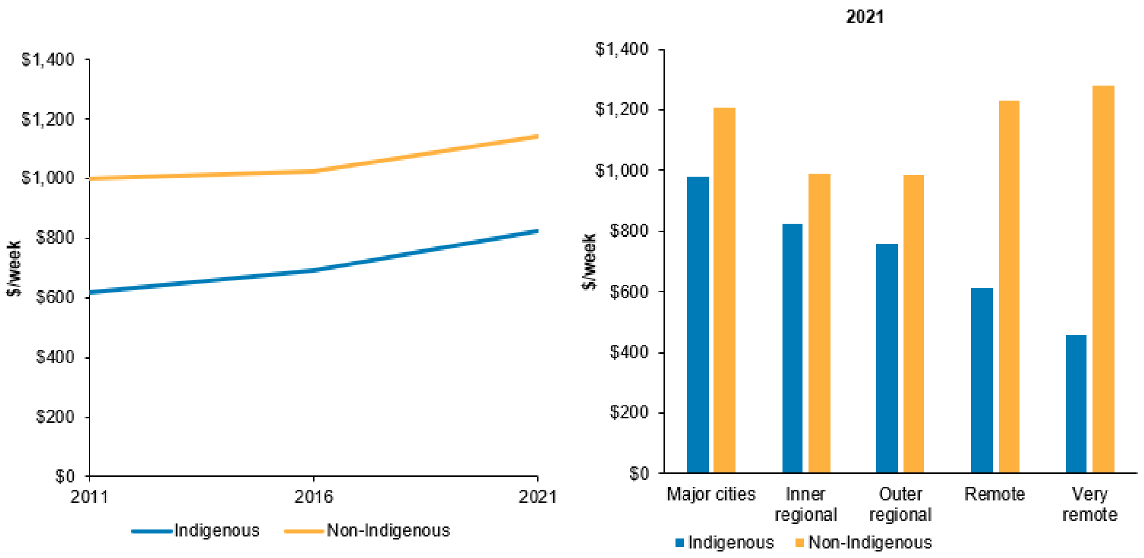
In the 2021 Census, more than 1 in 3 (35% or 137,600) Indigenous adults lived in households with incomes in the lowest 20% of incomes nationally (1st income quintile; based on equivalised gross household income, an adjusted income measure used to compare households of different types and sizes).

Between 2011 and 2021, after adjusting for inflation, the median gross weekly equivalised household income increased:

- from $619 to $825 for Indigenous adults
- from $998 to $1,141 for non-Indigenous adults.

Average weekly equivalised household income of Indigenous adults was highest among those living in *Major cities* ($982), and lowest among those living in *Very remote* areas ($459) (Figure 5.4).

**Figure 5.4: Median gross weekly equivalised household income of adults 2011–2021, by Indigenous status and remoteness area (2021)**



Sources: Measure 2.08, Table D2.08.16 –.AIHW analysis of the ABS Census of Population and Housing, data provided by the ABS, customised report, 2023 (ABS 2023b); and Measure 2.08, Table D2.08.12 – ABS Census of Population and Housing 2021.

The association between income and health works in both directions. An adequate income supports better health, but poor health can make it difficult to get a job and earn an income.

Comparing Indigenous adults living in households whose incomes were in the lowest 20% (lowest income quintile) of incomes nationally with those in the top 40% (top 2 income quintiles), in 2018–19:

- 32% (49,100) of those in the lowest group assessed their own health as fair or poor, compared with 13% (10,200) of those in the top 2 groups.
- 44% (65,700) of those in the lowest group were classed as experiencing high or very high psychological distress, compared with 18% (14,100) of those in the top 2 groups.

In 2018–19, a government cash pension or allowance was the main source of personal income for 45% (200,200) of Indigenous adults aged 18–64.

For further information, see:

- 2.08 Income

# Housing

Stable and secure housing is fundamentally important to health and wellbeing. Housing circumstances—such as tenure, affordability, the amount of living space and location—are key determinants of physical and mental health (Foster et al. 2011; Marsh et al. 2000). However, causal relationships between poor housing and poor health are complex, and directionality is not always clear. For example, poor housing circumstances can contribute to poor health, and poor health can result in households living in worse housing circumstances (Brackertz & Wilkinson 2017).

**Appropriately sized housing**

Overcrowding, according to the Canadian National Occupancy Standard (CNOS), is defined as a situation in which one or more additional bedrooms would be required to adequately house its inhabitants, given the number, age, sex and relationships of household members. It specifies that:

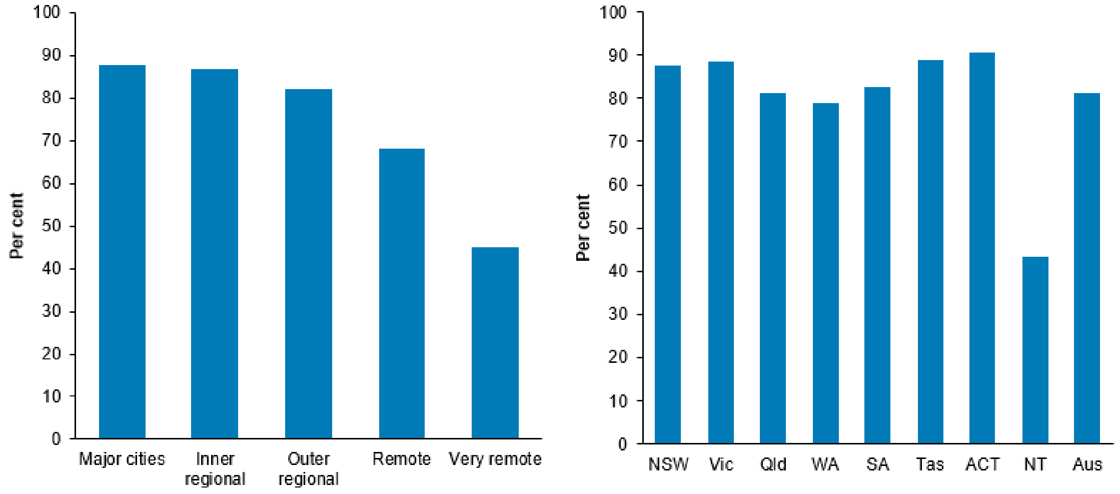
- there should be no more than 2 people per bedroom
- children aged less than 5 of different sexes may reasonably share a bedroom
- children aged 5 or over of the opposite sex should have separate bedrooms
- children aged less than 18 of the same sex may reasonably share a bedroom
- single household members aged 18 or over should have a separate bedroom, as should parents and couples
- a lone person household may reasonably occupy a bed sitter (AIHW 2014a).

The importance of secure, appropriate and affordable housing is reflected in the Closing the Gap target to increase the proportion of Aboriginal and Torres Strait Islander people living in appropriately sized (not overcrowded) housing to 88 per cent by 2031 – see Target 9A in the Closing the Gap Information Repository.

According to the ABS Census of Population and Housing, in 2021, about 569,400 (81%) Indigenous Australians lived in appropriately sized housing. This proportion ranged from 43% to 91% across states and territories. The proportion of Indigenous Australians living in appropriately sized housing was lower than for non-Indigenous Australians (81% compared with 94%, respectively) (Figure 5.5).

Indigenous Australians in remote areas had higher rates of household overcrowding than those in non-remote areas. In 2021, the proportion of Indigenous Australians living in appropriately sized housing ranged from 88% in *Major cities* to 45% in *Very remote* areas (Figure 5.5).

**Figure 5.5: Proportion of Indigenous Australians living in appropriately sized housing (not overcrowded), by jurisdiction, and by remoteness, 2021**



Sources: Measure 2.01, Table D2.01.10 and Table D2.01.9 – AIHW analysis of ABS Census of Population and Housing 2021 (ABS 2021).

## Housing assistance

The Australian and state and territory governments provide a range of assistance to people having difficulty with finding or sustaining affordable and appropriate housing in the private housing market. Housing assistance refers to both access to social housing (such as public housing) as well as targeted financial assistance for eligible Australians.

At 30 June 2021, there were around 77,350 Indigenous households living in one of the 4 main types of social housing:

- 36,727 in public housing,
- 13,954 in state owned and managed Indigenous housing (SOMIH),
- 10,081 in community housing, and
- 16,588 in Indigenous community housing (AIHW 2022f).

Commonwealth Rent Assistance (CRA) may be available for eligible tenants who rent in private rental market or community housing to help reduce rental stress (defined as spending more than 30% of gross income on rent). As at the end of June 2021, 93,922 income units receiving CRA reported having an Indigenous member (6.3% of all income units).

## Housing tenure

Housing tenure – whether a person owns or is buying a home, is renting privately or is living in social housing – can affect health. Home ownership can provide security, stability and autonomy, but housing costs can leave less money available for other necessities (Hulse et al. 2010).

Although Indigenous households are less likely than non-Indigenous households to own or be buying their own home, the gap has narrowed.

In 2021, over 4 in 10 (42%) Indigenous households were homeowners/buyers, compared with 37% in 2011 and 40% in 2016. The proportion of households that were home owners/buyers in 2021 was lower for Indigenous households than for other households (42% compared with 68%) (Table 5.3).

**Table 5.3: Housing tenure trends, 2011–2021 (%)**

| | Indigenous households | | | Other households | | |
|---|---|---|---|---|---|---|
| | **2011** | **2016** | **2021** | **2011** | **2016** | **2021** |
| **Home owners/buyers** | 37% | 40% | 42% | 70% | 68% | 68% |
| **Private renters** | 22% | 25% | 28% | 16% | 19% | 20% |
| **State or territory housing tenants** | 22% | 19% | 14% | 3.6% | 3.2% | 2.6% |
| **Community housing tenants** | 4.8% | 3.0% | 4.0% | 0.5% | 0.5% | 0.7% |

Note: An Indigenous household is a household that has at least 1 Indigenous person who is a usual resident and who was present on Census Night.

Source: Measure 2.01, Table D2.01.20. AIHW analysis of ABS Census of Population and Housing 2021 (AIHW 2019a).

## Homelessness

People are considered homeless if their current dwelling is inadequate; or if they have no tenure or their tenure is short and not able to be extended; or if their current living arrangement does not give them control of, or access to, space for social relations (ABS 2016b).

