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Aboriginal and Torres Strait Islander Health Performance Framework



New South Wales 2026 report



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Summary

Aboriginal people are often found to have relatively poorer access to health services than non-Aboriginal Australians in relation to need, for a range of reasons, including barriers such as availability, cost and a lack of culturally appropriate health services. The Health Performance Framework (HPF) highlights that enhanced health services and continued improvement in, and access to, comprehensive, culturally appropriate and safe primary health care services are needed to support improvements in health outcomes and reduce the burden of disease, preventable hospitalisations, and avoidable deaths among Aboriginal people.

Measures of health status (Tier 1), determinants of health (Tier 2), and health system performance (Tier 3) in this report 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 Aboriginal people may often be best understood by examining relevant measures of determinants of health, and health system performance.

Potentially avoidable deaths	**Cardiovascular disease mortality**	**Perinatal deaths**
There has been no significant change in the age-standardised rate of potentially avoidable deaths for Aboriginal people in New South Wales in the period from 2016 to 2021. However, the rate difference between Aboriginal and non-Aboriginal people in New South Wales increased by 8.5 deaths per 100,000 people annually.	Between 2019 and 2023, cardiovascular disease was the second leading cause of death for Aboriginal people in New South Wales (1,390 deaths or 20% of total deaths). From 2016 to 2023, the age-standardised rate of deaths due to cardiovascular disease for Aboriginal people in New South Wales did not change significantly.	The perinatal death rate among babies born to Aboriginal women in New South Wales in 2013–2017 was lower than the rate in 2018–2022 (11 compared with 13 per 1,000 births).
Smoking	**Income**	**Year 12 attainment**
The proportion of Aboriginal people aged 15 and over who smoked was 25% in New South Wales in 2022–23, compared with 36% in 2018–19 and with 42% in 2012–13.	In New South Wales the proportion of Aboriginal adults aged 18 and over living in the lower half of the income distribution decreased from 70% in 2006 to 64% in 2021, and the proportion of adults in the lowest-income households decreased from 39% to 30% in the same period.	In New South Wales over the period 2011 to 2021, the proportion of Aboriginal people aged 20–24 who had completed Year 12 or equivalent increased from 54% to 69%. Over the same period the rate difference between Aboriginal and non-Aboriginal people decreased from 32 to 21 percentage points.
Youth justice	**Access to GP or health service**	**Health workforce**
The proportion of Aboriginal youth aged 10–17 under youth justice supervision on an average day in New South Wales decreased by 31% from 2016–17 to 2023–24. Over the same period the rate difference between Aboriginal and non-Aboriginal youth decreased by 4.0 per 10,000 population annually.	In 2022–23, 87% of Aboriginal people in New South Wales had a usual place to go for health problems and advice: 64% usually went to a doctor/GP; 20% usually went to an Aboriginal Medical Services (AMS) or community clinic; and 2% usually went to a hospital.	The rate of Aboriginal people employed in health-related occupations in New South Wales increased by 20% between 2011 and 2021.

1. Introduction

This report provides the latest information on the health and wellbeing of Aboriginal and Torres Strait Islander (Aboriginal) people in New South Wales, compiling key findings from the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) measures.

Since 2006, HPF has provided information about health outcomes, key drivers of health and the performance of the health system for Aboriginal people. The HPF was designed, in consultation with Aboriginal stakeholder groups, to promote accountability, inform policy and research, and foster informed debate about the health of Aboriginal people. The HPF also provides information to support progressive improvements in national goals and targets.

The HPF is made up of 68 measures across 3 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 Aboriginal people (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) in addition to structural factors at play – such as policies, funding, access, and broader social conditions.

The HPF analyses variation within the population of Aboriginal people by age, geography, and other key characteristics, and provides insights through research and evaluations. The HPF also analyses trends across the measures and draws implications for further improvement. This helps identify what is working well and how to better target policy and services to meet the needs of Aboriginal people.

Changes over time cannot be assessed for all measures, as trend data are not available in all cases. It is sometimes 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 determinants of health 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 some insight into changing health outcomes. Many of the HPF measures are interrelated so that progress in one produce benefits across a range of others. For example, reductions in smoking are associated with lower mortality from cardiovascular diseases and a range of cancers, and reducing smoking in pregnant women is associated with healthier birthweight and lower infant and perinatal mortality, indicating the benefits of increased efforts to reduce smoking and to identify and fill service gaps. Improvements in housing can have health, education, employment and other social and economic benefits.

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 additional insight into areas of health and service delivery that are not well captured in routine data. They can show what is working well in communities and services, and where improvements are needed.

Terminology used in this report

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

In this report, Aboriginal and Torres Strait Islander people are referred to as Aboriginal people in recognition that Aboriginal people are the original inhabitants of New South Wales. The NSW Ministry of Health acknowledges Aboriginal people as the traditional custodians of the lands and waters of New South Wales. In this report, the term ‘non-Aboriginal’ is used when referring to non-Indigenous NSW residents/Australians.

Consistent with HPF standard statistical reporting terminology, data tables use ‘First Nations’, ‘non-Indigenous’ and ‘Indigenous status’ as the corresponding terms for ‘Aboriginal’, ‘non-Aboriginal’ and ‘Aboriginal status’ used elsewhere in this report.

In most of the data presented in this report, ‘Aboriginal people’ refers to people who have identified themselves or have been identified by a representative (for example, their parent or guardian), as being of Aboriginal and/or Torres Strait Islander origin. See also Resources and Glossary.

Aboriginal status in many data sets is self-reported by clients, consistent with Aboriginal peoples’ right to self-determination. Whether and how a person chooses to identify may vary across settings and over time and can be influenced by trust, cultural safety, and system and process factors, including how the question is asked and recorded. These factors should be considered when interpreting analyses that use Aboriginal status.

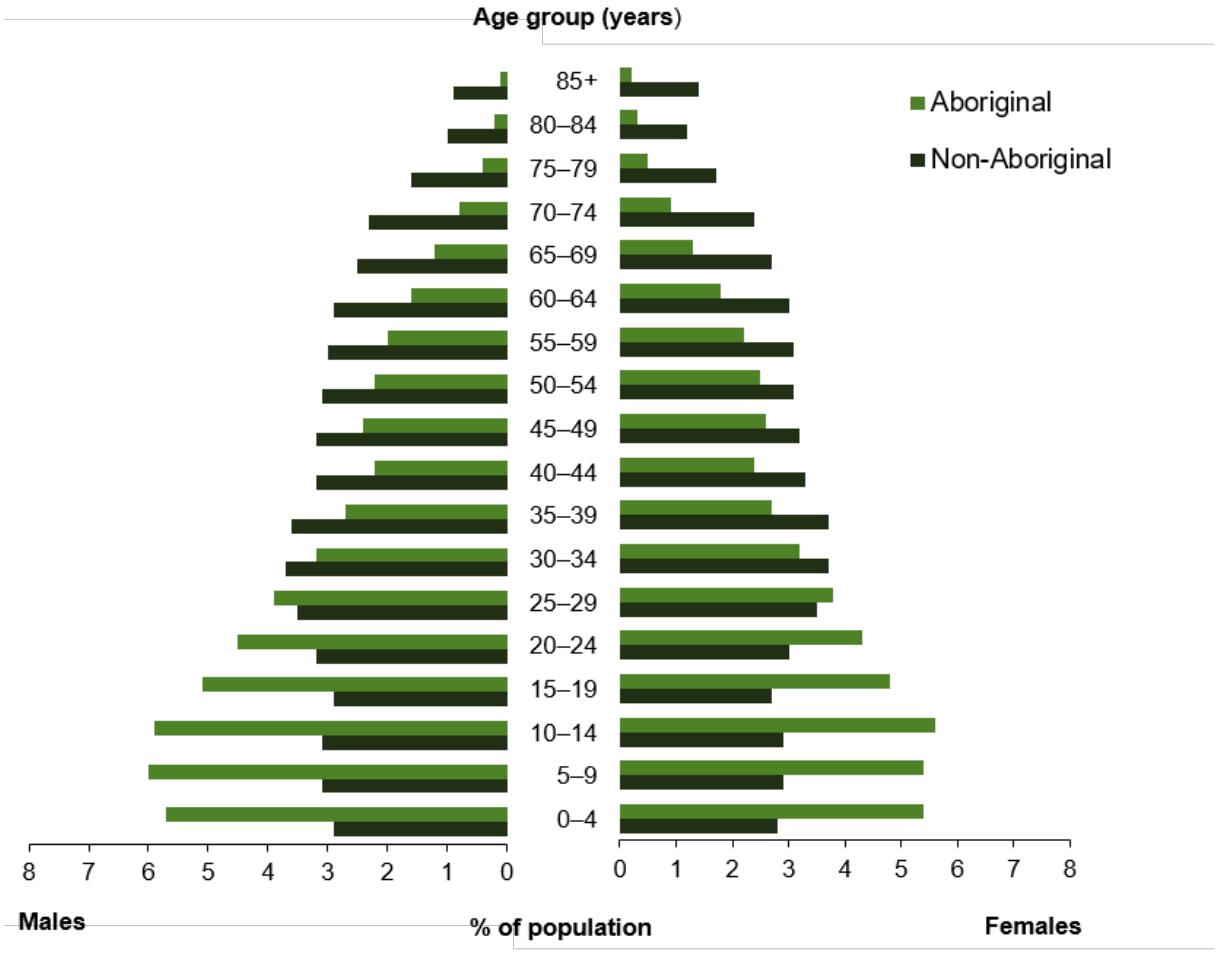
Note that references to ‘Aboriginal people’ in this report refer to Aboriginal and Torres Strait Islander people in Australia only. Where data are compared with those for First Nations people internationally, for clarity, ‘Indigenous peoples’ will be used.

2. Demographic and social context

In 2021, according to official population estimates:

- There were about 340,000 Aboriginal and Torres Strait Islander people in New South Wales, comprising 4.2% of the total state population and 35% of the Aboriginal people nationwide
- 98% of Aboriginal and Torres Strait Islander people in New South Wales were Aboriginal
- 97% of Aboriginal people in New South Wales lived in non-remote areas
- 34% of Aboriginal people in New South Wales were aged under 15
- In New South Wales at 30 June 2021, the Aboriginal population had an age structure that was significantly younger than that of non-Aboriginal New South Wales residents (Figure D1). For example, in New South Wales:
  - people aged under 15 accounted for 34% of the Aboriginal population compared with 18% of non-Aboriginal New South Wales residents
  - people aged 65 and over comprised 5.9% of the Aboriginal population in New South Wales, compared with 18% of non-Aboriginal New South Wales residents.

Figure D1: Estimated resident population, by Aboriginal status, age and sex, New South Wales, 30 June 2021



Source: AIHW analysis of ABS population estimates based on 2021 Census (Table D3.1 NSW).

Although there have been some important improvements in the health of Aboriginal people in NSW (HealthStats NSW 2026a), Aboriginal people do not always enjoy the same health outcomes or access to healthcare as the non-Aboriginal population. This can be observed across a wide range of morbidity, mortality, service usage and patient experience indicators. Many of these discrepancies can be attributed to the inequities experienced by Aboriginal people and communities in key determinants of health (Bond and Brough 2007; Bourke et al. 2019; Walter 2007), and there is a clear relationship between socioeconomic inequalities and the health gap due to the impacts of intergenerational trauma (AIHW 2018a; HealthStats NSW n.d.).

While acknowledging these inequities is important, a focus on the negative can create barriers to improving health outcomes. Understanding and addressing Aboriginal health and wellbeing priorities requires a focus on the strength and resilience of Aboriginal people.

The Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing identified a range of cultural determinants of health which act as protective factors to enhance resilience, strengthen identity and support good health, and social and emotional wellbeing.

Cultural and social determinants

Cultural factors – connection to Country, family, kinship and community, beliefs and knowledge, cultural expression and continuity, language, self-determination and leadership – can be protective and positively influence Aboriginal 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 on how culture is related to Aboriginal people's health and wellbeing (Mayi Kuwayu 2020; National Centre for Epidemiology and Population Health 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 al. (2014) and Priest et al. (2011)). Colonisation has a fundamental impact on disadvantage and health among Indigenous peoples worldwide, through social systems that maintain disparities (see, for example, Paradies and Cunningham (2012) and Paradies (2016)).

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 and Cunningham 2012).

Between March and May 2017, the Australian Government Department of Health (now Department of Health, Aging and Disability), together with the Advisory Group on the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, led a consultation process (My life my lead) across Australia that examined the role of cultural and social factors on a person's health and wellbeing. These consultations provided an opportunity for Aboriginal communities and leaders, governments, the non-government and private sectors to inform the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (released in December 2021).

National and New South Wales policy context

The National Agreement on Closing the Gap (the National Agreement) commits all Australian state and territory governments to a fundamentally new way of developing and implementing policies and programs that impact the lives of Aboriginal people. To support implementation of the National Agreement and guide the government's actions, the NSW Implementation Plan for Closing the Gap (CtG) sets out the NSW Government's strategies for delivering progress against the National Agreement's Priority Reforms and Socio-Economic Outcomes.

In 2024, NSW Health released the NSW Aboriginal Health Plan 2024–2034 (the Plan). The purpose of the Plan is to drive change to achieve the highest possible levels of health and wellbeing for Aboriginal people in New South Wales by:

- guiding how health systems are planned, delivered, and monitored

- elevating the focus on Aboriginal expertise to drive shared decision-making and innovative collaborations
- influencing the redesign of health services to achieve health equity
- providing direction for the elimination of racism in all aspects of health care.

While the National Agreement and the NSW CtG Implementation Plan cover all government agencies (for example, Health, Education, Justice, Transport and so forth), the NSW Aboriginal Health Plan was influenced by those plans, and adds more nuanced, health-specific strategies to ensure the overarching goals of the National Agreement are realised.

Political and economic context

During 2020, two major events with global effects occurred – the COVID-19 (coronavirus disease 2019) pandemic, and the escalation of the Black Lives Matter movement, with worldwide protests spilling over into Australia (Lo 2021).

The COVID-19 pandemic and response, and the Black Lives Matter movement, have highlighted recurring themes from Aboriginal health and social policy and research in Australia over the past 3 decades, including:

- continuing health inequalities between Aboriginal people and non-Aboriginal Australians. Aboriginal people are at higher risk of experiencing more severe complications from seasonal colds and flu and other viral contagions, including COVID-19, due to higher rates of pre-existing health conditions and challenges in accessing healthcare, particularly in remote areas. Between 2022 and 2024 the age-standardised death rate from COVID-19 for Aboriginal people was 1.5 times the rate for non-Aboriginal people (ABS 2024a).
- broader social inequalities between Aboriginal people and non-Aboriginal Australians, compounded by systemic racism, in areas that affect health, including housing, education, employment, transport, income, and access to adequate health care and other goods and services
- the health and wellbeing impacts on Aboriginal people of police brutality and Aboriginal deaths in custody
- how well the health system serves the needs of Aboriginal people
- how governments can work in partnership and share decision-making with Aboriginal communities and leadership in identifying and responding to health priorities.

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

In 2023 and 2024, Australia was experiencing high levels of inflation, with increased cost of living and higher interest rates impacting housing costs and household disposable income (Reserve Bank of Australia 2024b). Higher inflation has the potential to disproportionately impact the lowest income households and contribute to greater inequality, as lower income households spend a greater proportion of their income on essentials, tend to have fewer savings buffers, and have less scope to adjust spending patterns in response to rising costs (Wood et al. 2023).

On 14 October 2023, Australians voted in a referendum – the first of the 21st century – on whether to amend the Constitution to recognise Aboriginal and Torres Strait Islander peoples through the establishment of an advisory body known as the Aboriginal and Torres Strait Islander Voice. The referendum did not pass. Emerging evidence from New South Wales suggests the period was associated with increased exposure to negative and racist commentary for some Aboriginal people, particularly online, which influenced engagement with media and information (Department of Customer Service n.d.). Racism is recognised as a key determinant of health, contributing to stress, psychological distress, and reduced access to services, and is associated with poorer social and emotional wellbeing among Aboriginal and Torres Strait Islander people (AIHW 2022a; Paradies et al. 2015).

Broader economic and system pressures continue to influence health outcomes and access to services. Rising housing costs and cost-of-living pressures may increase housing stress and reduce capacity to meet basic needs, particularly for lower-income households (AIHW 2025f; Morris 2023; Reserve Bank of Australia 2024a). Health system factors, including access to services, remain key influences on health outcomes for Aboriginal people, with differences in access and availability affecting the use of care (AIHW 2022a).

3. How Aboriginal people in New South Wales are faring

The findings presented in this report highlight both areas of progress and ongoing challenges for Aboriginal people across health outcomes, determinants of health and health system performance.

Selected key measures from each HPF tier presenting Aboriginal people's health outcomes, determinants of health, and health system performance are shown in Figures S1 (6 out of 24 measures), S2 (4 out of 22 measures) and S3 (3 out of 22 measures), respectively. The time trend in the rate for Aboriginal people for each presented outcome is shown, along with change in the gap between Aboriginal people and non-Aboriginal people. This gap is shown using the rate difference – the absolute difference between the two rates.

In New South Wales among Aboriginal people there have been improvements in education, income, early detection, youth justice and some health outcomes, while mortality, imprisonment and several chronic disease outcomes remain areas of concern.

Areas of improvement

- Educational attainment continued to improve. The proportion of Aboriginal people in New South Wales aged 20–24 who had completed Year 12 or an equivalent qualification increased from 54% in 2011 to 69% in 2021, reducing the gap with non-Aboriginal young people.
- Improvements in income have been recorded. Aboriginal adults aged 18 and over in New South Wales were less likely to live in households with relatively low incomes in 2021 than in 2006. The proportion living in the lower half of the income distribution decreased from 70% to 64%, and the proportion living in the lowest-income households decreased from 39% to 30%.
- Youth justice supervision declined substantially in New South Wales. The rate of Aboriginal young people aged 10–17 under youth justice supervision fell by 31% (using linear regression analysis) from 108 per 10,000 in 2016–17 to 80 per 10,000 in 2023–24.

- Access to preventive health care improved in New South Wales. Participation in Aboriginal-specific Medicare health assessments increased from 18% in 2015–16 to 24% in 2023–24, with the largest improvement being among people aged 50 years and over.

Areas requiring continued attention

- Injury and poisoning continue to have a major impact. Between 2019 and 2023 there were 874 deaths, accounting for 13% of all Aboriginal deaths in New South Wales. Aboriginal people died from injury and poisoning at 1.9 times the rate for non-Aboriginal people in this 5-year period.
- Cardiovascular disease remained the second leading cause of death, accounting for 1,390 deaths (20% of all Aboriginal deaths in New South Wales) during 2019–2023. The age-standardised death rate due to cardiovascular disease for Aboriginal people has not changed significantly between 2016 and 2021. However, in the same period the rate difference between Aboriginal and non-Aboriginal people increased by 10 deaths per 100,000 people annually.
- Potentially avoidable death rates remain high. There were 2,762 avoidable deaths among Aboriginal people aged under 75 in New South Wales during 2019–2023. While the age-standardised death rates for Aboriginal people have not changed significantly from 2016 to 2021, the rate difference between Aboriginal and non-Aboriginal people increased by 8.5 deaths per 100,000 people annually between 2016 and 2021.
- Adult imprisonment continued to rise. In 2025, 4,519 Aboriginal adults were in prison custody in New South Wales. The age-standardised imprisonment rate increased by 22% between 2016 and 2025, while rates for non-Aboriginal adults decreased by 24% (based on linear regression analysis).
- Aboriginal children remain over-represented in the child protection system. In 2023–24 in New South Wales, 15,367 Aboriginal children came into contact with child protection services, corresponding to a rate of 110 per 1,000 Aboriginal children compared with 15 per 1,000 non-Aboriginal children in New South Wales. At 30 June 2024, there were 6,312 Aboriginal children in out-of-home care in New South Wales (45 per 1,000 children).
- Potentially preventable hospitalisations remain disproportionately high. From July 2021 to June 2023, Aboriginal people in New South Wales were around twice as likely as non-Aboriginal people to be hospitalised for conditions that may be prevented through timely and effective primary care (40 and 19 per 1,000 population, respectively).

Figure S1: Selected key measures of health status and outcomes for Aboriginal people in New South Wales over time

Measure	Time trend	Change over time: Rate for Aboriginal people	Change over time: Rate difference
Birthweight (measure 1.01)			
No significant change in the proportion of low birthweight births.		--	--
Cardiovascular disease (measure 1.05)			
No significant change in the age-standardised death rate due to cardiovascular disease. The rate difference increased by 10 deaths per 100,000 people annually.		--	⇧
Cancer (measure 1.08)			
Age-standardised rate of deaths due to cancer and other neoplasms increased by 10 deaths per 100,000 people annually. The rate difference increased by 11 deaths per 100,000 annually.		⇧	⇧
Mental health (measure 1.18)			
Age-standardised rate of deaths due to intentional self-harm increased by 25% over the period (0.8 deaths per 100,000 people).		⇧	n.p.
All-cause deaths (measure 1.22)			
Age-standardised rate of all-cause deaths has increased by 22 deaths per 100,000 people annually. Rate difference has increased by 32 deaths per 100,000 people annually.		⇧	⇧
Potentially avoidable deaths (measure 1.24)			
No significant change in the age-standardised rate of potentially avoidable deaths. The rate difference increased by 8.5 deaths per 100,000 people annually.		--	⇧

Figure S2: Selected key measures of determinants of health for Aboriginal people in New South Wales over time

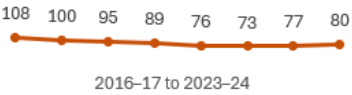
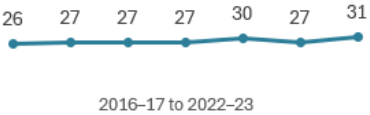
Measure	Time trend	Change over time: Rate for Aboriginal people	Change over time: Rate difference
Education (measure 2.05)			
Proportion of people aged 20–24 who have completed year 12 or equivalent, or attained a non-school qualification at AQF Certificate III or above has increased.		⇧	⇩
Income (measure 2.08)			
The proportion of adults aged 18 and over living in the lowest-income households decreased from 39% to 30%.		⇩	n.a.
Contact with the criminal justice system (measure 2.11)			
The proportion of people aged 10–17 under youth justice supervision on an average day decreased by 31%. The rate difference decreased by 4.0 per 10,000 population annually.		⇩	⇩
Age-standardised rates of adult imprisonment increased by 22% over the period. The rate difference also increased by 28% over this period.		⇧	⇧
Health behaviours during pregnancy (measure 2.21)			
No significant change in the proportion of women who gave birth and smoked tobacco at any time during pregnancy in remote areas.		--	n.a.

Figure S3: Selected key measures of health system performance for Aboriginal people in New South Wales over time

Measure	Time trend	Change over time: Rate for Aboriginal people	Change over time: Rate difference
Early detection and early treatment (measure 3.04)			
The rate of Aboriginal-specific MBS health checks claimed increased by 27% over the period.		⇧	n.a.
Access to mental health services (measure 3.10)			
The age-standardised hospitalisation rate for mental health-related conditions increased by an 13% over the period. However, the rate difference between Aboriginal and non-Aboriginal people also increased over the period		⇧	⇧
Aboriginal and Torres Strait Islander people in the health workforce (measure 3.12)			
The rate of people employed in health-related occupations increased by 20% over the period.		⇧	n.a.

Tier 1 – Health status and outcomes

1.01 Birthweight

Why it is important

This measure reports on birthweight among babies. Birthweight is a key indicator of infant health and a principal determinant of a baby's chance of survival and good health. A healthy birthweight helps to lay the foundations for lifelong health. Babies with birthweights outside the healthy range are at greater risk of illness, poor development, perinatal death, and poorer health in adulthood.

Socioeconomic outcome area 2 under the National Agreement on Closing the Gap monitors healthy birthweight to track the progress on the outcome 'Aboriginal children are born healthy and strong'. The target is to increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91% by 2031. While there are no state and territory targets, the Productivity Commission reports state and territory level progress from the baseline in 2017. In New South Wales, there has been no change in the progress of the proportion of live born singleton babies with healthy birthweight from 2017 to 2023 (Productivity Commission n.d.).

Key findings

Data presented for this measure are based on the Aboriginal status of the baby and refer to singleton live births. A singleton birth is the birth of one baby during a pregnancy. Multiple births are associated with low birthweight and as a result are generally excluded from analysis of birthweight (AIHW 2020a).

In this measure, birthweight is categorised as follows:

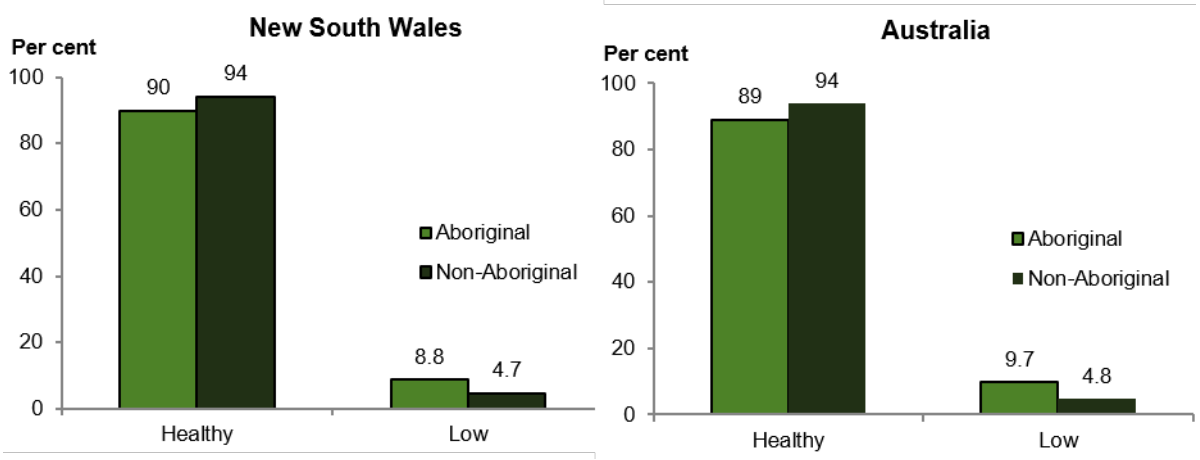
- low birthweight: less than 2,500 grams
- healthy (normal) birthweight: 2,500 to 4,499 grams
- high birthweight: 4,500 grams or more.

Note that these categories do not take into account gestational age. Low birthweight babies may have been born pre-term (that is, before 37 weeks of gestation), or be smaller than expected given the duration of the pregnancy (which is referred to as 'small-for-gestational age'), or be a combination of the two. Similarly, high birthweight babies can be either large-for-gestational age or large but of an appropriate weight for their gestational age.

Birthweight: In New South Wales in 2023, 89.8% (5,754) live born singleton Aboriginal babies were born with a healthy birthweight, while 8.8% (564 babies) had a low birthweight, and 1.4% (88) had a high birthweight. Low birthweight was 1.9 times as common among Aboriginal babies as non-Aboriginal babies in New South Wales (Figure 1.01.1).

Nationally in 2023, 88.9% (17,390) of live born singleton Aboriginal babies were born with a healthy birthweight, and 9.7% (1,895) with a low birthweight. Low birthweight was about twice as common among Aboriginal babies as among non-Aboriginal babies (Figure 1.01.1).

Figure 1.01.1: Live born singleton babies of healthy and low birthweight, by Aboriginal status of the baby, New South Wales and Australia, 2023

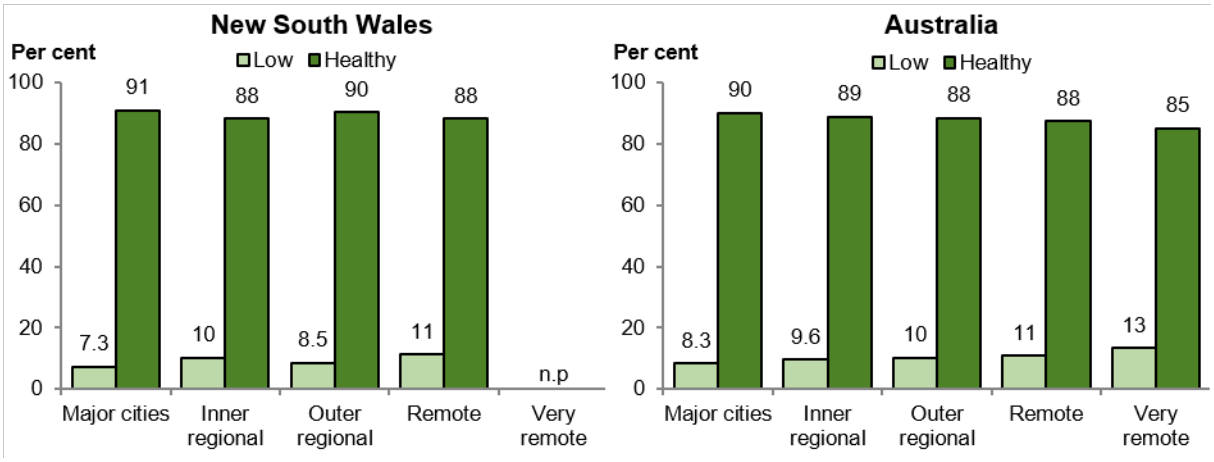


Source: National Perinatal Data Collection (Table D1.01.17).

By remoteness: In 2023 in New South Wales, the proportion of live born singleton Aboriginal babies born with a low birthweight in *Major cities* was 7.3% (205 babies) and in *Remote* areas it was 11.2% (19 babies). The proportion of live born singleton babies with a healthy birthweight was highest in *Major cities* (91%, 2,575) and lowest in *Remote* areas (88%, 151) (Figure 1.01.2).

Nationally in 2023, the proportion of live born singleton Aboriginal babies born with a low birthweight in *Major cities* was 8.3% and in *Very remote* areas it was 13.4%. The proportion of live born singleton babies with a healthy birthweight was highest in *Major cities* (90%) and lowest in *Very remote* areas (85%) (Figure 1.01.2).

Figure 1.01.2: Live born singleton Aboriginal babies of healthy and low birthweight, by remoteness, New South Wales and Australia, 2023

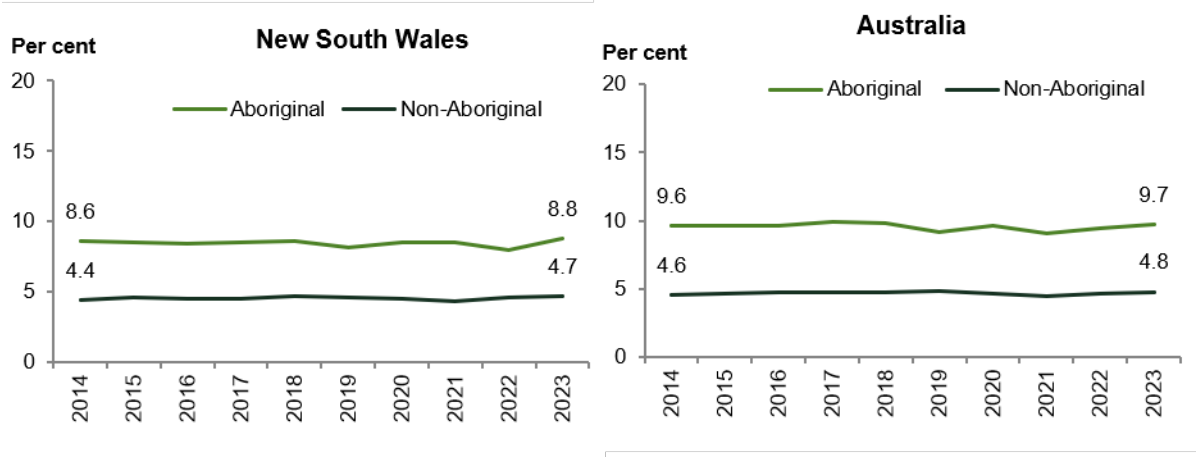


Source: National Perinatal Data Collection (AIHW 2026j, Table 6.7).

Trend over time: Between 2014 and 2023 in New South Wales, the proportion of live born singleton Aboriginal babies born with low birthweight ranged between a low of 8.2% (in 2019) and a high of 8.8% (in 2023). The proportion for non-Aboriginal babies ranged between a low of 4.3% and a high of 4.7% (Figure 1.01.3).

In Australia, the proportion of live born singleton babies born with a low birthweight ranged from a low of 9.1% and a high of 9.9% for Aboriginal babies and from a low of 4.5 and a high of 4.9 for non-Aboriginal babies between 2014 and 2023 (Figure 1.01.3).

Figure 1.01.3: Low birthweight live born singleton babies, by Aboriginal status of the baby, New South Wales and Australia, 2014 to 2023



Source: National Perinatal Data Collection (Table D1.01.20).

1.02 Hospitalisation trends and leading causes

Why it is important

This measure provides an overview of the trends and leading causes of hospitalisations. Hospitalisation rates reflect the occurrence in a population of serious acute illnesses or conditions that require hospital treatment, and the access to and use of hospital treatment by people with such conditions. Hospitalisation rates for a particular disease do not directly indicate the level of occurrence of that disease in the population. Hospitalisation rates are based on the number of hospital care episodes rather than on the number of individual people who are hospitalised. The reporting period (July 2021 to June 2023) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

Overall: In New South Wales, between July 2021 and June 2023, there were 195,805 hospitalisations (excluding dialysis) for Aboriginal people, at a rate of 283 per 1,000 population. After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised (excluding dialysis) at 1.2 times the rate for non-Aboriginal people in New South Wales (353 compared with 301 per 1,000 population).

In the same period, nationally, there were 736,105 hospitalisations (excluding dialysis) for Aboriginal people, a rate of 367 per 1,000 (Table D1.02.1). After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised (excluding dialysis) at 1.3 times the rate for non-Aboriginal people (456 compared with 339 per 1,000 population).

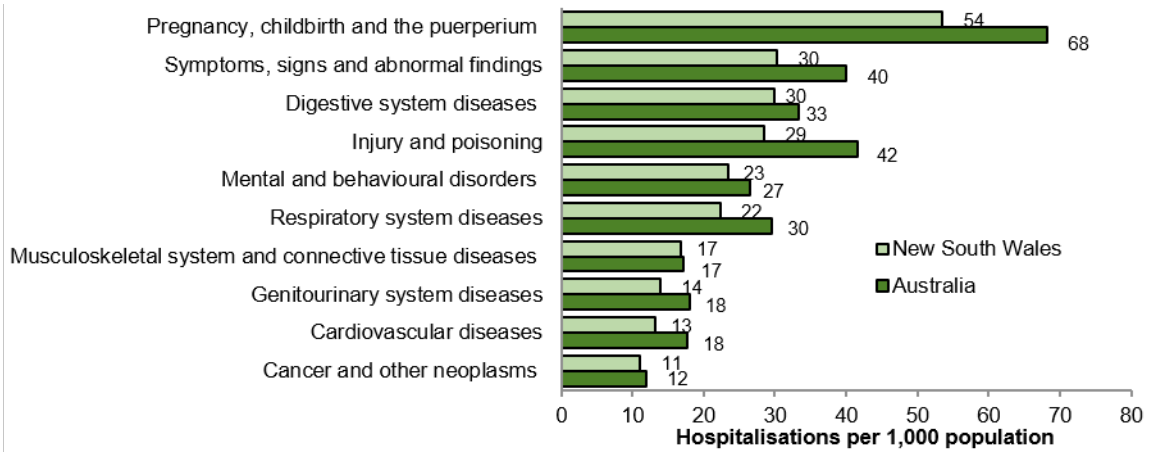
Leading causes for hospitalisation: Between July 2021 and June 2023 in New South Wales, the leading cause of hospitalisation for Aboriginal people was care involving dialysis (88 per 1,000 population) (Table D1.02.5 NSW). After dialysis, the causes with the highest rates of hospitalisation for Aboriginal people were:

- symptoms, signs and abnormal findings not elsewhere classified (30 hospitalisations per 1,000 population): this includes symptoms such as abnormalities of heartbeat, abnormalities of breathing, chest pain, nausea and vomiting, headache, and convulsions that are not attributable to a specific diagnosis based on the information available at the time of the care
- digestive system diseases (30 hospitalisations per 1,000 population): this includes non-infectious, non-malignant chronic diseases of the digestive tract from the oral cavity to the anus, including conditions affecting the oesophagus, stomach, small intestine, large intestine, pancreas, liver and biliary system
- injury, poisoning and certain other consequences of external causes (29 hospitalisations per 1,000 population): this includes falls, complications of medical and surgical care, exposure to inanimate mechanical forces and intentional self-harm.

Pregnancy, childbirth and the puerperium was the leading cause of hospitalisation for Aboriginal women (54 hospitalisations per 1,000 Aboriginal females; puerperium is the 6-week span immediately following childbirth).

The 3 leading causes for hospitalisation for Aboriginal people nationally (excluding dialysis) were ‘injury and poisoning’, followed by ‘symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified’, and then ‘digestive system diseases’, with ‘pregnancy, childbirth and the puerperium’ the leading cause for Aboriginal women (Figure 1.02.1).

Figure 1.02.1: Leading causes of hospitalisation (excluding dialysis) for Aboriginal people, New South Wales and Australia, July 2021 to June 2023



Note: For the category ‘pregnancy, childbirth and the puerperium’ rates are calculated for females only.

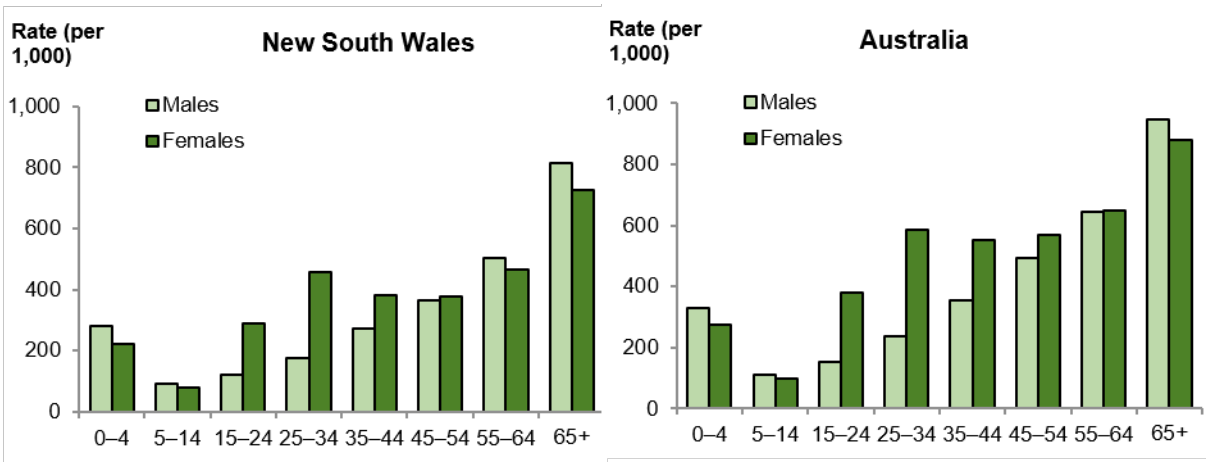
Source: National Hospital Morbidity Database (Table D1.02.5 NSW).

Hospitalisation by age and sex: In New South Wales between July 2021 and June 2023, 57% (110,714) of total hospitalisations (excluding dialysis) among Aboriginal people were for females. Aboriginal females were hospitalised at 1.3 times the rate for Aboriginal males (321 and 245 per 1,000 population, respectively) (Table D1.02.1).