In 2021, 24,900 Indigenous Australians were homeless on Census night (3.1% of Indigenous Australians (ABS 2023a). Among Indigenous Australians experiencing homelessness:

- 60% (or 15,000) of homeless Indigenous Australians were living in severely crowded dwellings (needing four or more extra bedrooms under CNOS)
- 19% (4,800) were living in supported accommodation for the homeless
- 9% (2,300) were living in improvised dwellings, tents or sleeping rough; and
- the remaining 12% (2,900) were staying temporarily with other households, living in boarding houses, or living in other temporary lodgings.

Between 2011 and 2021, the rate of homelessness among the Indigenous population declined from 487 to 307 per 10,000 population.

The rate of homelessness among Indigenous Australians was 8.8 times the rate for non-Indigenous Australians (306.8 compared with 34.9 per 10,000 population), however the gap in homelessness rates between Indigenous and non-Indigenous Australians decreased between 2011 and 2021 (from 453 to 272 per 10,000 population).

Specialist homelessness services (SHS) provide a wide range of services to assist people who are experiencing homelessness or who are at risk of homelessness, ranging from general support and assistance to immediate crisis accommodation (AIHW 2022b). In 2021–22, around 72,900 Indigenous clients received support from SHS, which is equivalent to 8% of the Indigenous population or 821 Indigenous clients per 100,000 population nationally. Indigenous Australians used specialist homelessness services at 11 times the rate of non-Indigenous Australians (74 per 10,000 population), after adjusting for differences in age structure between the two populations.

For further information, see:

- 2.01 Housing

# Child protection

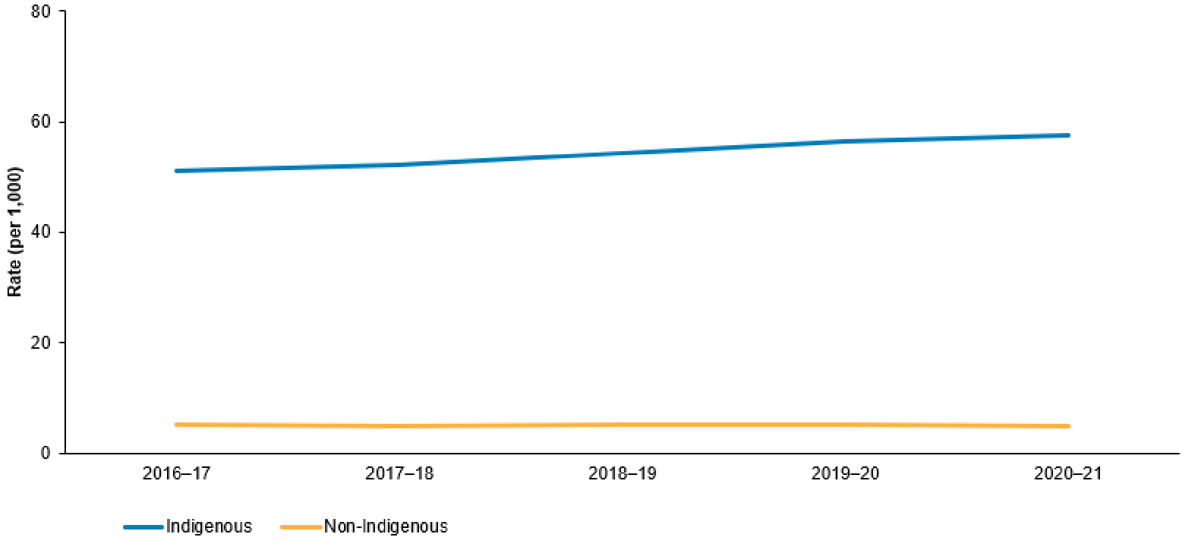
Experience of maltreatment during childhood has serious and long-term effects on social and emotional wellbeing and health (Emerson et al. 2015). In Australia, child protection functions are the responsibility of state and territory governments. Each jurisdiction has its own legislation, policies, and practices in relation to child protection (AIHW 2019a, 2019c; Guthridge et al. 2014).

Indigenous Australians' experience of child welfare policies has historically been traumatic, with the policy of forcible removal of children known as the Stolen Generations (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families 1997). Child protection issues continue to be very significant for Indigenous communities. This is reflected by the Closing the Gap target of reducing the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45% by 2031 – see Targe 12 in the Closing the Gap Information Repository.

According to the Child Protection Collection data, as at 30 June 2021, of the 46,212 children in out-of-home care in Australia, 19,480 (or 42%) were Aboriginal or Torres Strait Islander. Nearly 2 in 3 (63% or 12,290) Indigenous children in out-of-home care were placed with a relative/kin, with another Indigenous carer.

Between 30 June 2017 and 30 June 2021, the rate for Indigenous children who were in out-of-home care rose from 51 per 1,000 to 58 per 1,000 population, and the gap widened from 46 to 53 per 1,000 population between Indigenous and non-Indigenous children over the period. On 30 June 2021, Indigenous children were 11.5 times as likely as non-Indigenous children to be in out-of-home care (57.6 compared with 5.0 per 1,000 children, or 19,480 compared with 46,100) (Figure 5.6).

**Figure 5.6: Rate of out-of-home care, children aged 0–17, by Indigenous status, 30 June 2017 to 30 June 2021**



Source: Measure 2.12, Table D2.12.1 – AIHW analysis of Child Protection Collections 2016–18 to 2020–21.

For further information, see:

- 2.12 Child protection

# Justice

Criminal justice systems are the responsibility of state and territory governments. Each jurisdiction has its own legislation, and policies and practices in relation to courts, corrections and policing. Education, employment, income, and housing disparities are not only associated with a large part of the health gap between Indigenous and non-Indigenous Australians, but also with imprisonment among Indigenous Australians (Pricewaterhouse Coopers 2017).

Two Closing the Gap targets relate to overrepresentation of Indigenous Australians in the criminal justice system: reducing the rate of Aboriginal and Torres Strait Islander adults held in incarceration by at least 15 per cent by 2031 (Target 10), and reducing the rate of Aboriginal and Torres Strait Islander young people (10-17 years) in detention by at least 30 per cent by 2031 (Target 11) – see Targets 10 and 11 in the Closing the Gap Information Repository.

Most Indigenous Australians have never been imprisoned (ABS 2016a). However, they have contact with the criminal justice system – as both offenders and victims – at much higher rates than non-Indigenous Australians (SCRGSP 2016).

As at 30 June 2021, there were 13,039 Indigenous adults in prison. Of these:

- 9 in 10 (90%, 11,781) were male and
- 2 in 5 (40%, 5,271) were aged 25–34.

The rate of imprisonment among Indigenous adults (2,223 per 100,000 population) was 14 times the rate of non-Indigenous adults in 2021. The median aggregate sentence (total length of imprisonment if an offender committed multiple offences) for Indigenous prisoners was lower, with 73% of Indigenous prisoners sentenced under 5 years compared with 52% for non-Indigenous prisoners. Over the decade between 2012 and 2021, based on the age-standardised rates, there was a 40% and 28% increase in the rate of imprisonment for Indigenous and non-Indigenous adults, respectively.

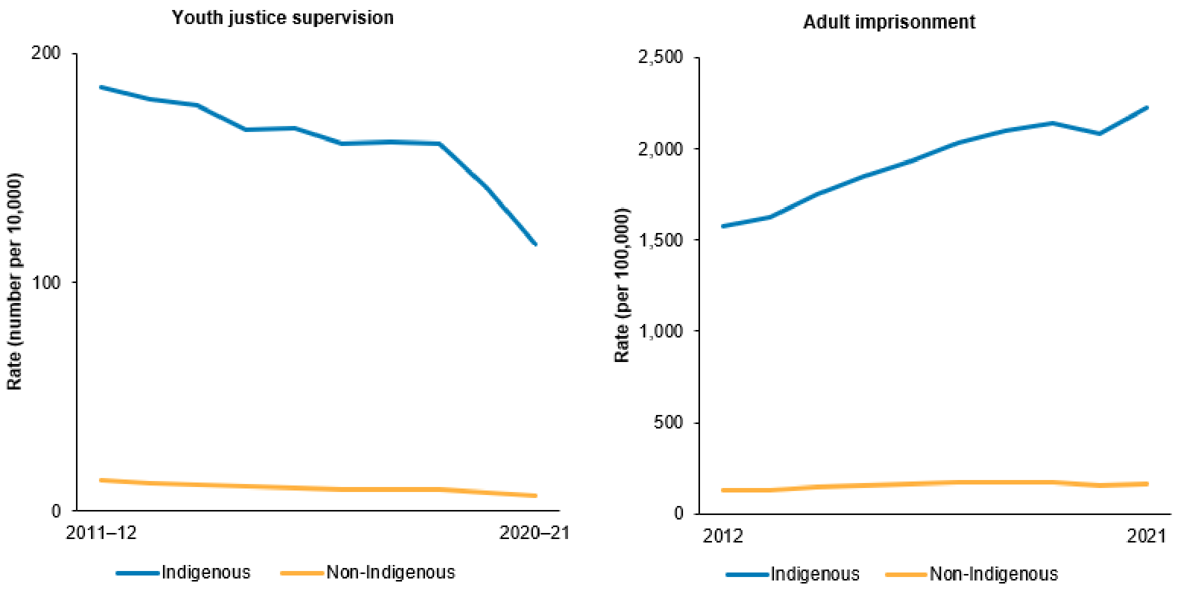
In 2020–21, a total of 4,092 Indigenous young people were under youth justice supervision at some time during the year. Of these, 86% (3,501) were aged 10–17 and 14% (591) were aged 18 and over.

On an average day in 2020–21 there were 1,697 Indigenous young persons aged 10–17 under youth justice supervision (AIHW 2021).

In 2020–21, on an average day, Indigenous young people (117 per 10,000 population) were 16 times as likely to be under youth justice supervision than non-Indigenous (7.2 per 10,000) young people.

Over the decade from 2011–12 to 2020–21, the rate of Indigenous young people aged 10–17 under youth justice supervision decreased by 29%, and the gap with non-Indigenous young people narrowed by 28% (Figure 5.7).

**Figure 5.7: Youth justice supervision rate on an average day during 2011–12 and 2020–21 (youth aged 10–17); and age-standardised adult imprisonment rate, by Indigenous status, from 2012 to 2021**



Note: Youth justice supervision presents the rate of young people aged 10–17 under youth justice supervision on an average day. The ABS National Prisoner Census of adult imprisonment is a census of all persons in the legal custody of adult corrective services in all states and territories as at midnight 30 June of the reference year. Data in Qld prior to 2019 include people aged 17.

Sources: Measure 2.11, Table D2.11.1 – AIHW Youth Justice National Minimum Dataset (YJ NMDS); and Measure 2.11, Table D2.11.12 – AIHW analysis of ABS National Prisoner Census data.

Based on self-reported data from the 2014–15 National Aboriginal and Torres Strait Islander Social Survey:

- nearly half (48%) of Indigenous men aged 15 and over had ever been formally charged by the police
- 1 in 5 (20%) had been arrested in the previous 5 years
- 1 in 20 (5.3%) had been imprisoned in the previous 5 years.

For further information, see:

- 2.11 Contact with the criminal justice system

# Overweight and obesity

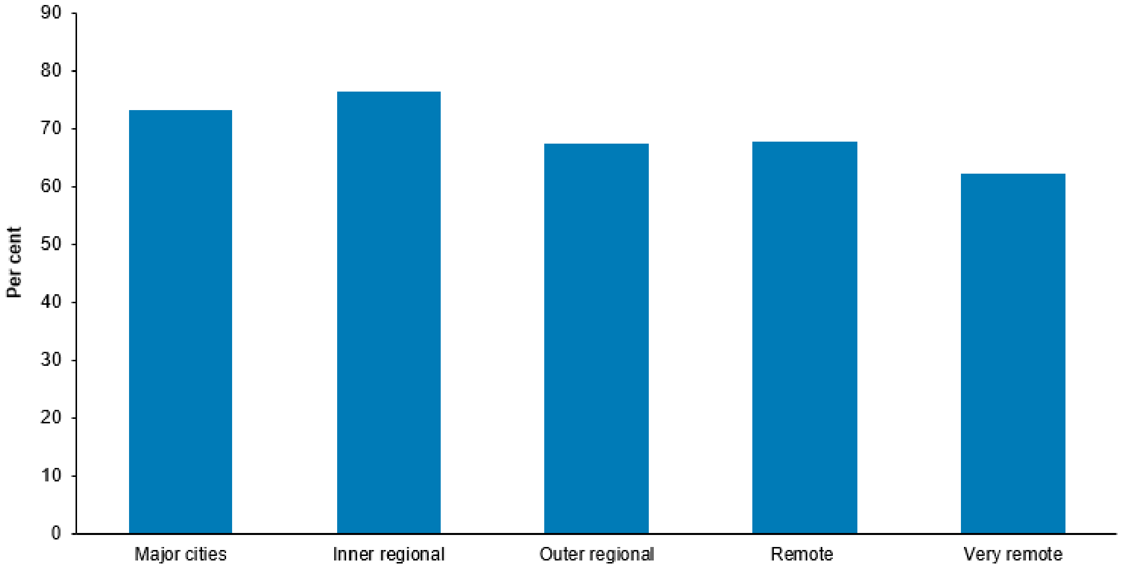
Worldwide, rates of overweight and obesity have increased substantially over the past 4 decades, due to diets higher in saturated fats and sugar, and to people being less active (World Health Organization 2020). Being overweight or obese is a risk factor for cardiovascular disease, diabetes, and kidney disease – health conditions that often occur together (AIHW 2015a, 2022d).

A poorer quality of diet – lacking in important nutrients and high in processed food – can contribute to obesity. Diet can be affected by what foods are affordable and readily available. For example, fresh fruit and vegetables can be difficult to access by people with low incomes and in more remote areas (Thurber et al. 2017).

In 2018–19, based on voluntary physical measurements, 71% (381,800) of Indigenous Australians aged 15 and over were overweight (BMI 25.0 - 29.9) or obese (BMI ≥30.0). After adjusting for differences in the age structure between the two populations, Indigenous Australians aged 15 and over were less likely than non-Indigenous Australians to be overweight (29% and 35%, respectively) but 1.5 times as likely to be obese (46% and 30%, respectively).

Across remoteness areas, the proportion of Indigenous Australians who were overweight or obese ranged from 62% in *Very remote* areas to 76% in *Inner regional* areas (Figure 5.8).

**Figure 5.8: Proportion of Indigenous Australians aged 15 and over who were overweight or obese, by remoteness area, 2018–19**

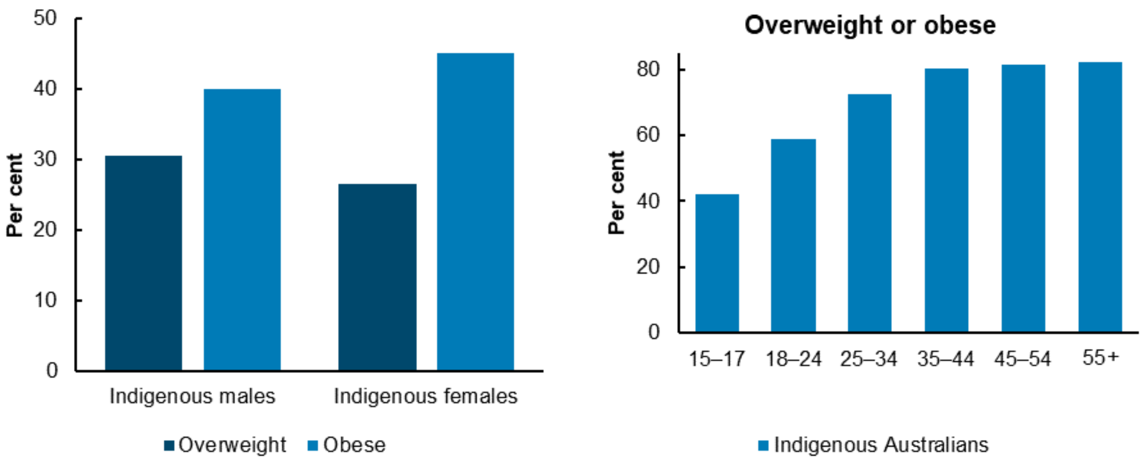


Note: In the 2018–19 National Aboriginal and Torres Strait Islander Health Survey Body Mass Index was derived from measured height and weight.

Source: Measure 2.22, National Aboriginal and Torres Strait Islander Health Survey 2018–19.

In 2018–19, 72% of Indigenous females and 71% of Indigenous males were overweight or obese. A higher proportion of Indigenous females were obese than Indigenous males (45% compared with 40%, respectively). The proportion of Indigenous Australians who had a BMI indicating overweight or obesity increased with age, ranging from 42% for those aged 15–17 to 80%–82% for those aged 35 and over (ABS 2019) (Figure 5.9).

**Figure 5.9: Proportion of Indigenous Australians aged 15 and over who were overweight or obese, by sex, and by age group, 2018–19**



Source: National Aboriginal and Torres Strait Islander Health Survey 2018–19.

For further information, see:

- 2.22 Overweight and obesity

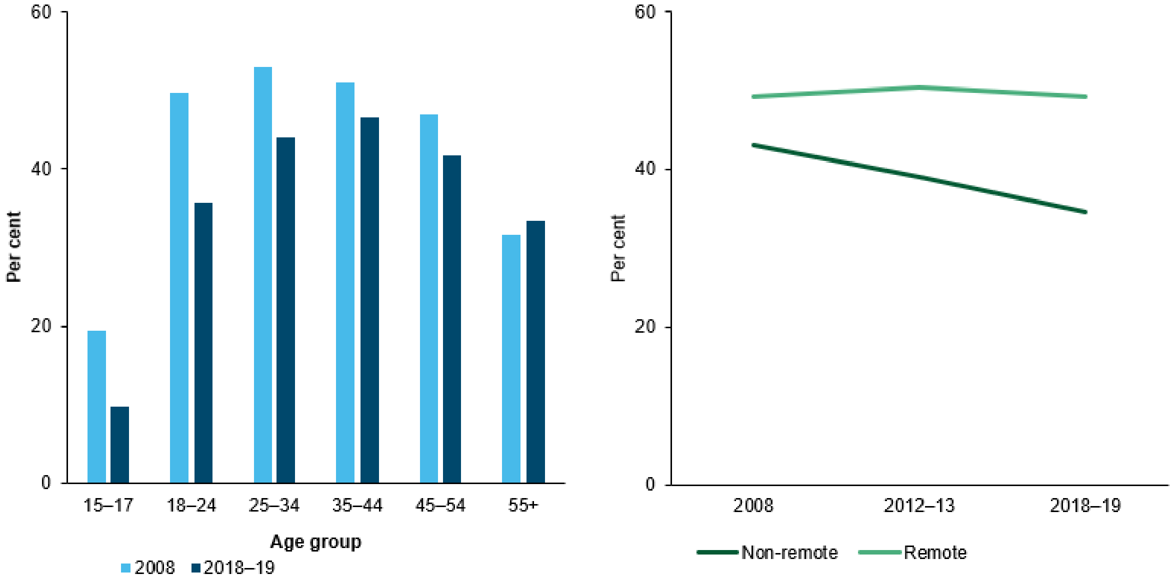
# Tobacco use

Smoking is a major risk factor for cancer, cardiovascular disease, and respiratory disease – in 2018, it accounted for 37% of the burden due to cancer, 34% of the burden due to cardiovascular disease, and 47% of the burden due to respiratory disease (AIHW 2022g). Overall, 12% of the total disease burden experienced by Indigenous Australians in 2018 was attributed to tobacco use.

The proportion of Indigenous Australians aged 15 and over who smoke every day has fallen substantially over the past decade, from 45% (about 145,800 people) in 2008 to 37% (200,400) in 2018–19.

The largest falls in daily smoking rates have occurred among younger Indigenous Australians. In 2018–19, 85% of Indigenous Australians aged 15–17 reported that they had never smoked, compared with 72% in 2008. The decline in daily smoking rates among Indigenous adults has occurred in non-remote areas – there has been no significant change over this period in daily smoking rates among Indigenous adults in remote areas (Figure 5.10).

**Figure 5.10: Indigenous Australians aged 15 and over who were current daily smokers, 2008 to 2018–19**



Source: Measure 2.15, Table D2.15.4 – AIHW and ABS analysis of National Aboriginal Torres Strait Islander Social Survey 2008, Australian Aboriginal and Torres Strait Islander Health Survey 2012–13 and National Aboriginal Torres Strait Islander Health Survey 2018–19.

**Table 5.4: Reasons Indigenous Australians tried to quit or reduce smoking, 2014–15 (% of those who tried to quit smoking in last 12 months)**

| | |
|---|---|
| General health | 73% |
| Cost | 56% |
| To improve fitness | 31% |
| Encouraged by family or friends to quit or reduce | 27% |
| Medical advice | 17% |
| Concerned about effect on others in household | 16% |

Source: Measure 2.15, Table D2.15.11 – AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Social Survey 2014–15.