In New South Wales, Aboriginal children aged 0–4 had a hospitalisation rate of 251 hospitalisations per 1,000 population between July 2021 and June 2023. The hospitalisation rate was lowest among those aged 5–14 (85 per 1,000), then increased with age and was highest for those aged 65 and over (767 per 1,000).

In the same period in New South Wales, Aboriginal females had higher hospitalisation rates (excluding dialysis) than Aboriginal males across all age groups between ages 15–54, with a notable spike among females aged 25–34 (456 per 1,000), likely reflecting pregnancy and childbirth related admissions. Aboriginal males had higher hospitalisation rates (excluding dialysis) than Aboriginal females in other age groups (Figure 1.02.2).

Figure 1.02.2: Age-specific hospitalisation rates (excluding dialysis) for Aboriginal people, by sex and age group, New South Wales and Australia, July 2021 to June 2023

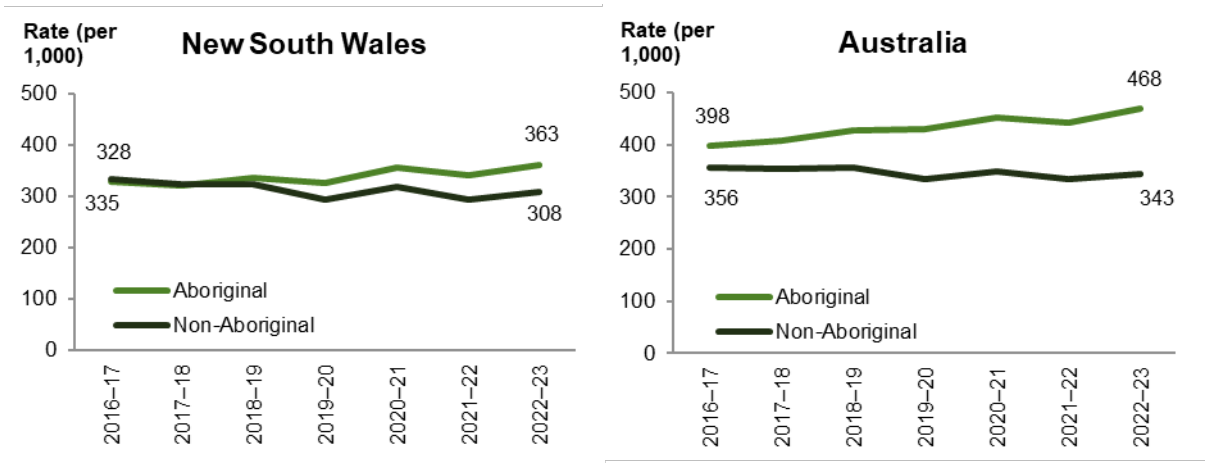


Source: National Hospital Morbidity Database (Table D1.02.2 NSW).

Trend over time: In New South Wales, over the period 2016–17 to 2022–23, after adjusting for differences in the age structure between the two populations, the hospitalisation rate (excluding dialysis) increased by 11% for Aboriginal people and decreased by 9.3% for non-Aboriginal Australians in New South Wales, based on linear regression.

Nationally, over the same period, the age-standardised hospitalisation rate (excluding dialysis) increased by 16% for Aboriginal people and decreased by 5.0% for non-Aboriginal Australians (Figure 1.02.3).

Figure 1.02.3: Age-standardised hospitalisation rates (excluding dialysis), by Aboriginal status, New South Wales and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.02.4 NSW).

1.03 Injury and poisoning

Why it is important

This measure reports on deaths and hospitalisations due to injuries and poisoning. Injuries can cause long-term disability and disadvantage including reduced opportunities in education and employment, communication impairment and burden on caregivers (Stephens et al. 2014).

Nationally, injuries were the second leading cause (13% or 40,037 Disability Adjusted Life Years) of the total disease burden for Aboriginal people in 2022, behind mental and substance use disorders (20%, 64,147 Disability Adjusted Life Years). Injuries were the leading cause of the fatal burden in 2022 (22% of fatal burden) (AIHW 2026k).

The reporting period (July 2021 to June 2023) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

Hospitalisations for injury and poisoning: Only a small proportion of all incidents of injury result in admission to a hospital. For each hospital admission, many more cases present to hospital emergency departments but are not admitted or are seen by a general practitioner. A larger number of generally minor injuries do not receive any medical treatment.

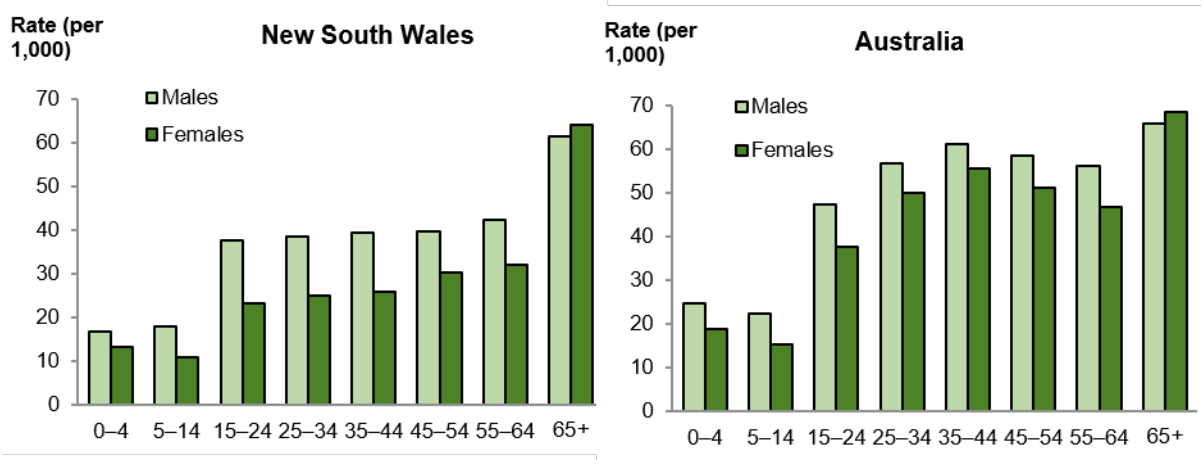
In the period between July 2021 and June 2023, there were 19,720 hospitalisations due to injury and poisoning for Aboriginal people in New South Wales – a crude rate of 29 per 1,000 population. After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised for injury and poisoning at 1.3 times the rate for non-Aboriginal people in New South Wales.

Nationally in the same period, there were 83,503 hospitalisations due to injury and poisoning for Aboriginal people – a rate of 42 per 1,000 population. After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised for injury and poisoning at 1.8 times the rate for non-Aboriginal people nationally.

Hospitalisation rates for injury and poisoning were higher for Aboriginal people living in remote areas than in non-remote areas both in New South Wales and nationally (44 and 28 per 1,000, respectively in New South Wales, and 74 and 35 per 1,000 in Australia) (Table D1.03.16).

Hospitalisations by age and sex: In New South Wales between July 2021 and June 2023, Aboriginal males had higher hospitalisation rates for injury and poisoning than Aboriginal females across all age groups apart from the 65 and over age group. For both Aboriginal males and females, hospitalisation rates for injury and poisoning were highest for those aged 65 and over (62 and 64 per 1,000 population, respectively) (Figure 1.03.1).

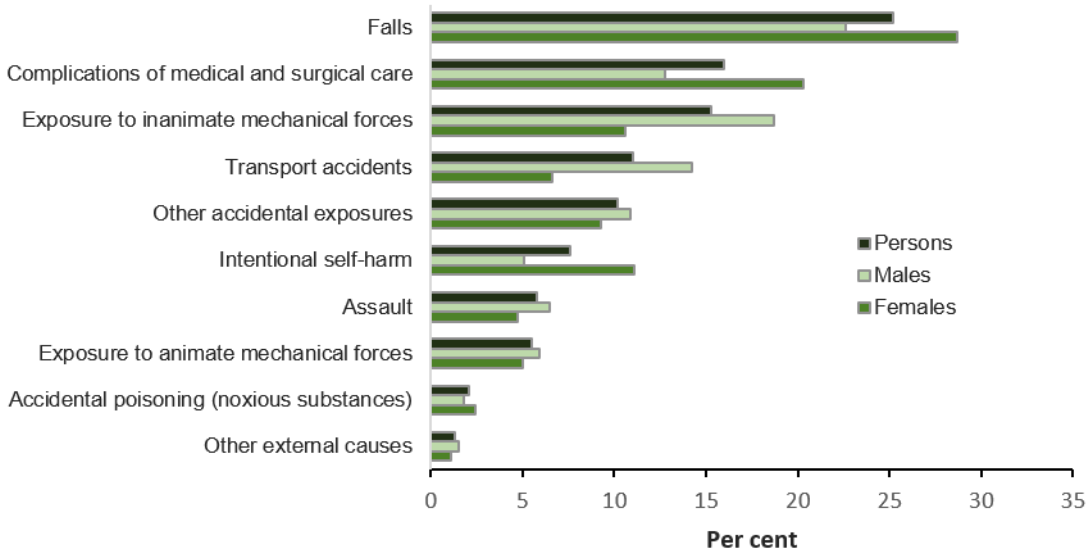
Figure 1.03.1: Age-specific hospitalisation rates for injury and poisoning for Aboriginal people, by sex and age group, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.03.2 NSW).

Leading external causes of injury and poisoning hospitalisations: Between July 2021 and June 2023 in New South Wales, falls were the leading external cause of hospitalisation due to injury and poisoning for Aboriginal males (23% or 2,576 hospitalisations) and females (29%; 2,384). Complications of medical and surgical care was the second leading external cause of hospitalisation due to injury and poisoning for Aboriginal persons overall (16%, 3,152). They were also the second leading cause for Aboriginal females (20%; 1,687), and the fourth leading cause for Aboriginal males (13%; 1,464). Exposure to inanimate mechanical forces was the third leading cause of hospitalisation due to injury and poisoning for Aboriginal people (15%; 3,012). It was the second leading cause for Aboriginal males (19%; 2,131), but fourth leading cause for Aboriginal females (11%; 880). Intentional self-harm accounted for 11% (924) of hospitalisations due to injury and poisoning for Aboriginal females in New South Wales, twice the proportion for Aboriginal males (5.1%; 577) (Figure 1.03.2).

Figure 1.03.2: First reported external causes of hospitalisations for a principal diagnosis of injury and poisoning for Aboriginal people in New South Wales, by sex, July 2021 to June 2023



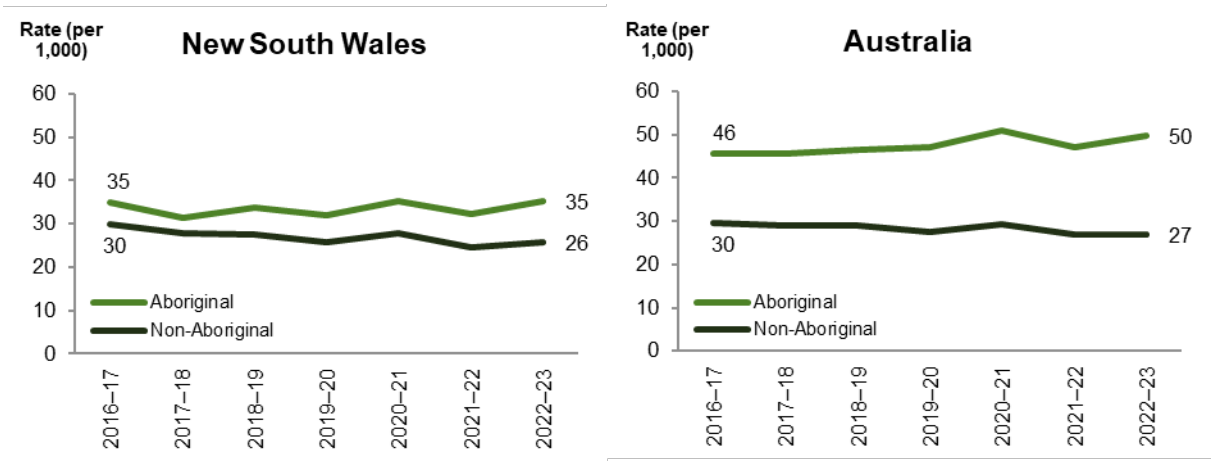
Note: See Table D1.03.7 NSW for the ICD-10-AM codes included in each grouping.

Source: National Hospital Morbidity Database (Table D1.03.7 NSW).

Trend over time: In New South Wales, from 2016–17 to 2022–23, the age-standardised hospitalisation rate for injury and poisoning remained steady (35 per 1,000 population) for Aboriginal people but decreased by 14% (based on linear regression) for non-Aboriginal people.

Nationally, over the same period, the age-standardised hospitalisation rate for injury and poisoning increased by 9% for Aboriginal people and decreased by 8% for non-Aboriginal Australians (Figure 1.03.3).

Figure 1.03.3: Age-standardised hospitalisation rates for a principal diagnosis of injury and poisoning, by Aboriginal status, New South Wales and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.03.5 NSW).

Deaths due to injury and poisoning: Between 2019 and 2023, injury and poisoning was the third leading cause of death among Aboriginal people in New South Wales, accounting for 13% (874) of all Aboriginal deaths at a crude rate of 51 per 100,000. After adjusting for differences in the age structure between the two populations, Aboriginal people in New South Wales died from injury and poisoning at 1.9 times the rate for non-Aboriginal people (67 compared with 35 per 100,000 population, respectively).

In the same period, in the 5 jurisdictions with adequate level of Indigenous identification (NSW, QLD, WA, SA and the NT combined), there were 2,739 deaths of Aboriginal people due to injury and poisoning, accounting for 14% of all Aboriginal deaths. After adjusting for differences in the age structure between the two populations, Aboriginal people died from injury and poisoning at twice the rate for non-Aboriginal people (79.7 compared with 39.2 per 100,000 population, respectively) (Table D1.23.2).

1.04 Respiratory disease

Why it is important

This measure reports on prevalence, incidence, deaths and hospitalisations caused by respiratory diseases. Respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD) (including chronic bronchitis and emphysema), pneumonia and invasive pneumococcal disease, are a major cause of poor health and death for Aboriginal people. Respiratory diseases accounted for 7.7% of the total disease burden for Aboriginal people in 2022 (AIHW 2026k).

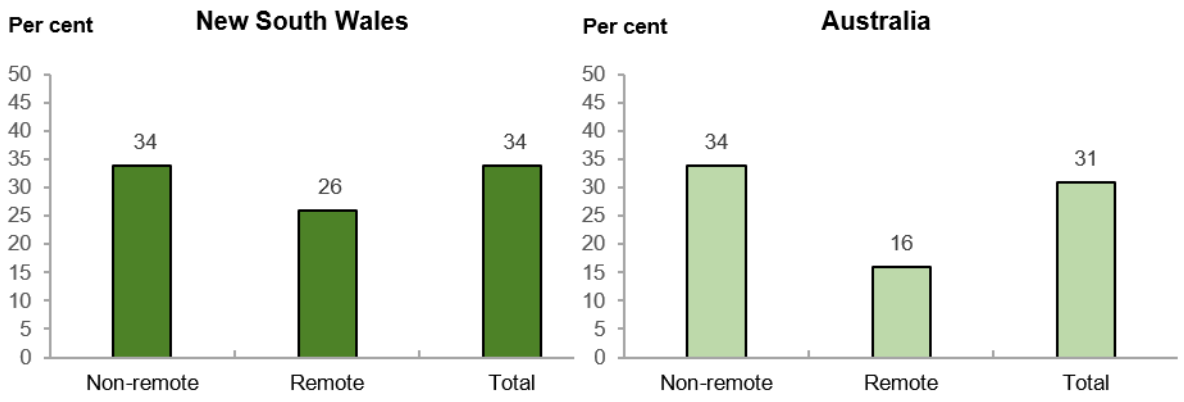
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Overall prevalence (self-reported): Based on the 2022–23 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), in New South Wales an estimated 34% (118,700) of Aboriginal people reported having a respiratory disease that lasted or was likely to last for 6 months or more (Table D1.04.2). After adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people reporting having a respiratory disease was 1.3 times that for non-Aboriginal people in New South Wales (Table D1.04.3). In New South Wales in non-remote areas 34% (115,700) of Aboriginal people reported respiratory disease compared with 26% (2,400) in remote areas (Table D1.04.2).

Nationally in 2022–23, 31% (310,900) of Aboriginal people reported having a respiratory disease that lasted or was likely to last for 6 months or more (Figure 1.04.1). After adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people reporting having a respiratory disease was similar to the rate for non-Aboriginal people (Table D1.04.3). In non-remote areas of Australia, 34% (287,200) of Aboriginal people reported having a respiratory disease compared with 16% (23,500) living in remote areas (Figure 1.04.1).

Figure 1.04.1: Aboriginal people reporting respiratory diseases, by remoteness, New South Wales and Australia, 2022–23



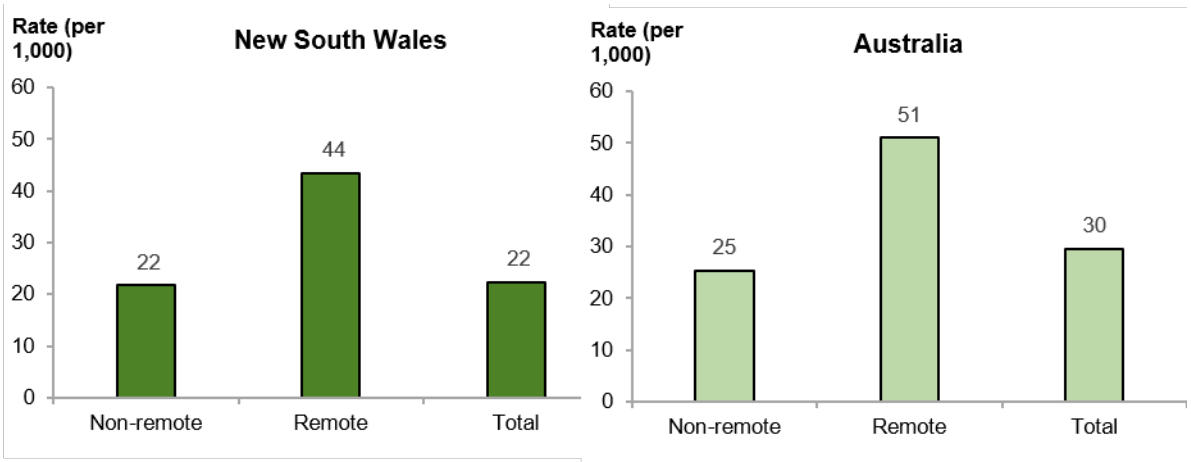
Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D1.04.2).

Hospitalisations for respiratory disease: Between July 2021 and June 2023, there were 15,447 hospitalisations for respiratory diseases for Aboriginal people in New South Wales (a rate of 22 per 1,000 population). Hospitalisation rates for respiratory diseases in New South Wales were higher for Aboriginal people living in remote areas (44 per 1,000 population) than in non-remote areas (22 per 1,000 population) (Figure 1.04.2).

After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for respiratory diseases for Aboriginal people was 1.8 times the rate for non-Aboriginal people in New South Wales (26 compared with 15 per 1,000 population, respectively) (Table D1.04.17).

Nationally over the same period, there were 59,271 (30 per 1,000) hospitalisations for respiratory diseases for Aboriginal people. The rate of hospitalisations for respiratory diseases for all Aboriginal people was also higher for those living in remote areas (51 per 1,000 population) than in non-remote areas (25 per 1,000 population) (Figure 1.04.2). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for respiratory diseases for Aboriginal people was 2.3 times the rate for non-Aboriginal people nationally (36 compared with 15 per 1,000 population, respectively) (Table D1.04.17).

Figure 1.04.2: Rate of hospitalisations due to respiratory diseases for Aboriginal people, by remoteness, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.04.17).

Hospitalisations by age and sex: In New South Wales between July 2021 and June 2023, the highest rates of hospitalisations for respiratory diseases were for Aboriginal males and females in the 65 and over age group (70 and 71 per 1,000 population, respectively), followed by Aboriginal males and females in the 0–4 age group (61 and 47 per 1,000, respectively). This pattern was similar for Aboriginal people nationally.

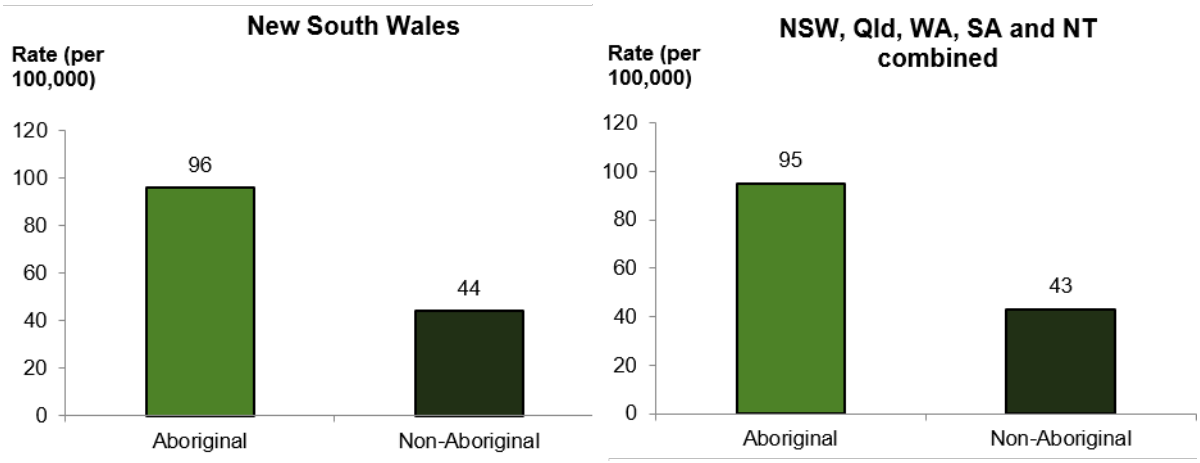
In the same period in New South Wales, the rate of hospitalisations for respiratory diseases were higher for Aboriginal females than Aboriginal males in all age groups between 15–64, about the same in the 65 and over age group, and higher for males than females in the 0–4 and 5–14 age groups. The same trend was observed nationally in hospitalisations rates for respiratory diseases among Aboriginal males and females (Table D1.04.8 NSW).

Hospitalisations trend over time: In New South Wales from 2016–17 to 2022–23, the age-standardised hospitalisation rate for respiratory diseases decreased by 15% for Aboriginal people (based on linear regression). This was larger than the national decrease in the age-standardised hospitalisation rate for Aboriginal people (10%) (Table D1.04.11 NSW).

Deaths due to respiratory diseases: Between 2019 and 2023, respiratory disease was the fourth leading cause of death among Aboriginal people in New South Wales, accounting for 11% (790) of all Aboriginal deaths at a crude rate of 47 per 100,000. After adjusting for differences in the age structure between the two populations, in New South Wales, Aboriginal people died from respiratory disease at 2.2 times the rate for non-Aboriginal people (96 compared with 44 per 100,000 population, respectively) (Table D1.23.2).

Over the same time period, a similar pattern was seen in age-standardised rates in the 5 jurisdictions with adequate level of Indigenous identification (NSW, QLD, WA, SA and the NT combined) (Figure 1.04.3).

Figure 1.04.3: Age-standardised rate of deaths due to respiratory diseases, by Aboriginal status, New South Wales, and NSW, Qld, WA, SA and the NT combined, 2019–2023



Source: AIHW National Mortality Database (Table D1.23.2).

1.05 Cardiovascular disease

Why it is important

This measure reports on prevalence, incidence, deaths and hospitalisations caused by cardiovascular (circulatory) disease. Cardiovascular disease, which includes conditions such as coronary heart disease, heart failure, and stroke, is a major cause of illness and death for Aboriginal people. Cardiovascular disease is more common among Aboriginal people than non-Aboriginal Australians, and its onset tends to occur between 10 and 20 years earlier than for non-Aboriginal Australians (AIHW 2015a; Bradshaw et al. 2011; Brown 2012; Brown and Kritharides 2017; Katzenellenbogen et al. 2014).

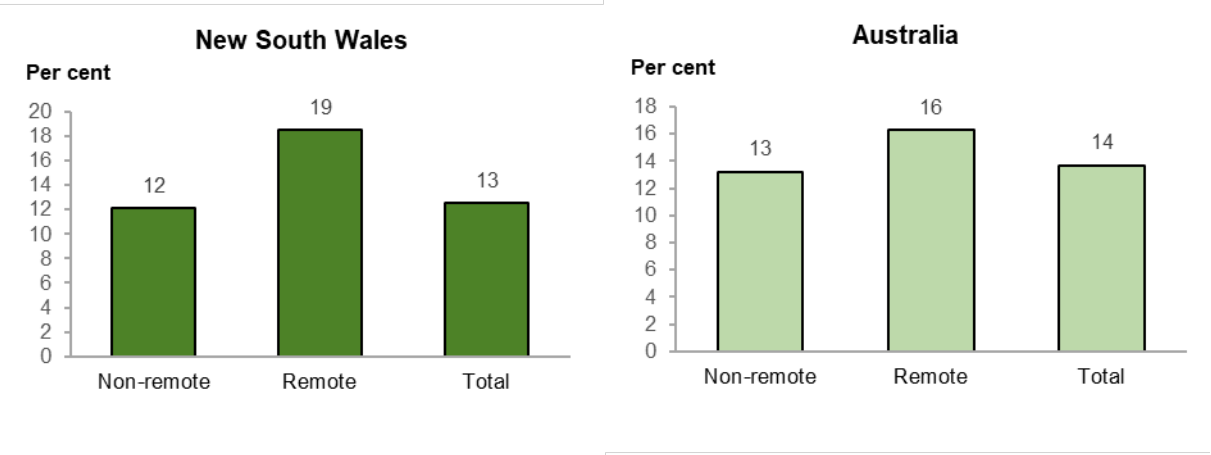
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Overall prevalence (self-reported): Based on NATSIHS 2022–23 in New South Wales, 13% (43,700) of Aboriginal people reported having cardiovascular disease. In remote areas, 19% (1,700) of Aboriginal people reported a cardiovascular disease compared with 12% (41,300) of those living in non-remote areas (Table D1.05.1). Note that for remote areas, the proportion and estimate should be used with caution as they have a high margin of error and a relative standard error of 25% to 50%, respectively. After adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people reporting having cardiovascular disease was 1.3 times that for non-Aboriginal people in New South Wales (18% compared with 14%) (Table D1.05.2).

Nationally in 2022–23, 14% (136,100) of Aboriginal people reported having cardiovascular disease. In remote areas of Australia 16% (24,400) of Aboriginal people reported having cardiovascular disease compared with 13% (111,600) of those living in non-remote areas (Figure 1.05.1). After adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people reporting having cardiovascular disease was 1.3 times that for non-Aboriginal people in Australia (19% compared with 15%) (Table D1.05.2).

Figure 1.05.1: Aboriginal people reporting cardiovascular disease, by remoteness, New South Wales and Australia, 2022–23



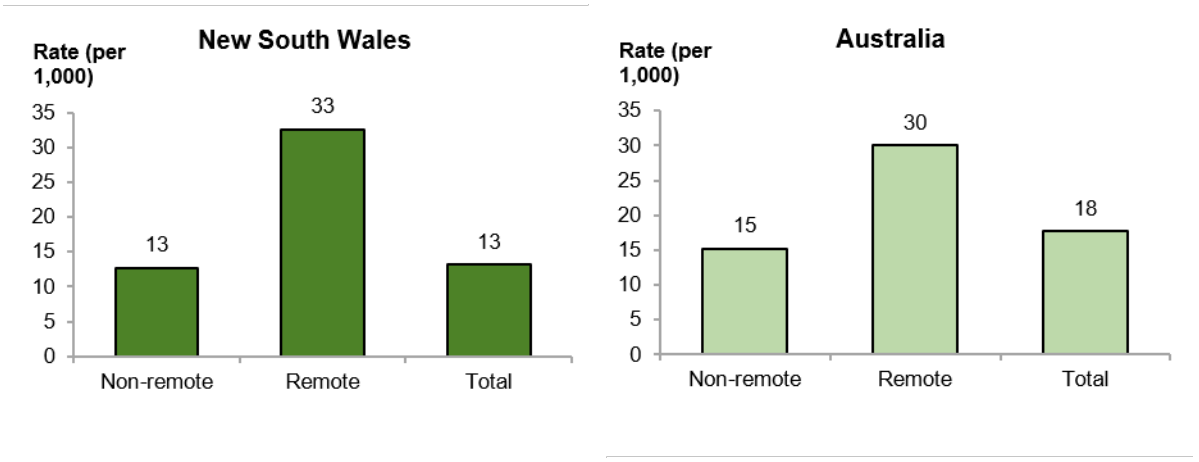
Note: Data are for people who had a current heart or circulatory (cardiovascular) condition which has lasted, or is likely to last, for 6 months or more (based on reported survey data).

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D1.05.1).

Hospitalisations for cardiovascular disease: Between July 2021 and June 2023, there were 9,155 hospitalisations for cardiovascular disease (based on principal diagnosis) for Aboriginal people in New South Wales (a rate of 13 per 1,000 population). Hospitalisation rates for cardiovascular disease in New South Wales were higher for Aboriginal people living in remote areas (33 per 1,000 population) than those living in non-remote areas (13 per 1,000 population) (Figure 1.05.2). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for cardiovascular disease for Aboriginal people was 1.2 times the rate for non-Aboriginal people in New South Wales (22 compared with 18 per 1,000, respectively) (Table D1.05.12).

Nationally over the same period, the rate of hospitalisations for cardiovascular disease for Aboriginal people was 18 per 1,000 and was higher for those living in remote (30 per 1,000 population) than those living in non-remote areas (15 per 1,000 population) (Figure 1.05.2). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for cardiovascular disease for Aboriginal people was 1.6 times the rate for non-Aboriginal people in Australia (28 compared with 18 per 1,000, respectively) (Table D1.05.12).

Figure 1.05.2: Hospitalisations for diseases of the cardiovascular system (based on principal diagnosis) for Aboriginal people, by remoteness, New South Wales and Australia, July 2021 to June 2023

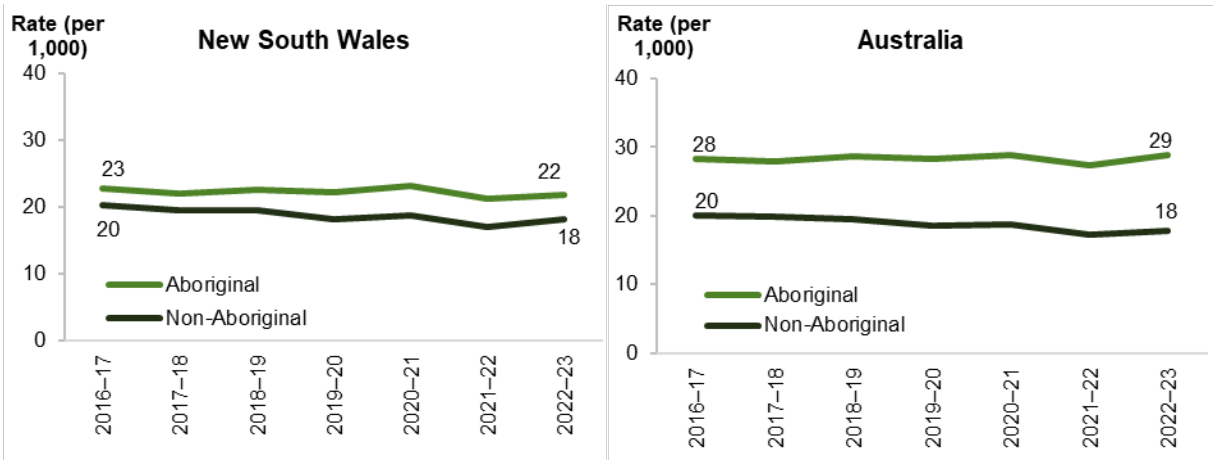


Source: National Hospital Morbidity Database (Table D1.05.12).

Hospitalisations trend over time: In New South Wales, from 2016–17 to 2022–23, based on linear regression analysis, the age-standardised rate of hospitalisations for cardiovascular disease remained stable for Aboriginal people. For non-Aboriginal people the rate decreased by 13% (Table D1.05.11). This resulted in a widening of the gap between Aboriginal and non-Aboriginal hospitalisations rates over this period.

Nationally, from 2016–17 to 2022–23, the age-standardised rate of hospitalisations for Aboriginal people for cardiovascular disease remained stable. For non-Aboriginal people the age-standardised rate decreased by 14% over this period, widening the gap between Aboriginal and non-Aboriginal hospitalisations rates (Figure 1.05.3).

Figure 1.05.3: Age-standardised hospitalisation rates for cardiovascular disease (based on principal diagnosis), by Aboriginal status, New South Wales and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.05.11 NSW).

Deaths due to cardiovascular disease: Between 2019 and 2023, cardiovascular disease was the second leading cause of death for Aboriginal people in New South Wales (1,390 deaths or 20% of total deaths). After adjusting for differences in the age structure between the two populations, the rate of deaths due to cardiovascular disease for Aboriginal people was 168 per 100,000 compared with 133 per 100,000 for non-Aboriginal people in New South Wales.

Similarly, in the 5 jurisdictions with adequate level of Indigenous identification (NSW, Qld, WA, SA and the NT combined), cardiovascular disease was the second leading cause of death for Aboriginal people (4,283 deaths or 21% of total deaths) (Table D1.23.2). After adjusting for differences in the age structure between the two populations, the rate of deaths due to cardiovascular disease for Aboriginal people was 206 per 100,000 compared with 129 per 100,000 for non-Aboriginal people in the 5 jurisdictions combined.

Deaths trend over time: Due to changes in identification of Aboriginal status in New South Wales in 2022, data on deaths registered for New South Wales and for combined jurisdictions since 2022 are not comparable to data for previous years. The time trend analysis is therefore limited to the period 2016 to 2021. These changes also impact the combined data for 2019–2023 for New South Wales and the combined jurisdictions. Comparisons in death rates over time between jurisdictions, particularly New South Wales, should therefore be interpreted with caution. For more information see Interpretation of results section in this report.

From 2016 to 2021, the age-standardised rate of deaths due to cardiovascular disease for Aboriginal people in New South Wales increased by 15%, although the increase was not statistically significant, while for non-Aboriginal Australians in New South Wales it statistically significantly decreased by 20% (based on linear regression analysis). This resulted in an increase in the rate difference between Aboriginal and non-Aboriginal people by 10 deaths per 100,000 annually (Table D1.23.28).

1.06 Acute rheumatic fever and rheumatic heart disease

Why it is important

This measure reports on prevalence of rheumatic heart disease (RHD), as well as hospitalisations for acute rheumatic fever (ARF) or RHD. ARF and RHD are preventable diseases disproportionately affecting Aboriginal people living in regional and remote areas of Australia (AIHW 2023a). ARF symptoms can include arthritis, fever, and swelling of the heart and heart valves (Menzies School of Health Research (ARF/RHD writing group) 2025). RHD is damage to the valves of the heart caused by one or repeated episodes of ARF (AIHW 2023a). ARF and RHD are associated with social and environmental factors such as poverty, overcrowded housing and poor functioning of 'health hardware' such as facilities for washing people, clothes and bedding (Ali et al. 2018).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

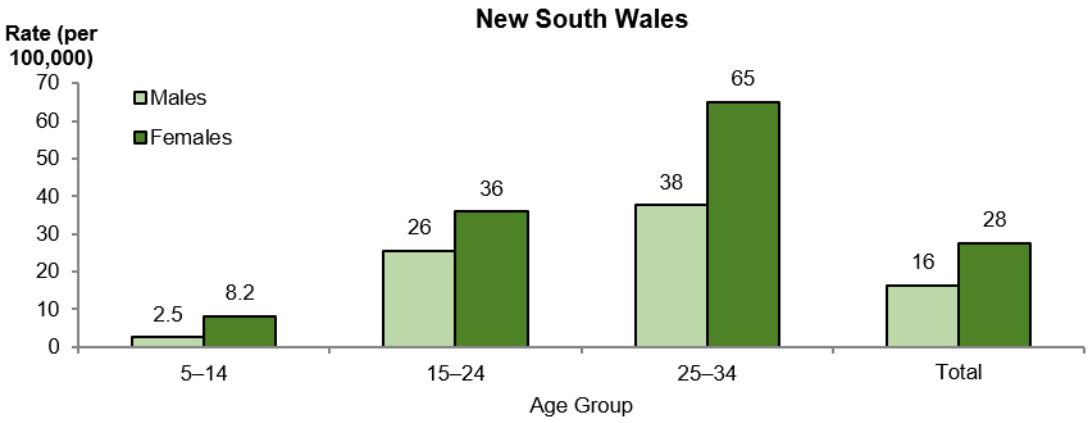
Prevalence of RHD: National data on RHD cases are available for Queensland, Western Australia, South Australia, and the Northern Territory. Data are also available for New South Wales, however RHD is only notifiable for those aged under 35 in New South Wales. Therefore, data from New South Wales are not comparable with those from the other 4 jurisdictions.

At 31 December 2024, there were 52 Aboriginal people aged under 35 living with RHD recorded on the register in New South Wales at the time of diagnosis, accounting for 35% of all RHD cases in New South Wales (52 of 147 cases) and corresponding to a rate of 22 per 100,000 population (AIHW 2025c, Table 4.2). This was an increase from 35 (17 per 100,000) Aboriginal people living with RHD in New South Wales in 2016 (AIHW 2025c, Table 4.5a). By age group, 7.7% of these cases were among Aboriginal people aged 5 to 14 (4 cases), 40% were aged 15 to 24 (21 cases) and 52% were aged 25 to 35 (27 cases) (AIHW 2025c, Table 4.1a).

The prevalence of RHD for Aboriginal females in New South Wales was higher than Aboriginal males (28 compared with 16 per 100,000 population). The prevalence of RHD for Aboriginal females was 3.2 times as high as for Aboriginal males in the 5–14 age group, 1.4 times as high in the 15–24 age group and 1.7 times as high in the 25–34 age group in New South Wales (Figure 1.06.1).

In 2024, 4 Australians were newly diagnosed with RHD, with a total of 4 surgical events recorded in the New South Wales register (AIHW 2023a, Table 4.7a).

Figure 1.06.1: Prevalence of Rheumatic heart disease among Aboriginal people aged 5–35, by sex and age group, New South Wales, as at 31 December 2024



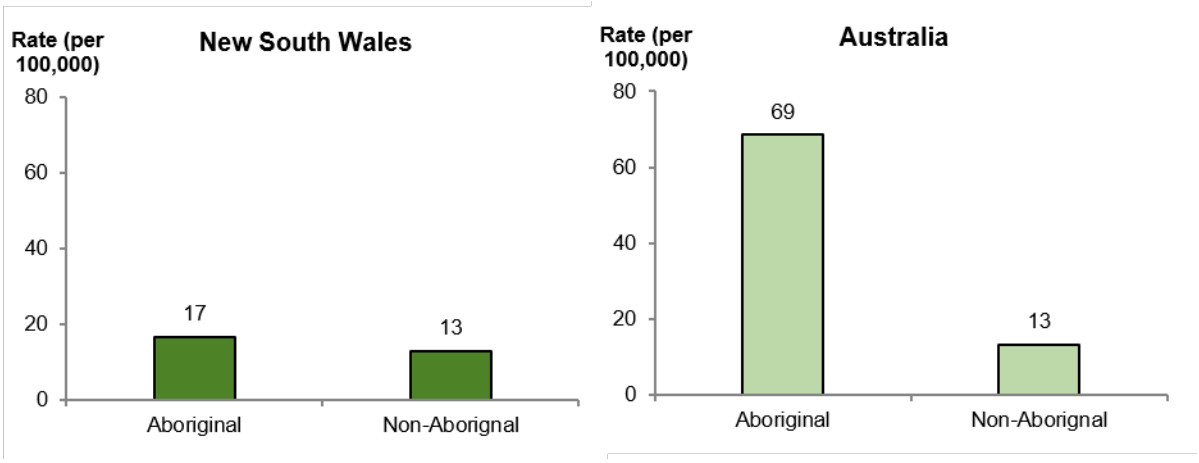
Source: National Rheumatic Heart Disease data collection (AIHW 2025c, Table 4.1a).