For further information, see:

- 2.15 Tobacco use

# Alcohol consumption

In 2018–19, about 30% of Indigenous Australians aged 15 and over had not consumed alcohol in the previous 12 months or had never consumed alcohol – 27% in non-remote areas and 41% in remote areas (ABS 2019). The proportion of the Indigenous population who had abstained from alcohol was higher than in the non-Indigenous population.

**Risky alcohol consumption**

The National Health and Medical Research Council (NHMRC) published the latest alcohol guidelines in 2020: drink no more than 4 standard drinks on any one day to reduce alcohol-related injury from a single occasion; and no more than 10 standard drinks per week to reduce alcohol-related disease or injury over a lifetime.

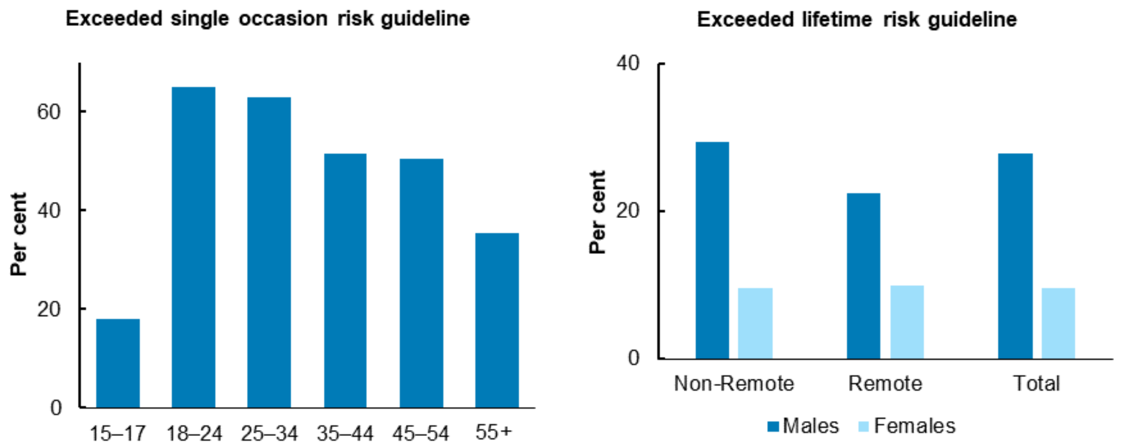
The 2018–19 National Aboriginal and Torres Strait Islander Health Survey reporting of single occasion risk and lifetime risk was based on the NHMRC's previously released guideline in 2009. These were the guidelines that applied at the time the survey was undertaken: no more than 4 standard drinks on a single occasion (single occasion risk) and no more than two standard drinks on any day (lifetime risk). The following reporting of single occasion risk and lifetime risk are based on the 2009 alcohol guideline outlined above.

In 2018–19, 50% of Indigenous Australians aged 15 years and over reported drinking alcohol at levels exceeding the single occasion risk guideline (more than 4 drinks) at least once in the two weeks prior to the survey. This was a decrease of 4 percentage points since 2012–13 (54%).

The proportion of Indigenous Australians aged 18 and over who exceeded the single occasion risk guideline generally decreased with age from 65% of those aged 18–24 to 35% of those aged 55 and over (Figure 5.11). Among those aged 15–17, 18% reported drinking at levels that exceeded the single occasion risk guidelines,

In 2018–19, 18% of Indigenous Australians aged 15 years and over drank at levels that exceeded the NHMRC lifetime risk guidelines that were current at the time the survey was conducted (no more than 2 standard drinks per day on average). A higher proportion of Indigenous males (28%) exceeded the guidelines than Indigenous females (10%) (Figure 5.11).

**Figure 5.11: Risky alcohol consumption among Indigenous adults, 2018–19**



Source: Measure 2.16, Table D2.16.19 – AIHW and ABS analysis of 2018–19 National Aboriginal and Torres Strait Islander Health Survey; Table D2.16.20 – AIHW and ABS analysis of 2018–19 National Aboriginal and Torres Strait Islander Health Survey

In 2014–15, about 1 in 20 (5.9%) Indigenous Australians aged 15 and over in non-remote areas, and 1 in 10 (8.9%) in remote areas, said alcohol-related problems had been a personal stressor for them in the previous 12 months.

For further information, see:

- 2.16 Risky alcohol consumption

# Tier 3 – Health system performance

To provide effective health care, health services must be accessible, responsive, and culturally respectful. Some aspects of health system performance for Aboriginal and Torres Strait Islander people have improved over the last decade. However, there are still barriers to, and disparities in level of, access for Indigenous Australians compared with non-Indigenous Australians.

Barriers to accessing health services for Indigenous Australians include services not being available in their area (especially for those living in remote areas), services being too far away and lack of transport, cost, waiting times, and the availability of culturally safe and responsive health services.

For Aboriginal and Torres Strait Islander people to feel confident and safe in accessing health care, health services should ensure that they provide services equitably, and the level and range of accessible health care should be driven by patient needs. Cultural safety and cultural respect should be an integral part of all health services provided.

**Cultural safety in the health system**

To measure progress in achieving cultural safety in the Australian health system, the AIHW has developed the *Cultural safety in health care for Indigenous Australians: monitoring framework*. This framework looks at 3 elements of cultural safety:

**Culturally respectful health care services** – does provider behaviour, attitude, and culture understand and respect Indigenous Australians and culture, including cultural differences?

**Patient experience of health care** – what are the experiences of Indigenous health care users? Is their cultural identity respected?

**Access to health care services** – do Indigenous Australians have the same level of access to health services as non-Indigenous Australians? **(AIHW 2022e)**.

## Access to primary health care

Primary health care is delivered in community settings, such as general practices, community health centres, Aboriginal health services, and allied health practices like physiotherapy. It is usually people's first point of contact with the health system, and the gateway to specialised health services. There is evidence presented in this report showing that there is a relative lack of access to PHC services in remote areas where health care needs are highest. In addition, 30% of the Indigenous population who reported that they needed to, but did not see a health care provider on at least one occasion in the previous 12 months.

### Use of Indigenous-specific primary health care services

The Australian Government provides funding to organisations to provide culturally appropriate primary health care services to Aboriginal and Torres Strait Islander people.

Indigenous-specific primary health care services are run by Aboriginal Community Controlled Health Organisations (ACCHOs), state/territory or local health services, or non-government organisations.

In 2021–22, there were 211 Commonwealth-funded Indigenous primary health care organisations providing services. An estimated 67% (or 142) were operated by ACCHOs. In

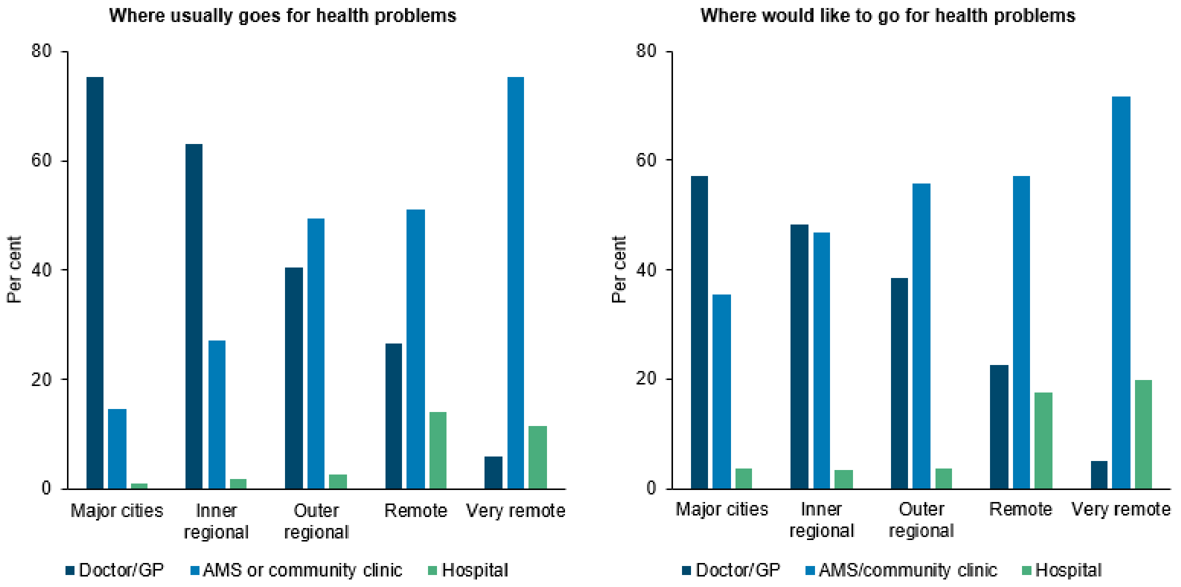
2021–22, organisations provided around 4.0 million episodes of care. Of these services, 84% (3.4 million) were provided to Indigenous clients, and 88% (3.6 million) were provided by ACCHOs (AIHW 2023; AIHW & NIAA 2022).

Although 4 in 5 Indigenous Australians live in *Major cities* and regional areas where mainstream health services are typically located, these services are not always accessible, for geographic, social, and cultural reasons (AIHW 2016). So, Indigenous-specific health services are important providers of comprehensive primary health services for Indigenous Australians living in various locations.

In 2018-19 in *Very remote* areas, 3 in 4 (75%) Indigenous Australians usually went to an Aboriginal Medical Service (AMS) or community clinic (in many cases that might be the only primary health care option available) (Figure 6.1).

In contrast, in *Major cities*, while more than 1 in 3 (35%) Indigenous Australians would like to go to an AMS or community clinic for health problems, fewer than 1 in 6 (15%) usually went to these types of services.

**Figure 6.1: Health service use and preferences among Indigenous Australians, 2018–19**



Source: Measure 3.17, Table D3.17.2 – AIHW and ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19.

For further information, see:

- 3.12 Aboriginal and Torres Strait Islander people in the health workforce
- 3.14 Access to services compared with need
- 3.17 Regular general practitioner or health service

## General practitioner services and health checks

Aboriginal and Torres Strait Islander people have a slightly higher rate of GP service use than non-Indigenous Australians, measured by the number of Medicare claims for GP services.

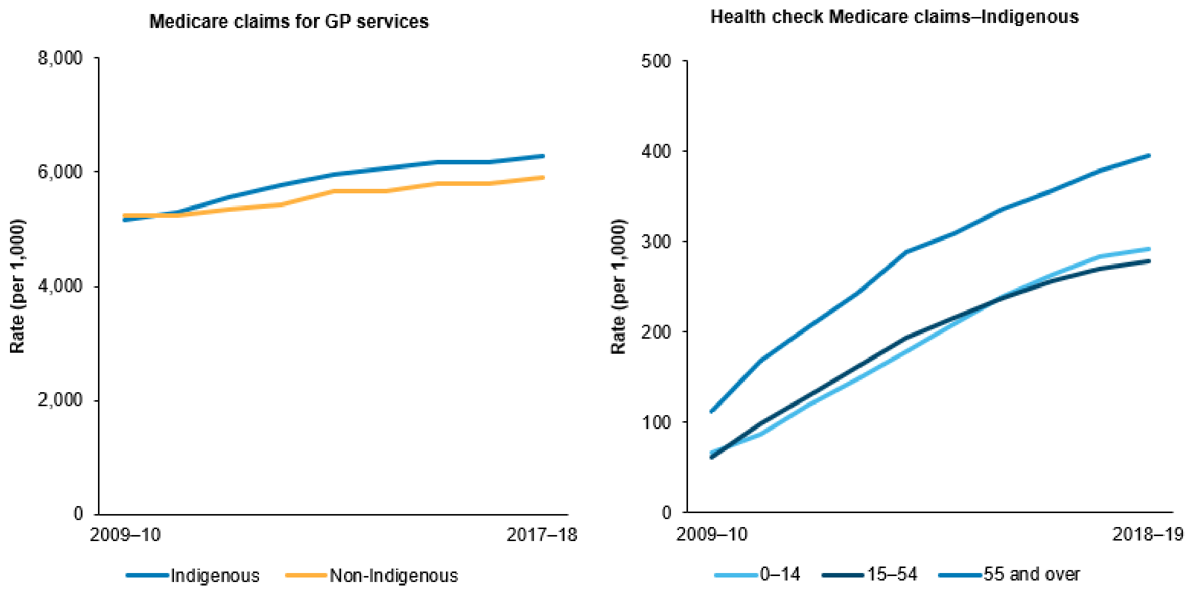
For both Indigenous and non-Indigenous Australians, the rate of GP service use rose over the decade to 2017–18 (Figure 6.2).

The first Indigenous-specific health check, for those aged 55 and over, was introduced in 1999, and health checks for Aboriginal and Torres Strait Islander people of all ages were in place from

May 2006. In May 2010, the frequency of health checks was standardised so that Aboriginal and Torres Strait Islander people of all ages were able to have a health check every year (AIHW 2017).

Between 2009–10 and 2018–19, the number of Indigenous Australians accessing these health checks increased by about fivefold, from 47,283 in 2009–10 to 248,841 in 2018–19. Health check rates increased across all age groups from 68 per 1,000 to 297 per 1,000 population over this period (Figure 6.2).

**Figure 6.2: GP service use (2009–10 to 2017–18) and Indigenous-specific health checks (2009–10 to 2018–19)**



Sources: Measure 3.04 and 3.14, Tables D3.04.5, D3.04.6, D3.04.7, D3.14.20 – AIHW analysis of Medicare Benefits Schedule data.

For further information, see:

- 3.04 Early detection and early treatment
- 3.14 Access to services compared with need

## Child immunisation

Immunisation is highly effective in reducing morbidity and mortality caused by vaccine-preventable diseases. According to the National Immunisation Program Schedule, Australian children are expected to have received specific immunisations by age 1, 2 and 5.

As at December 2022, based on data from the Australian Immunisation Register (AIR), the proportion of Indigenous children who were fully immunised was slightly less than non-Indigenous children for those aged 1 (91% compared with 94%, respectively) and 2 (89% compared with 92%, respectively). However, for those aged 5, the proportion of Indigenous children who were fully immunised was higher than that of non-Indigenous children (96% compared with 94%).

The proportion of Indigenous children aged 1 and 5 who were fully immunised increased from 2013 (86% and 93%, respectively) to 2022 (91% and 96%, respectively), with no statistically significant change for Indigenous children aged 2. While there was an overall improvement in immunisation coverage over the decade for Indigenous children aged 1 and 5, coverage rates decreased between 2020 and 2022, coinciding with the COVID-19 pandemic. The proportion of Indigenous children aged 1 who were fully immunised decreased from 94% in 2020 to 91% in 2022. For Indigenous children aged 5, the proportion who were fully immunised decreased from 97% in 2020 to 96% in 2022.

For further information, see:

- 3.02 Immunisation

## Adult immunisation

As at 31 May 2023, of the 502,765 individuals aged 18 and over within the AIR who identified as being of Aboriginal and/or Torres Strait Islander origin, 7.3% (36,631) had received a COVID-19 vaccination in the previous 6 months, 79% (395,893) had received a COVID-19 vaccination more than 6 months ago, and 14% (70,241) were unvaccinated.

Until recently, data on influenza vaccination coverage had been based on population surveys. Since 1 March 2021, there has been mandatory reporting of influenza vaccines to the AIR. Note that these data may underestimate true coverage, due to under-reporting of adult vaccinations to the AIR, and relatively recent introduction of mandatory reporting (NCIRS 2022).

In 2021, based on data from the AIR, one-quarter (25.0%) of Indigenous Australians aged 6 months and over received an influenza vaccination. Among older Indigenous adults, 43.5% of those aged 50–64 had an influenza vaccination in 2021, as did 64.6% of those aged 65–74, and 67.7% of those aged 75 and over.

In 2018–19, based on survey data, an estimated 32% of Indigenous Australians aged 50 and over had been vaccinated against invasive pneumococcal disease in the last five years, with similar rates in remote and non-remote areas (34% and 32% respectively).

For further information, see:

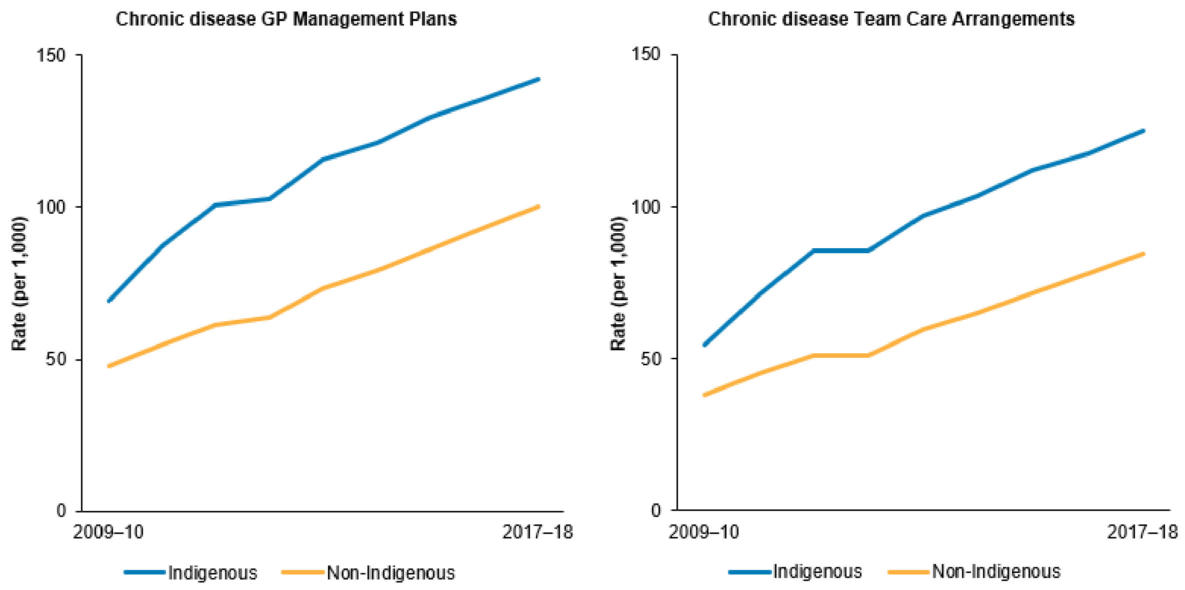
- 3.02 Immunisation

## Chronic disease management

Good quality health care for people with chronic disease often involves multiple providers across multiple settings. The Chronic Disease Management GP services on the Medicare Benefits Schedule enable GPs to coordinate the health care of patients with chronic or terminal medical conditions, including patients who require multidisciplinary, team-based care from multiple providers. The Chronic Disease Management services include general practitioner management plans (GPMPs) and team care arrangements (TCAs).

In general, Indigenous Australians have higher rates of chronic disease than non-Indigenous Australians, and hence, have a higher need for Chronic Disease Management services. Rates of Medicare claims for GPMPs and TCAs have increased steadily 2009–10 (Figure 6.3). The rate of increase has been higher among Indigenous Australians than among non-Indigenous Australians (annual increase in the age-standardised rate of GPMPs and TCAs were 8.5 and 8.2 per 1,000 for Indigenous Australians, compared with 6.5 and 5.7 per 1,000 for non-Indigenous Australians, respectively)

**Figure 6.3: Age-standardised rate of chronic disease GP management plans and team care arrangements, by Indigenous status, 2009–10 to 2017–18**



Source: Measure 3.05, Table D3.05.1 – AIHW analysis of Department of Health Medicare claims data.

For further information, see:

- 3.05 Chronic disease management

## Access to primary health services in different areas

Measuring access to health services is complex. ‘Access’ can include:

- physical access (whether health services with sufficient capacity are located within a certain distance or drive time from where a person lives)
- approachability (awareness of a service and how it impacts health outcomes)
- appropriateness (fit between services and client needs)
- affordability
- cultural acceptability (AIHW 2014b; Levesque et al. 2013; Melbourne Vaccine Education Centre 2022).

The AIHW has modelled how Aboriginal and Torres Strait Islander people’s physical access to primary health care services (Indigenous-specific primary health care services and other GP-based primary health services) varies geographically across Australia (see also AIHW 2014b, 2015b). This modelling can be used to identify areas where access to primary health care services appears to be relatively poor.

Physical access to services was modelled with reference to:

- Indigenous-specific primary health care services, based on drive time to services.
- GP services in general, based on drive time to services, the capacity of GP services, the size of local populations, and their per person need for primary health care.

The need for primary health care was estimated using demographic and socioeconomic characteristics of the local population.

This work shows that, overall, Australian Government-funded Indigenous-specific primary health care services appear to be well positioned relative to the geographic distribution of the Aboriginal and Torres Strait Islander population, and of other GP services. But there are several areas where the Indigenous population has potentially limited access to both Indigenous-specific services and GP services in general.