Hospitalisations: Between July 2021 and June 2023, there were 98 hospitalisations for ARF or RHD for Aboriginal people in New South Wales, a rate of 14 hospitalisations per 100,000 population (Table D1.06.17). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for ARF and RHD was 1.3 times that for non-Aboriginal people in New South Wales (17 compared with 13 per 100,000, respectively) (Figure 1.06.1).

Nationally between July 2021 and June 2023, 1,449 Aboriginal people were hospitalised for ARF or RHD, a rate of 72 hospitalisations per 100,000 population. After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for ARF and RHD was over 5 times that for non-Aboriginal people in New South Wales (69 compared with 13 per 100,000, respectively) (Figure 1.06.2).

In this period, hospitalisation rates for ARF or RHD nationally were higher among Aboriginal people living in remote areas (312 per 100,000) than in non-remote areas (28 per 100,000) (Table D1.06.17).

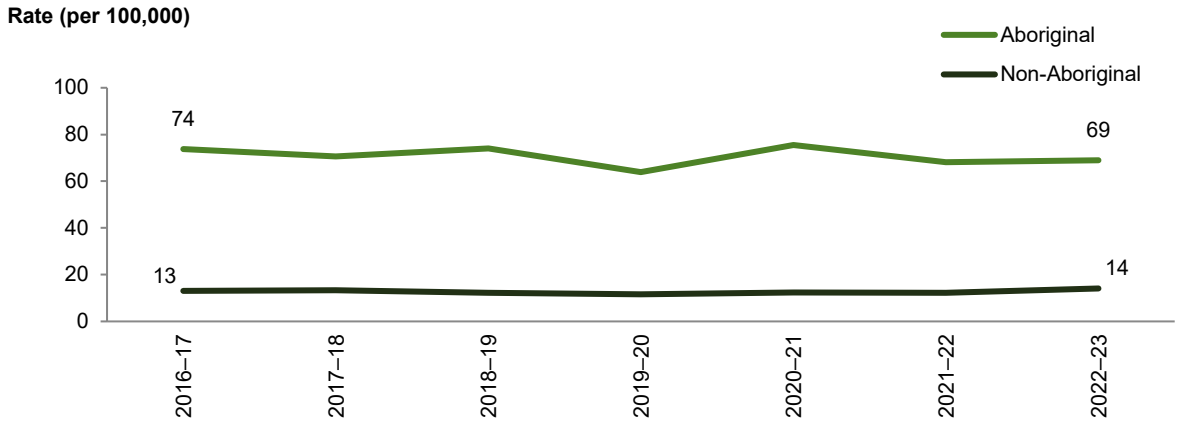
Figure 1.06.2: Age-standardised rate of hospitalisations with a principal diagnosis of acute rheumatic fever or rheumatic heart disease, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.06.17).

Trend over time: From 2016–17 to 2022–23, the age-standardised hospitalisation rates for ARF and RHD among Aboriginal people in Australia decreased by 5%, however the change was not statistically significant. Similarly, there was no statistically significant change in the non-Aboriginal rate of hospitalisations for ARF and RHD over this period (Figure 1.06.3).

Figure 1.06.3: Age-standardised rate of hospitalisations for acute rheumatic fever and rheumatic heart disease among Aboriginal people, Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.06.24).

1.07 High blood pressure

Why it is important

This measure reports on the prevalence of high blood pressure, also referred to as hypertension. High blood pressure is a major risk factor for stroke, coronary heart disease, heart failure, kidney disease, deteriorating vision and peripheral vascular disease (which leads to leg ulcers and gangrene). Reducing the prevalence of high blood pressure is one of the most important means of reducing serious cardiovascular (circulatory) diseases, which are among the leading causes of death for Aboriginal people (see measure 1.23 Leading causes of death).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

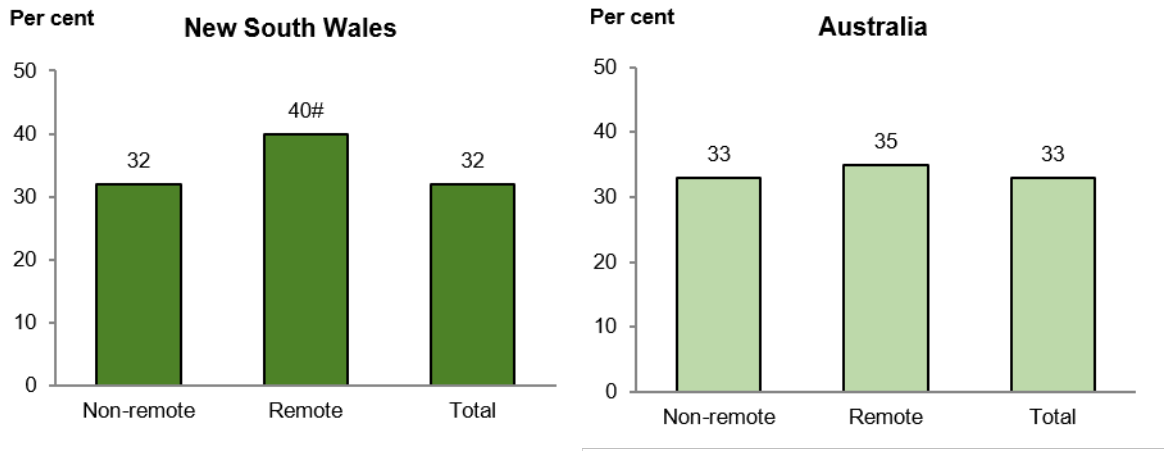
In 2022–23, the NATSIHS collected both measured blood pressure and self-reported blood pressure. For measured blood pressure, where a valid measurement was not obtained (for example, due to equipment issues or incomplete readings) the imputation of values (a process to replace missing data with estimates) was used to improve completeness and reduce bias in estimates of measured blood pressure (ABS 2024c).

Adults with high blood pressure: In 2022–23, based on both measured and reported data, 32% (67,900) of Aboriginal adults in New South Wales were estimated to have high blood pressure (140/90 mmHg or higher) (Table D1.07.4). The rate of high blood pressure for Aboriginal adults in non-remote areas was 32% (66,100), compared with 40% (2,100) in remote areas, however the rate in remote areas should be used with caution due to a high margin of error (Figure 1.07.1).

After adjusting for differences in the age structure between the two populations, rate of high blood pressure for Aboriginal adults was 1.2 times the rate for non-Aboriginal adults in New South Wales (36% compared with 30%, respectively) (Table D1.07.7).

Nationally in 2022–23, based on both measured and reported data, 33% (198,400) of Aboriginal adults were estimated to have high blood pressure (Table D1.07.4). The rate of high blood pressure for Aboriginal adults was similar in remote and non-remote areas (35% and 33%, respectively) (Figure 1.07.1). After adjusting for differences in the age structure between the two populations, the rate of high blood pressure for Aboriginal adults was 1.3 times the rate for non-Aboriginal adults in Australia (37% compared with 30%, respectively) (Table D1.07.7).

Figure 1.07.1: Proportion of Aboriginal people aged 18 and over with high blood pressure (self-reported and measured) by remoteness, New South Wales and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D1.07.4)

Hospitalisation for hypertensive disease: Prolonged high blood pressure, known as hypertensive disease, could cause damage to the heart and other organs (AIHW 2026l). Between July 2021 and June 2023, there were 213 hospitalisations of Aboriginal people with a principal diagnosis of hypertensive disease in New South Wales, at a rate of 31 hospitalisations per 100,000. After adjusting for differences in the age structure between the two populations, the rate of hospitalisations due to hypertensive disease for Aboriginal people was 1.5 times the rate for non-Aboriginal Australians in New South Wales (52 compared with 35 per 100,000 population).

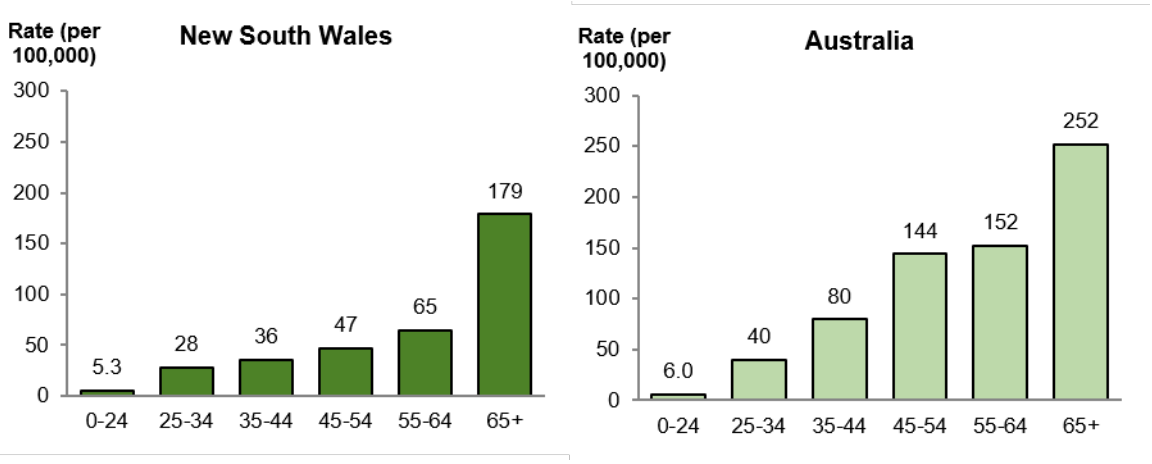
Nationally, between July 2021 and June 2023, there were 1,147 hospitalisations of Aboriginal people with a principal diagnosis of hypertensive disease at a rate of 57 per 100,000. The age-standardised rate of hospitalisations for hypertensive disease was 2.2 times as high for Aboriginal people as for non-Aboriginal people (90 compared with 42 per 100,000) (Table D1.07.10).

Hospitalisations by age and sex: In New South Wales, between July 2021 and June 2023, the hospitalisation rate for hypertensive disease was higher for Aboriginal females than for Aboriginal males (36 and 26 hospitalisations per 100,000 population, respectively) (Table D1.07.9).

Hospitalisation rates for hypertensive disease increased with age in both New South Wales and nationally. In New South Wales, the rate of hospitalisations was 5.3 per 100,000 among Aboriginal people aged under 25, ranged from 28 to 65 per 100,000 across the age groups 25–34 to 55–64 and was as high as 179 per 100,000 among Aboriginal people aged 65 and over.

Nationally, this rate increased 1.8–2.0 times with each successive age group for those aged between 25 and 54 and was as high as 252 per 100,000 among Aboriginal people aged 65 and over (Figure 1.07.2).

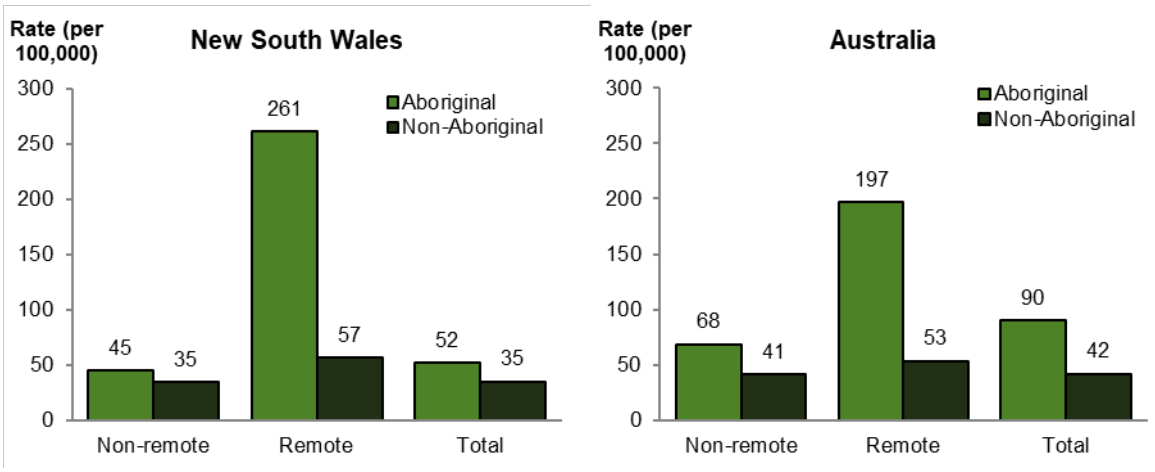
Figure 1.07.2: Hospitalisation rates for hypertensive disease (based on principal diagnosis) for Aboriginal people, by age group, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.07.9 NSW).

By remoteness: Between July 2021 and June 2023, in New South Wales, the rate of hospitalisations due to hypertensive disease for Aboriginal people was higher in remote than non-remote areas (160 and 27 per 100,000 population, respectively) (Table D1.07.14). After adjusting for differences in the age structure between the two populations, hospitalisation rates for hypertensive disease among Aboriginal people in New South Wales were 4.6 times as high as non-Aboriginal people in remote areas and 1.3 times as high as non-Aboriginal people in non-remote areas (Figure 1.07.3).

Figure 1.07.3: Age-standardised hospitalisation rates for hypertensive disease (based on principal diagnosis), by Aboriginal status and remoteness, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.07.14).

1.08 Cancer

Why it is important

This measure reports on the number of new cases, deaths and hospitalisations for cancer. Aboriginal people have a higher incidence of fatal, screen-detectable and preventable cancers and are more likely to be diagnosed at more advanced stages, often with comorbidities that are more complex (Cunningham et al. 2008).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Cancer incidence rates in this report are not directly comparable with previously published estimates. The 2017–2021 cancer incidence rates for Aboriginal people are calculated using interpolated populations as denominators. Comparisons with historical rates and trends should therefore be interpreted with caution. For more information see Interpretation of results section in this report.

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

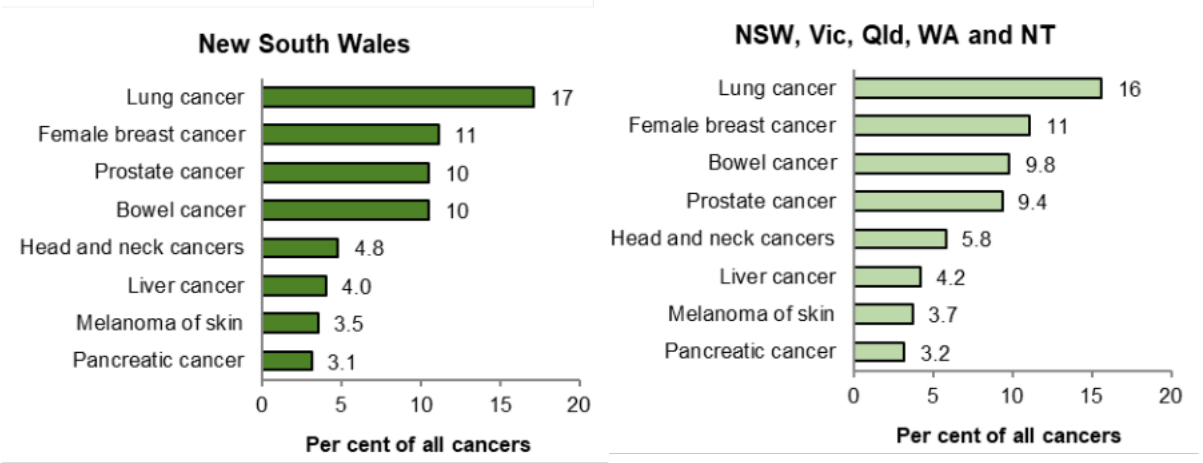
Cancer incidence (new cases): Aboriginal cancer incidence data are available from 5 jurisdictions: NSW, Vic, Qld, WA and the NT.

In the 5-year period 2017–2021, there were 4,522 new cases of cancer diagnosed among Aboriginal people in New South Wales, an incidence rate of 292 new cases per 100,000 population. After adjusting for differences in the age structure between the two populations, Aboriginal people had an incidence rate 1.2 times as high as for non-Aboriginal people in New South Wales (517 compared with 433 per 100,000, respectively).

In the 5 jurisdictions combined, there were 11,615 new cases of cancer diagnosed among Aboriginal people, an incidence rate of 283 new cases per 100,000 population in 2017–2021. After adjusting for differences in the age structure between the two populations, Aboriginal people had an incidence rate 1.1 times as high as for non-Aboriginal people in the 5 jurisdictions combined (522 compared with 457 per 100,000, respectively) (Table D1.08.3).

In New South Wales and across the 5 jurisdictions combined, lung cancer was the most common cancer, followed by female breast cancer. In New South Wales, prostate and bowel cancer were equal third most common. Across the 5 jurisdictions, bowel cancer was slightly more common than prostate cancer (third and fourth, respectively) (Figure 1.08.1).

Figure 1.08.1: Selected cancers as a proportion of total new cancer cases among Aboriginal people, New South Wales and NSW, Vic, Qld, WA, and NT combined, 2017–21



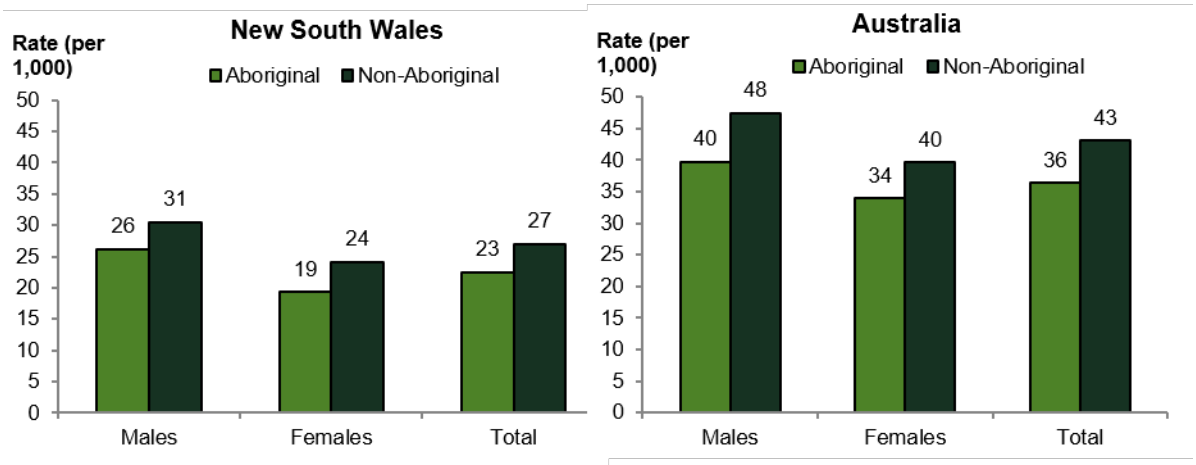
Source: Australian Cancer Database (Table D1.08.3).

Hospitalisation due to cancer: In New South Wales between July 2021 and June 2023, there were 9,737 cancer-related hospitalisations for Aboriginal people, a rate of 14 per 1,000 population. The rates were higher for Aboriginal males than Aboriginal females in New South Wales (15 compared with 13 per 1,000, respectively) (Table D1.08.12).

After adjusting for differences in the age structure between the two populations, cancer-related hospitalisation rates for Aboriginal people were 0.8 times the rate for non-Aboriginal people in New South Wales (23 compared with 27 per 1,000, respectively) (Figure 1.08.2).

Nationally in the same period, there were 44,829 cancer-related hospitalisations for Aboriginal people, a rate of 22 per 1,000 population. The national rates were similar for Aboriginal males and Aboriginal females (22 and 23 per 1,000, respectively) (Table D1.08.12). After adjusting for differences in the age structure between the two populations, cancer-related hospitalisation rates for Aboriginal people nationally were also 0.8 times the rate for non-Aboriginal people (36 compared with 43 per 1,000) (Figure 1.08.2).

Figure 1.08.2: Cancer-related age-standardised hospitalisation rates, by Aboriginal status and sex, New South Wales and Australia, July 2021 to June 2023

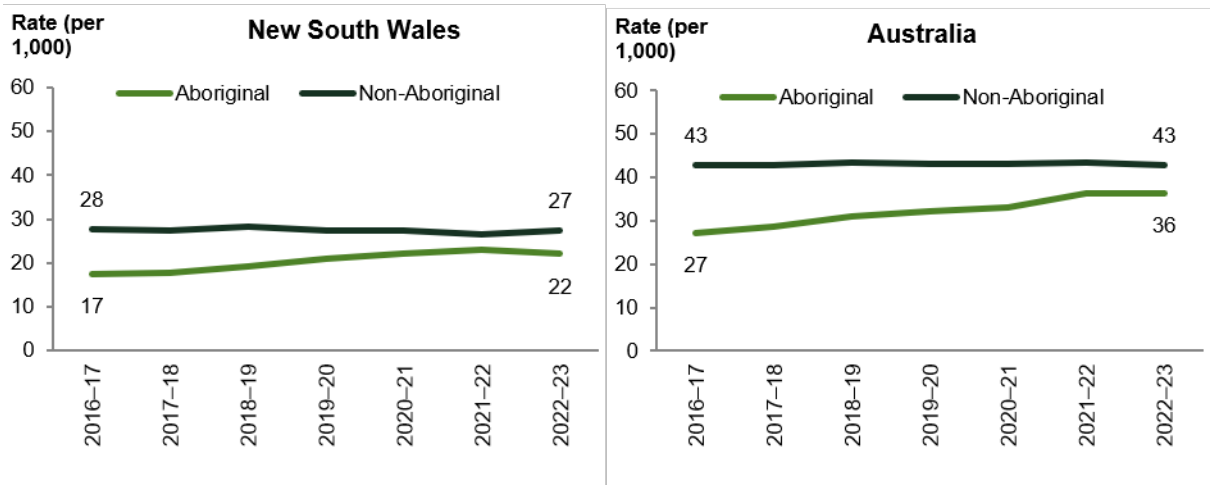


Source: National Hospital Morbidity Database (Table D1.08.12).

Hospitalisation trend over time: Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change (see Interpretation of results section in this report).

In New South Wales, from 2016–17 to 2022–23, after adjusting for differences in the age structure between the two populations, cancer-related hospitalisation rates increased by 33% for Aboriginal people and did not change significantly for non-Aboriginal people. Nationally, over the same time period, cancer-related hospitalisation rates increased by 36% for Aboriginal people and were stable for non-Aboriginal people (Figure 1.08.3).

Figure 1.08.3: Cancer-related age-standardised hospitalisation rates, by Aboriginal status, New South Wales and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.08.15 NSW).

Deaths due to cancer: Deaths data for Aboriginal people are available from 5 jurisdictions: NSW, Qld, WA, SA and the NT.

Over the period 2019–2023, cancer and other neoplasms was the leading cause of death among Aboriginal people in New South Wales, accounting for 27% (1,876 deaths) of all deaths of Aboriginal people. Similarly, in the 5 jurisdictions combined, cancer and other neoplasms was the leading cause of death among Aboriginal people, accounting for 24% (4,773 deaths) of all deaths of Aboriginal people (Table D1.23.2).

Deaths trend over time: Due to changes in identification of Aboriginal status in New South Wales in 2022, data on deaths registered for New South Wales and for combined jurisdictions since 2022 are not comparable to data for previous years. The time trend analysis is therefore limited to the period 2016 to 2021. These changes also impact the combined data for 2019–2023 for New South Wales and the combined jurisdictions. Comparisons in death rates over time between jurisdictions, particularly New South Wales, should therefore be interpreted with caution. For more information see Interpretation of results section in this report.

Over the period from 2016 to 2021, the age-standardised rate of deaths for Aboriginal people due to cancer and other neoplasms increased by 33% (10 deaths per 100,000 annually) in New South Wales and increased by 15% (5.9 deaths per 100,000 annually) in the 5 jurisdictions combined (both statistically significant increases) (Table D1.23.29).

1.09 Diabetes

Why it is important

This measure reports on deaths, hospitalisations and the prevalence of diabetes. Diabetes is a long-term chronic condition in which blood glucose levels become too high because the body produces little or no insulin or cannot use insulin properly. Over many years, high blood glucose levels can damage various parts of the body, especially the heart and blood vessels, eyes, kidneys and nerves. It can result in permanent disability (such as blindness and lower limb amputations), mental health problems, reduced quality of life and premature death (AIHW 2026a; Burrow and Ride 2016). In 2022, among Aboriginal people nationally, 11,632 years of healthy life (DALY) were lost due to endocrine disorders (largely diabetes), accounting for 3.7% of the total disease burden (AIHW 2026k).

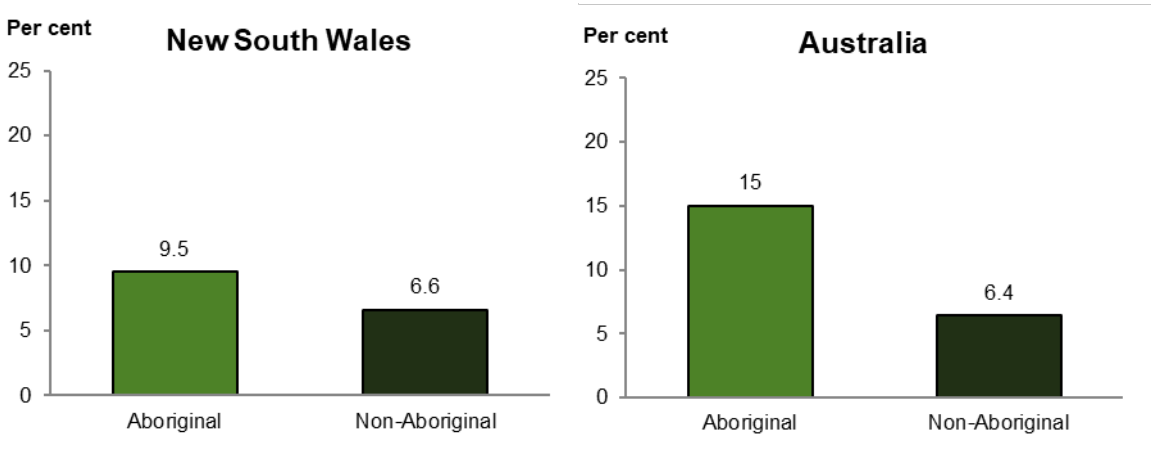
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Prevalence of diabetes: Based on NATSIHS 2022–23 in New South Wales, 8.4% (17,600) of Aboriginal adults reported having diabetes or high blood/urine sugar levels (HSL) (Table D1.09.14). After adjusting for differences in the age structure between the two populations, Aboriginal adults were 1.4 times as likely to report having diabetes or HSL as non-Aboriginal adults in New South Wales (6.6%) (Figure 1.09.1).

Nationally, estimated 13% (75,700) of Aboriginal adults reported having diabetes or HSL (Table D1.09.14). The age-standardised rate for Aboriginal adults was 2.3 times the rate for non-Aboriginal adults (15% compared with 6.4%, respectively) in 2022–23 (Figure 1.09.1). The proportion of Aboriginal people reporting diabetes or HSL was higher in remote (21% or 20,100 people) than in non-remote areas nationally (11%, 55,500) (Table D1.09.14).

Figure 1.09.1: Age-standardised proportion of persons aged 18 and over who reported having diabetes or high sugar levels, by Aboriginal status, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D1.09.2).

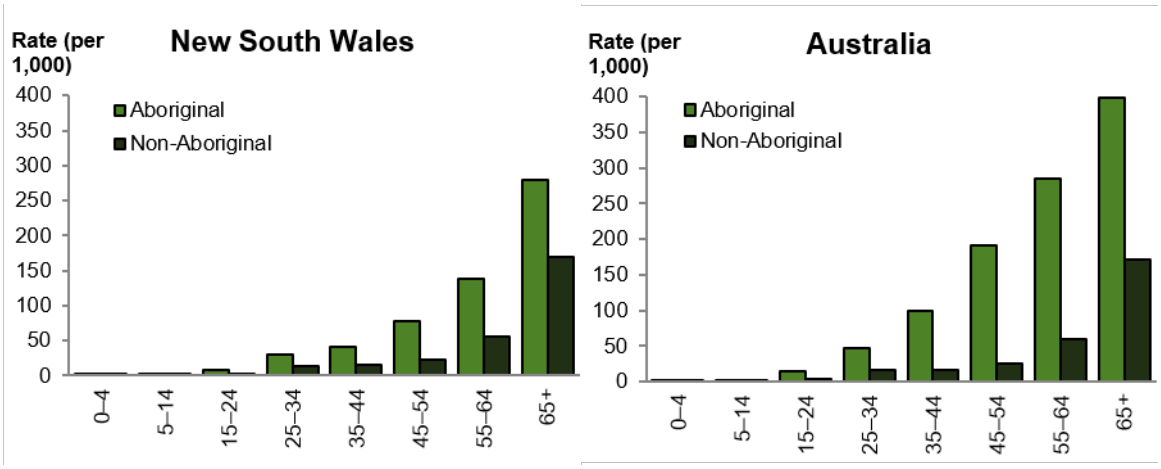
Hospitalisations for diabetes: In New South Wales, between July 2021 and June 2023, there were 2,179 hospitalisations (3.2 per 1,000 population) of Aboriginal people with a principal diagnosis of diabetes (Table D1.09.8). When hospitalisations with diabetes as an additional diagnosis are also included, there were 31,384 hospitalisations (45 per 1,000 population) in this period (Table D1.09.15).

After adjusting for differences in the age structure between the two populations, the rate of hospitalisations with a principal or additional diagnosis of diabetes for Aboriginal people was 2.1 times the rate for non-Aboriginal Australians in New South Wales (73 compared with 34 per 1,000 population, respectively) (Table D1.09.15).

Nationally, between July 2021 and June 2023, there were 167,054 (83 per 1,000) hospitalisations with a principal or additional diagnosis of diabetes for Aboriginal people. The age-standardised rate of hospitalisations for diabetes (principal or additional diagnosis) for Aboriginal people was 3.6 times the rate for non-Aboriginal people (129 compared with 36 per 1,000 population, respectively) (Table D1.09.15).

Hospitalisations for diabetes by age: For both New South Wales and Australia, between July 2021 and June 2023, hospitalisation rates for diabetes (principal or additional diagnosis) increased with age. The relative difference in rates (rate ratio) between Aboriginal and non-Aboriginal people was highest for those aged 45–54. In New South Wales for this age group, Aboriginal people were 3.4 times as likely as non-Aboriginal Australians to be hospitalised for diabetes. Nationally, Aboriginal people aged 45–54 were 7.5 times as likely as non-Aboriginal people of the same age group to be hospitalised for diabetes (Figure 1.09.2).

Figure 1.09.2: Hospitalisation rates for diabetes (principal or additional diagnosis), by Aboriginal status and age group, New South Wales and Australia, July 2021 to June 2023



Note: Includes principal and additional diagnosis for type 1 and type 2 diabetes and other diabetes mellitus (ICD-10-AM codes E10–14). Australian Coding Standards require diabetes to be coded whenever documented in the medical record, even where diabetes may not be directly related to the hospitalisation. These standards mean that diabetes is more likely to appear in hospitals data compared with some other chronic conditions.

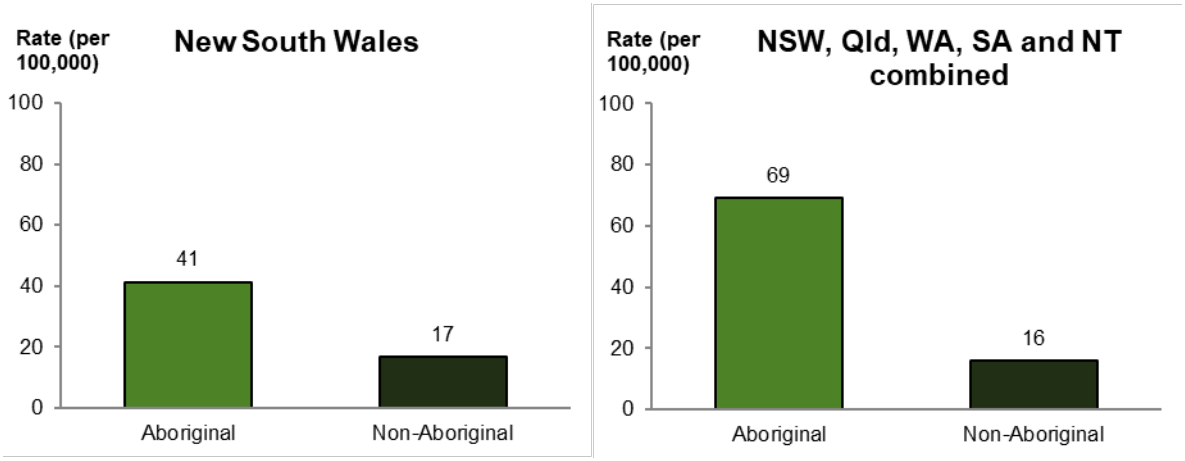
Source: National Hospital Morbidity Database (Table D1.09.7 NSW).

Deaths from diabetes: In New South Wales, endocrine, metabolic, and nutritional disorders (which include mostly diabetes) are among the top 5 leading causes of death for Aboriginal people. In New South Wales, in the 5-year period between 2019 and 2023, 5.1% (356) of total deaths of Aboriginal people were due to diabetes at a rate of 21 deaths per 100,000 population (Table D1.23.2). After adjusting for differences in the age structure between the

two populations, the rate of deaths due to diabetes for Aboriginal people was 2.5 times the rate for non-Aboriginal Australians in New South Wales (Figure 1.09.3).

In the 5 jurisdictions with adequate level of Indigenous identification (NSW, Qld, WA, SA and the NT, combined), in 2019–2023, there were 1,452 (34 per 100,000) deaths of Aboriginal people due to diabetes (7.3% of all Aboriginal deaths) (Table D1.23.2). The age-standardised rate of deaths due to diabetes for Aboriginal people was 4.4 times the rate for non-Aboriginal Australians (Figure 1.09.3).

Figure 1.09.3: Age-standardised death rates due to diabetes, by Aboriginal status, New South Wales and NSW, Qld, WA, SA and NT combined, 2019–2023



Source: AIHW National Mortality Database (Table D1.23.2).

1.10 Kidney disease

Why it is important

This measure reports on prevalence, deaths and hospitalisation for chronic kidney disease, and incidence of kidney replacement therapy after kidney failure. Kidneys are crucial to overall health, playing a vital role in cleaning the blood, removing waste and extra fluid from the body, managing Vitamin D production and regulating blood pressure (Kidney Health Australia 2025). Aboriginal people with kidney disease are less likely to receive kidney transplants than non-Aboriginal Australians and many require dialysis for the rest of their lives, impacting quality of life and social and emotional wellbeing for patients and their carers (see measure 1.18 Social and emotional wellbeing) (ABS 2024b; Chadban et al. 2005; Devitt et al. 2008; Khanal et al. 2018; Rix et al. 2015).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Self-reported prevalence of chronic kidney disease: Due to the asymptomatic nature of chronic kidney disease, and because diagnosis requires the presence of measured biomedical markers that persist for at least 3 months, people often do not realise they have the disease. As a result, numbers based on self-report are often underestimates of the true number of people living with chronic kidney disease in Australia.

Based on self-reported data from the 2022–23 NATSIHS, 2.0% (4,100) of Aboriginal adults in New South Wales had chronic kidney disease. Note that this proportion is based on an estimate with high statistical uncertainty and should be interpreted with caution (Table D1.10.23).

After adjusting for differences in the age structure between the two populations, the rate of Aboriginal adults reporting having chronic kidney disease was 2.9 times the rate for non-Aboriginal adults in New South Wales (2.2% compared with 0.8%, respectively) (Table D1.10.1).

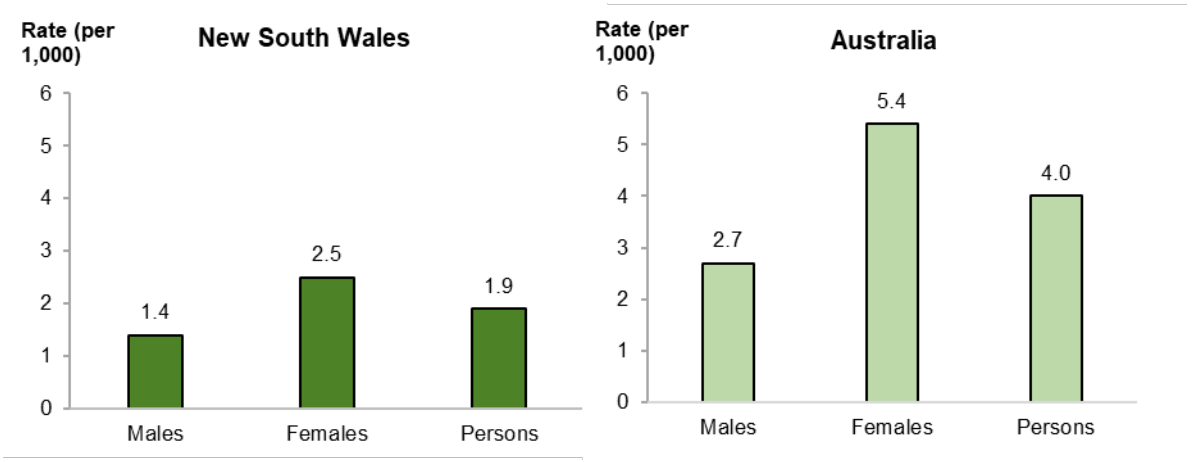
Nationally 2.1% (12,900) of Aboriginal adults had chronic kidney disease (Table D1.10.23). After adjusting for differences in the age structure between the two populations, the rate of Aboriginal adults reporting having chronic kidney disease was 2.5 times the rate for non-Aboriginal adults in Australia (2.6% compared with 1.0%, respectively) (Table D1.10.1).

Hospitalisations due to chronic kidney disease: Between July 2021 and June 2023 in New South Wales, there were 1,318 hospitalisations for chronic kidney disease (excluding dialysis) for Aboriginal people, at a rate of 1.9 per 1,000. Aboriginal females were hospitalised at a higher rate than Aboriginal males (2.5 compared with 1.4 per 1,000, respectively) (Figure 1.10.1). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for chronic kidney disease (excluding dialysis) for Aboriginal people was 1.2 times the rate for non-Aboriginal people in New South Wales (2.4 compared with 2.1 per 1,000 population, respectively) (Table D1.10.7).

Nationally over the same period, there were 8,104 (4.0 per 1,000) hospitalisations for chronic kidney disease (excluding dialysis) for Aboriginal people. Similarly, Aboriginal females were hospitalised at a higher rate (5.4 per 1,000) than Aboriginal males (2.7 per 1,000) (Figure

1.10.1). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for chronic kidney disease (excluding dialysis) for Aboriginal people was 3.0 times the rate for non-Aboriginal people in Australia (5.4 compared with 1.8 per 1,000 population, respectively) (Table D1.10.7).

Figure 1.10.1: Hospitalisation rate for chronic kidney disease (excluding dialysis) (based on principal diagnosis), Aboriginal people, by sex, New South Wales and Australia, July 2021 to June 2023

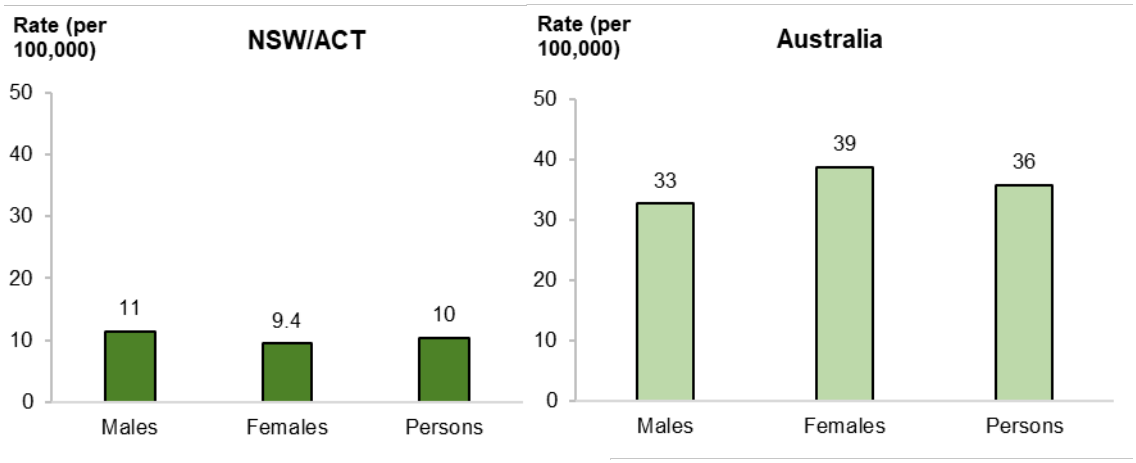


Source: National Hospital Morbidity Database (Table D1.10.7).

Kidney failure with replacement therapy: During 2020–2022 in New South Wales and the Australian Capital Territory combined, for Aboriginal people the incidence rate of kidney failure with kidney replacement therapy was 10 new cases per 100,000 population. The incidence of kidney failure with replacement therapy was slightly higher for Aboriginal males than Aboriginal females (11 compared with 9.4 per 100,000, respectively).

Nationally over the same period, the incidence of kidney failure with replacement therapy was higher for Aboriginal females than for Aboriginal males (39 compared with 33 per 100,000, respectively) (Figure 1.10.2).

Figure 1.10.2: Incidence (new cases) of kidney failure with replacement therapy, Aboriginal people, by sex, NSW and ACT combined, compared with Australia, 2020–2022

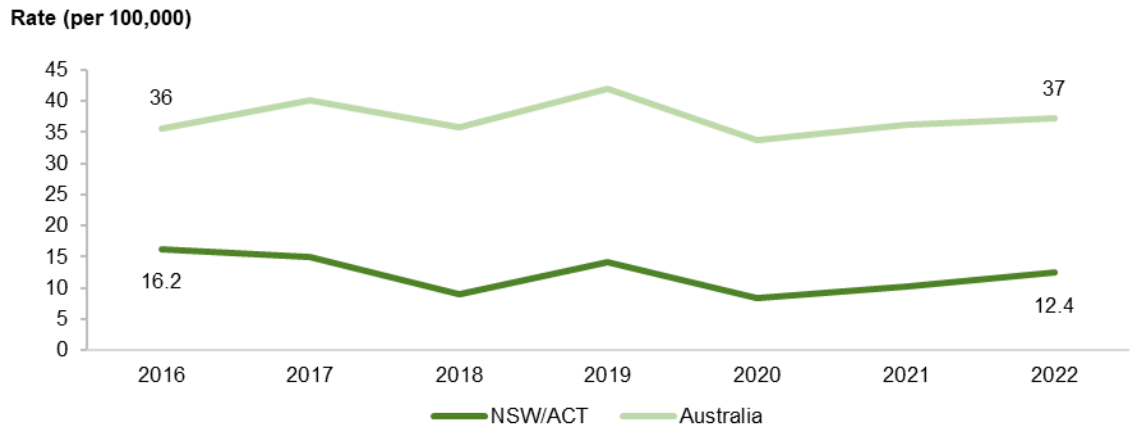


Note: Due to small numbers in some states and territories, data for New South Wales and the Australian Capital Territory have been combined.

Source: Australia and New Zealand Dialysis and Transplant Registry (Table D1.10.11).

Kidney failure with replacement therapy trend over time: In the period from 2016 to 2022 there was no clear trend in the incidence rate of kidney failure with replacement therapy for Aboriginal people in New South Wales and the Australian Capital Territory combined, or nationally (Figure 1.10.3).

Figure 1.10.3: Incidence (new cases) of kidney failure with replacement therapy, Aboriginal people, New South Wales and Australian Capital Territory combined compared with Australia, 2016–2022



Note: Due to small numbers in some states and territories, data for New South Wales and the Australian Capital Territory have been combined.

Source: Australia and New Zealand Dialysis and Transplant Registry (Table D1.10.15).

Deaths due to kidney disease: In 2019–2023 in New South Wales, there were 117 deaths of Aboriginal people where kidney diseases were the underlying cause of death (a rate of 6.9 per 100,000). After adjusting for differences in the age structure between the two populations, the rate of deaths due to kidney diseases for Aboriginal people was 1.7 times the rate for non-Aboriginal people in New South Wales (16 compared with 9.4 per 100,000 population, respectively) (Table D1.23.2).

Over the same period in the 5 jurisdictions with adequate levels of Indigenous identification (NSW, Qld, WA, SA and NT combined), there were 396 deaths of Aboriginal people due to kidney diseases at a rate of 9.2 per 100,000. After adjusting for differences in the age structure between the two populations, the rate of deaths due to kidney diseases for Aboriginal people was 2.6 times the rate for non-Aboriginal people in the 5 jurisdictions combined (21 compared with 8.3 per 100,000 population, respectively) (Table D1.23.2).

1.11 Oral health

Why it is important

This measure reports on dentist visits, tooth loss, teeth and gum problems, and hospitalisations for dental problems. The two most frequently occurring oral diseases are tooth decay (termed ‘caries’) and gum (periodontal) disease. If not treated in a timely manner, these can cause discomfort and tooth loss, impacting a person's ability to eat, speak, and socialise without discomfort or embarrassment (Williams et al. 2011). Oral diseases can intensify other chronic diseases (Jamieson et al. 2010) and have been found to be associated with cardiovascular diseases (Ylöstalo et al. 2006), diabetes (Taylor and Borgnakke 2008), and stroke (Joshipura et al. 2003).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Seen a dentist in last 12 months: Based on data from the 2022–23 NATSIHS, in New South Wales, estimated 46% (151,800) of Aboriginal people aged 2 and over had seen a dentist or a dental professional in the last 12 months. Nationally, 45% (427,600) Aboriginal people had seen a dentist or a dental professional in the last 12 months (ABS 2024e, Tables 27.1 and 27.3).

Tooth loss: In New South Wales in 2022–23, an estimated 3.7% (8,500) of Aboriginal people aged 15 and over had complete tooth loss. Nationally, an estimated 4.3% (27,700) of Aboriginal people aged 15 and over had complete tooth loss in 2022–23. This proportion was slightly lower in remote (3.3% or 3,300 people) than in non-remote areas (4.5% or 24,300) (Table D1.11.10).

Teeth or gum problems in children: Based on data from the 2014–15 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 31% (22,400) of Aboriginal children aged under 15 in New South Wales had teeth or gum problems, compared with 28% (63,400) of Aboriginal children nationally (Table D1.11.1). Note, that the NATSISS has not been conducted since 2014–15 and these data cannot be updated.

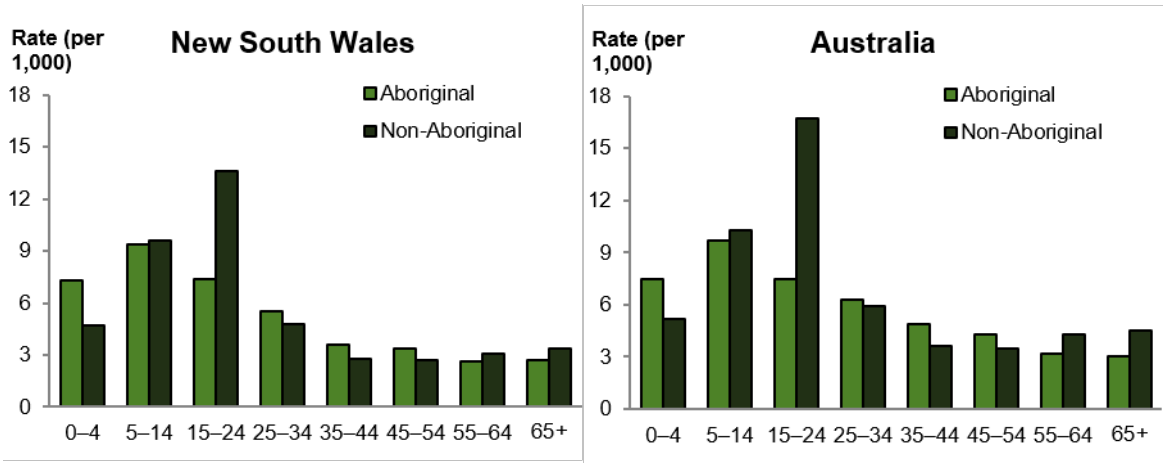
Hospitalisations for dental problems: In New South Wales between July 2021 and June 2023, 4,247 Aboriginal people were hospitalised for dental conditions such as: dental caries; loss of teeth due to accident, extraction or local periodontal disease; or dental examination, at a rate of 6.1 per 1,000 population. After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for dental conditions for Aboriginal people was 0.9 times the rate for non-Aboriginal people in New South Wales (5.2 compared with 5.8 per 1,000, respectively) (Table D1.11.33).

Among Aboriginal people in New South Wales, the highest rate of hospitalisations was for those aged 5–14 (9.4 per 1,000 population). For non-Aboriginal Australians in New South Wales, the rate was highest for those aged 15–24 (14 per 1,000) (Figure 1.11.1).

Nationally, between July 2021 and June 2023, there were 13,277 hospitalisations for dental problems for Aboriginal people at a rate of 6.6 per 1,000 population. After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for dental conditions for Aboriginal people was 0.8 times the rate for non-Aboriginal people

nationally (5.8 compared with 7.0 per 1,000, respectively) (Table D1.11.33). Rates were highest among Aboriginal people aged 5–14 (9.7 per 1,000 population), whereas among non-Aboriginal people the rate was highest for those aged 15–24 (17 per 1,000) (Figure 1.11.1).

Figure 1.11.1: Age-specific hospitalisation rates for a principal diagnosis of dental problems, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023



Note: Dental problems category based on ICD-10-AM codes K00 to K14.

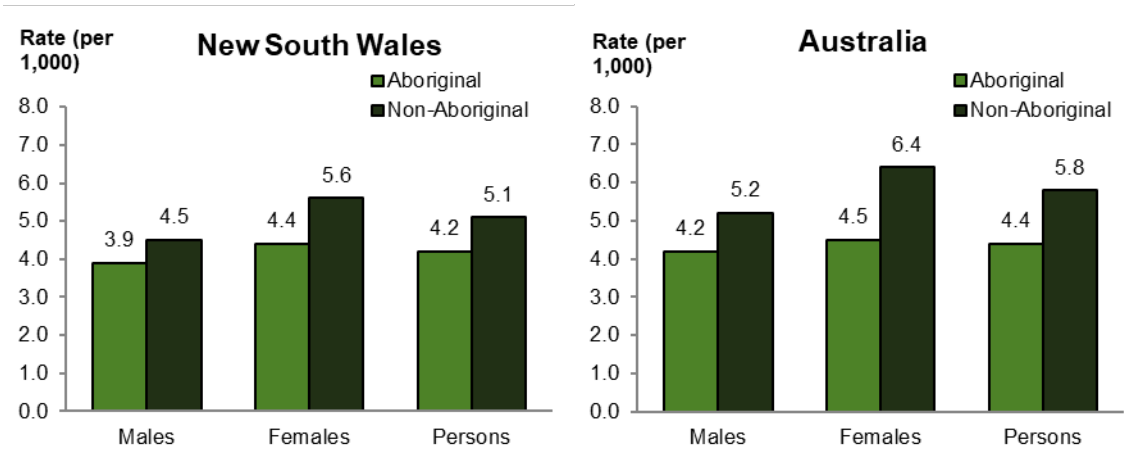
Source: National Hospital Morbidity Database (Table D1.11.21 NSW).

Hospitalisations under general anaesthetic: Dental care under general anaesthetic carries an additional risk. In New South Wales, between July 2021 and June 2023, there were 3,622 hospitalisations of Aboriginal people for dental procedures that involved general anaesthesia, at a rate of 5.2 per 1,000 population (Table D1.11.34).

After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for dental procedures involving general anaesthesia was lower for Aboriginal people than for non-Aboriginal people in New South Wales (4.2 compared with 5.1 per 1,000, rate ratio 0.8) (Figure 1.11.3).

Similar trends were observed at the national level in the same period, where the rates of hospitalisation for dental procedures involving general anaesthesia for Aboriginal people were lower than for non-Aboriginal people (4.4 compared with 5.8 per 1,000; rate ratio of 0.8) (Figure 1.11.3).

Figure 1.11.2: Age-standardised hospitalisation rates for dental procedures involving general anaesthesia, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.11.34).

1.12 HIV, hepatitis and sexually transmissible infections

Why it is important

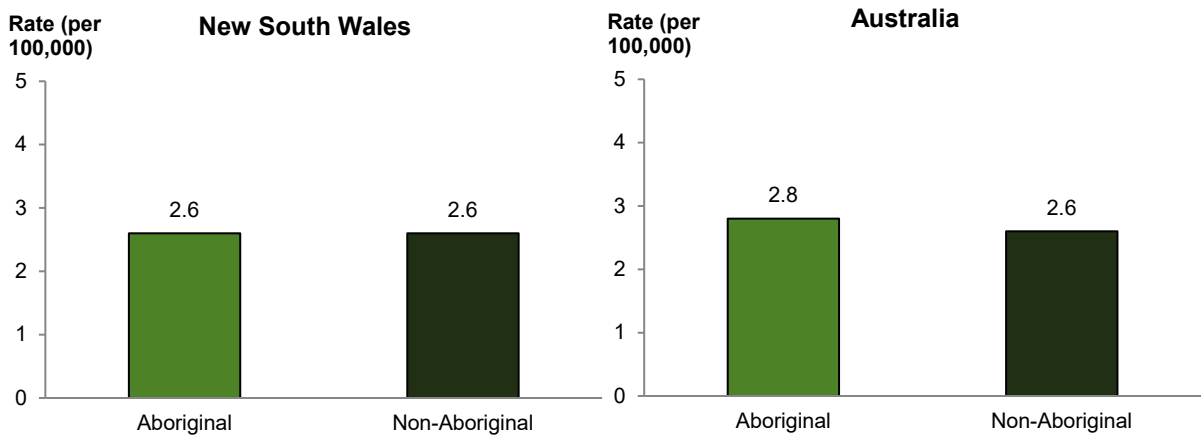
This measure reports on the notification rates of HIV, and some bacterial sexually transmissible infections (STIs) including non-congenital infectious syphilis (≤2 years duration) (henceforth referred to as 'infectious syphilis') and chlamydia. These infections can have potentially serious consequences if left untreated. HIV is a bloodborne virus that targets the immune system and gradually weakens the body's immune response. As the body becomes immunodeficient, it is at increased susceptibility to a wide range of infections and some types of cancers (WHO n.d.–b). STIs can have serious long-term consequences such as pelvic inflammatory disease, infertility, adverse pregnancy outcomes, miscarriage, and neonatal infections. Untreated syphilis can cause heart and brain damage (Bowden et al. 2002; Guy et al. 2012).

Key findings

HIV: In the 3-year period 2022–2024, there were 620 notifications of HIV in New South Wales with a known Aboriginal status. Of these, Aboriginal people accounted for 3.5% of HIV notifications. The HIV notification rate was 2.1 per 100,000 population for Aboriginal people (Table D1.12.8). After adjusting for differences in the age structure between the two populations, the HIV notification rate was the same between the Aboriginal and non-Aboriginal people in New South Wales (2.6 per 100,000) (Figure 1.12.1).

Nationally, there were 2,002 notifications of HIV in 2022–2024. Of these, Aboriginal people accounted for 3.6% of HIV notifications (2.4 per 100,000 population) (Table D1.12.8). After adjusting for differences in the age structure between the two populations, the HIV notification rate for Aboriginal people was 1.1 times the rate for non-Aboriginal people nationally (2.8 compared with 2.6 per 100,000) (Figure 1.12.1).

Figure 1.12.1: Age-standardised notification rates for HIV, by Aboriginal status, NSW and Australia, 2022–2024

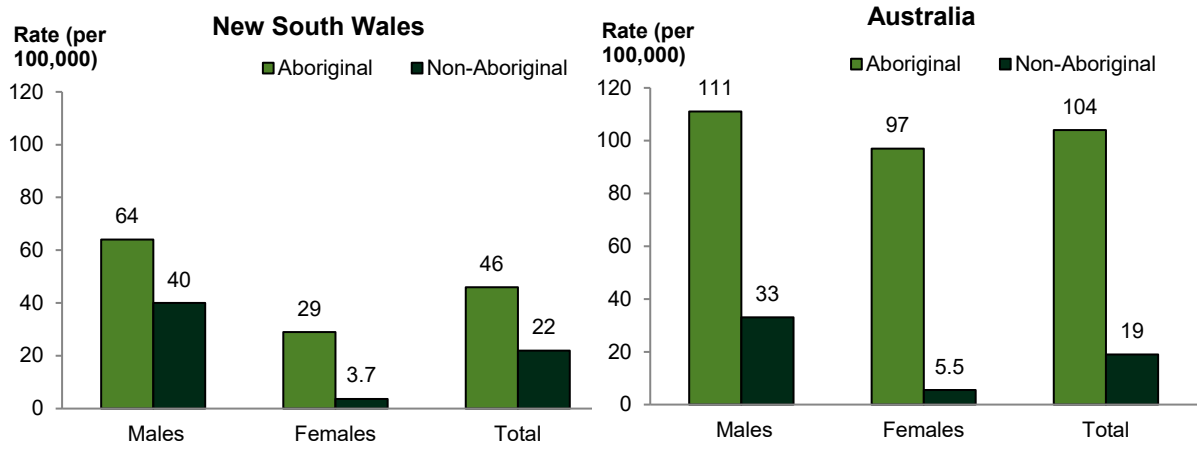


Source: National HIV Registry data (Table D1.12.8).

Infectious syphilis: In New South Wales over the 3-year period 2022–2024, there were 429 notifications for infectious syphilis among Aboriginal people, corresponding to 41 notifications per 100,000 population (Table D1.12.1). After adjusting for differences in the age structure between the two populations, the notification rate for Aboriginal people was 2.1 times as high as the rate for non-Aboriginal people in New South Wales. Notification rates of syphilis were higher for males than females in both Aboriginal and non-Aboriginal populations (Figure 1.12.2).

Nationally in 2022–2024, there were 3,076 notifications for infectious syphilis among Aboriginal people, corresponding to 101 notifications per 100,000 population (Table D1.12.1). After adjusting for differences in the age structure between the two populations, the notification rate for Aboriginal people was 5.4 times the rate for non-Aboriginal people. Consistent with New South Wales, notification rates of syphilis were higher for males than females in both Aboriginal and non-Aboriginal populations. Among Aboriginal people, notification rates were lower in New South Wales than nationally for both males and females (Figure 1.12.2).

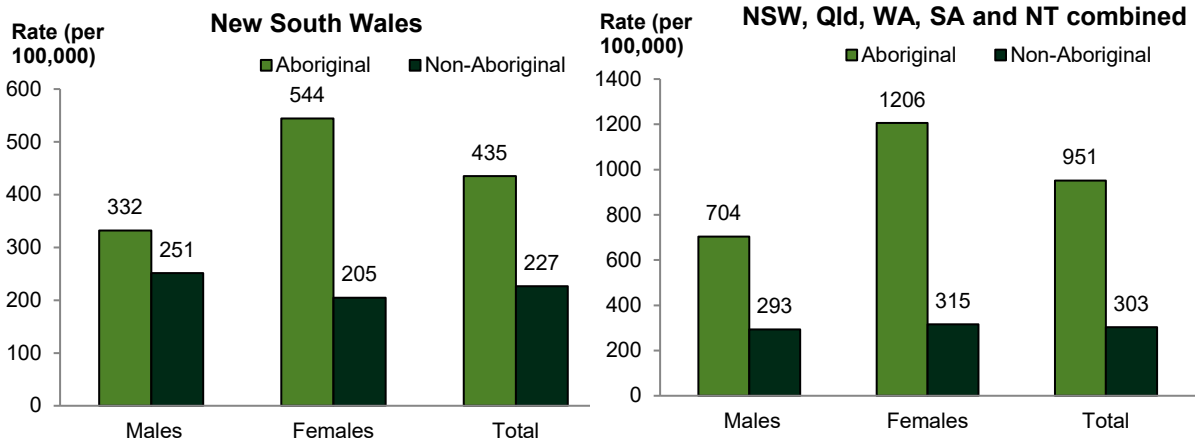
Figure 1.12.2: Age-standardised notification rates for infectious syphilis, by Aboriginal status and sex, NSW and Australia, 2022–2024



Source: National Notifiable Diseases Surveillance System (Table D1.12.1).

Other STIs: In 2022–2024 there were 5,162 notifications of chlamydia and 1,706 notifications of gonorrhoea among Aboriginal people in New South Wales, with notification rates 1.9 times and 1.4 times the rate for non-Aboriginal people, respectively. Notification rates of chlamydia were higher for Aboriginal females than Aboriginal males in both New South Wales and combined jurisdictions (Figure 1.12.3).

Figure 1.12.3: Age-standardised notification rates for chlamydia, New South Wales, and NSW, Qld, WA, SA and the NT combined, by Aboriginal status, 2022–2024



Note: Data for chlamydia are reported for NSW, Qld, WA, SA and NT. Analysis has been limited to jurisdictions where there is greater than 50% Aboriginal status completeness in the time period presented. They do not represent a quasi-Australian figure.

Source: National Notifiable Diseases Surveillance System (Table D1.12.1).

1.13 Community functioning

Why it is important

This measure reports on factors used to describe community functioning for Aboriginal people. Community functioning is defined as the ability and freedom of community members and communities to determine the context of their lives (for example, social, cultural, spiritual, and organisational) and to translate their capability (knowledge, skills, understanding) into action (to make things happen and achieve a life they value).

The National Aboriginal and Torres Strait Islander Social Survey, which collects detailed information on the social and cultural experiences of Aboriginal people, has not been conducted since 2014–15. As a result, data in this measure cannot be updated and should be interpreted with caution, as it may not reflect current circumstances.

Key findings

Resilience: In 2014–15 in New South Wales, 97% (134,300) of Aboriginal adults had participated in sport, social or community activities in the last 12 months and 85% (117,800) of Aboriginal people aged 15 and over did not avoid situations due to past unfair treatment. Among employed Aboriginal people aged 15 and over, 38% (26,000) said work allowed them to fulfil cultural responsibilities.

Nationally in 2014–15, 97% of Aboriginal adults had participated in sport, social or community activities in the last 12 months and 86% of Aboriginal people aged 15 and over did not avoid situations due to past discrimination. Around 41% of employed Aboriginal people aged 15 and over said work allowed them to fulfil cultural responsibilities (Figure 1.13.1).

Figure 1.13.1: Measures of resilience among Aboriginal people aged 15 and over, New South Wales and Australia, 2014–15



Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15 (Table D1.13.12).

Having a role, structure and routine: In 2014–15 in New South Wales, 29% (39,600) of Aboriginal people aged 15 and over had lived in one dwelling in the last 12 months. Nationally, 32% of Aboriginal people had lived in one dwelling in the last 12 months (Table D1.13.12).

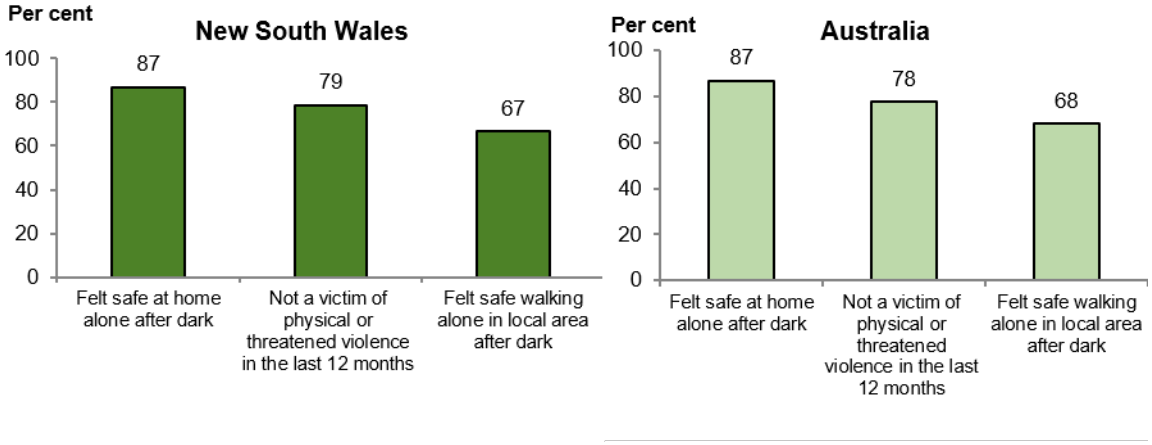
Feeling safe: In 2014–15 in New South Wales, of Aboriginal people aged 15 and over, 79% (108,900) had not experienced physical or threatened violence in the last 12 months, 87% (115,600) felt safe at home alone after dark and 67% (72,400) felt safe walking alone in the local area after dark.

Nationally in 2014–15, 78% of Aboriginal people aged 15 and over had not experienced physical or threatened violence in the last 12 months, 87% felt safe at home alone after dark and 68% felt safe walking alone in the local area after dark (Figure 1.13.2).

Vitality: In 2014–15 in New South Wales, of Aboriginal people aged 15 and over, 69% (94,200) had experienced low/moderate levels of psychological distress in the 4 weeks before the survey, 81% (112,100) could easily get to places as needed and 83% (115,500) had accessed the internet in the last 12 months.

Nationally in 2014–15, of Aboriginal people aged 15 and over, 67% experienced low/moderate levels of psychological distress in the 4 weeks before the survey, 75% could easily get to places as needed and 79% had accessed the internet in the last 12 months (Table D1.13.12).

Figure 1.13.2: Feeling of safety measures among Aboriginal people aged 15 and over, New South Wales and Australia, 2014–15



Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15 (Table D1.13.12).

1.14 Disability

Why it is important

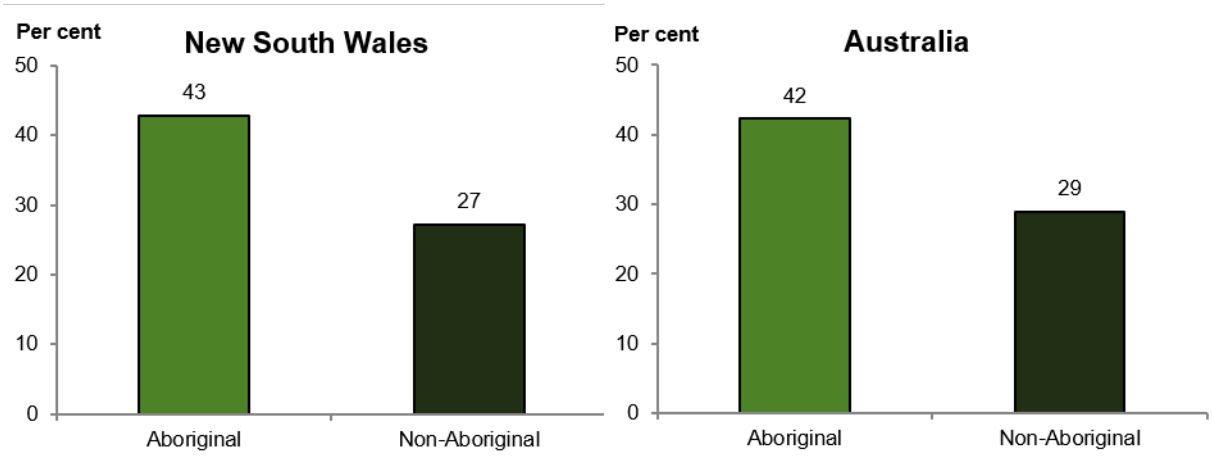
This measure reports on the prevalence of disability, including use of disability support services. Disability may be an impairment of body structure or function, a limitation in activities or a restriction in a person's participation in specific activities. A person's functioning involves an interaction between health conditions and environmental and personal factors. Aboriginal people are at greater risk of disability due to increased exposure to factors such as low birthweight, chronic disease, preventable disease and illness (for example, otitis media and acute rheumatic fever), injury and substance use. Importantly, disability is not solely a medical condition, but also a social experience shaped by environmental, cultural, and historical factors. For Aboriginal people, experiences of disability are shaped by broader social determinants and systemic inequities. These include limited access to culturally safe health care, early intervention, and rehabilitation services, as well as the impacts of colonisation and intergenerational trauma and disadvantage.

Key findings

Overall: Based on the NATSIHS 2022–23, in New South Wales, 37% (130,700) of Aboriginal people (all ages) reported having a disability or restrictive long-term health condition (Table D1.14.2). After adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people reporting having a disability or restrictive long-term health condition was 1.6 times as high as for non-Aboriginal Australians in New South Wales (43% compared with 27%) (Figure 1.14.1).

Similar trends were observed nationally in 2022–23, where 37% (367,700) of Aboriginal people reported having a disability or restrictive long term health condition (Table D1.14.2). After adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people reporting having a disability or restrictive long term health condition was 1.5 times as high as for non-Aboriginal Australians (42% compared with 29%) (Figure 1.14.1).

Figure 1.14.1: Age-standardised proportion of people reporting disability or a restrictive long-term health condition, by Aboriginal status, New South Wales and Australia, 2022–23

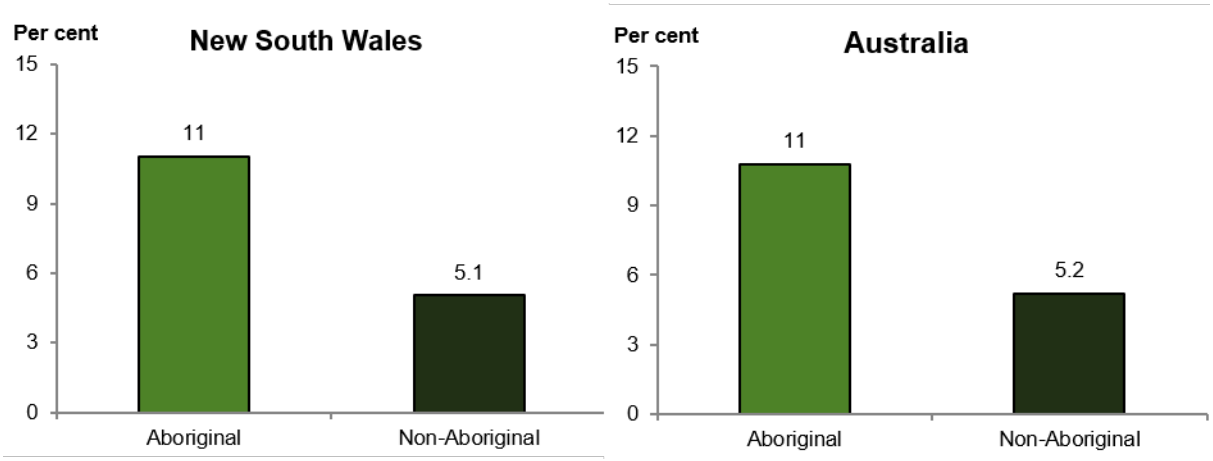


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D1.14.1).

Assistance with core activities: Based on the Census of Population and Housing in 2021 in New South Wales, 9.1% (24,500) of Aboriginal people needed assistance with a core activity (self-care, mobility or communication) (Table D1.14.12). The age-standardised proportion of Aboriginal people needing assistance with core activities was 2.2 times as high as for non-Aboriginal Australians in New South Wales (11% compared with 5.1%) (Figure 1.14.2).

Nationally in 2021, 8.6% of Aboriginal people needed assistance with a core activity. The age-standardised proportion of Aboriginal people needing assistance was 2 times as high as for non-Aboriginal Australians (11% compared with 5.2%) (Figure 1.14.2).

Figure 1.14.2: Age-standardised proportion needing core-activity assistance, by Aboriginal status, New South Wales and Australia, 2021

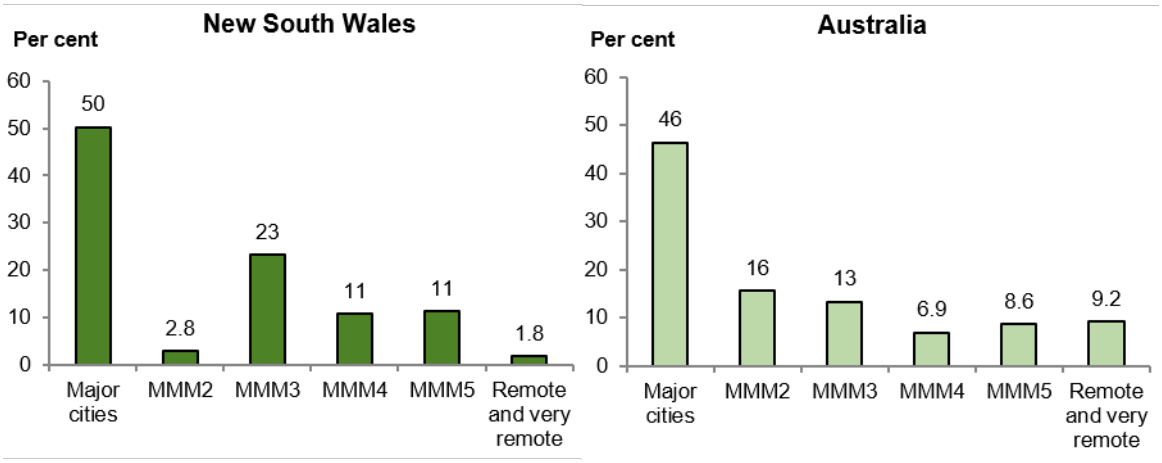


Source: ABS Census of Population and Housing 2021 (Table D1.14.12).

Users of disability support services: As at 30 June 2025 in New South Wales, there were 20,539 Aboriginal people using disability support services (NDIS 2025). Half (50%, 10,322) of the Aboriginal people using disability support services were in *Major cities* and 1.8% (367) were in *Remote and very remote* areas (Figure 1.14.3).

Nationally as at 30 June 2025, there were 60,529 Aboriginal people using disability support services (NDIS 2025). About 46% of the Aboriginal people using disability support services were in *Major cities* and 9.2% were in *Remote and very remote* areas (Figure 1.14.3).

Figure 1.14.3: Aboriginal people using disability support services, by remoteness, New South Wales and Australia, 30 June 2025



Note: MMM refers to the Modified Monash Model, which classifies areas according to geographic remoteness and town size. It is used by some government programs to define eligibility. MMM2 includes regional centres, MMM3 – Large rural towns, MMM4 – Medium rural towns, and MMM5 – Small rural towns. For more information see https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm.

Source: AIHW analysis of NDIS data (NDIS 2025).

1.15 Ear health

Why it is important

This measure reports on hearing loss, including measured and reported hearing loss as well as hospitalisation rates for diseases of the ear and mastoid process (the small bony lump just behind your ear, linked to the ear and hearing). Hearing loss, especially in childhood, can lead to linguistic, social and learning difficulties and behavioural problems in school. Such difficulties may reduce educational achievements and have lifelong consequences for wellbeing, employment, income, social success, contact with the criminal justice system and attaining future potential (Burrow et al. 2009; Hogan et al. 2011; Williams and Jacobs 2009; Yiengprugsawan et al. 2013).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Measured hearing loss: In 2018–19, the NATSIHS offered a voluntary hearing test for participants aged 7 and over. In New South Wales, an estimated 38% (86,000) Aboriginal people aged 7 and over were found to have hearing loss in one or both ears.

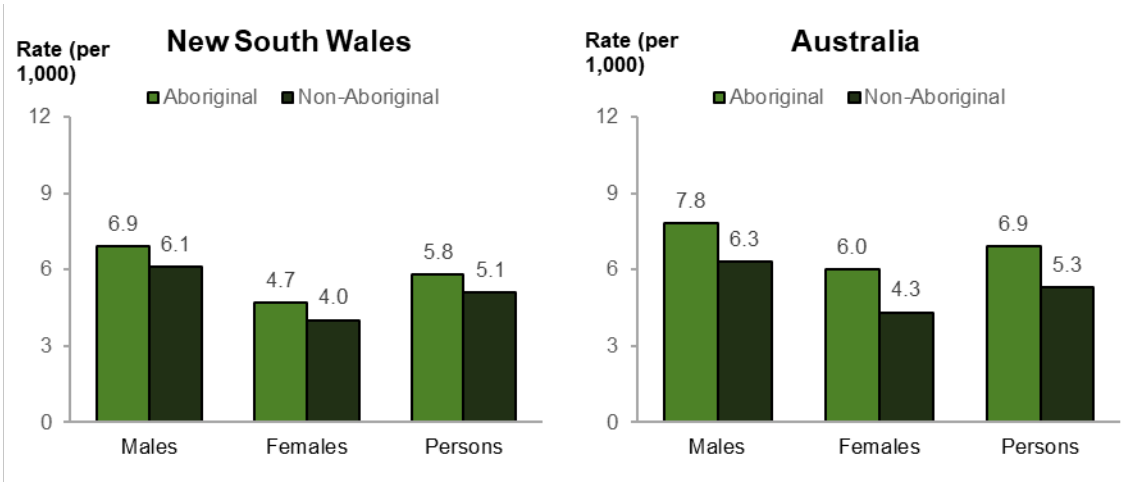
Nationally in 2018–19, an estimated 43% (290,400) of Aboriginal people aged 7 and over were found to have hearing loss in one or both ears (ABS 2019, ABS tables 32.1 and 32.3).

Reported ear and hearing problems: In 2022–23, an estimated 14% (48,900) of Aboriginal people in New South Wales were reported to have an ear or hearing problem compared with 13% nationally (ABS 2024c, ABS tables 26.1 and 26.3).

Hospitalisations for ear disease in children aged 0–14: From July 2021 to June 2023, for Aboriginal children aged 0–14 in New South Wales, there were 1,355 hospitalisations for diseases of the ear and mastoid process (ear disease) (based on principal diagnosis), a rate of 5.9 per 1,000 population (Table D1.15.10). The rates were higher for Aboriginal boys than Aboriginal girls (6.9 compared with 4.7 per 1,000 children, respectively). After adjusting for differences in the age structure between the two populations, the hospitalisation rate for ear disease for Aboriginal children was 1.1 times the rate for non-Aboriginal children in New South Wales (Figure 1.15.1).

Nationally, from July 2021 to June 2023 for Aboriginal children aged 0–14, there were 4,572 hospitalisations for ear disease, a rate of 7.0 per 1,000 population (Table D1.15.10). Similarly, the national rates were higher for Aboriginal boys than Aboriginal girls (7.8 compared with 6.0 per 1,000, respectively). After adjusting for differences in the age structure between the two populations, the hospitalisation rate for ear disease for Aboriginal children was 1.3 times the rate for non-Aboriginal children in Australia (Figure 1.15.1).