In total, 29 medium-sized areas were estimated to have at least 200 Indigenous Australians with no Indigenous-specific primary health care services within one hour's drive and relatively poor access to GP services based on drive times and local population needs. Table 6.1 shows the number of areas in each state/territory and remoteness classification while specific areas are shown in Table 6.2. The areas are Statistical Areas Level 2 (SA2s) as described in the Australian Statistical Geography Standard (ASGS) (ABS 2016c). With populations generally ranging from 3,000 to 25,000 people, SA2s are designed to reflect communities that interact socially and economically.

Identifying areas based on the number of people in them with poor access rather than on average access for the whole area is a different approach to earlier reports (AIHW 2015b) and gives somewhat different results. This approach ensures that areas that have relatively good average access but also have substantial numbers of people with poor access are not overlooked.

**Table 6.1: Number of areas with potentially poor access to primary health care services, by state/territory and predominant remoteness classification, 2018**

| | Number of areas by predominant remoteness classification[(a)(b)(c)] | | |
|---|---|---|---|
| **State/territory** | **Inner and Outer Regional** | **Remote and Very Remote** | **Total** |
| New South Wales | 7 | 1 | 8 |
| Queensland | 4 | 4 | 8 |
| Western Australia | 2 | 6 | 8 |
| South Australia | – | 1 | 1 |
| Tasmania | 1 | – | 1 |
| Northern Territory | – | 3 | 3 |
| **Australia** | **14** | **15** | **29** |

(a) Areas correspond to the Australian Bureau of Statistics' SA2 boundaries (see Table 6.2 for detailed list).

(b) Predominant remoteness classification based on the distribution of the Indigenous populations identified as having potentially poor access.

(c) None of the identified areas were part of Victoria or the ACT, nor were any of the areas predominantly classified as Major Cities in terms of Remoteness.

Source: AIHW analyses.

### Table 6.2: SA2s with potentially poor access to primary health care services, 2018

| State/territory | SA2 name (code) | Estimated Indigenous population with low access to GPs and no ISPHCS within 1 hour's drive[(a)(b)(c)(d)] |
|---|---|---:|
| NSW | Young (101061543) | 555 |
| NSW | Lithgow Region (103031071) | 285 |
| NSW | Narrabri (110031197) | 270 |
| NSW | Mudgee Region - West (103031074) | 260 |
| NSW | Bourke - Brewarrina (105011092) | 250 |
| NSW | Young Region (101061544) | 215 |
| NSW | Mudgee Region - East (103031073) | 210 |
| NSW | Scone Region (106041129) | 210 |
| QLD | Central Highlands - East (308011190) | 670 |
| QLD | Broadsound - Nebo (312011338) | 360 |
| QLD | Gympie Region (319031514) | 295 |
| QLD | Barcaldine - Blackall (315031408) | 290 |
| QLD | Cape York (315011396) | 275 |
| QLD | Cooloola (319031511) | 275 |
| QLD | Mount Isa Region (315021406) | 205 |
| QLD | Collinsville (312011340) | 205 |
| WA | Ashburton (510031271) | 820 |
| WA | Derby - West Kimberley (510011263) | 755 |
| WA | East Pilbara (510021267) | 560 |
| WA | Brookton (509031246) | 405 |
| WA | Cunderdin (509021237) | 325 |
| WA | Kununurra (510011265) | 320 |
| WA | Exmouth (511021277) | 250 |
| WA | Halls Creek (510011264) | 250 |
| SA | Outback (406021141) | 255 |
| TAS | North West (604031094) | 355 |
| NT | West Arnhem (702031061) | 670 |
| NT | Sandover - Plenty (702011052) | 410 |
| NT | Thamarrurr (702031059) | 225 |

(a) With regards to this analysis, low access to GPs was defined by an AIHW Access score of less than 7 (for comparison, the average Access score measured for Sydney's residents was ~10.5). This analysis is part of a forthcoming AIHW publication. Previous analysis related to this can be found in the 'Access to primary health care relative to need for Indigenous Australians' report (AIHW 2014).

(b) Indigenous-specific primary health care services (ISPHCSs) included in this analysis correspond to clinical services funded by the Department of Health's Indigenous Australians' Health Programme that reported a GP workforce in the 2017–18 Online Services Report.

(c) Indigenous populations were estimated for small geographic areas (SA1) by the AIHW for years 2016 to 2018 using Iterative Proportional Fitting with available ABS data. The analysis in this table refers to 2018 population estimates (rounded to the nearest 5 persons).

(d) The results shown include only SA2s where a sum of at least 200 Indigenous Australians live in SA1s with access scores below 7 and who seem to live further than 1 hour's drive from an ISPHCS clinic, based on simplified representation of peoples' usual addresses, and drive-times calculated with Pitney Bowes' MapInfo RouteFinder software.

Notes

1. These areas have been identified based on supporting analysis, which may be subject to small changes.

2. Areas are identified by two mechanisms. 1. The AIHW's access scores, which are derived from several estimated data inputs, including GP capacities, population sizes, population distribution, per capita need, drive-times, as well as modelling parameters. Uncertainties in all of these inputs affect the quality of the results. 2. The location of Indigenous-specific primary health care services (ISPHCSs). Due to data gaps, some relevant service locations may not have been included and other service locations may have been included that do not offer clinical services.

3. A small number of areas were removed from the list due to known data issues or the opening of new ISPHCS clinics.
Sources: AIHW analyses; Online Services Report (2017–18).

For further information, see:

- 3.14 Access to services compared with need

# Preventable hospitalisations

**Potentially preventable hospitalisations**

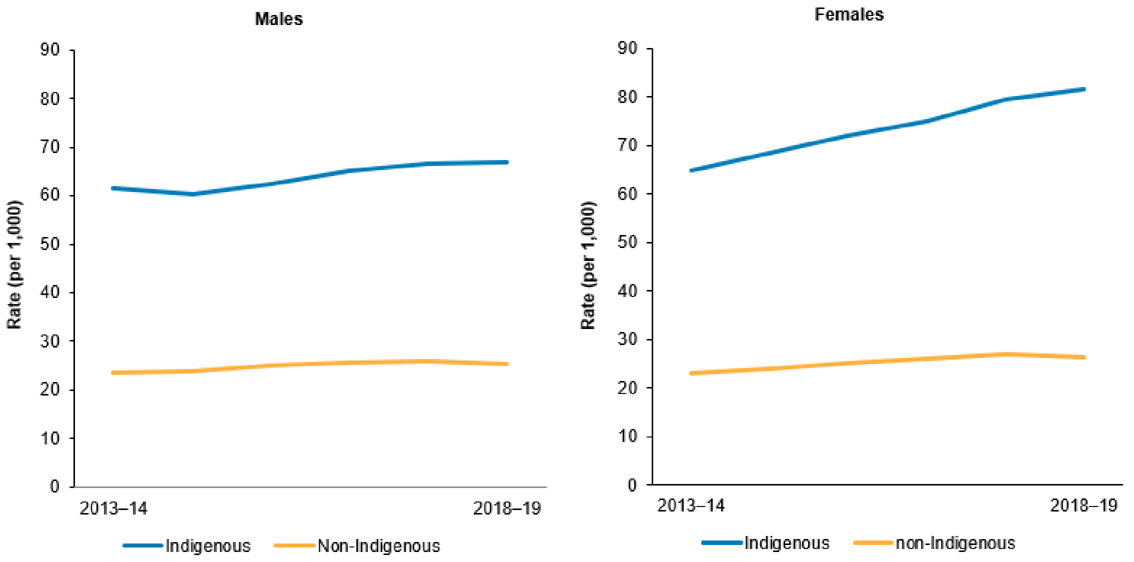
Potentially preventable hospitalisations signal an unmet need for primary health care. They are hospital admissions that could have been avoided through preventive measures like vaccination, or through timely and effective diagnosis and treatment outside the hospital setting.

From July 2017 to June 2019, 92,019 hospitalisations of Aboriginal and Torres Strait Islander people were potentially preventable. This equates to a rate of 55 potentially preventable hospitalisations per 1,000 Indigenous Australians.

After adjusting for differences in the age-structure between the two populations, the rate of potentially preventable hospitalisations for Indigenous Australians was 2.8 times as high as the rate for non-Indigenous Australians.

The age-standardised rate of preventable hospitalisations among Indigenous Australians has increased since 2013–14 for both Indigenous males and Indigenous females (Figure 6.4).

**Figure 6.4: Preventable hospitalisation rates (age-standardised), by Indigenous status and sex,2013–14 to 2018–19**

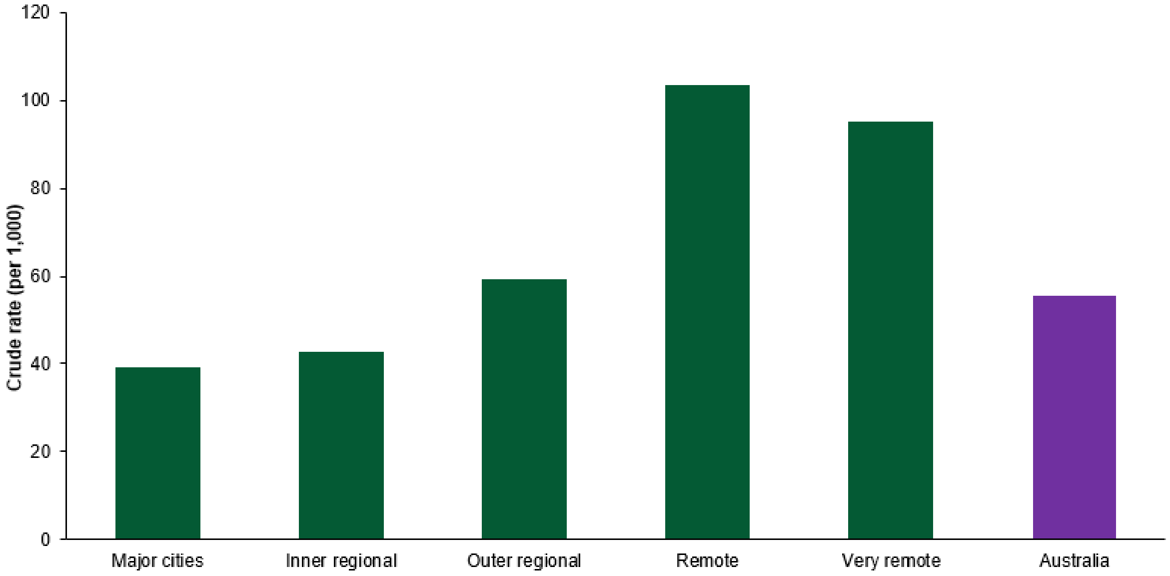


Note Comparable data prior to 2013–14 is not available.