Figure 1.15.1: Age-standardised rate of hospitalisations for diseases of the ear and mastoid process (based on principal diagnosis), for children aged 0–14, by Aboriginal status and sex, New South Wales and Australia, July 2021 to June 2023

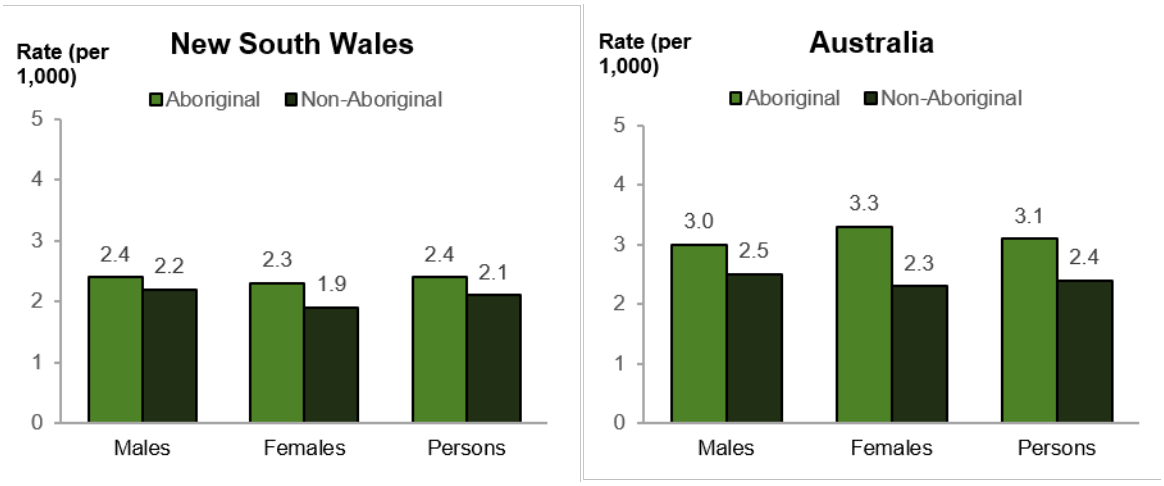


Source: National Hospital Morbidity Database (Table D1.15.10).

Hospitalisations for ear disease in Aboriginal people: From July 2021 to June 2023, for Aboriginal people in New South Wales, there were 1,933 hospitalisations for ear disease (based on principal diagnosis), a rate of 2.8 per 1,000 population (Table D1.15.12). The age-standardised hospitalisation rate for ear disease for Aboriginal people was 1.1 times the rate for non-Aboriginal Australians in New South Wales (Figure 1.15.2). In New South Wales from 2016–17 to 2022–23, the age-standardised hospitalisation rate for ear disease among Aboriginal people increased by 2.7%, while for non-Aboriginal people it decreased by 21% based on linear regression analysis, however neither change was statistically significant (Figure 1.15.3).

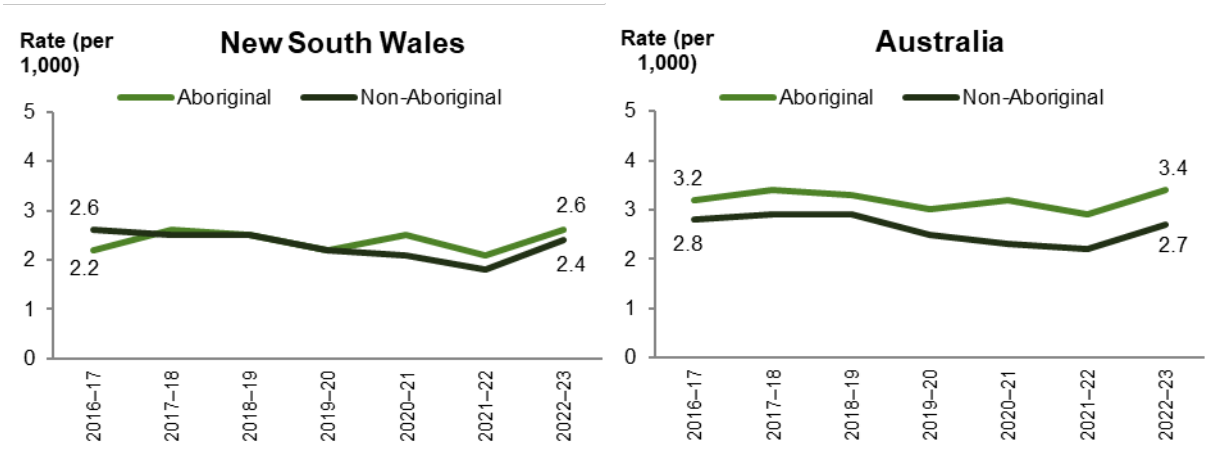
Nationally from July 2021 to June 2023, for Aboriginal people there were 7,142 hospitalisations for ear disease, a rate of 3.6 per 1,000 population (Table D1.15.12). After adjusting for age, the hospitalisation rate for ear disease for Aboriginal people was 1.3 times the rate for non-Aboriginal people (Figure 1.15.2). From 2016–17 to 2022–23, the hospitalisation rate for ear disease among Aboriginal people decreased by 3.5% and for non-Aboriginal people it decreased by 19% based on linear regression analysis, however neither change was statistically significant (Figure 1.15.3). Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change (see Interpretation of results).

Figure 1.15.2: Age-standardised rate of hospitalisations for diseases of the ear and mastoid process (based on principal diagnosis), by Aboriginal status and sex, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.15.12).

Figure 1.15.3: Age-standardised rate of hospitalisations for diseases of the ear and mastoid process (based on principal diagnosis), by Aboriginal status, New South Wales, and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.15.15 NSW).

1.16 Eye health

Why it is important

This measure reports on the prevalence of eye or sight problems, eye health checks and hospitalisations for diseases of the eye and adnexa (the supporting parts of the eyeball). The partial or full loss of vision affects all dimensions of life. Vision loss and eye disease can lead to linguistic, social and learning difficulties and behavioural problems during schooling years, which can then limit opportunities in education, employment and social engagement. In 2018, after adjusting for the differences in the age structure between the two populations, the burden due to hearing and vision disorders was 3.3 times as high for Aboriginal people as for non-Aboriginal Australians (AIHW 2026k).

Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

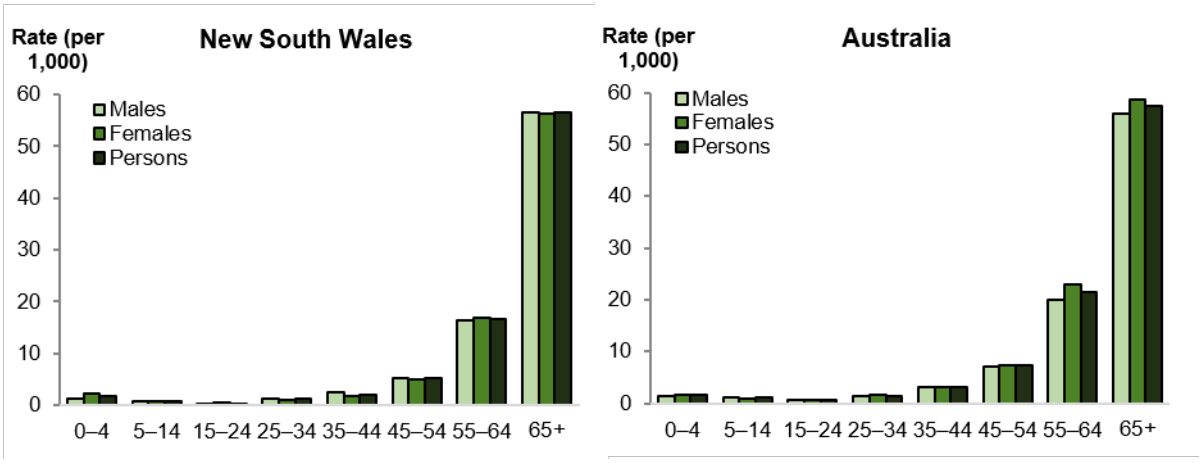
Eye health based on self-reported data: In 2022–23, 42% (147,100 people) of Aboriginal people (all ages) in New South Wales reported eye or sight problems. This is similar to the rate reported by Aboriginal people at the national level (41%) (ABS 2024c, ABS tables 26.1 and 26.3).

Nationally in 2022–23, the proportion of Aboriginal reporting eye or sight problems in non-remote areas was 43% compared with 29% in remote areas (ABS 2024c, ABS Table 2.3).

Hospitalisations: In New South Wales, between July 2021 and June 2023, there were 4,226 hospitalisations of Aboriginal people with a principal diagnosis of diseases of the eye and adnexa (Table D1.16.14). For those aged 15 and over the hospitalisation rate broadly increased with age, from 0.4 per 1,000 for those aged 15–24, to 57 per 1,000 for those aged 65 and over (Figure 1.16.1). The age-standardised hospitalisation rate for diseases of the eye and adnexa was around 19% lower for Aboriginal people than for non-Aboriginal Australians in New South Wales (11 compared with 13 per 1,000 population, respectively; rate ratio 0.8).

Nationally between July 2021 and June 2023, the hospitalisation rate for diseases of the eye and adnexa was around 14% lower for Aboriginal people than for non-Aboriginal people (12 compared with 14 per 1,000 population, respectively; rate ratio 0.9) (Table D1.16.12 NSW).

Figure 1.16.1: Hospitalisation rates for a principal diagnosis of diseases of the eye and adnexa, Aboriginal people, by sex and age group, New South Wales and Australia, July 2021 to June 2023



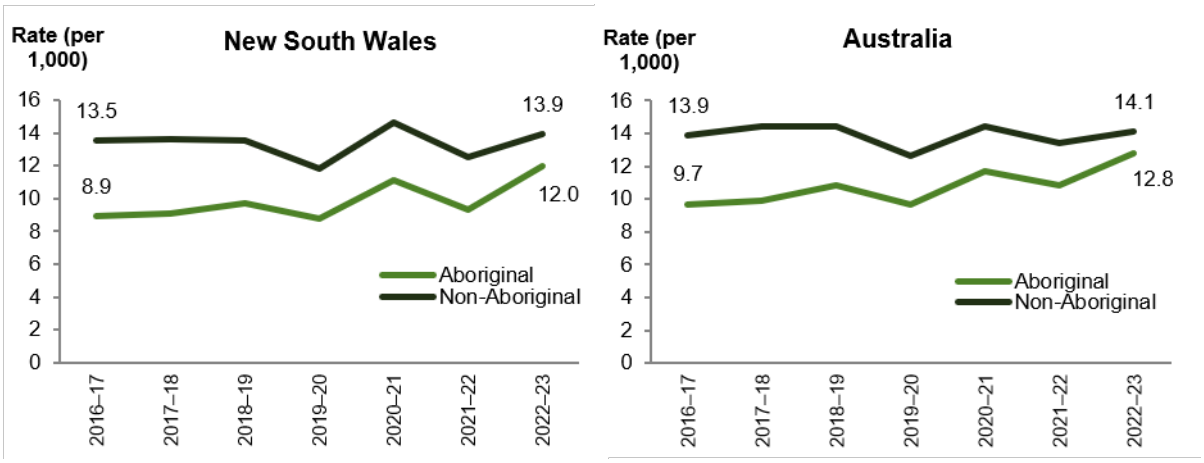
Source: National Hospital Morbidity Database (Table D1.16.12 NSW).

Hospitalisations trend over time: Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change (see Interpretation of results).

Between 2016–17 and 2022–23 in New South Wales, the age-standardised hospitalisation rate for diseases of the eye and adnexa increased by 28% for Aboriginal people compared with a 0.1% decrease for non-Aboriginal Australians in New South Wales (based on linear regression). However, neither change was statistically significant. Despite the higher increase in rates over time for Aboriginal people compared with non-Aboriginal people, eye and adnexa hospitalisation rates for Aboriginal people remained lower than for non-Aboriginal people in 2016–17 through to 2022–23.

Nationally between 2016–17 and 2022–23, the hospitalisation rate for Aboriginal people for diseases of the eye and adnexa also increased by 28%, while there was no statistically significant change in the rate for non-Aboriginal Australians (Figure 1.16.2).

Figure 1.16.2: Age-standardised hospitalisation rates for a principal diagnosis of diseases of the eye and adnexa, by Aboriginal status, New South Wales and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D1.16.18 NSW).

1.17 Perceived health status

Why it is important

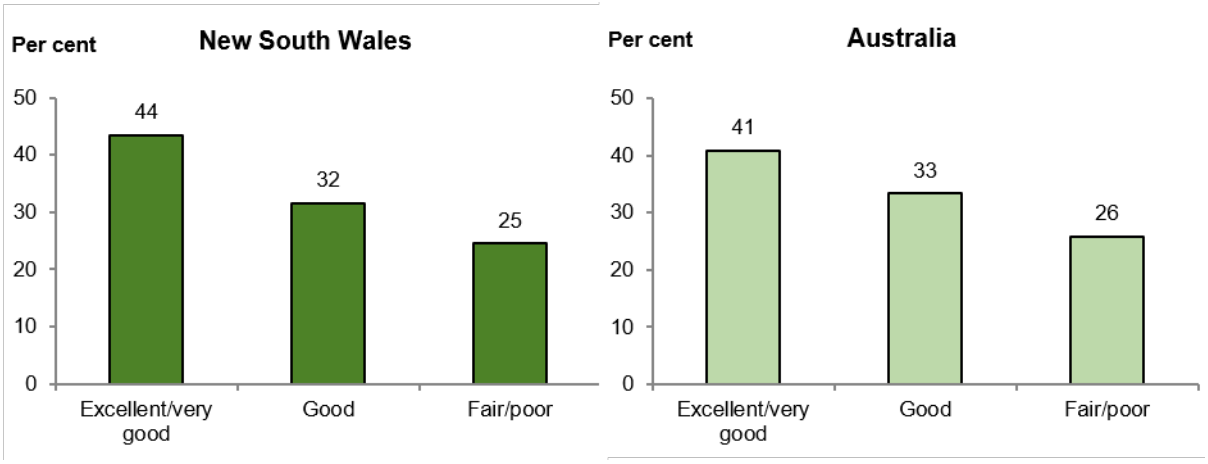
This measure reports on self-assessed health status of Aboriginal people. Self-assessed health status provides a measure of the overall level of a population's health based on individuals' personal perceptions of their own health. Self-assessed health status is a subjective measure dependent on an individual's awareness and expectations regarding their health and their comparisons with others around them. It is influenced by various factors, including access to health services and information, the extent to which health conditions have been diagnosed and level of education (AIHW 2018b; Delpierre et al. 2009).

Key findings

Self-assessed health status: Based on data from the 2022–23 NATSIHS, in New South Wales, an estimated 44% (101,000) of Aboriginal people aged 15 and over reported their health as excellent/very good, 32% (73,500) as good, and 25% (56,900) as fair/poor (Figure 1.17.1).

Nationally, 41% of Aboriginal people aged 15 and over reported their health as excellent/very good, 33% as good, and 26% as fair/poor (Figure 1.17.1).

Figure 1.17.1: Self-assessed health status, Aboriginal people aged 15 and over, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (ABS 2024c, Table 26.3).

Trend over time: The proportion of Aboriginal people in New South Wales aged 15 and over who reported their health as excellent/very good was at its highest in 2018–19 (47%) and its lowest in 2014–15 (39%). Meanwhile, the proportion of Aboriginal people in New South Wales who reported their health as fair/poor was lowest in 2018–19 (24%) and highest in 2002 (27%).

Nationally, the proportion of Aboriginal people who reported their health as excellent/very good between 2002 and 2022–23 ranged from 39% to 45% (Figure 1.17.2). Meanwhile, the proportion of Aboriginal people who reported their health as fair/poor varied between a low of 22% in 2004–05 to a high of 26% in 2022–23 (Table D1.17.8).

1.18 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
- **Suicide Call Back Service:** 1300 659 467
- **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.

Why it is important

Social and emotional wellbeing underpins the physical and mental health of Aboriginal people (PM&C 2017). The term 'Aboriginal people' refers to a wide variety of diverse nations, cultures, and language groups within Australia. It is important to take into consideration that different groups may have varying definitions and values of what social and emotional wellbeing looks like to a specific Aboriginal culture (see Closing the Gap information Repository). The AIHW describes social and emotional wellbeing as encompassing 7 interrelated domains: body; mind and emotions; family and kin; community; culture; country; spirituality and ancestors. This holistic approach is different to Western approaches to wellbeing as it focuses on Aboriginal health as a system and connects Aboriginal health to the health of their family, kin, community and their connection to country and culture. Disrupting these connections is highly associated with poor social and emotional wellbeing in Aboriginal people so it is crucial to have interventions that foster these connections to improve social and emotional wellbeing.

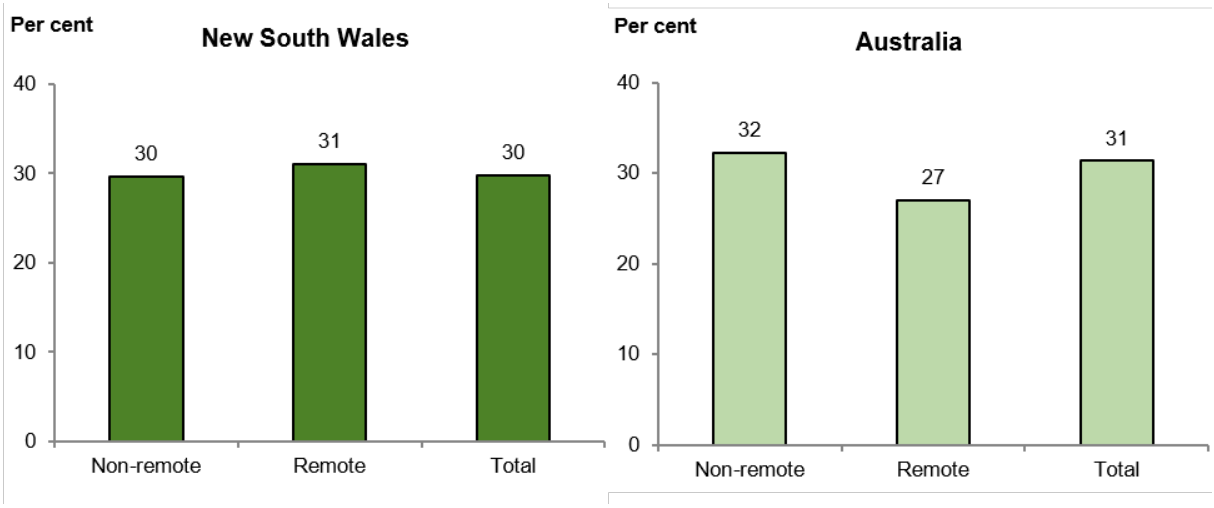
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Psychological distress: The 2022–23 NATSIHS showed that 30% (estimated 57,500) of Aboriginal people aged 18 and over in New South Wales reported high/very high levels of psychological distress. This proportion was very similar in remote (31%; 1,400) and non-remote areas (30%; 55,500).

Nationally, 31% of Aboriginal people aged 18 and over had high/very high levels of psychological distress and the proportion was higher in non-remote (32%) than remote areas (27%) (Figure 1.18.1).

Figure 1.18.1: Proportion of Aboriginal people aged 18 and over reporting high/very high levels of psychological distress, by remoteness, New South Wales and Australia, 2022–23

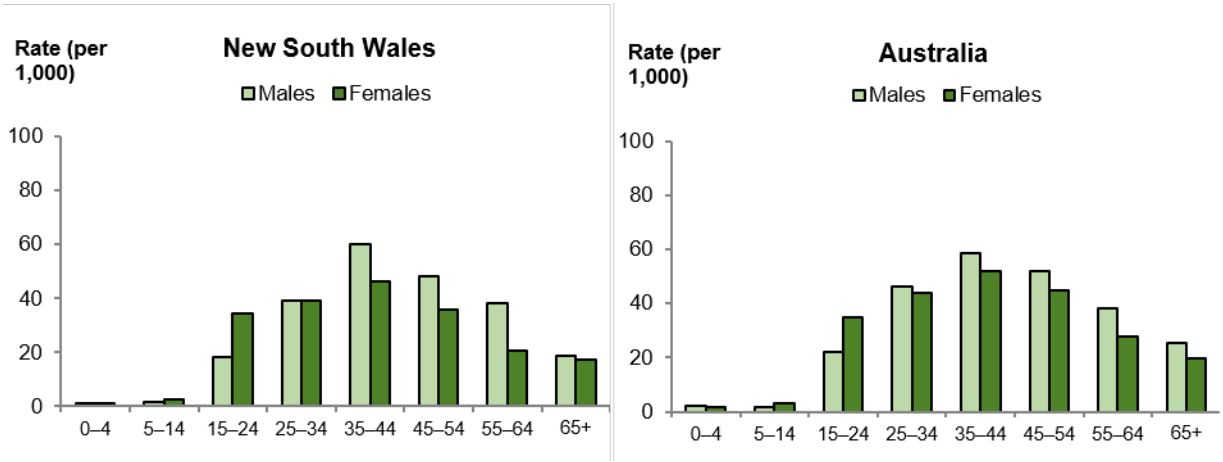


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D1.18.2).

Mental health related hospitalisations: Between July 2021 and June 2023, the hospitalisation rate for mental health-related conditions among Aboriginal people in New South Wales was 24 per 1,000 population and was similar for males and females overall (both 24 per 1,000) (Table D1.18.14 NSW). However, the age-specific rates differed by sex, with the rates being higher for Aboriginal females than for Aboriginal males among those aged 15–24 (35 and 18 per 1,000 population, respectively), the rates being similar for Aboriginal males and females aged 25–34 (39 per 1,000 population) and the rates being higher for Aboriginal males than Aboriginal females from ages 35–44 onwards. The highest rates in both sexes were for those aged 35-44 (60 and 47 per 1,000 population, for males and females, respectively). Rates for both sexes declined after the 35–44 year age group (Figure 1.18.2).

Nationally, between July 2021 and June 2023, the hospitalisation rate for mental health-related conditions among Aboriginal people was 27 per 1,000 population for both males and females (Table D1.18.14 NSW). Hospitalisation rates for mental health-related conditions nationally were also highest at age 35–44 for both males (59 per 1,000) and females (52 per 1,000) (Figure 1.18.2).

Figure 1.18.2: Hospitalisation rates for mental health-related conditions (based on principal diagnosis) for Aboriginal people, by sex and age group, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D1.18.14 NSW).

Deaths due to intentional self-harm: Between 2019 and 2023, the intentional self-harm death rate was 19 per 100,000 (314 deaths) among Aboriginal people in New South Wales. This rate was higher for Aboriginal males (28 per 100,000, 240 deaths) than for Aboriginal females (8.7 per 100,000, 74 deaths).

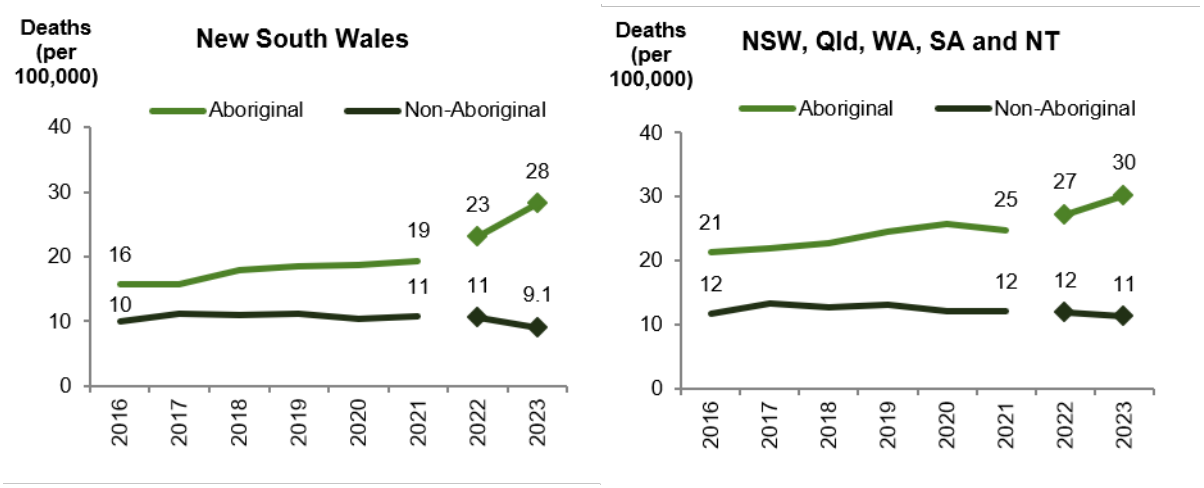
For the 5 jurisdictions with adequate Indigenous identification combined (NSW, Qld, WA, SA and NT), in 2019–2023, the intentional self-harm death rate was 24 per 100,000 for Aboriginal people (Table D1.18.30).

Deaths due to intentional self-harm trend over time: Due to changes in identification of Aboriginal status in New South Wales in 2022, data on deaths registered for New South Wales and for combined jurisdictions since 2022 are not comparable to data for previous years. The time trend analysis is therefore limited to the period 2016 to 2021. These changes also impact the combined data for 2019–2023 for New South Wales and the combined jurisdictions. Comparisons in death rates over time between jurisdictions, particularly New South Wales, should therefore be interpreted with caution. For more information see Interpretation of results section in this report.

In New South Wales, over the period from 2016 to 2021, the age-standardised death rate due to intentional self-harm for Aboriginal people increased by 25% (0.8 per 100,000 annually) (a statistically significant increase), while remaining about the same for non-Aboriginal Australians.

For NSW, Qld, WA, SA, and NT combined, from 2016 to 2021, the age-standardised death rate due to intentional self-harm for Aboriginal people increased by 21% (0.9 per 100,000 annually) and did not change significantly for non-Aboriginal people (Figure 1.18.3, Table D1.18.26).

Figure 1.18.3: Age-standardised intentional self-harm death rates, by Aboriginal status, New South Wales, and NSW, Qld, WA, SA and NT combined, 2016–2023



Source: AIHW National Mortality Database (Table D1.18.26).

1.19 Life expectancy at birth

Why it is important

This measure reports on life expectancy at birth. Life expectancy is a measure of how long, on average, a person is expected to live based on current age and sex-specific death rates. While life expectancy at birth measures how long, on average, a group of people might expect to live, it is not an exact measure of how long individuals will live or how healthy and happy they will be throughout their life (ABS 2018). Life expectancy reflects the combined effects of socioeconomic factors, health risk behaviours and access to high-quality health care services. Variations in life expectancy not only express the expected differences in population longevity but are also indicators of socioeconomic equity and justice.

The life expectancy gap between Aboriginal people and non-Aboriginal Australians represents 'arguably the most important, and certainly most symbolic, indicator of Aboriginal disadvantage' (Banks 2009). In 2008, the Council of Australian Governments committed to closing the gap in life expectancy between Aboriginal people and non-Aboriginal Australians within a generation (by 2031) (COAG 2008). This is also a target under the 2020 National Agreement on Closing the Gap.

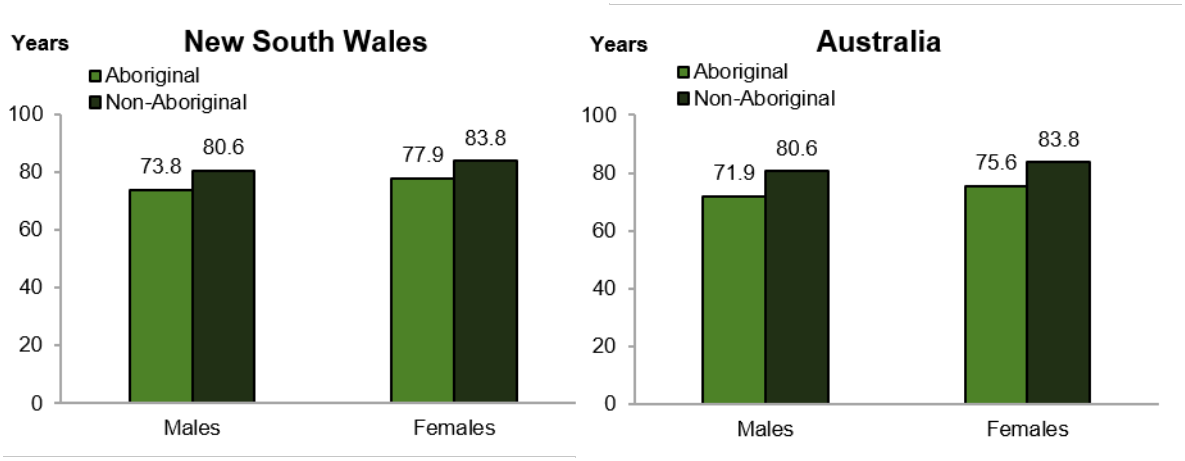
The reporting period (2020 to 2022) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

Overall: In 2020–2022 in New South Wales, life expectancy at birth was estimated to be 73.8 years for Aboriginal males and 77.9 years for Aboriginal females. These estimates were lower than for non-Aboriginal males (80.6 years) and females (83.8 years) in New South Wales, representing a gap of 6.8 years for males and 5.9 years for females.

Nationally in 2020–2022, life expectancy at birth for Aboriginal people was estimated to be 71.9 years for males and 75.6 years for females. For non-Aboriginal Australians, life expectancy at birth was estimated to be 80.6 years for males, and 83.8 years for females, representing a gap of 8.8 years for males and 8.1 years for females (Figure 1.19.1).

Figure 1.19.1: Life expectancy at birth, by Aboriginal status and sex, New South Wales and Australia, 2020–2022

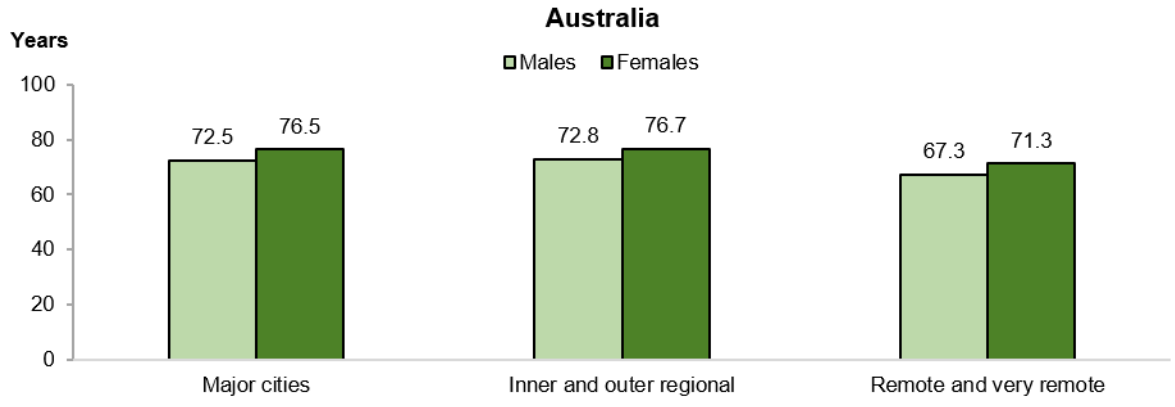


Source: ABS Aboriginal and Torres Strait Islander life expectancy 2020–2022 (Table D1.19.1).

By remoteness: Life expectancy estimates that are disaggregated by remoteness are not available for individual jurisdictions.

Nationally in 2020–2022, life expectancy for Aboriginal males living in *Major cities* and *Inner and outer regional* areas was higher than for Aboriginal males living in *Remote and very remote* areas (72.5 and 72.8 years compared with 67.3 years, respectively). Similarly, Aboriginal females living in *Major cities* and *Inner and outer regional* areas, had a higher life expectancy than Aboriginal females living in *Remote and very remote* areas (76.5 and 76.7 years compared with 71.3 years, respectively) (Figure 1.19.2).

Figure 1.19.2: Life expectancy at birth, Aboriginal people, by sex and remoteness, Australia, 2020–2022



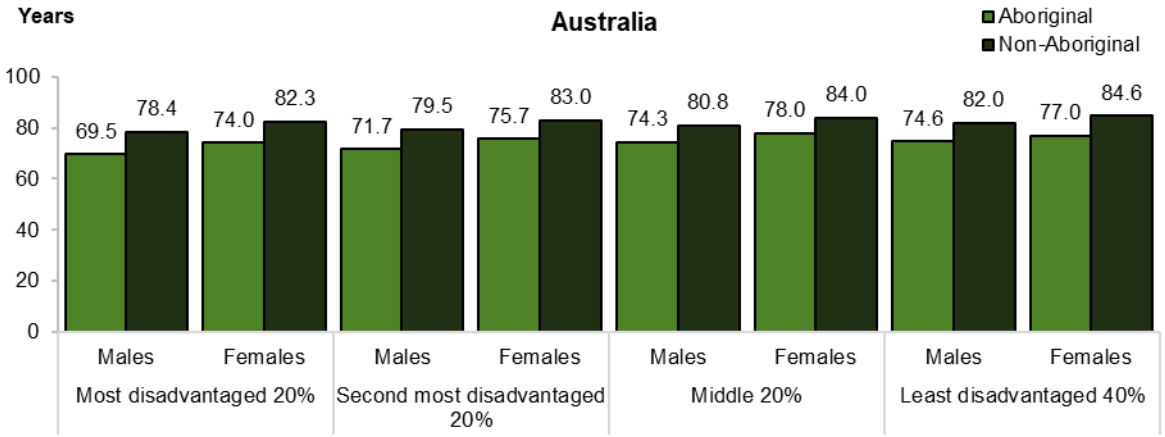
Source: ABS Aboriginal and Torres Strait Islander life expectancy 2020–2022 (Table D1.19.3).

Socioeconomic areas: Life expectancy estimates that are disaggregated by areas of socioeconomic disadvantage (quintiles of the Socio-Economic Index for Areas (SEIFA)) are not available for individual jurisdictions.

In 2020–2022, life expectancy was highest for Aboriginal people living in the least socioeconomically disadvantaged areas (top SEIFA quintile) (74.6 years for males and 77.0 years for females), and lowest for Aboriginal people living in the most disadvantaged areas (lowest SEIFA quintile) (69.5 years for males and 74.0 years for females).

Life expectancy for Aboriginal people was lower than for non-Aboriginal Australians living across all areas of socioeconomic disadvantage (all quintiles of SEIFA). Life expectancy for Aboriginal people living in the least disadvantaged areas (top SEIFA quintile) was lower than life expectancy for non-Aboriginal Australians living in the most disadvantaged areas (lowest SEIFA quintile) (Figure 1.19.3).

Figure 1.19.3: Life expectancy at birth, by Aboriginal status, sex and areas of socioeconomic disadvantage, Australia, 2020–2022



Source: ABS Aboriginal and Torres Strait Islander life expectancy 2020–2022 (Table D1.19.4).

1.20 Infant and child mortality

Content warning:

This and the following measure (1.21 Perinatal mortality) contain information some readers may find distressing. If this material raises any issues for you, these services can help:

- **Red Nose Grief and Loss**: 1300 308 307
- **13YARN:** 13 92 76

Go to the **AIHW support services page** for a full list of support services.

Why it is important

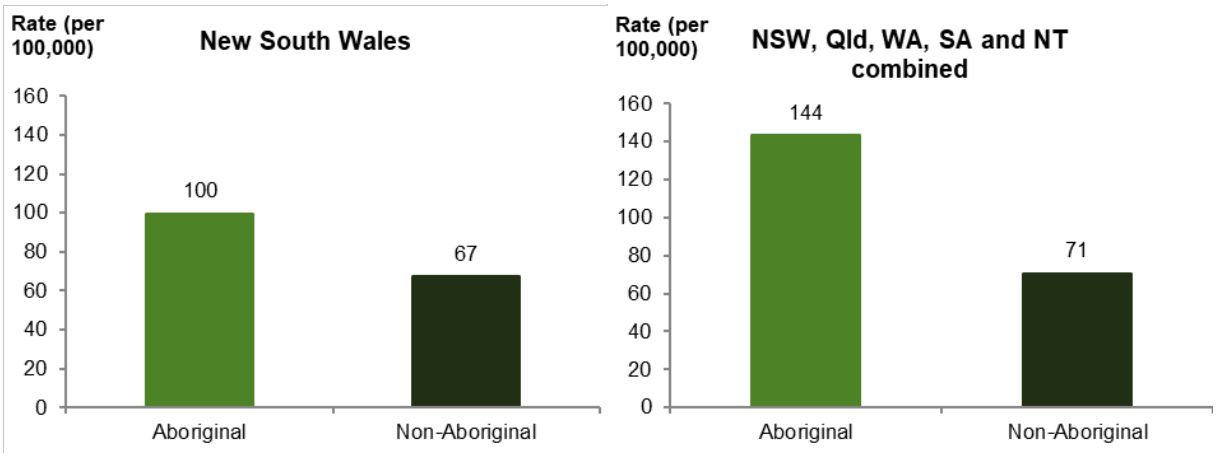
This measure reports on the death rates of Aboriginal infants (less than 1 year of age) and children aged 0–4. Infant and child mortality are long-established measures of child health, as well as the overall health of the population, and its physical and social environment. Australia's infant and child death rates (for the whole population) have declined over the last 100 years due to improved social and public health conditions, followed by the development of immunisation and, in more recent years, better treatment in neonatal intensive care and interventions for Sudden Infant Death Syndrome (SIDS). The key risk factors associated with infant and child mortality include low birthweight and pre-term births, maternal health and behaviours (for example, nutrition during pregnancy, smoking and alcohol use), socioeconomic status and access to health services (AIHW 2014b; NIAA 2020). The rates of infant mortality and child mortality for Aboriginal people need to be understood and interpreted in the context of the devastating impact of colonisation and subsequent discriminatory government policies.

Key findings

Child (aged 0–4) mortality: In the period 2019–2023 in New South Wales, there were 190 deaths of Aboriginal children aged 0–4 (84% or 159 of these were infant deaths) and 1,496 deaths of non-Aboriginal New South Wales children of the same age group (86% or 1,291 of these were infant deaths) (Table D1.20.1). Among this age group, the death rate for Aboriginal children was 1.5 times the rate for non-Aboriginal children (100 and 67 per 100,000, respectively) (Figure 1.20.1).

For the 5 jurisdictions with adequate level of Indigenous identification (NSW, Qld, WA, SA, and NT combined), there were 677 deaths of Aboriginal children aged 0–4 (83% or 569 of these were infant deaths) and 3,467 deaths of non-Aboriginal children of the same age group (85% or 2,945 of these were infant deaths) (Table D1.20.1). The death rate for Aboriginal children aged 0–4 was 2.0 times the rate for non-Aboriginal children (144 and 71 per 100,000, respectively) (Figure 1.20.1).

Figure 1.20.1: Death rate of children (aged 0–4), by Aboriginal status, New South Wales and NSW, Qld, WA, SA and the NT combined, 2019–2023

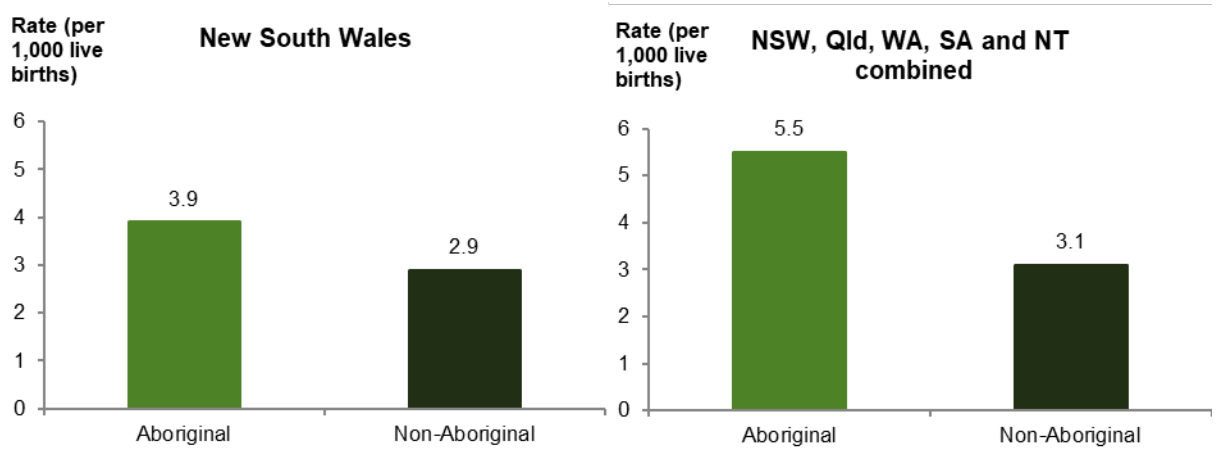


Source: AIHW National Mortality Database (Table D1.20.1).

Infant (aged 0–1) mortality: Of the 159 Aboriginal infant deaths in New South Wales in 2019–2023, 99 deaths were in the neonatal period (aged under 28 days) which accounted for 62% of all infant deaths and 52% of all child deaths (aged 0–4). For non-Aboriginal New South Wales infants, 77% (988) of the 1,291 deaths were in the neonatal period (Table D1.20.4). The death rate for Aboriginal infants was 1.3 times the rate for non-Aboriginal infants in New South Wales (3.9 and 2.9 per 1,000 live births, respectively) (Figure 1.20.2).

For NSW, Qld, WA, SA and the NT combined, the death rate for Aboriginal infants was 1.8 times the rate for non-Aboriginal infants (5.5 compared with 3.1 per 1,000 live births) (Figure 1.20.2).

Figure 1.20.2: Death rate of infants (aged less than 1 year), by Aboriginal status, New South Wales and NSW, Qld, WA, SA and the NT combined, 2019–2023



Source: AIHW National Mortality Database (Table D1.20.4).

Trend over time: Due to changes in identification of Aboriginal status in New South Wales in 2022, data on deaths registered for New South Wales and for combined jurisdictions since 2022 are not comparable to data for previous years. The time trend analysis is therefore limited to the period 2016 to 2021. These changes also impact the combined data for 2019–2023 for New South Wales and the combined jurisdictions. Comparisons in death rates over time between jurisdictions, particularly New South Wales, should therefore be interpreted with caution. For more information see Interpretation of results.

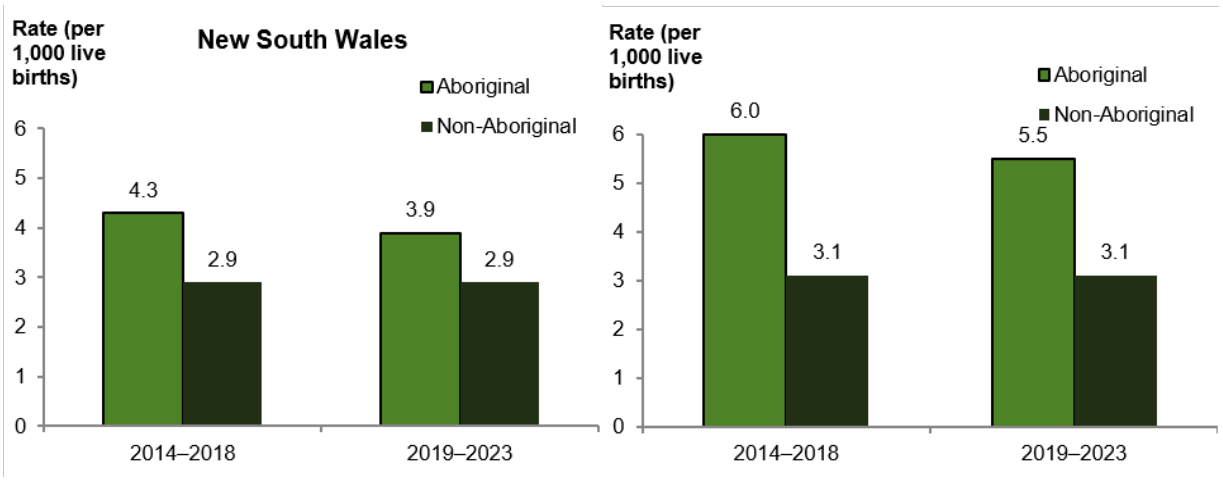
In New South Wales, the death rate for Aboriginal infants was 4.3 per 1,000 live births (131 deaths) in 2014–2018 and 3.9 per 1,000 live births (159 deaths) in 2019–2023 (deaths are presented in 5-year groupings because of small numbers in each year). Between 2014–2018 and 2019–2023, the absolute gap (rate difference) between Aboriginal and non-Aboriginal infant death rates narrowed from 1.4 to 1.0 per 1,000 live births (Figure 1.20.3).

For NSW, Qld, WA, SA, and NT combined, the death rate for Aboriginal infants was 6.0 per 1,000 live births in 2014–2018 and 5.5 per 1,000 live births in 2019–2023. Over the same period, the absolute gap (rate difference) between Aboriginal and non-Aboriginal infant death rates narrowed from 2.9 to 2.4 per 1,000 live births (Figure 1.20.3).

In New South Wales between 2016 and 2021, the death rate for Aboriginal children aged 0–4 increased by 11% (based on linear regression), but this was not statistically significant. For non-Aboriginal children, there was decrease of 15% which was also not statistically significant (Table D1.20.16).

For NSW, Qld, WA, SA and NT combined, there was a non-significant decrease of 1.2% in the death rate for Aboriginal children aged 0–4 between 2016 and 2021, and a non-significant increase of 2.1% for non-Aboriginal children over the same period (Table D1.20.16). Data from 2022 and 2023 are not comparable to previous years due to a change in the process for deriving Aboriginal status for deaths in NSW.

Figure 1.20.3: Death rate of infants (aged less than 1 year), by Aboriginal status, New South Wales, and NSW, Qld, WA, SA and the NT combined, 2014–2018 and 2019–2023



Source: AIHW National Mortality Database (Tables D1.20.9).

1.21 Perinatal mortality

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:

- **Red Nose Grief and Loss** 1300 308 307
- **13YARN** 13 92 76

Why it is important

This measure reports on the number of deaths in the perinatal period. Perinatal mortality is defined as deaths commencing from at least 20 weeks gestation (fetal deaths or 'stillbirths') and deaths of liveborn babies within 28 days of birth (neonatal deaths). Perinatal mortality reflects the health status and health care of the general population, access to and quality of preconception, reproductive, antenatal and obstetric services for women, and health care in the neonatal period. Broader social factors such as maternal education, nutrition, smoking, alcohol use in pregnancy and socioeconomic disadvantage are also important (Eades 2004; Performance Indicator Reporting Committee 2002).

Key findings

Overall: In the 5-year period 2018–2022, there were 300 perinatal deaths among babies born to Aboriginal women in New South Wales (Table D1.21.4). Stillbirths accounted for 71% (214) of deaths, 14% (43) occurred in the first 24 hours after birth, and the remaining 14% (42) occurred within 28 days of birth (Table D1.21.6).

In New South Wales in 2018–2022, the perinatal death rate among babies born to Aboriginal women was 1.5 times as high as the rate for non-Aboriginal women (13 compared with 8.5 deaths per 1,000 births). The national perinatal death rate among babies born to Aboriginal women was 1.8 times the rate for non-Aboriginal women (17 compared with 9.4 deaths per 1,000) (Figure 1.21.1).

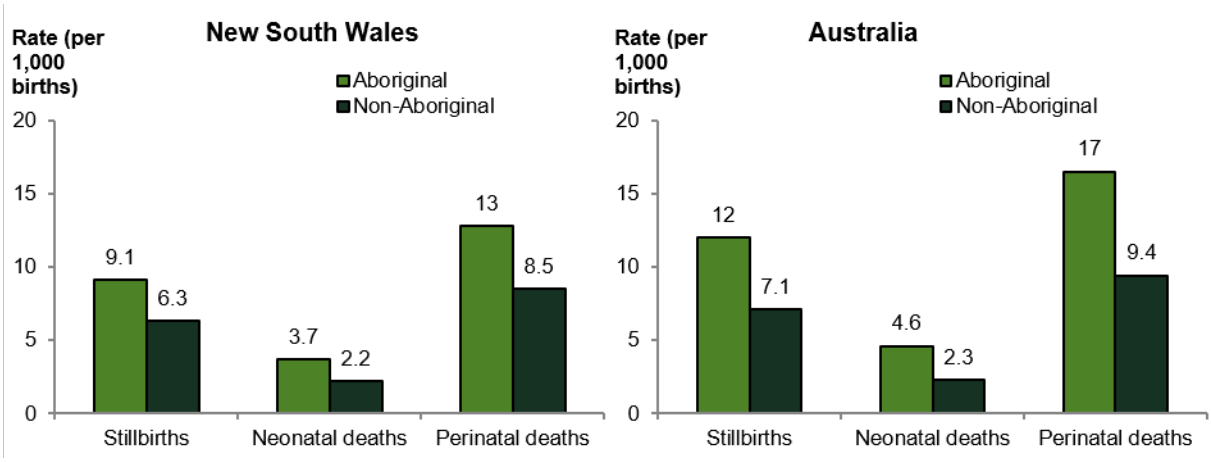
Stillbirths (fetal deaths): In 2018–2022, the stillbirth rate among babies born to Aboriginal women in New South Wales was 9.1 per 1,000 births, compared with 6.3 per 1,000 for babies born to non-Aboriginal women.

The national stillbirth rate among babies born to Aboriginal women was 12 per 1,000 births, compared with 7.1 per 1,000 for babies born to non-Aboriginal women (Figure 1.21.1).

Neonatal deaths: In New South Wales in 2018–2022, for neonates born to Aboriginal women the death rate was 3.7 per 1,000 live births, 1.7 times as high as the rate for neonates born to non-Aboriginal women in New South Wales (2.2 per 1,000).

Nationally, the death rate for neonates born to Aboriginal women was twice the rate for neonates born to non-Aboriginal women (4.6 compared with 2.3 per 1,000) (Figure 1.21.1).

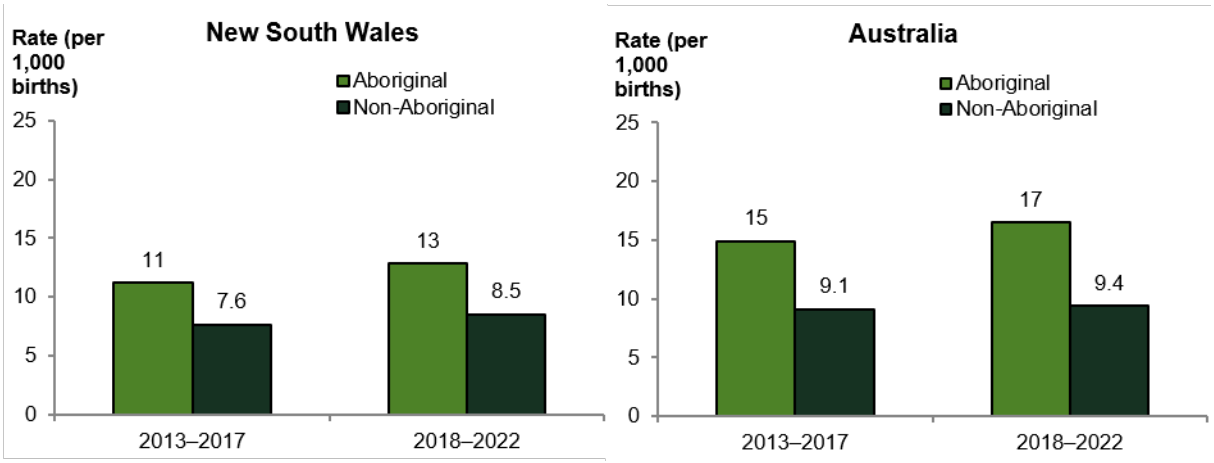
Figure 1.21.1: Stillbirth, neonatal and perinatal death rates, by Aboriginal status, New South Wales and Australia, 2018–2022



Source: National Perinatal Mortality Data Collection and the National Perinatal Data Collection (Table D1.21.4).

Trend over time: In New South Wales, the perinatal death rate among babies born to Aboriginal women in 2013–2017 was lower than the rate in 2018–2022 (11 compared with 13 per 1,000 births). The perinatal death rates for babies born to non-Aboriginal New South Wales women also rose slightly over the two periods (7.6 and 8.5 per 1,000) (Figure 1.21.2).

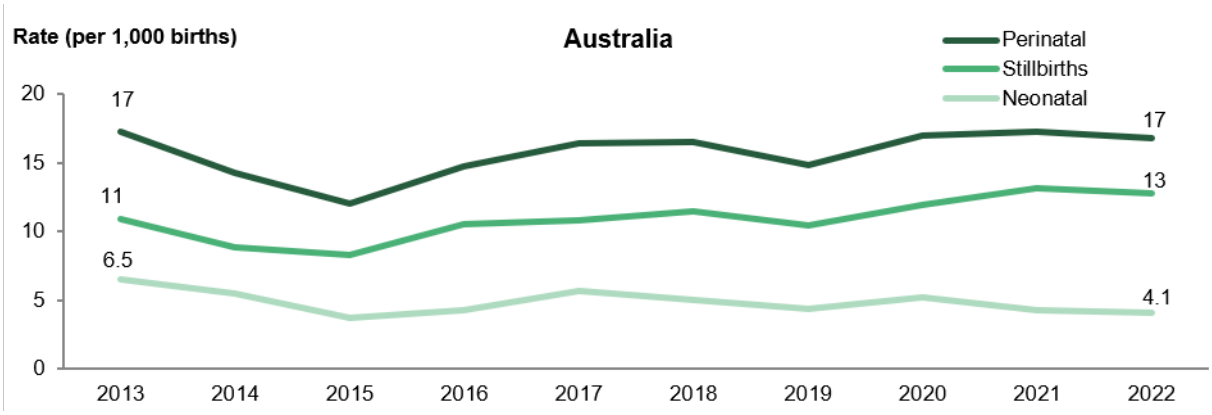
Figure 1.21.2: Perinatal death rates, by Aboriginal status, New South Wales and Australia, 2013–2017 and 2018–2022



Source: National Perinatal Mortality Data Collection and the National Perinatal Data Collection (Table D1.21.4).

Nationally, based on linear regression, over the decade between 2013 and 2022, there was no statistically significant change in the perinatal death rate or the neonatal death rate among babies born to Aboriginal or non-Aboriginal mothers. However, there were statistically significant changes in the stillbirth rates, with the rate for babies born to Aboriginal mothers increasing by 39% over the period and the rate for babies born to non-Aboriginal mothers increasing by 10%. (Figure 1.21.3).

Figure 1.21.3: Stillbirth, neonatal and perinatal death rates among babies born to Aboriginal women, Australia, 2013–2022



Note: The per cent change over time presented in the text may appear inconsistent with the first and last rates in the time series due to the use of linear regression to calculate the per cent change (see Interpretation of results).

Source: National Perinatal Mortality Data Collection and the National Perinatal Data Collection (Tables D1.21.2, D1.21.3).

1.22 All-cause age-standardised death rates

Why it is important

This measure reports on the death rate from all causes. The death rate of a population provides a summary measure of the overall health status of that population. Death rates are a useful measure with which to compare the overall health status of different populations and to monitor changes in overall health status of populations over time. However, there may be delays for many years before improvements in health status can lead to reductions in mortality.

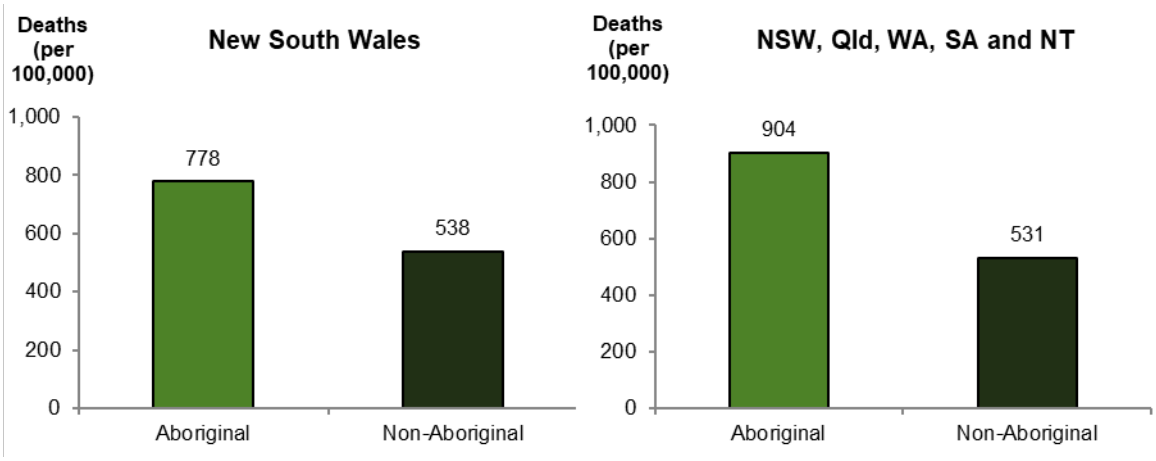
Key findings

The reporting of the national data in this measure has been limited to 5 jurisdictions (New South Wales, Queensland, Western Australia, South Australia and the Northern Territory), in which the quality of Indigenous status identification in the deaths data is considered adequate. Data are aggregated into 5-year groupings due to small number of deaths in each individual year.

Overall: In 2019–2023 in New South Wales, there were 6,953 deaths of Aboriginal people, corresponding to a crude death rate of 409 per 100,000 population (Table D1.22.3). After adjusting for differences in the age structure between the two populations, the death rate for Aboriginal people was 1.4 times the rate for non-Aboriginal Australians in New South Wales (778 compared with 538 per 100,000, respectively).

In 2019–2023 for NSW, Qld, WA, SA and the NT combined, there were 19,993 deaths of Aboriginal people, corresponding to a crude death rate of 464 per 100,000 population (Table D1.22.3). After adjusting for differences in the age structure between the two populations, the death rate for Aboriginal people was 1.7 times the rate for non-Aboriginal Australians (904 compared with 531 per 100,000, respectively) (Figure 1.22.1).

Figure 1.22.1: Age-standardised death rates, by Aboriginal status, New South Wales, and NSW, Qld, WA, SA and NT combined, 2019–2023



Source: AIHW National Mortality Database (Table D1.22.3).

Trend over time: Although there is data on Aboriginal deaths up to 2023, time series analysis in this measure has been limited to the period 2016 to 2021. Due to changes in identification of Aboriginal status in New South Wales in 2022, data on deaths registered for New South Wales and for combined jurisdictions since 2022 are not comparable to data for previous years. These changes also impact the combined data for 2019–2023 for New South Wales and the combined jurisdictions. Comparisons in death rates over time between jurisdictions, particularly New South Wales, should therefore be interpreted with caution. For more information see Interpretation of results.

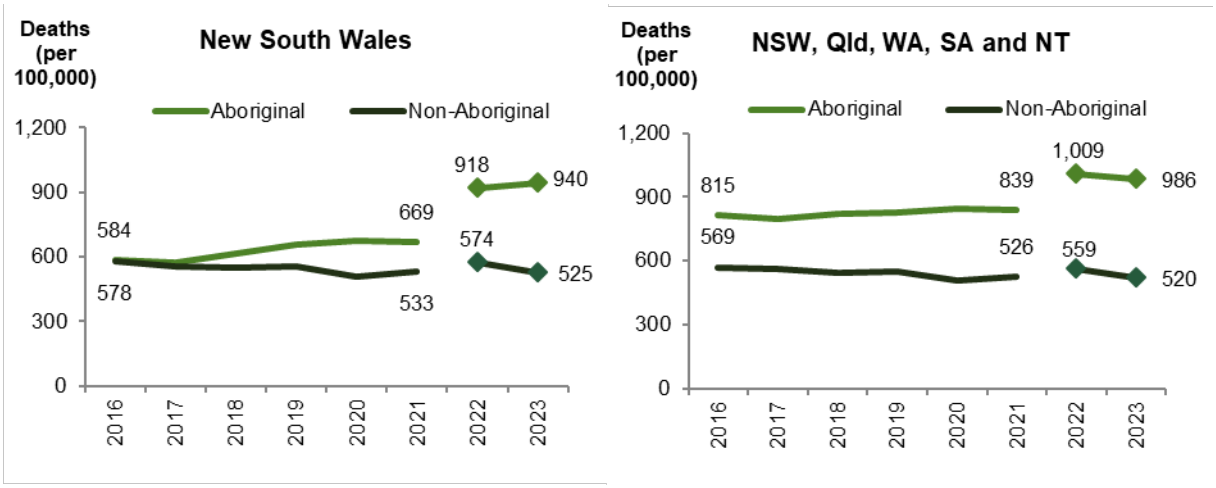
From 2016 to 2021 in New South Wales, the age-standardised death rate increased by 19% for Aboriginal people based on linear regression results. In the same period the age-standardised death rate stayed about the same among non-Aboriginal Australians in New South Wales (9.0% decrease that was statistically not significant) (Figure 1.22.2).

This resulted in a widening of the gap between the two populations, with the absolute gap (rate difference) in the age-standardised death rate between Aboriginal people and non-Aboriginal Australians in New South Wales increasing from 5.1 to 136 per 100,000. Over the same period, the relative difference (rate ratio) increased slightly from 1.0 to 1.3 times as high for Aboriginal people as for non-Aboriginal Australians in New South Wales (Figure 1.22.3).

From 2016 to 2021 for NSW, Qld, WA, SA and the NT combined, the age-standardised death rate for Aboriginal people increased by 5.1% based on linear regression. For non-Aboriginal people, it decreased by 9.5% over the same period (Figure 1.22.2). Data from 2022 and 2023 are not comparable to previous years due to a change in the process for deriving Aboriginal status for deaths in New South Wales.

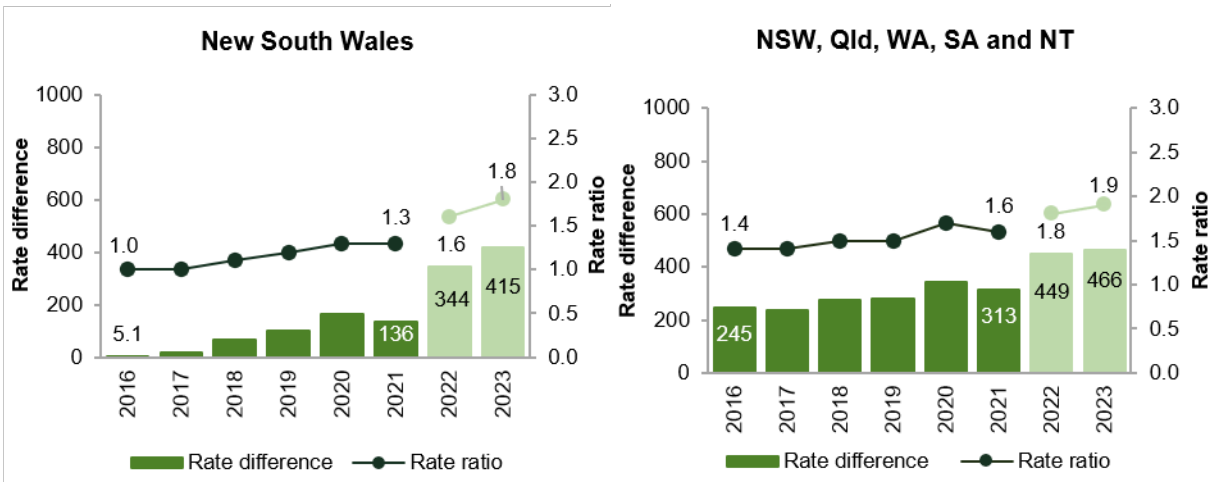
From 2016 to 2021 in the 5 jurisdictions combined, the absolute difference in the age-standardised death rate between Aboriginal people and non-Aboriginal Australians increased from 245 to 313 per 100,000. Over the same period, the relative difference (rate ratio) increased from 1.4 to 1.6 (Figure 1.22.3).

Figure 1.22.2: Age-standardised death rate, by Aboriginal status, New South Wales, and NSW, Qld, WA SA and the NT combined, 2016 to 2023



Source: AIHW National Mortality Database (Table D1.22.6).

Figure 1.22.3 Age-standardised death rate differences and rate ratios, by Aboriginal status, New South Wales, and NSW, Qld, WA, SA and NT, 2016 to 2023



Note: Data for the combined jurisdictions from 2022 and 2023 are not comparable to previous years due to data quality issues (see Interpretation of results).

Source: AIHW National Mortality Database (Table D1.22.6).

1.23 Leading causes of death

Why it is important

This measure reports on the main causes of death. Analysis of leading causes of death can provide insights into the overall health status of different populations as well as the contributing factors and can indicate areas needing policy focus. Disparities in mortality within the Aboriginal population and between Aboriginal people and non-Aboriginal Australians for particular causes of death can provide insight into where policy attention is needed to close the gap.

Key findings

The reporting of the national data in this measure has been limited to 5 jurisdictions (New South Wales, Queensland, Western Australia, South Australia and the Northern Territory), in which the quality of Indigenous status identification in the deaths data is considered adequate. Data are aggregated into 5-year groupings due to small number of deaths in each individual year.

Overall: In the 5-year period 2019–2023, for Aboriginal people in New South Wales, the top 5 leading causes of death accounted for 5,403, or 78% of all deaths (Table D1.23.2).

Based on crude rates, the top 5 leading causes of death were:

- cancer and other neoplasms (tumours) (110 per 100,000 population)
- cardiovascular (circulatory) disease (82 per 100,000)
- injury and poisoning (51 per 100,000)
- respiratory diseases (47 per 100,000)
- endocrine, nutritional and metabolic diseases which include mostly diabetes (28 per 100,000).

After adjusting for differences in the age structure between the two populations, the top 5 leading causes of death for Aboriginal people in New South Wales were:

- cancer and other neoplasms (216 per 100,000 population)
- cardiovascular (circulatory) diseases (168 per 100,000)
- respiratory diseases (96 per 100,000)
- injury and poisoning (67 per 100,000)
- endocrine, nutritional and metabolic diseases which include mostly diabetes (54 per 100,000).

The change in ranking between injury and poisoning and respiratory diseases reflects differences in the ages at which these causes most commonly occur, rather than a change in the underlying patterns of mortality.

For non-Aboriginal Australians in New South Wales during the same period, after adjusting for differences in the age structure between the two populations, the top 5 leading causes of death were similar although occurring at lower rates:

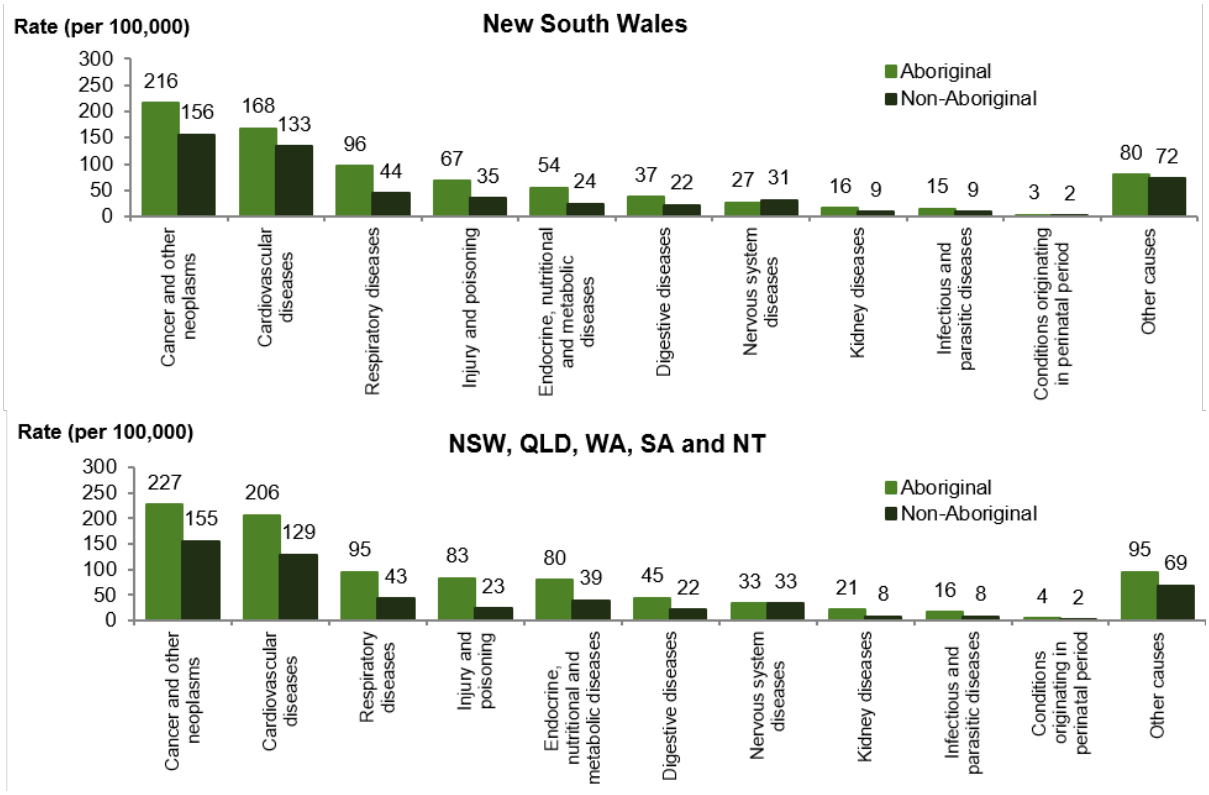
- cancer and other neoplasms (156 per 100,000 population)
- cardiovascular (circulatory) diseases (133 per 100,000)

- respiratory diseases (44 per 100,000)
- injury and poisoning (35 per 100,000)
- nervous system diseases (31 per 100,000) (Figure 1.23.1).

In NSW, Qld, WA, SA and NT combined, in the 5-year period 2019–2023, the top 5 leading causes of death for Aboriginal people accounted for 77% of all deaths. After adjusting for differences in age structure between the two populations, these were: cancer and other neoplasms (227 per 100,000); cardiovascular diseases (206 per 100,000); respiratory diseases (95 per 100,000); endocrine, nutritional and metabolic diseases which include mostly diabetes (83 per 100,000); and injury and poisoning (80 per 100,000).

In the same period, for non-Aboriginal Australians in NSW, Qld, WA, SA and NT combined, the top 5 leading causes of death based on age-standardised rates were cancer and other neoplasms (155 per 100,000); cardiovascular diseases (129 per 100,000); respiratory diseases (43 per 100,000); injury and poisoning (39 per 100,000) and nervous system diseases (33 per 100,000) (Figure 1.23.1).

Figure 1.23.1: Age-standardised death rates, by cause and Aboriginal status, New South Wales, and NSW, Qld, WA, SA and the NT combined, 2019–2023



Source: AIHW National Mortality Database (Table D1.23.2).

1.24 Avoidable and preventable deaths

Why it is important

This measure reports on potentially avoidable deaths of people aged 0–74. Potentially avoidable deaths are classified using nationally agreed definitions based on cause of death. They include deaths from conditions that are potentially preventable through individualised care and/or treatable through existing primary or hospital care (AIHW 2025d). Avoidable deaths have been used in various studies to measure the quality, effectiveness and accessibility of the health system. Deaths from most conditions are influenced by various factors in addition to health system performance, including the underlying prevalence of conditions in the community, environmental and social factors and health behaviours.

The reporting period included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

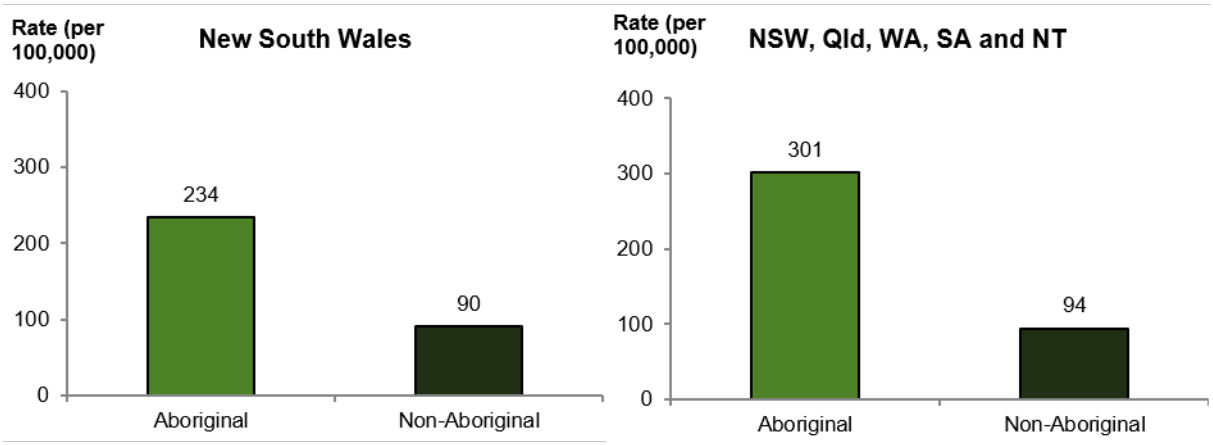
Key findings

The reporting of the national data in this measure has been limited to 5 jurisdictions (New South Wales, Queensland, Western Australia, South Australia and the Northern Territory), in which the quality of Indigenous status identification in the deaths data is considered adequate. Data are aggregated into 5-year groupings due to small number of deaths in each individual year.

Overall: In 2019–2023 in New South Wales, there were 2,762 deaths of Aboriginal people aged 0–74 from avoidable causes, equating to a rate of 165 deaths per 100,000 population (Table D1.24.4). After adjusting for differences in the age structure between the two populations, Aboriginal people died from potentially avoidable causes at 2.6 times the rate for non-Aboriginal New South Wales residents (234 compared with 90 per 100,000, respectively) (Figure 1.24.1).

In NSW, Qld, WA, SA and the NT combined in the same period, there were 8,972 deaths of Aboriginal people aged 0–74 from avoidable causes, equating to a rate of 211 deaths per 100,000 population (Table D1.24.4). After adjusting for differences in the age structure between the two populations, Aboriginal people died from potentially avoidable causes at 3.2 times the rate for non-Aboriginal Australians (301 compared with 94 per 100,000, respectively) (Figure 1.24.1).

Figure 1.24.1: Potentially avoidable age-standardised death rates, persons aged 0–74 years, by Aboriginal status, New South Wales, and NSW, Qld, WA, SA and NT combined, 2019–2023



Note: Data for the combined years 2019–2023 should be interpreted with caution due to data quality issues (see Interpretation of results).

Source: AIHW National Mortality Database (Table D1.24.4).

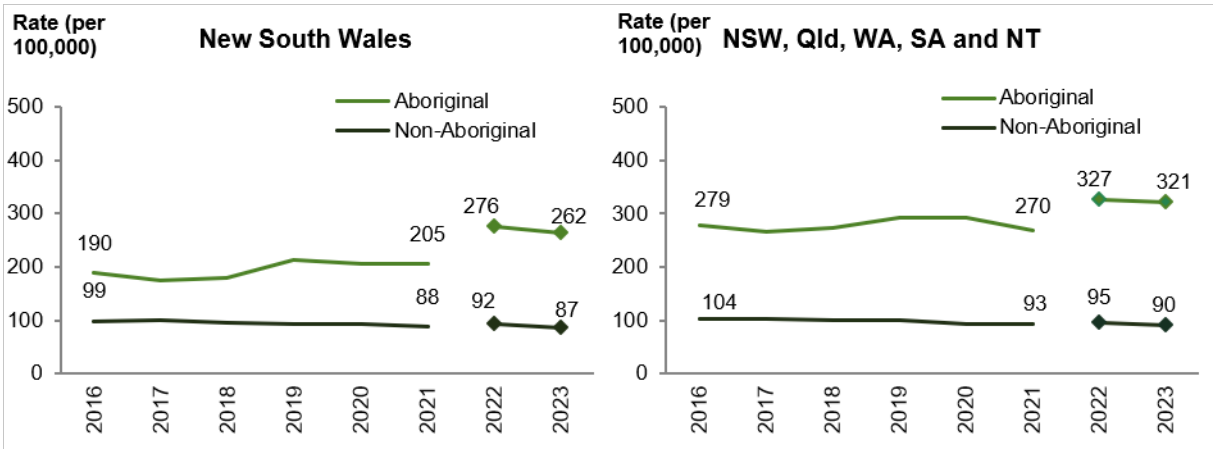
Trend over time: Although there is data on Aboriginal deaths up to 2023, time series analysis in this measure has been limited to the period 2016 to 2021. Due to changes in identification of Aboriginal status in New South Wales in 2022, data on deaths registered for New South Wales and for combined jurisdictions since 2022 are not comparable to data for previous years. These changes also impact the combined data for 2019–2023 for New South Wales and the combined jurisdictions. Comparisons in death rates over time between jurisdictions, particularly New South Wales, should therefore be interpreted with caution. For more information see Interpretation of results.

Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change.

From 2016 to 2021 in New South Wales, the age-standardised rate of potentially avoidable deaths for Aboriginal people increased by 17% based on linear regression analysis, however this was not statistically significant. Meanwhile for non-Aboriginal New South Wales residents it saw a statistically significant decrease of 13%. This resulted in the increase in the rate ratio between the two populations from 1.9 in 2016 to 2.3 in 2021. Over the same period, the rate difference between Aboriginal and non-Aboriginal people in New South Wales increased by 8.5 deaths per 100,000 people annually (Table D1.24.8).

For NSW, Qld, WA, SA and the NT combined, the age-standardised rate of potentially avoidable deaths for Aboriginal people did not change significantly from 2016 to 2021, while for non-Aboriginal people it decreased by 11% based on linear regression analysis (Figure 1.24.2). The relative gap between the two populations varied from 2.6 to 3.1 in this period with no clear trend over time (Table D1.24.8).

Figure 1.24.2: Potentially avoidable age-standardised death rates, people aged 0–74 years, by Aboriginal status, New South Wales and NSW, Qld, WA, SA and NT combined, 2016 to 2023



Note: Data for the combined jurisdictions from 2022 and 2023 are not comparable to previous years due to data quality issues.

Source: AIHW National Mortality Database (Table D1.24.8).

Tier 2 – Determinants of health

2.01 Housing

Why it is important

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). There are indirect relationships between housing circumstances, health and socioeconomic factors such as education, income and employment (Thomson et al. 2013).

The importance of secure, appropriate and affordable housing is reflected in Target 9A of the National Agreement on Closing the Gap: By 2031, increase the proportion of Aboriginal people living in appropriately sized (not overcrowded) housing to 88 per cent – see Target 9A in the Closing the Gap Information Repository.