Source: Measure 3.07, Table D3.07.11 – AIHW analysis of National Hospital Morbidity Database.

Among Indigenous Australians in 2017–19, the rate of potentially preventable hospitalisations was highest for those living in *Remote* areas (104 hospitalisations per 1,000 population), followed by those in *Very remote* areas (95 per 1,000). The rate was lowest for those in *Major cities* (39 per 1,000) (Figure 6.5).

**Figure 6.5: Preventable hospitalisations by remoteness area, Indigenous Australians, July 2017 to June 2019**



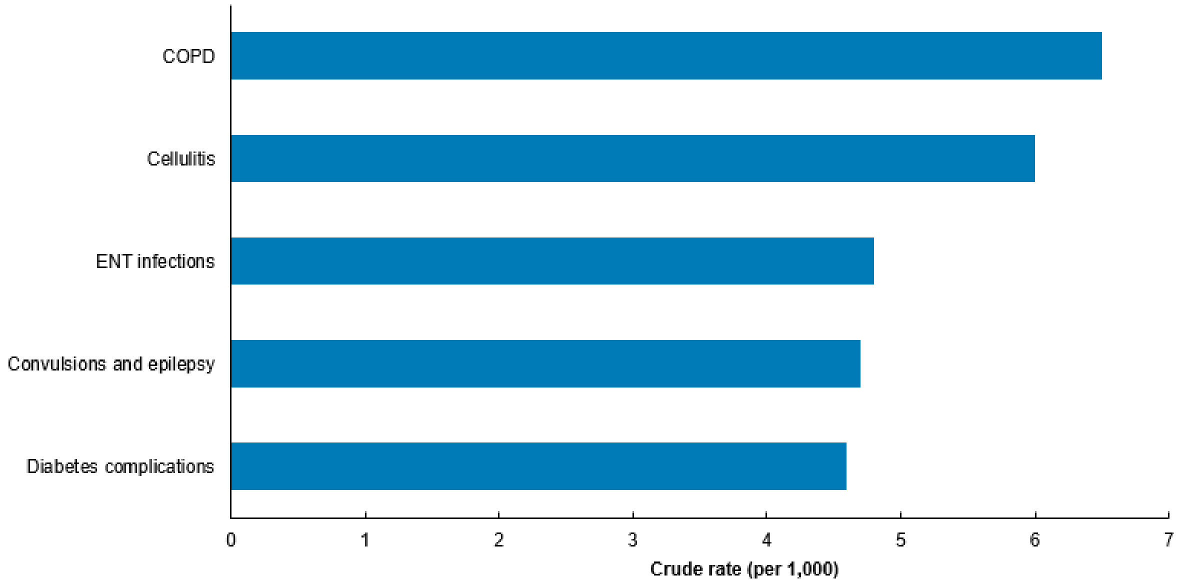
Note: ‘Remote’ excludes remote Victoria.

Source: Measure 3.07, Table D3.07.3 – AIHW analysis of National Hospital Morbidity Database.

From July 2017 to June 2019, the top 5 causes of potentially preventable hospitalisations among Indigenous Australians accounted for almost half (48% or 44,192) of all potentially preventable hospitalisations. These included:

- 10,810 (12%) chronic obstructive pulmonary disease (COPD) hospitalisations (6.5 per 1,000)
- 9,954 (11%) hospitalisations for cellulitis – a bacterial skin condition (6 per 1,000)
- 7,990 (8.7%) hospitalisations for ENT infections (4.8 per 1,000)
- 7,774 (8.4%) hospitalisations for convulsions and epilepsy (4.7 per 1,000)
- 7,664 (8.3%) hospitalisations for diabetes complications (4.6 per 1,000) (Figure 6.6).

**Figure 6.6: Top 5 causes of potentially preventable hospitalisations among Indigenous Australians, July 2017 to June 2019**



Source: Measure 3.07, Table D3.07.5 – AIHW analysis of National Hospital Morbidity Database.

After adjusting for differences in the age-structure between the two populations, the rate of hospitalisations for the top 5 potentially preventable conditions was higher for Indigenous Australians than non-Indigenous Australians (ranging between 2.1 and 5.1 times as high).

For further information, see:

- 3.07 Selected potentially preventable hospital admission

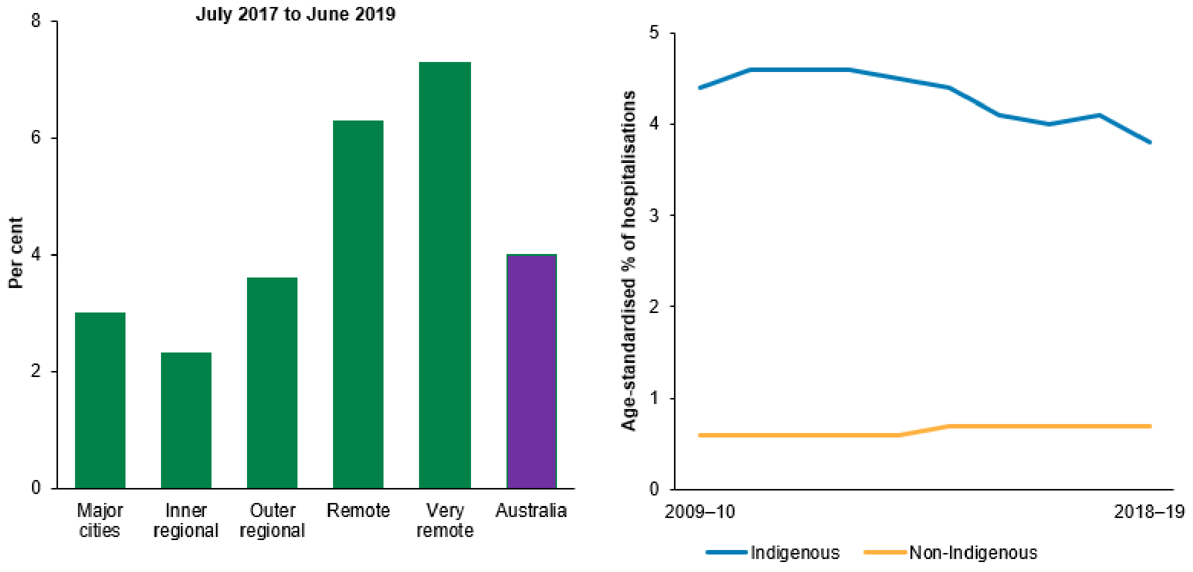
# Discharge against medical advice

People who leave hospital before completing treatment provides indirect evidence of how well hospital services are meeting patients’ needs.

Nationally, 24,278 Aboriginal and Torres Strait Islander hospitalisations for Indigenous patients were discharged at their own risk between July 2017 and June 2019. In general, the proportion of hospitalisations for Indigenous Australians where the patient was discharged at their own risk increased with remoteness of usual residence (ranging from 3% of all hospitalisations for people living in *Major cities* to 7.3% in *Very remote* areas), the exception being for those living in *Inner regional* areas who were the least likely to leave at their own risk (2.3%) (Figure 6.7).

Over the decade 2009–10 to 2018–19, in the six jurisdictions with adequate Indigenous identification in hospitals data over the period considered (NSW, Vic, Qld, WA, SA and NT), the age-standardised proportion of hospitalisations for Indigenous Australians ending with discharge at own risk declined from 4.4% to 3.8%. In contrast, the age-standardised proportion for non-Indigenous Australians increased from 0.6% to 0.7%. However, these changes were not statistically significant (Figure 6.7).

**Figure 6.7: Proportion of hospitalisations (excluding dialysis) where the patient was discharged at own risk, for Indigenous Australians by remoteness area (crude proportion, July 2017 to June 2019), and by Indigenous status (age-standardised, 2009–10 to 2018–19)**



Note: Graph showing trend over time (right hand side) is data from NSW, Vic, Qld, WA, SA and NT combined.
Sources: Measure 3.09, Table D3.09.4 and Table D3.09.6 – AIHW analysis of National Hospital Morbidity Database.

For further information, see:

- 3.09 Discharge against medical advice

# Access to hospital procedures

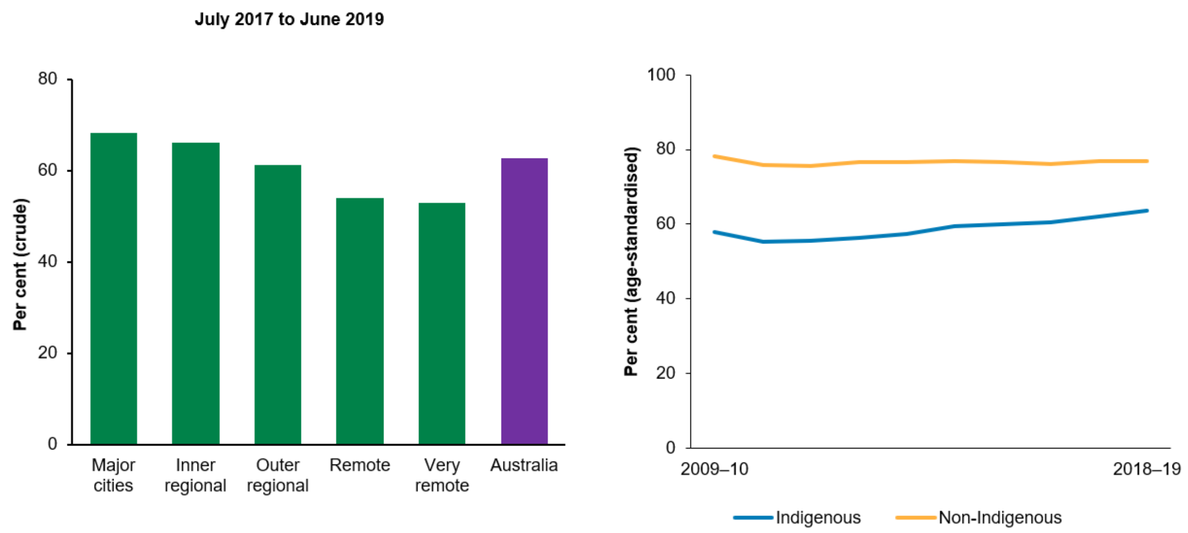
Aboriginal and Torres Strait Islander people are more likely to be hospitalised than non-Indigenous Australians, but are less likely to receive a medical or surgical procedure while in hospital.