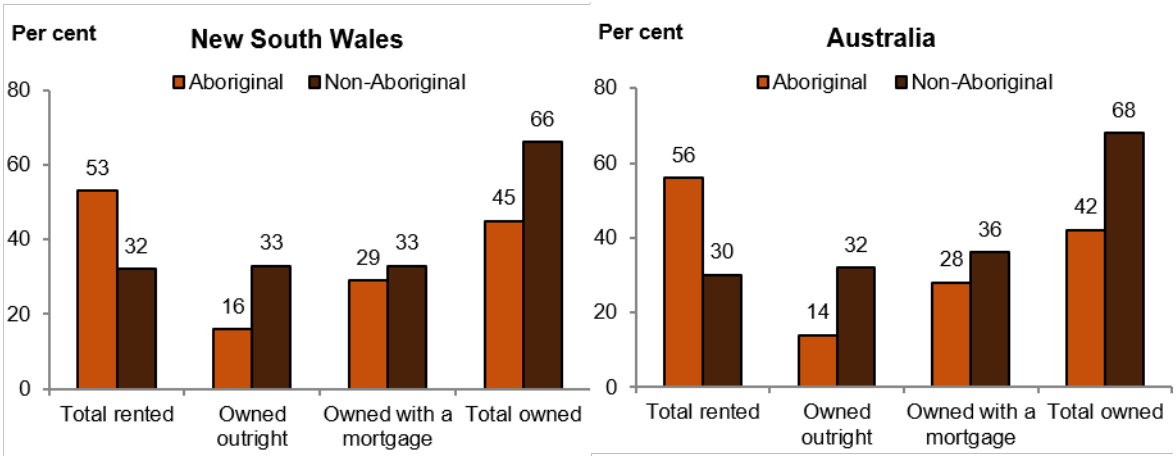
Key findings

Housing tenure: According to data from the ABS Census of Population and Housing, in New South Wales in 2021, 29% (36,600) of Aboriginal households owned their home with a mortgage, 16% (20,400) owned their home outright, 53% (66,600) were renting, and other tenure accounted for the remaining 1.5% (1,800) (Table D2.01.17).

The proportion of New South Wales households that owned their own home (with or without a mortgage) in 2021 was lower for Aboriginal households than for non-Aboriginal households (45% compared with 66%) (Figure 2.01.1).

Nationally, 28% (96,600) of Aboriginal households owned their home with a mortgage, 14% (48,500) owned their home outright, 56% (192,700) were renting, and other tenure accounted for the remaining 1.6% (5,600). The proportion of households that owned their own home (with or without a mortgage) in 2021 was lower for Aboriginal households than for non-Aboriginal households (42% compared with 68%) (Figure 2.01.1).

Figure 2.01.1: Tenure type of households, by Aboriginal status, New South Wales and Australia, 2021

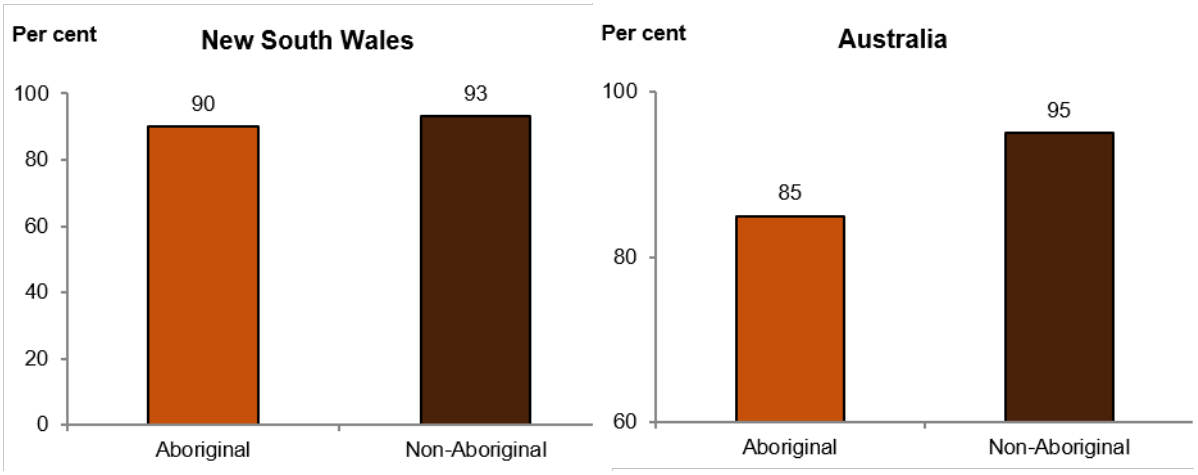


Source: ABS Census of Population and Housing 2021 (Table D2.01.17).

Appropriately sized housing: Based on NATSIHS in 2022–23 in New South Wales, an estimated 90% (315,500) of Aboriginal people lived in appropriately sized housing – this was lower than for non-Aboriginal New South Wales residents at 93% (7,190,700). Aboriginal people were 1.3 times as likely to live in an overcrowded households as non-Aboriginal New South Wales residents (Table D2.01.2).

Nationally, 85% (841,000) of Aboriginal people lived in appropriately sized housing compared with 95% of non-Aboriginal Australians (Figure 2.01.2). Aboriginal people were 2.8 times as likely to live in overcrowded households as non-Aboriginal Australians (Table D2.01.2).

Figure 2.01.2: People living in appropriately sized households, by Aboriginal status, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.01.2).

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 in an appropriately sized housing:

- 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).

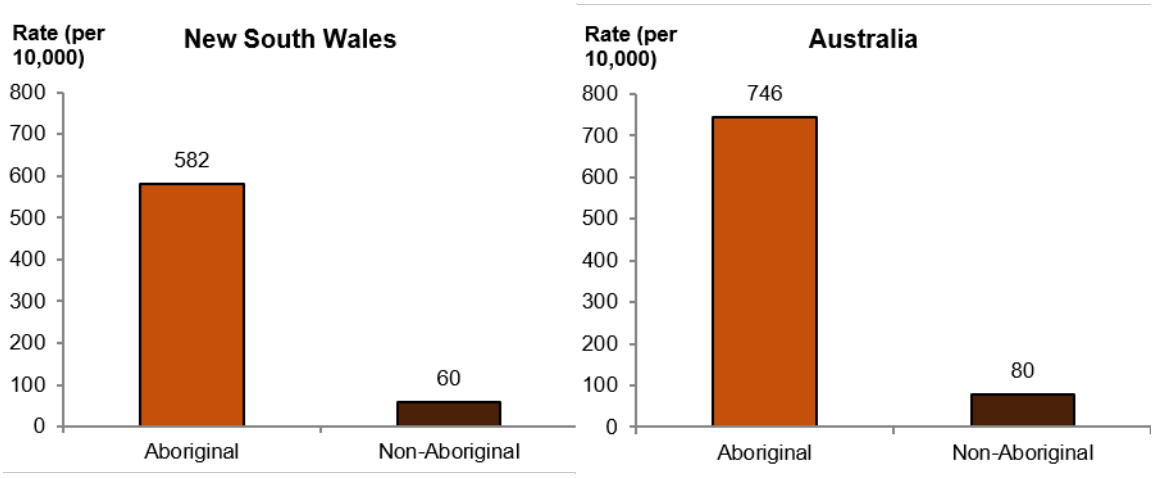
Specialist homelessness services (SHS):

In New South Wales in 2023–24, around 22,000 Aboriginal clients received support from SHS, which is equivalent to 4.2% of the Aboriginal population and 33% of all SHS clients in New South Wales (Table D2.01.30).

After adjusting for differences in age structure between the two populations, in New South Wales, Aboriginal people used specialist homelessness services at almost 10 times the rate for non-Aboriginal people (582 and 60 per 10,000 population, respectively) (Figure 2.01.3).

Nationally in 2023–24, 3.8% of the Aboriginal population used SHS (760 Aboriginal SHS clients per 10,000 population). After adjusting for age, Aboriginal people were about 9 times as likely to have used SHS as non-Aboriginal people (746 and 80 per 10,000 population, respectively) (Table D2.01.30, Figure 2.01.3).

Figure 2.01.3: Age-standardised rate of service use by specialist homelessness services clients, by Aboriginal status, New South Wales and Australia, 2023–24



Source: Specialist Homelessness Services Collection 2023–24 (Table D2.01.30).

2.02 Access to functional housing with utilities

Why it is important

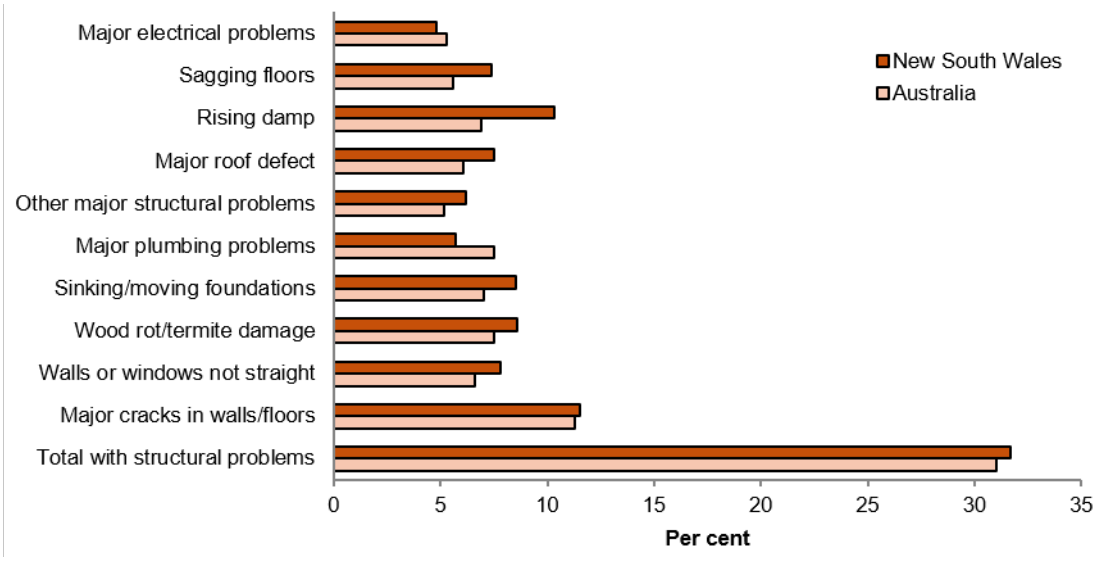
This measure reports on the functionality of Aboriginal housing facilities needed for healthy living. Housing is an important environmental factor for health and wellbeing. Functional housing encompasses basic services and facilities, infrastructure and habitability. These factors combined enable households to carry out healthy living practices including: waste removal; maintaining cleanliness through washing (including personal washing and laundering of clothing and bedding); managing environmental risk factors such as electrical safety and temperature in the living environment; controlling air pollution for allergens; and preparing food safely (Bailie and Wayte 2006; FaCHSIA 2007; Nganampa Health Council et al. 1987; NSW Department of Health 2019).

Key findings

Major structural problems: Based on the 2022–23 NATSIHS in New South Wales, an estimated 32% (57,800) of Aboriginal households were living in dwellings with major structural problems (including problems such as sinking/moving foundations, sagging floors, wood rot/termite damage and roof defects). The most common structural problems were major cracks in walls/floors (12%) and rising damp (10%).

Nationally in 2022–23, an estimated 31% (148,600) of Aboriginal households were living in dwellings with major structural problems. The most common structural problems were major cracks in walls/floors (11%), major plumbing problems and wood rot/termite damage (both at 7.5%) (Figure 2.02.1).

Figure 2.02.1: Aboriginal households living in dwellings with major structural problems, by type of structural problems, New South Wales and Australia, 2022–23



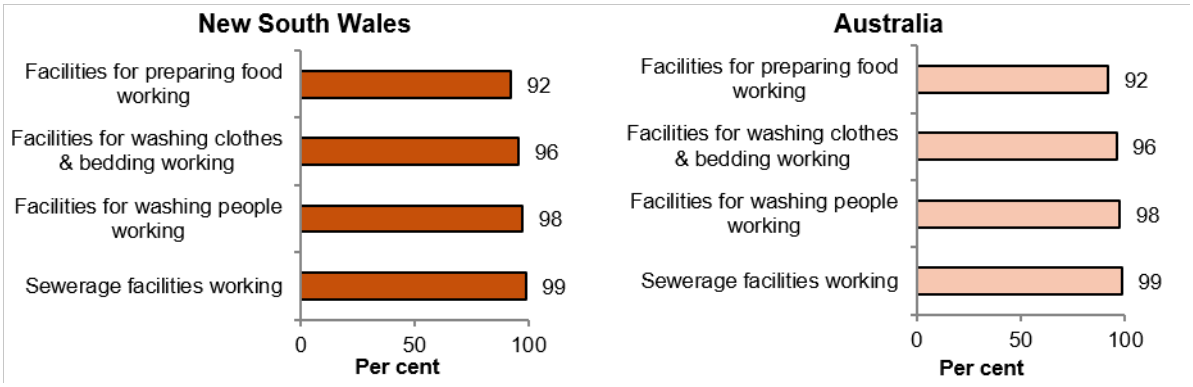
Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.02.1).

Access to working facilities: In 2022–23 in New South Wales, among Aboriginal households:

- 92% had access to facilities for preparing food
- 96% had access to facilities for washing clothes and bedding
- 98% had access to facilities for washing people
- 99% had access to working sewerage facilities.

Similar distribution was observed among Aboriginal households nationally in 2022–23 (Figure 2.02.2).

Figure 2.02.2: Access to working household facilities, Aboriginal households, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.02.8).

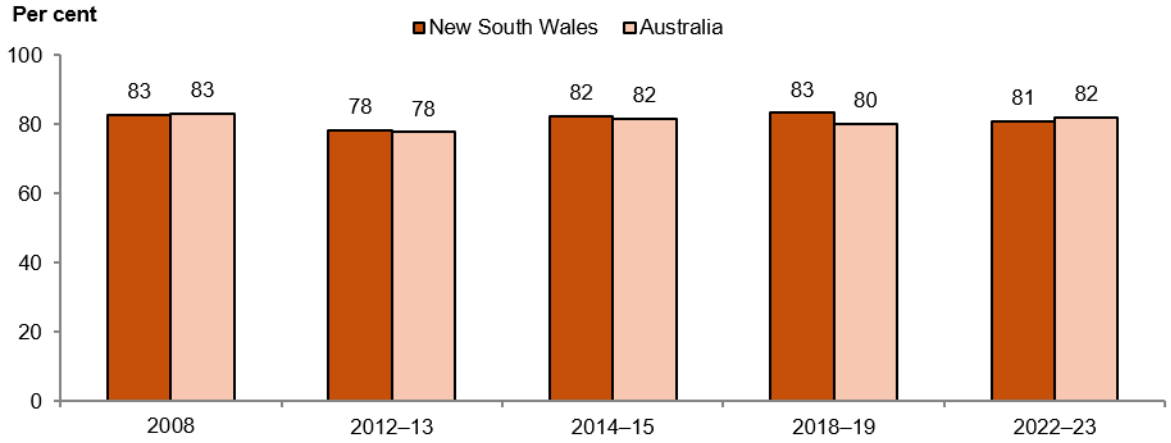
Dwellings of an acceptable standard: In 2022–23 in New South Wales, 81% of Aboriginal households were living in dwellings of an 'acceptable standard' (households with working facilities for washing people, clothes/bedding, storing/preparing food and sewerage and not more than 2 major structural problems).

Nationally in 2022–23, 82% of Aboriginal households were living in dwellings of an acceptable standard (Figure 2.02.3).

Dwellings of an acceptable standard over time: Between 2008 and 2022–23 in New South Wales, the proportion of Aboriginal households living in dwellings of an acceptable standard varied between a low of 78% in 2012–13 and a high of 83% in 2008 and 2018–19.

Nationally, between 2008 and 2022–23, the proportion of Aboriginal households living in dwellings of an acceptable standard varied between 78% and 83% (Figure 2.02.3).

Figure 2.02.3: Aboriginal households living in dwellings of an acceptable standard, New South Wales and Australia, 2008, 2012–13, 2014–15, 2018–19 and 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.02.6).

2.03 Environmental tobacco smoke

Why it is important

This measure reports on Aboriginal children aged 0–14 who live in households with daily smokers and indoor smokers. Environmental tobacco smoke (also known as second-hand smoke) is a significant cause of illness and death. There is consistent evidence that second-hand smoke causes lung cancer and ischaemic heart disease (also known as coronary artery disease). It is also associated with an increased risk of respiratory diseases in adults, an increased risk of sudden infant death syndrome (SIDS), and the exacerbation of asthma (Burke et al. 2012) and ear infections such as otitis media in children (Thomas and Stevens 2014). Second-hand smoke is associated with an increased risk of hospital readmission of Aboriginal infants with bronchitis and hospitalisation of Aboriginal children for acute asthma (Giarola et al. 2014).

Children's exposure to environmental tobacco smoke is determined by whether the adults around them smoke, where they smoke (inside the house, outside the house or in the car) and how often they smoke.

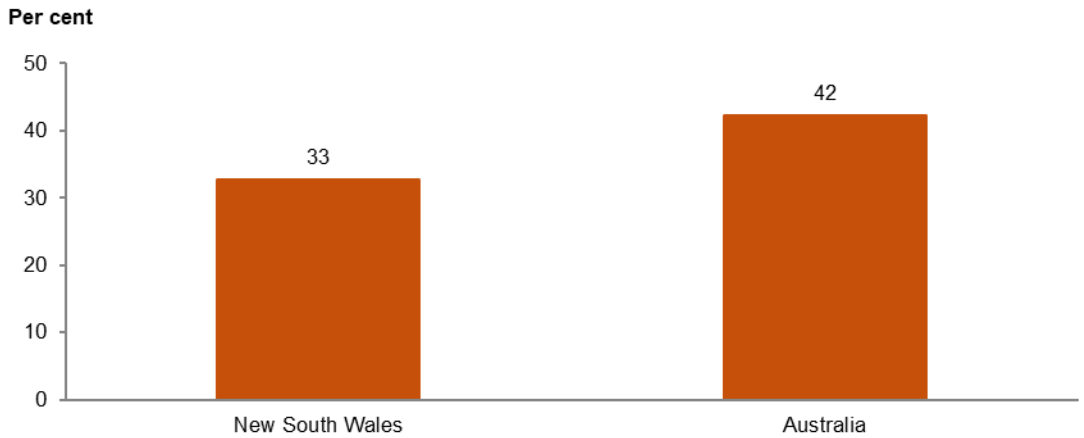
Key findings

Households with daily smokers: In 2022–23, 33% (estimated 38,800) of Aboriginal children aged 0–14 in New South Wales lived in households with daily smokers. Nationally, 42% of Aboriginal children aged 0–14 lived in households with daily smokers (Figure 2.03.1).

Nationally in 2022–23, the proportion of Aboriginal children aged 0–14 who lived in a household with a daily smoker was lower in non-remote areas than in remote areas (39% compared with 69%, respectively) (Table D2.03.5).

The 2014–15 National Aboriginal and Torres Strait Islander Social Survey (the most recent comparable data) found that nationally Aboriginal children aged 0–14 lived in households with a daily smoker at 2.7 times the rate for non-Aboriginal children (57% compared with 21%, respectively) (Table D2.03.7).

Figure 2.03.1: Aboriginal children aged 0–14 living in households with daily smokers, New South Wales and Australia, 2022–23

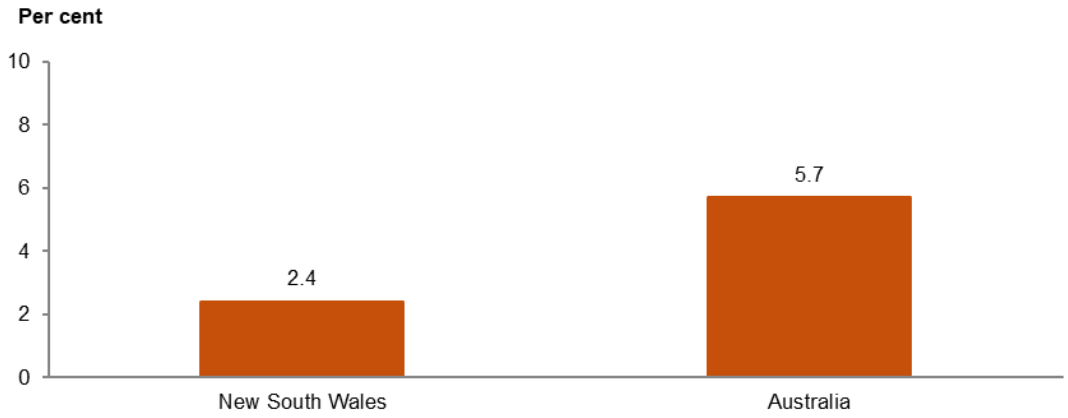


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.03.3).

Households with indoor smoking: In 2022–23 in New South Wales, 2.4% of Aboriginal children aged 0–14 lived in households where smoking occurred indoors. Nationally, 5.7% of Aboriginal children lived in households where smoking occurred indoors (Figure 2.03.2).

Nationally in 2022–23, the proportion of Aboriginal children aged 0–14, who lived in households where smoking was reported to occur indoors, was higher for those living in remote areas than for those living in non-remote areas (13% and 4.6%) (Table D2.03.5).

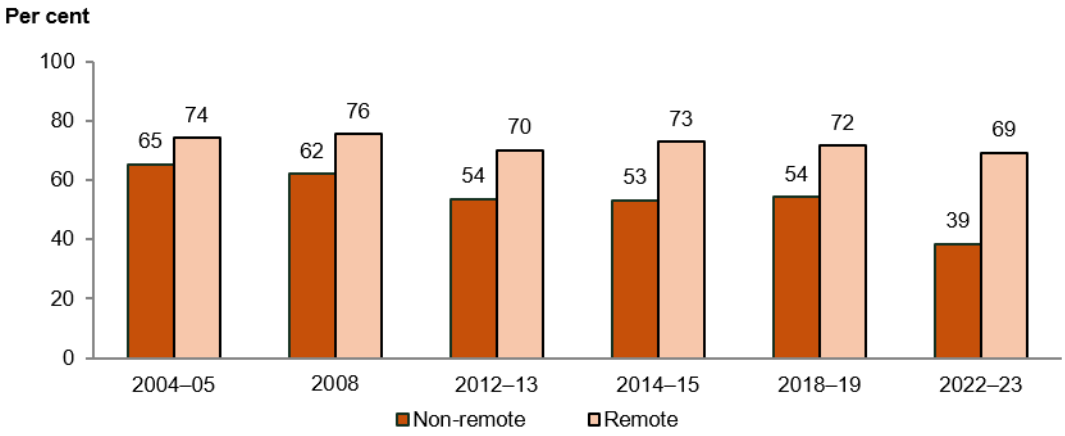
Figure 2.03.2: Aboriginal children aged 0–14 living in households where smoking occurs indoors, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.03.4).

Daily smokers trend over time: Nationally in non-remote areas, the proportion of Aboriginal children who lived in households with daily smokers declined by 26 percentage points from 65% in 2004–05 to 39% in 2022–23, but in remote areas, this had reduced by only 5 percentage points from 74% in 2004–05 to 69% in 2022–23 (Figure 2.03.3).

Figure 2.03.3: Aboriginal children aged 0–14 living in households with daily smokers by remoteness, Australia, 2004–05 to 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.03.7).

Socioeconomic characteristics: Strong associations exist between the socioeconomic circumstances of Aboriginal households and whether children are exposed to second-hand smoke. Nationally in 2022–23, Aboriginal children aged 0–14 who lived in households in the lowest income quintile were about 2.8 times as likely to live with a daily smoker as those who lived in households in the highest 2 income quintiles (51% compared with 19%) (Table D2.03.8).

2.04 Literacy and numeracy

Why it is important

This measure presents data from the National Assessment Program – Literacy and Numeracy (NAPLAN). NAPLAN is an annual assessment for students in Years 3, 5, 7 and 9 that includes tests in reading, writing, spelling, grammar and punctuation, and numeracy. These tests aim to determine whether young Australians are developing the literacy and numeracy skills that provide the critical foundation for other learning. Length and quality of education is associated with future employment opportunities and income, and opportunities to escape the poverty cycle. These social and economic outcomes in the future can influence an individual's access to health care and quality of life (Zajacova and Lawrence 2018).

Various changes were made to the NAPLAN in 2023. Note that as a result of these changes, 2023 NAPLAN data are not comparable with those from previous years.

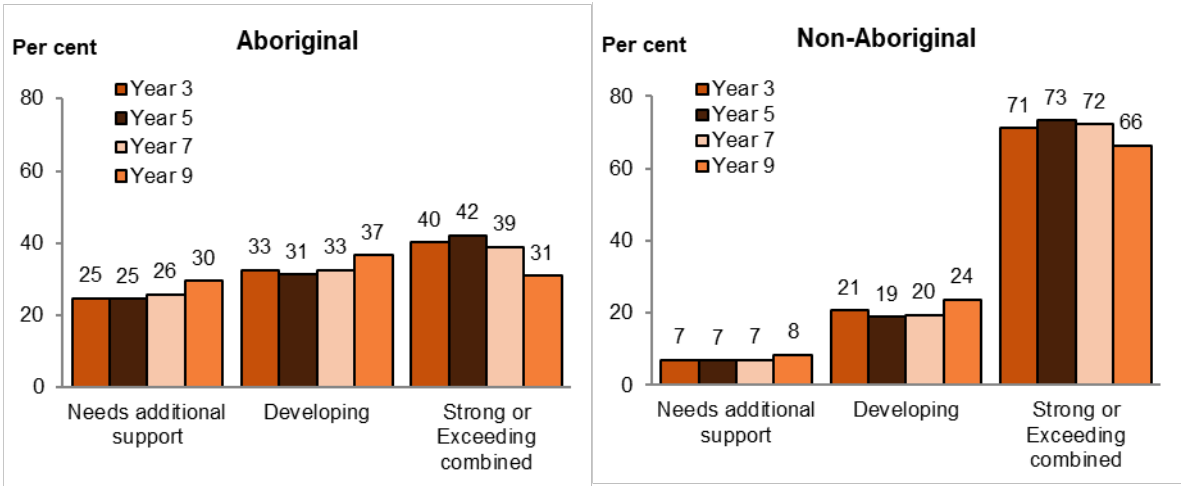
Key findings

Overall: In New South Wales in 2023, based on averaging results across the five NAPLAN learning areas, 31%–42% of Aboriginal students in each year level met or exceeded proficiency expectations ('Strong' or 'Exceeding'), 31%–37% had results in the 'Developing' category, indicating they were working towards expectations while 25%–30% had results in the 'Needs additional support' category.

In contrast among non-Aboriginal students in New South Wales, 66%–73% met or exceeded proficiency expectations ('Strong' or 'Exceeding'), 19%–24% had results in the 'Developing' category, and 7%–8% had results in the 'Needs additional support' category in 2023 (Figure 2.04.1).

This was similar to the national pattern of results for Aboriginal students in 2023 (Table D2.04.19).

Figure 2.04.1: NAPLAN results, averaged across the five learning areas, by proficiency level, school year and Aboriginal status, New South Wales, 2023



Note: Data have been averaged across the five learning areas: reading, writing, spelling, grammar and punctuation, and numeracy.

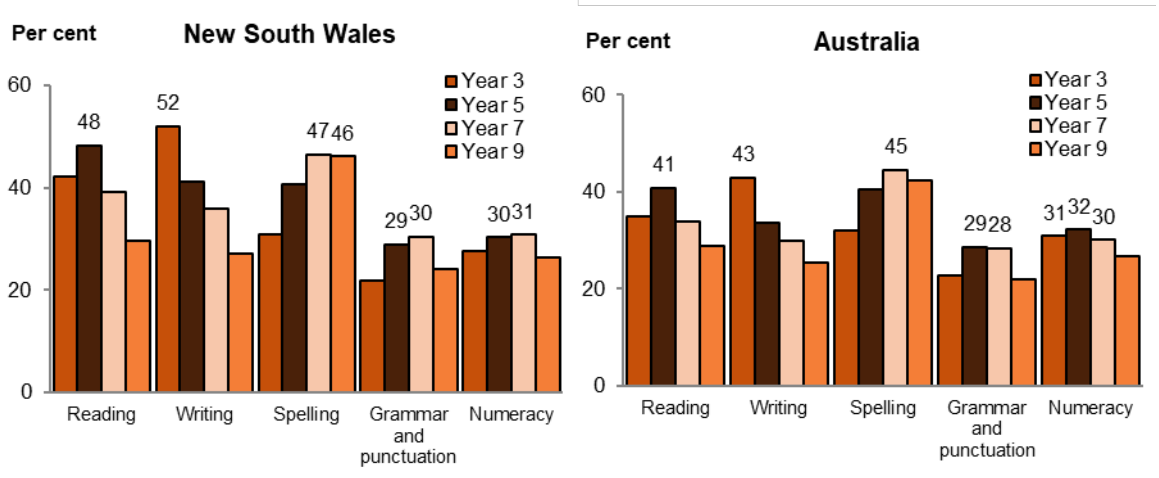
Source: Australian Curriculum, Assessment and Reporting Authority (ACARA) (Table D2.04.19).

By learning area: In New South Wales in 2023, the proportion of assessed Aboriginal students who achieved a 'Strong' or 'Exceeding' proficiency level was:

- highest for reading for students in Year 5 (48%)
- highest for writing for students in Year 3 (52%)
- highest for spelling for students in Year 7 (47%) and Year 9 (46%)
- highest for grammar and punctuation for students in Year 5 (29%) and Year 7 (30%)
- highest for numeracy for students in Year 5 (30%) and Year 7 (31%).

This was similar to the national pattern of results for Aboriginal students in 2023 (Figure 2.04.2).

Figure 2.04.2: Proportion of Aboriginal students achieving Strong or Exceeding proficiency levels, by NAPLAN learning area and school year, New South Wales and Australia, 2023

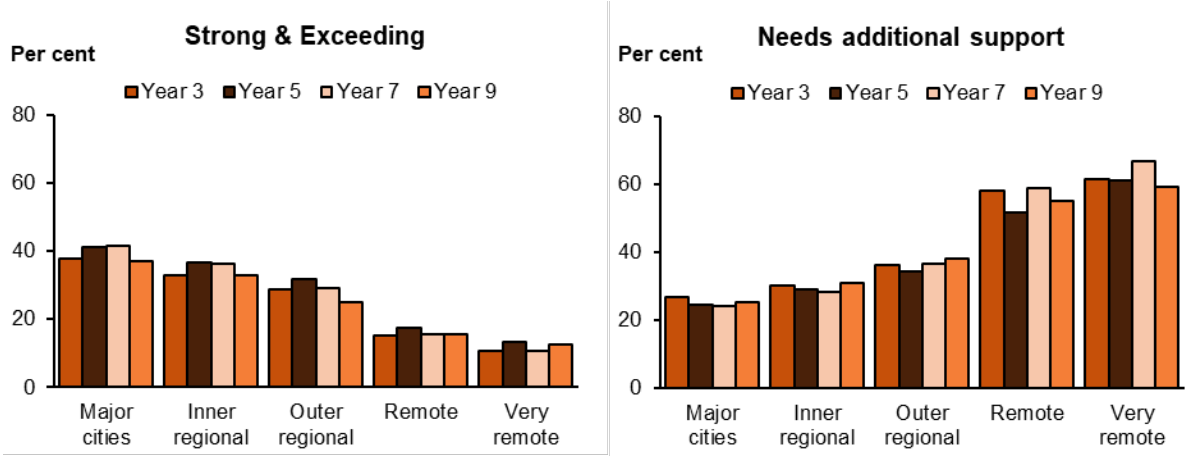


Source: ACARA (Tables D2.04.1, D2.04.3, D2.04.5, D2.04.7 and D2.04.9).

By remoteness: On average, across all five NAPLAN learning areas, the proportion of Aboriginal students in New South Wales achieving 'Strong' or 'Exceeding' proficiency levels increased as remoteness decreased. For example, among Aboriginal students in Year 3, the average proportion achieving 'Strong' or 'Exceeding' proficiency levels across the five learning areas was 17% in *Very remote* areas, 24% in *Remote* areas, 31% in *Outer regional* areas, 40% in *Inner regional* areas, and 44% in *Major cities*.

Consistent with this pattern, across the five learning areas, a lower proportion of New South Wales Aboriginal students in *Major cities* required additional academic support, ranging from 21% to 25% across different year levels. These figures were notably lower compared with *Very remote* areas, where the range was between 49% and 62% (Figure 2.04.3).

Figure 2.04.3: Average proportion of Aboriginal students achieving 'Strong' or 'Exceeding' proficiency or needing additional support across five learning areas, by remoteness and school year, New South Wales, 2023



Source: ACARA (Table D2.04.11 NSW).

2.05 Education outcomes for young people

Why it is important

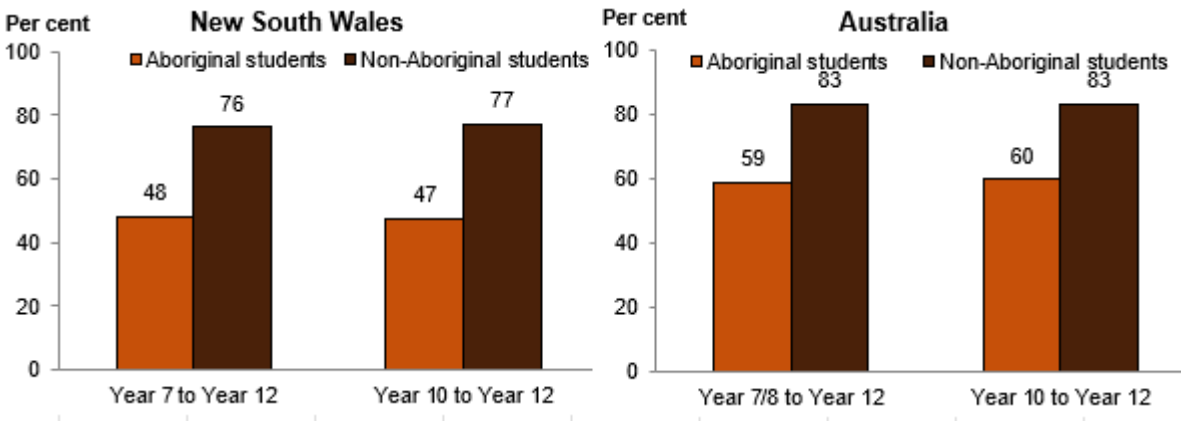
This measure reports on the proportion of students who stay in education through Year 12 (the 'apparent retention rate'), as well as the proportion who completed Year 12 or equivalent (the 'attainment rate'). Higher levels of education are associated with improved health outcomes through greater health literacy and better prospects for socioeconomic wellbeing (including higher income and employment), though higher education levels are associated with improved health regardless of socioeconomic status (Baker et al. 2011; Hart et al. 2017; Marmot et al. 2008). Higher education levels also support increased access to safe and healthy housing; healthy lifestyle choices such as regularly eating fruit and vegetables; and lower likelihood of smoking (Clark and Utz 2014). Research has highlighted that improving school attendance in Aboriginal communities requires concerted action between well-resourced schools and communities to create local strategies that are context sensitive, culturally appropriate, collaborative, and foster lifelong learning (Hancock et al. 2013; SCRGSP 2014a, 2016).

Key findings

School retention: In New South Wales in 2025, there were 38,915 Aboriginal students in Years 7 to 12, making up 7.0% of total students in New South Wales (Table D2.05.4, Table D2.05.5). The apparent retention rate from Year 7 to Year 12 in New South Wales was 48% for Aboriginal students and 76% for non-Aboriginal students. These rates are similar to apparent retention rates for Year 10 to Year 12, with 47% for Aboriginal and 77% for non-Aboriginal students (Figure 2.05.1).

Nationally in 2025, the apparent retention rate from Year 7/8 to Year 12 and for Year 10 to Year 12 was 59% and 60%, respectively, for Aboriginal students, and 83% for both for non-Aboriginal students (Figure 2.05.1).

Figure 2.05.1: Apparent school retention rates, by Aboriginal status, New South Wales and Australia, 2025



Note: Between 2019 and 2022, South Australia underwent a secondary school transition period where the first year of secondary schooling moved from Year 8 to Year 7. In the current data period (2025 data), this change is not yet reflected in the Year 7/8 to Year 12 retention rates, as the Year 7 transition does not yet apply to the full senior secondary cohort.

Source: Australian Bureau of Statistics (ABS) National Schools Statistics Collection (Table D2.05.2).

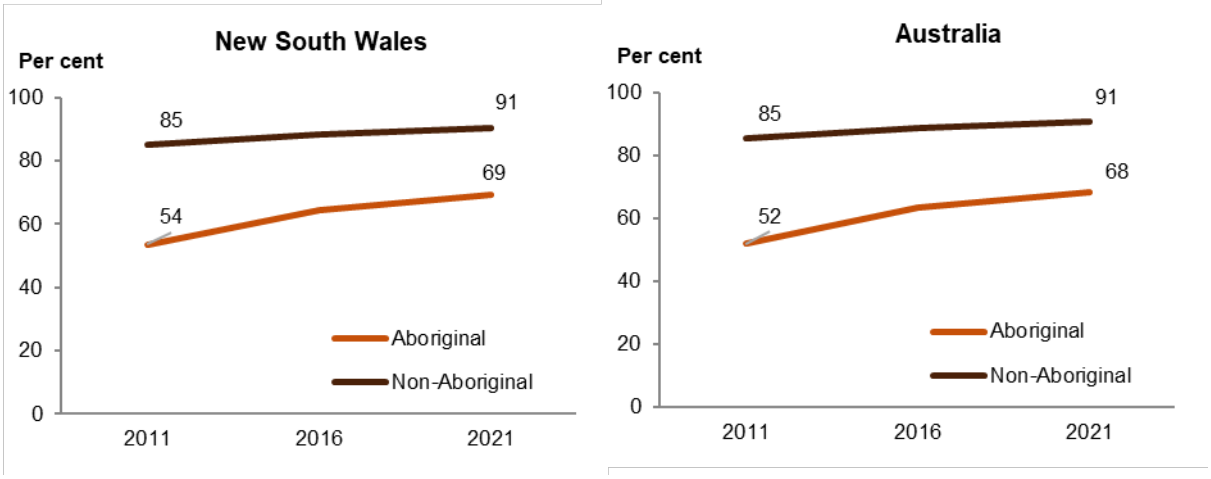
Year 12 or equivalent: In 2021 in New South Wales, 15,722 (69%) Aboriginal people aged 20–24 had attained a Year 12 or equivalent qualification (Certificate III or above). The attainment rate was 1.3 times as high for non-Aboriginal New South Wales people aged 20–24 as for Aboriginal people (91% compared with 69%) (Figure 2.05.2).

Nationally in 2021, 68% (45,822) of Aboriginal people aged 20–24 had attained a Year 12 or equivalent qualification. The attainment rate for non-Aboriginal Australians was 1.3 times as high as for Aboriginal people of the same age (91% compared with 68%) (Figure 2.05.2).

Trend over time: In New South Wales over the period 2011 to 2021, the proportion of Aboriginal people aged 20–24 who had completed Year 12 or equivalent increased from 54% (6,634) to 69% (15,722). Over the same period, the proportion among non-Aboriginal New South Wales people increased from 85% (338,945) to 91% (398,516). As rates of Year 12 attainment increased more for Aboriginal people over the period, the gap (rate difference) decreased, from 32 to 21 percentage points (Figure 2.05.2).

Nationally, the proportion of Aboriginal people aged 20–24 who had completed Year 12 or equivalent increased from 52% in 2011 to 68% in 2021 (Figure 2.05.2).