Over the period July 2017 to June 2019, there were 385,020 hospitalisations (excluding dialysis) for Indigenous Australians where a medical or surgical procedure was recorded, and 15,231,823 for non-Indigenous Australians. After adjusting for differences in the age structure between the two populations, Indigenous Australians were 0.8 times as likely to have a medical or surgical procedure recorded than non-Indigenous Australians (63% compared with 77%).

For Indigenous Australians, the proportion of hospitalisations where a procedure was recorded decreased as remoteness of usual residence increased, declining from 68% in *Major cities* to 53% in *Very remote* areas (Figure 6.8).

Between 2009–10 and 2018–19, in the six jurisdictions with adequate Indigenous identification (NSW, Vic, Qld, WA, SA and NT), the age-standardised proportion of hospitalisations where a procedure was recorded increased by 14% for Indigenous Australians, with no significant change for non-Indigenous Australians (Figure 6.8).

**Figure 6.8: Proportion of hospitalisations that included a procedure, for Indigenous Australians by remoteness area (crude proportion, July 2017 to June 2019), and by Indigenous status (age-standardised, 2009–10 to 2016–17)**



Note: Graph showing trend over time (right hand side) includes data from NSW, Vic, Qld, WA, SA and NT combined. The graph by remoteness includes data for all states and territories.
Sources: Measure 3.06, Table D3.06.1 and Table D3.06.11 – AIHW analysis of National Hospital Morbidity Database.

For further information, see:

- 3.06 Access to hospital procedures

# Health expenditure

Health expenditure is defined as spending on health goods and services by all levels of governments as well as non-government entities such as individuals, private health insurers, and injury compensation insurers, which includes hospitals (both public and private); primary health care (unreferred medical services, dental services, other health practitioners, community health, public health, and medications); referred medical services; other services (patient transport services, aids and appliances, and administration); research; and capital expenditure ((AIHW 2022c)).

Health expenditure should reflect the relative need for health services – it should be higher for population groups with higher levels of need (AHMAC 2016; Whitehead 1991). One way to assess this is to compare differences in health status with differences in per person health expenditure.

This section presents information on health expenditure for Aboriginal and Torres Strait Islander people, with the exception of expenditure on medications as this information is not currently available by Indigenous status.

The burden of disease and overall death rates for Aboriginal and Torres Strait Islander people are more than twice those of non-Indigenous Australians. In 2019–20, the average amount of money per person spent on health for Indigenous Australians, excluding medications, was $9,619, of which $5,244 (55%) was spent on hospital services. The average health expenditure per person for Indigenous Australians was 1.5 times as high as for non-Indigenous Australians.

**Table 6.3: Average health expenditure per person (excluding medications), 2019–20[a][b]**

| | Indigenous | Non-Indigenous | Ratio Indigenous to non-Indigenous |
|---|---|---|---|
| Hospitals | $5,244 | $3,227 | 1.6 |
| Medicare services | $1,162 | $1,156 | 1.0 |
| Community health services | $1,270 | $367 | 3.5 |
| Dental services | $396 | $376 | 1.1 |
| Patient transport services | $365 | $173 | 2.1 |
| **Total health expenditure (excluding medications)[b][c]** | $9,619 | $6,473 | 1.5 |

(a) Not age-standardised

(b) Table excludes medications, as expenditure on medications by Indigenous status is not currently available. Ordinarily, this would include funding for the Pharmaceutical Benefits Scheme, Repatriation Pharmaceutical Benefits Scheme and other pharmaceutical related funding (such as under-copayment drugs, private scripts, over the counter medications and other schemes).

(c) Includes other health expenditure items not listed separately here, except medications – see Measure 3.21, Table D3.21.1.

Source: Measure 3.21, Table D3.21.1 – AIHW Health Expenditure Database.

Between 2010–11 and 2019–20, Australian Government health expenditure per person for Indigenous Australians increased by 7.3% per year in real terms, from $2,269 to $4,295 per person (excluding expenditure on medications)

Expenditure by the Australian Government on health services tailored to the needs of Indigenous Australians increased from $703 million in 2010–11¬ to $972 million in 2019–20, a growth 38%. In real terms, expenditure increased $716 to $923 million (29% increase).

For further information, see:

- 3.21 Expenditure on Aboriginal and Torres Strait Islander health compared with need

# Aboriginal and Torres Strait Islander health workers

It is the responsibility of the whole health system to provide culturally appropriate health care for Australians from diverse backgrounds. Increasing the representation of Aboriginal and Torres Strait Islander people in the health workforce is one way to improve access to culturally appropriate health services for Indigenous Australians (AHMAC 2016).

In the 2021 Census of Population and Housing, around 16,700 (3.1%) Indigenous Australians aged 15 and over were employed in health-related occupations. Between 2011 and 2021, the number of Indigenous Australians aged 15 and over employed in health-related occupations increased from about 8,800 to about 16,700 people. As a population rate, for Indigenous Australians aged 15 and over, this corresponds to an increase from 255 Indigenous Australians working in health-related occupations per 10,000 population, to 309 per 10,000 population.

The National Registration and Accreditation Scheme regulates 16 health professions across Australia: Aboriginal and Torres Strait Islander Health Practitioners, Chinese Medicine Practitioners, Chiropractors, Dental Practitioners, Medical Practitioners, Medical Radiation Practitioners, Nurses, Midwives, Occupational therapists, Optometrists, Osteopaths, Paramedics, Pharmacists, Physiotherapists, Podiatrists, and Psychologists (AHPRA 2022). People may be registered in more than one health profession.

The National Health Workforce Data Set contains data on these registered health professionals. It shows that in 2021 there were 9,274 Indigenous Australians registered as health professionals. This included 792 registered Aboriginal and Torres Strait Islander

Health Practitioners. Relative to population size, Indigenous Australians were employed in registered health professions at a rate that was about one-third that of non-Indigenous Australians – 89 compared with 267 per 10,000 population respectively. Across registered health professions, the largest absolute gap in rates between Indigenous and non-Indigenous Australians was among nurses and midwives (rate difference of 87 per 10,000), followed by medical practitioners (37 per 10,000 population).

In 2021, there were 7,107 enrolments of Indigenous students in Vocational Education and Training (VET) health-related courses in 2021, 77% of which were for females. Indigenous students completed 1,772 VET health-related courses in 2021. The most common courses were in public health (804 course completions) and nursing (229 course completions). There were 304 VET qualifications completed in Aboriginal and Torres Strait Islander health worker occupations.

Between 2001 and 2018, the enrolment rates for Indigenous students in health-related courses in the higher education sector increased from 27 to 61 per 10,000 population (157% increase, based on linear regression), and completion rates increased from 5 to 11 per 10,000 population (134%). In 2018, the completion rate for Indigenous students studying health-related courses was 81% compared with 92% for non-Indigenous students.

For further information, see:

- 3.12 Aboriginal and Torres Strait Islander people in the health workforce
- 3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines

# Barriers to accessing health services

In 2018–19, 30% (243,700) of Aboriginal and Torres Strait Islander people reported that they needed to, but did not see a health care provider on at least one occasion in the previous 12 months. Among those who did not see a health care provider when they needed to, the following reasons were given (more than one reason could be provided):

- 36% said they were too busy – higher in non-remote areas at 37%, compared with 30% in remote areas.
- 34% said cost was a factor – higher in non-remote areas at 36%, compared with 21% in remote areas.
- 23% said they disliked the service, or were embarrassed or afraid – higher in non-remote areas at 24%, compared with 15% in remote areas.
- About 1 in 3 (33%) said reasons related to service availability and/or transport/distance:
  - waiting times were too long or the service was not available at the time required (21%)
  - they did not have transport or the service was too far away (13%)
  - the service was not available in their area (7%) – higher in remote areas at 22%, compared with 4.7% in non-remote areas.

Among Indigenous Australians who did not see a health care provider when they needed to, the proportion who said this was due to reasons related to service availability and/or transport/distance was higher in remote areas than non-remote areas (54% compared with 29%).

In 2018–19, about 1 in 8 (13% or 102,000) Indigenous Australians did not go to the doctor when they needed to. A larger proportion of those living in non-remote areas (14%) did not go to the doctor when they needed to, compared with those in remote areas (8%).

Reasons most commonly reported for not going to the doctor when needed were similar in non-remote and remote areas, though logistic reasons were greater barriers in remote areas and personal reasons were greater barriers in non-remote areas. The greatest difference between remote and non-remote areas were:

- deciding not to seek care – 31% in non-remote areas, and 9.3% in remote areas
- service not available in area – 0.9% in non-remote areas, and 10% in remote areas.

About 1 in 5 (19% or 146,700) Indigenous Australians did not go to the dentist when they needed to. A larger proportion of those living in non-remote areas (20%) did not go to the dentist when they needed to than those in remote areas (15%).

Cost was the main barrier to going to the dentist for those in non-remote areas (44%). For those in remote areas who did not go to the dentist when they needed to, cost was also an important factor (29%). Other key barriers included:

- disliking service/professional, embarrassed or afraid (23% in non-remote areas compared with 13% in remote)
- waiting time too long or not available at time required (13% in non-remote areas compared with 24% in remote areas).

For further information, see:

- 3.14 Access to services compared with need

# For more information

This summary report presents a small selection of key findings drawn from the full set of information compiled for reporting against the Indigenous Health Performance Framework (HPF).

The detailed findings and data are presented across the HPF website, including:

- comprehensive national, and state and territory reporting
- supplementary data tables
- interactive data visualisations.

The Measures section of the website provides a full list of HPF measures with links to the associated webpages.

## Data sources and limitations

The report draws on data from various sources, and the reference period reported varies between topic areas.

There are well-documented limitations with the availability and quality of data about the health of Aboriginal and Torres Strait Islander people. These include:

- the quality of data on all key health measures, including mortality and morbidity
- uncertainty about the size and composition of the Aboriginal and Torres Strait Islander population
- a lack of data on other health issues, such as access to health services.

In some cases, national data are based on combined information from states/territories with data of adequate quality, as specified.

Technical notes and information about data sources and quality is available from the Resources section of the website, including Data sources and quality, Data development and Statistical terms and methods.

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The *Aboriginal and Torres Strait Islander Health Performance Framework summary report* summarises the latest information on how Indigenous Australians are faring, drawing from the Health Performance Framework (HPF) measures. Detailed findings, including comprehensive national, and state and territory reporting, supplementary data tables, and interactive data visualisations, are presented together on a dedicated website, indigenoushpf.gov.au.

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