Figure 2.05.2: Completion of Year 12 or equivalent (Certificate III or above) for people aged 20–24, by Aboriginal status, New South Wales and Australia, 2011, 2016 and 2021



Source: ABS Census of Population and Housing 2011, 2016 and 2021 (Table D2.05.1).

School attendance: In 2025, the attendance rate for students in Years 1–6 in New South Wales was 86% for Aboriginal students and 92% for non-Aboriginal students. For students in Years 7–10, the attendance rates were lower – 73% among Aboriginal students and 88% among non-Aboriginal students.

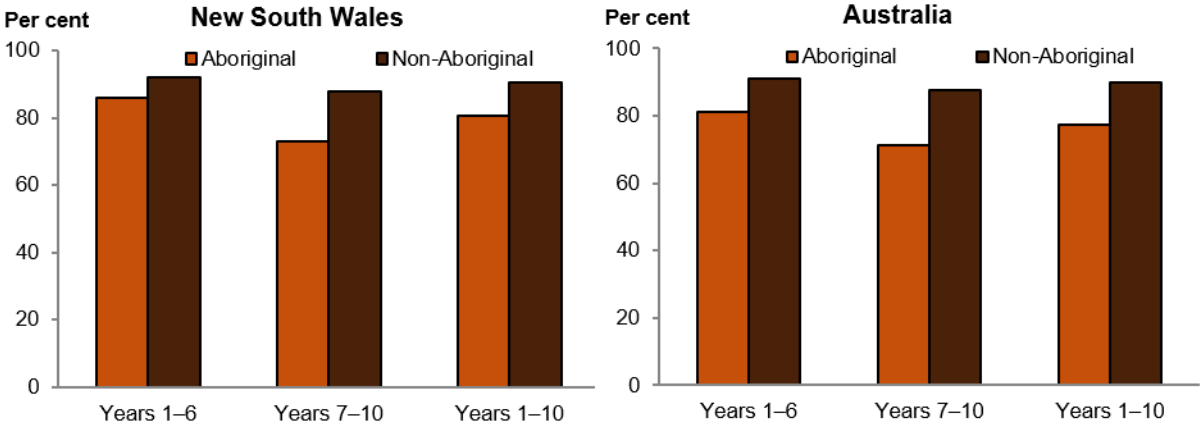
Nationally similar patterns were observed. The attendance rates for Years 1–6 were 81% for Aboriginal students and 91% for non-Aboriginal students, and for Years 7–10 they were 71% for Aboriginal students and 88% for non-Aboriginal students (Figure 2.05.3).

Attendance rates among Aboriginal students varied by school type. In 2025, attendance rate among Aboriginal students in Years 1–10 in New South Wales were 79% in Government schools and 87% in non-government schools. Similar trends were observed among Aboriginal students nationally, as well as among non-Aboriginal students in New South

Wales and nationally. However, the differences among non-Aboriginal students by school type were smaller than among Aboriginal students (SCRGSP 2026).

Attendance rates among Aboriginal students declined by increasing remoteness. In 2025, attendance rate among Aboriginal students in Years 1–10 in New South Wales were highest in *Major cities* (82%) and lowest in *Very remote* areas (68%). Similar trends were observed nationally, although the decline was larger with 80% in *Major cities* and 54% in *Very remote* areas (SCRGSP 2026).

Figure 2.05.3: School attendance for Aboriginal and Non-Aboriginal children, by year group, New South Wales and Australia, 2025



Source: National Student Attendance Data Collection (SCRGSP 2026, Table 4A.19).

2.06 Educational participation and attainment of adults

Why it is important

This measure reports on educational participation by adults (undertaking formal education or training) and educational attainment (completion of a particular level of school education or non-school qualification). Adult learning is a powerful tool in achieving better health, education and economic outcomes (Chandola and Jenkins 2014). The employment gap between Aboriginal people and non-Aboriginal Australians declines as the level of education attainment increases. The transition from education to work is usually smoother for vocational education and training (VET) and university graduates, and salary outcomes are higher than for those who enter the workforce directly from school (Lamb and McKenzie 2001).

The reporting period (2021) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

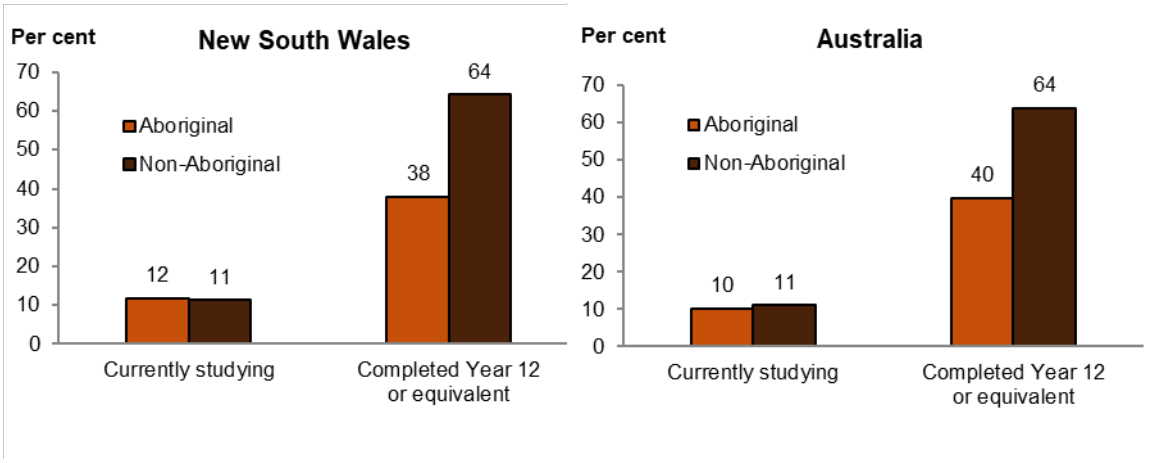
Currently studying: In 2021 in New South Wales, 12% (18,900) of Aboriginal adults (aged 18 and over) reported that they were currently studying, compared with 11% among non-Aboriginal adults (Figure 2.06.1).

Nationally in 2021, 10% of Aboriginal adults reported that they were currently studying, compared with 11% of non-Aboriginal adults (Figure 2.06.1).

Highest level of school completed: In New South Wales in 2021, 38% (60,300) of Aboriginal adults (aged 18 and over) reported Year 12 or equivalent as their highest level of school completed, compared with 64% (3,664,700) of non-Aboriginal adults.

Nationally, the proportions were 40% for Aboriginal adults and 64% for non-Aboriginal adults (Figure 2.06.1).

Figure 2.06.1: Adults aged 18 and over who were currently studying and adults who had completed Year 12, by Aboriginal status, New South Wales and Australia, 2021



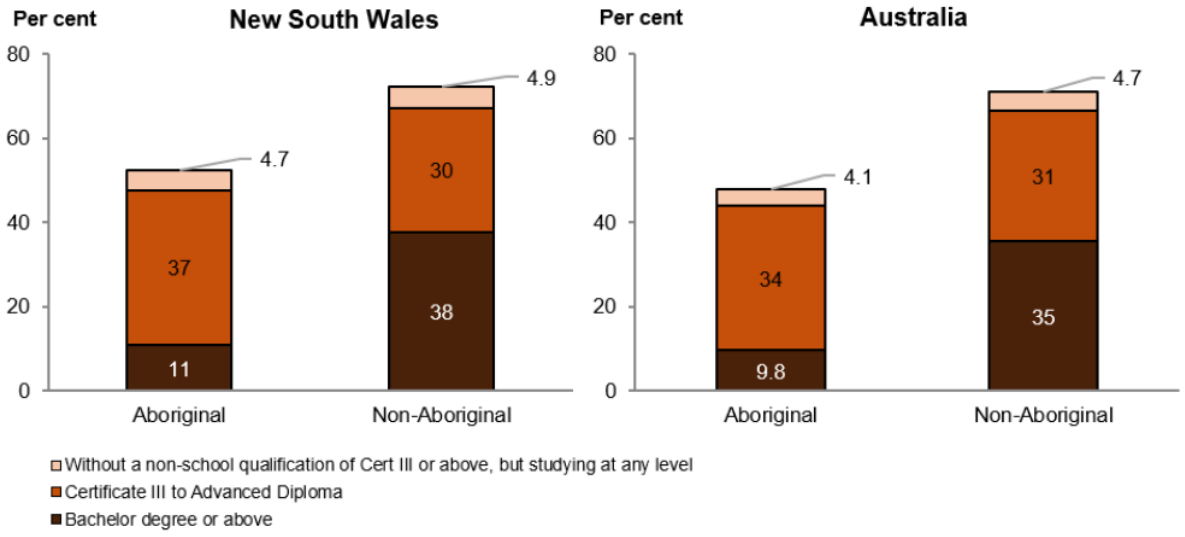
Source: ABS Census of Population and Housing 2021 (Tables D2.06.3 and D2.06.7).

VET Completions: In 2024 in New South Wales, 6,093 Aboriginal people aged 15 and over completed Certificate III, Certificate IV, diploma or higher, out of 8,045 total VET completions. The proportion of Aboriginal people aged 15 and over who completed Certificate III, Certificate IV, diploma or higher out of total VET completions, was higher in New South Wales than that for Aboriginal people nationally (76% and 59%, respectively). The proportion of non-Aboriginal people in New South Wales completing VET courses who completed Certificate III, Certificate IV, diploma or higher was similar to the proportion for non-Aboriginal people nationally (83% and 78%, respectively) (Table D2.06.16).

Non-school qualification: In New South Wales in 2021, 52% (67,500) of Aboriginal adults aged 20–64 reported they had either completed a non-school qualification at Certificate III or above or were studying for a non-school qualification, compared with 72% (3,040,300) of non-Aboriginal New South Wales adults aged 20–64. This gap was due to lower rates of attainment at Bachelor's Degree and above, with 11% (14,000) of Aboriginal adults aged 20–64 having a Bachelor's Degree or above, compared with 38% (1,588,800) of non-Aboriginal New South Wales people aged 20–64.

Nationally in 2021, 48% of Aboriginal adults aged 20–64 reported they either had a Certificate III or above, or were studying at any level, compared with 71% of non-Aboriginal adults aged 20–64 (Figure 2.06.2).

Figure 2.06.2: Adults aged 20–64 with non-school qualifications at Certificate III level or above and/or currently studying, by Aboriginal status, New South Wales and Australia, 2021



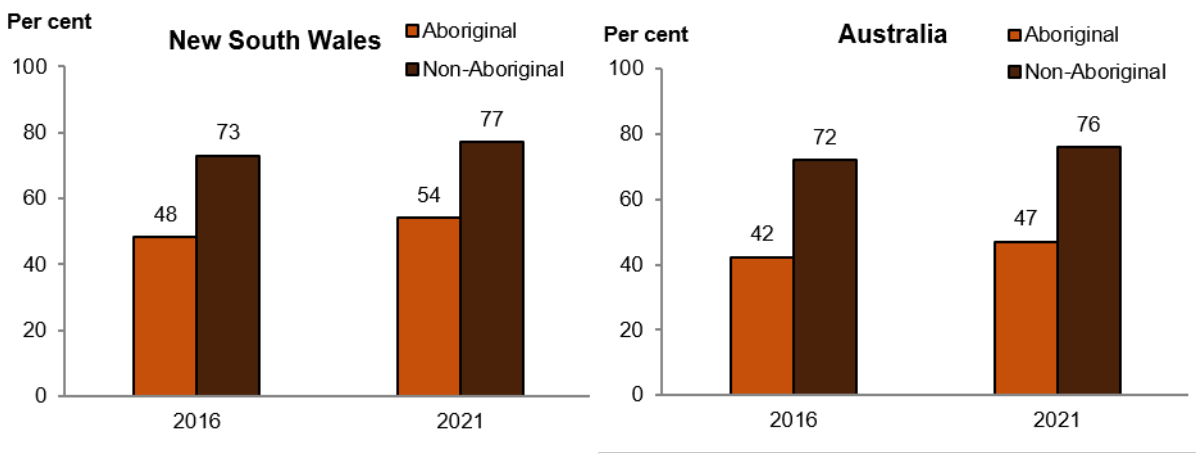
Source: ABS Census of Population and Housing 2021 (Table D2.06.11).

Adults aged 25–34: The National Agreement on Closing the Gap includes an outcome (Socioeconomic outcome area 6) where the target is to increase the proportion of Aboriginal and Torres Strait Islander people aged 25–34 who have completed a tertiary qualification (Certificate III and above) to 70 per cent by 2031.

In New South Wales in 2021, 54% (18,800) of Aboriginal adults aged 25–34 had completed a non-school qualification at Certificate III or above, an increase from 48% (11,600) in 2016 (Figure 2.06.3).

Nationally in 2021, 47% (50,700) of Aboriginal adults aged 25–34 had completed a qualification at Certificate III or above, an increase from 42% in 2016 (Figure 2.06.3).

Figure 2.06.3: Adults aged 25–34 with a non-school qualification at Certificate III level or above, by Aboriginal status, New South Wales and Australia, 2016 and 2021



Source: ABS Census of Population and Housing 2016 and 2021 (Table D2.06.36).

2.07 Employment

Why it is important

This measure reports on the employment status of Australians aged 15–64. Employment is beneficial for individual and community health as it boosts financial security, social status, personal development, social relations, self-esteem and emotional wellbeing (Lowry and Moskos 2007; Marmot et al. 2008). Employment and financial security are key drivers of better mental health outcomes, with employed Aboriginal people half as likely to have high or very high levels of mental distress than those who are unemployed (Hunter et al. 2022). Employment leads to a measurable reduction in suicidal behaviour for Aboriginal people (Dudgeon et al. 2016). Employment has the capacity to break cycles of poverty and trauma that impact Aboriginal people, especially women (Evans 2021). Conversely, being sick or disabled, or looking after someone in poor health, acts as a barrier to labour force participation (Belachew and Kumar 2014).

Key findings

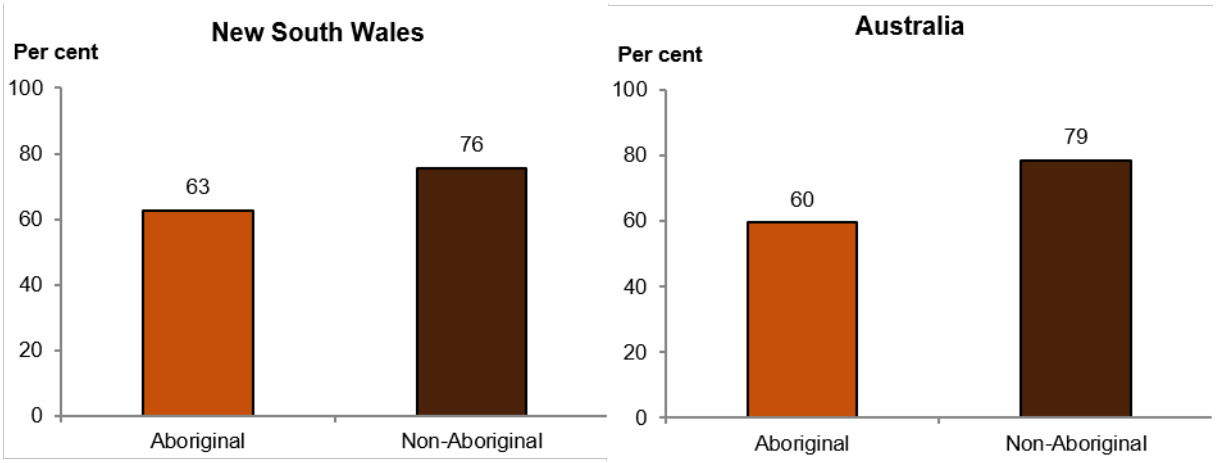
Data presented in this section are from the 2021 ABS Census of Population and Housing. People for whom labour force status was not stated were excluded prior to calculating percentages.

Note that the Census was held on 10 August 2021, during which most states and territories in Australia were under restrictions due to the COVID-19 pandemic. These conditions may have affected labour force participation and employment patterns, including reduced working hours and disruptions to employment, as COVID-19 restrictions had significant impacts on the Australian labour market (AIHW 2023b).

Labour force participation: In 2021 in New South Wales, 63% (102,600) of Aboriginal people of working age (15–64) reported they were in the labour force. In comparison, non-Aboriginal people were 1.2 times as likely to report being in the labour force.

In 2021 nationally, 60% (289,700) of Aboriginal people of working age reported they were in the labour force. In comparison, non-Aboriginal people were 1.3 times as likely to report being in the labour force (Figure 2.07.1).

Figure 2.07.1: Labour force participation rate, by Aboriginal status, New South Wales and Australia, 2021

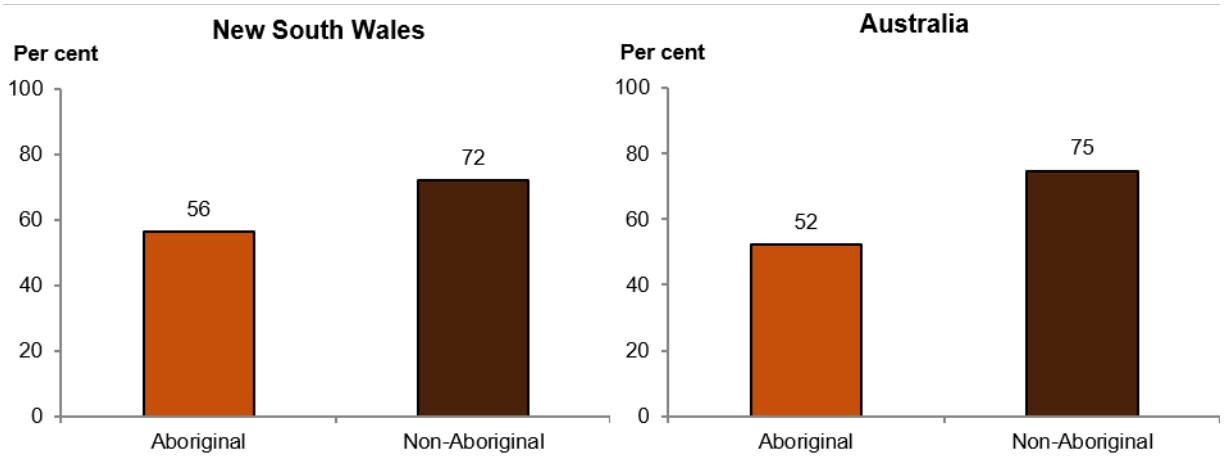


Source: ABS Census of Population and Housing 2021 (Table D2.07.5).

Employment: In 2021 in New South Wales, 56% (92,400) of the Aboriginal working age (15–64) population reported they were employed; 31% (50,400) were working full time and 19% (30,900) part time (the rest were away from work due to COVID lockdowns). Nationally, 52% (253,600) of the Aboriginal working age population reported they were employed; 29% (142,000) were working full time and 17% (84,400) part time.

For non-Aboriginal New South Wales people in 2021, 72% (3,395,400) of the working age population were employed; 43% (2,008,200) were working full time and 22% (1,026,800) part time. For non-Aboriginal Australians nationally, 75% (11,173,300) of the working age population were employed; 45% (6,701,200) were working full time and 24% (3,572,500) part time (Figure 2.07.2).

Figure 2.07.2: Employment rate, people aged 15–64, by Aboriginal status, New South Wales and Australia, 2021

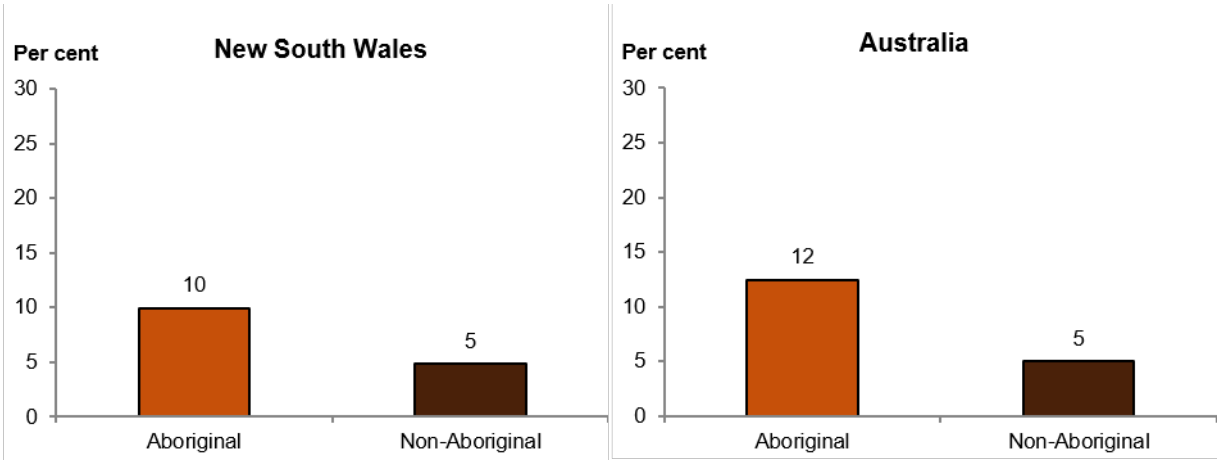


Source: ABS Census of Population and Housing 2021 (Table D2.07.5).

Unemployment: In 2021, in New South Wales, 6.2% (10,200) of Aboriginal people of working age (15–64) were unemployed. The reported unemployment rate (that is, the number of people unemployed as a proportion of the number in the labour force) for Aboriginal people was 2.1 times the rate reported for non-Aboriginal people (10% compared with 4.9%, respectively).

In 2021 nationally, the reported unemployment rate for Aboriginal people was more than double the rate reported for non-Aboriginal people (12% compared with 5.0%, respectively) (Figure 2.07.3).

Figure 2.07.3: Unemployment rate, people aged 15–64, by Aboriginal status, New South Wales and Australia, 2021



Source: ABS Census of Population and Housing 2021 (Table D2.07.5).

Difficulty in finding work: Note – the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) which collects detailed information on the social and cultural experiences of Aboriginal people has not been conducted since 2014–15. The following data therefore cannot be updated.

Nationally in 2014–15, 92% (48,700) of Aboriginal people of working age (15–64) who were unemployed reported difficulties in finding work. The most common reasons provided were that there were no jobs in the local area or line of work (41%), and transport problems or distance (32%) (Table D2.07.10).

2.08 Income

Why it is important

This measure reports on equivalised gross household and individual income. Adequate and reliable income allows a person to support themselves, their family and their community (AIHW 2019a). Income inequality is associated with poor health and social dysfunction, such as psychological distress, poor education performance, substance misuse, crime and violence (Isaacs et al. 2018; Kessels et al. 2020; Wilkinson and Pickett 2009). Low income can limit choices and opportunities for improving health outcomes and may influence other health-related factors, such as dietary choices and access to health care (AIHW 2015b). Disparities in income can help explain both the gaps in average health status of Aboriginal and non-Aboriginal Australians, and also the wide variation observed in health outcomes within the Aboriginal population (AIHW 2016a).

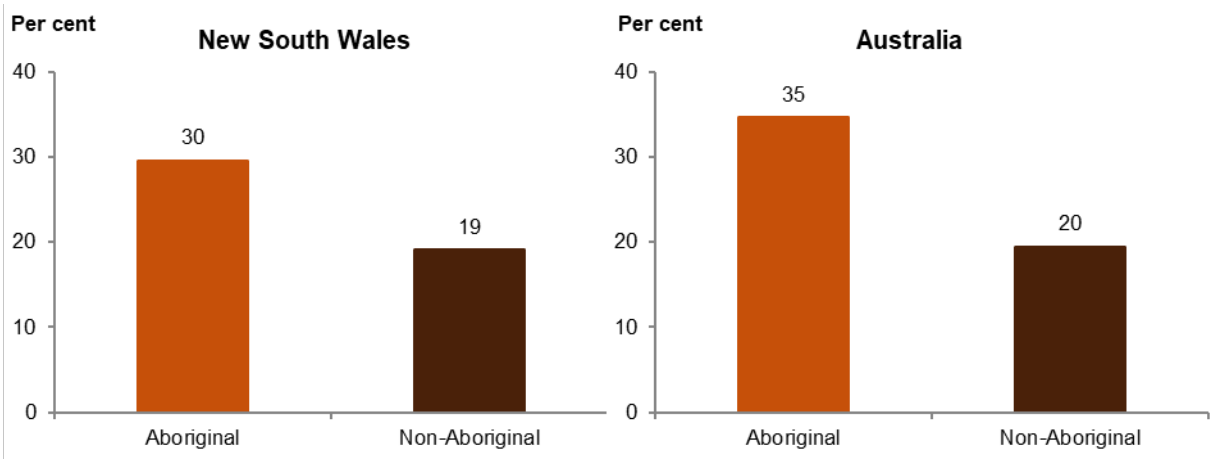
Key findings

The reporting period (2021) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Equivalised gross weekly household income (see Glossary): Data from the 2021 Census of Population and Housing show that in New South Wales, 11% (14,900) of Aboriginal adults (aged 18 and over) lived in households with a weekly income in the highest quintile compared with 22% of non-Aboriginal adults. In 2021, 30% (41,400) of Aboriginal adults were living in households in the lowest equivalised weekly household income quintile. This was 1.5 times the proportion for non-Aboriginal adults (Figure 2.08.1, Table D2.08.15).

In 2021 nationally, 10% of Aboriginal adults lived in households with a weekly income in the highest quintile compared with 20% of non-Aboriginal adults. In contrast, 35% of Aboriginal adults were living in households in the lowest income quintile. This was 1.8 times the proportion for non-Aboriginal adults (Figure 2.08.1, Table D2.08.15).

Figure 2.08.1: Adults (aged 18 or over) with equivalised gross weekly household income in the lowest quintile, by Aboriginal status, New South Wales and Australia, 2021



Source: ABS Census of Population and Housing 2021 (Table D2.08.15).

Median equivalised gross weekly household income (see Glossary): In 2021, in New South Wales, the median equivalised gross weekly household income for Aboriginal adults was reported to be $901 compared with $1,187 for non-Aboriginal adults.

Nationally in 2021, the median equivalised gross weekly household income for Aboriginal adults was reported to be $825, compared with $1,141 for non-Aboriginal adults (Table D2.08.11).

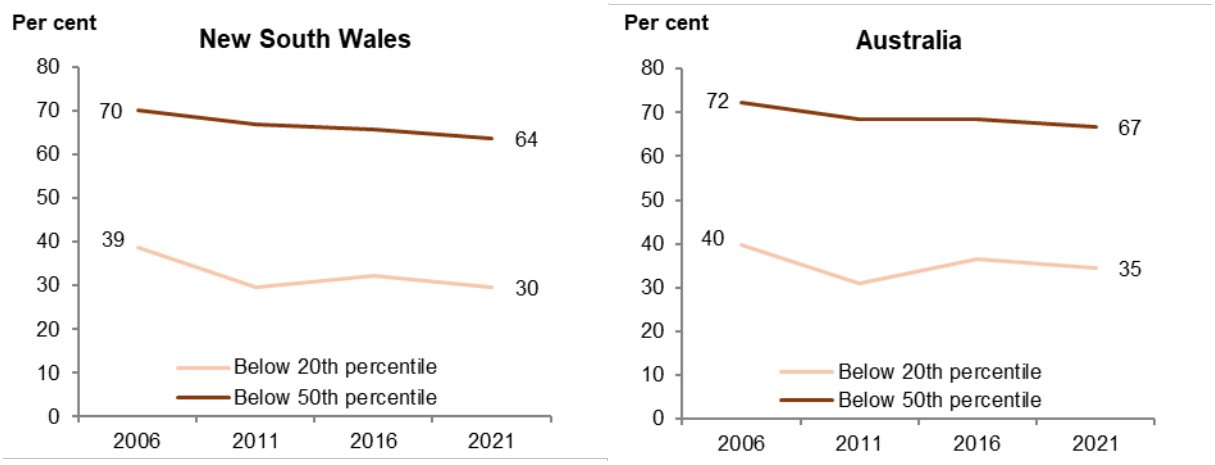
Ability to raise $2,000 in a week: In 2022–23 in New South Wales, an estimated 45% (147,100) of Aboriginal people were living in households that were not able to raise $2,000 within a week in an emergency.

Nationally in 2022–23, an estimated 49% (466,900) of Aboriginal people were living in households that were not able to raise $2,000 within a week in an emergency. The rate was considerably lower in non-remote areas (46%; 371,400) than remote areas (69%; 95,600) (Table D2.08.6).

Trend over time: In New South Wales, Aboriginal adults aged 18 and over were less likely to live in households with relatively low incomes in 2021 than in 2006. The proportion living in the lower half of the income distribution decreased from 70% to 64%, and the proportion living in the lowest-income households decreased from 39% to 30%.

A similar pattern was seen nationally. Aboriginal adults aged 18 and over were less likely to live in households with relatively low incomes in 2021 than in 2006. The proportion living in the lower half of the income distribution decreased from 72% to 67%, while the proportion living in the lowest-income households decreased from 40% to 35% (Figure 2.08.2).

Figure 2.08.2: Aboriginal adults (aged 18 or over) who were below the 20th and 50th percentiles of equivalised gross weekly household income, 2006 to 2021



Source: ABS Census of Population and Housing 2021 (Table D2.08.16).

2.09 Socioeconomic indexes

Why it is important

This measure reports on the distribution of people in areas of relative advantage and disadvantage based on the ABS Socio-Economic Indexes for Areas (SEIFA).
SEIFA provides measures of socioeconomic conditions by geographic area and ranks areas from most disadvantaged to most advantaged. The links between different forms of socioeconomic disadvantage such as poverty, unemployment, poor education, social dysfunction, stress, social exclusion, racism and poor health are well established and documented (Marmot 2015; Paradies 2006; Sassi 2009; Saunders and Davidson 2007).

The association between socioeconomic disadvantage and health can explain a substantial part of the health gap between Aboriginal people and non-Aboriginal people (Booth and Carroll 2008). That said, for many Aboriginal people, culture, community and history also play a fundamental part in their health and wellbeing. Therefore, the socioeconomic indexes only reflect some aspects of wellbeing for Aboriginal people.

Note that the results presented here should be interpreted carefully. Aboriginal residents often represent a small proportion of an area's total population, and therefore the socioeconomic status of that area as a whole will not always reflect the socioeconomic status of its Aboriginal residents (the 'ecological fallacy'). One study found that Aboriginal people consistently had a lower socioeconomic status than the SEIFA score for their area (Kennedy and Firman 2004).

Key findings

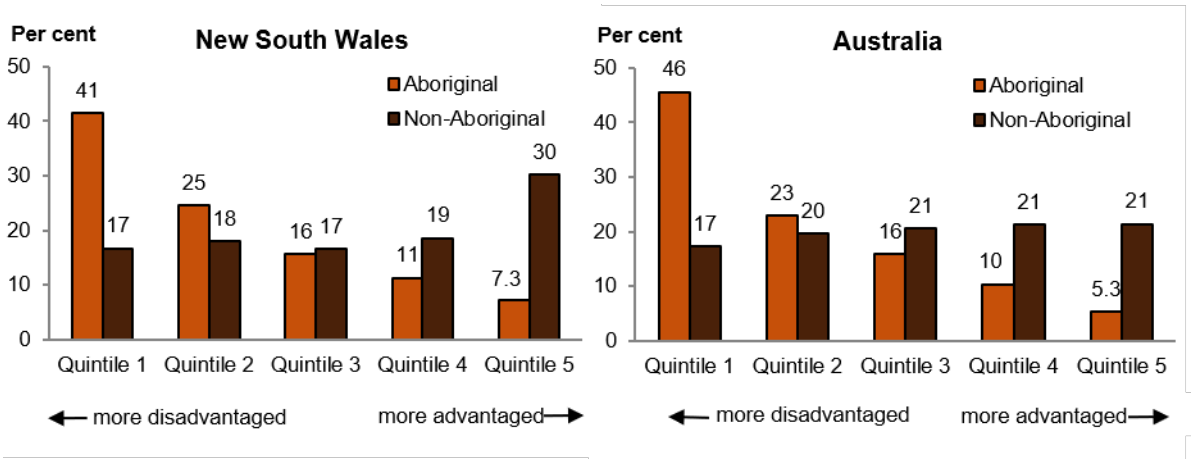
The reporting period (2021) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Areas were ranked from lowest to highest based on SEIFA scores and then grouped into 5 equal quintiles, each containing 20% of areas. Quintile 1 contains the 20% of areas with the lowest SEIFA scores, the most disadvantaged areas. Quintile 5 contains the 20% of areas with the highest SEIFA scores, the most advantaged areas.

In 2021, in both New South Wales and Australia, Aboriginal people were over-represented in areas ranked in the most disadvantaged quintiles by SEIFA and under-represented in more advantaged areas. In New South Wales in 2021, 7.3% (19,900) of the Aboriginal population lived in the most advantaged quintile (Quintile 5), and 41% (112,900) lived in the most disadvantaged quintile (Quintile 1) (Figure 2.09.1).

Nationally in 2021, 5.3% (42,100) of the Aboriginal population lived in the most advantaged quintile (Quintile 5), compared with 21% (4,981,800) of non-Aboriginal people. Conversely, 46% (360,600) of the Aboriginal population lived in the most disadvantaged areas (Quintile 1) compared with 17% (4,028,200) of non-Aboriginal people (Figure 2.09.1).

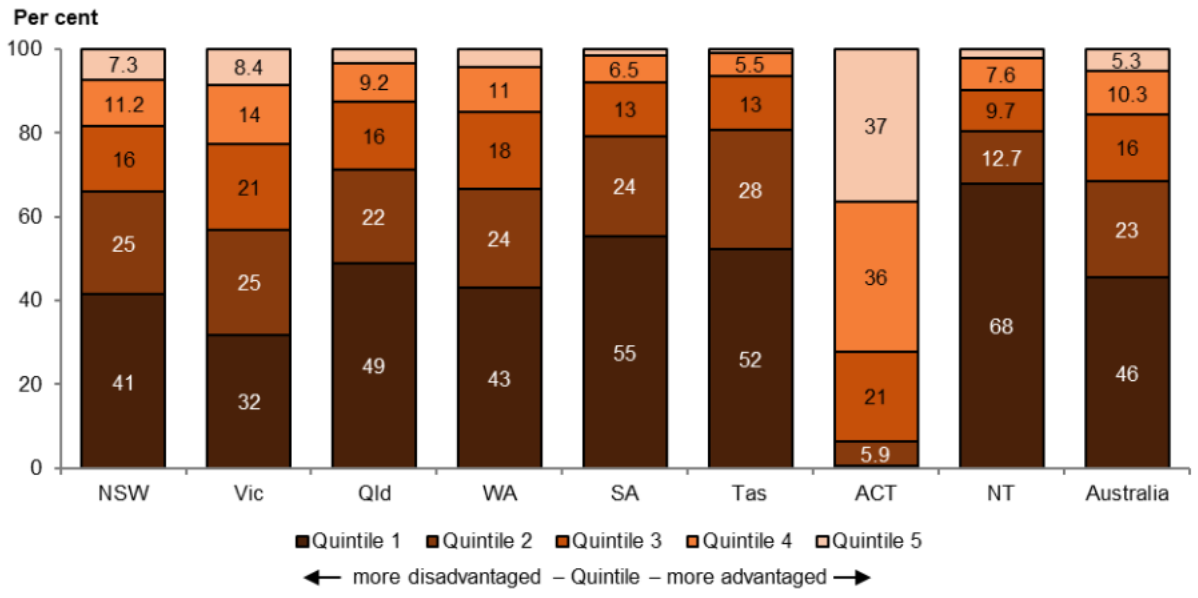
Figure 2.09.1: Population distribution by SEIFA quintiles, by Aboriginal status, New South Wales and Australia, 2021



Source: ABS Census of Population and Housing 2021 (Table D2.09.2).

In all states and territories in 2021, a greater proportion of Aboriginal people lived in the most disadvantaged quintile compared with non-Aboriginal people. The highest proportion of Aboriginal people living in areas in the most disadvantaged quintile was in the Northern Territory (68%), which was 8 times the rate for non-Aboriginal people (8.3%). The Australian Capital Territory had the highest proportion of Aboriginal people who lived in areas in the most advantaged quintile (37%), and Tasmania had the lowest (0.9%) (Table D2.09.2, Figure 2.09.2).

Figure 2.09.2: Distribution of Aboriginal population by SEIFA quintiles, by jurisdiction, 2021



Note: Columns may not sum to 100% because not all Census responses could be allocated a SEIFA score.

Source: ABS Census of Population and Housing 2021 (Table D2.09.2).

2.10 Community safety

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
- **1800RESPECT**: 1800 737 732

Why it is important

This measure reports on hospitalisations and deaths due to assault. Safe communities, where people feel secure and protected from harm within their home, workplace and community, are important for physical and social and emotional wellbeing (AIHW 2019b). Community wellbeing and safety are shaped by social determinants such as access to health supports, access to suitable housing, education, employment and income (AIHW 2025a). Poverty and lack of opportunities can diminish hope and aspiration, leading to substance abuse, poor mental health, and increased involvement in crime. For Aboriginal people, long-term social disadvantage and the ongoing impact of past dispossession and forced child-removal policies, which result in intergenerational trauma and a breakdown of access to traditional culture and kinship practices, have contributed to social problems (AIHW 2025g). Experiencing threats and acts of violence, living in an environment where personal safety is at risk and facing social settings where violence is common can have negative health effects on victims of violence, including women, children and their families (AIHW 2018c; Coles et al. 2015; Loxton et al. 2019).

The reporting period (July 2021 to June 2023) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

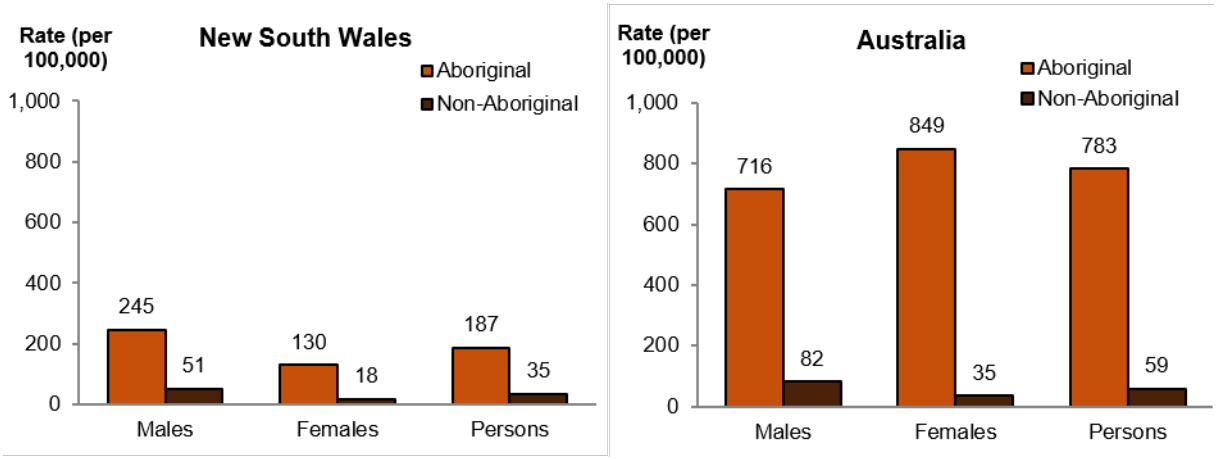
Key findings

Hospitalisations due to assault: Hospitalisations due to assault are defined as hospitalisations (both fatal and non-fatal) where the principal diagnosis was injury and poisoning, and where the first reported 'external cause' was assault. External cause is defined as the environmental event, circumstance, or condition that is regarded as the cause of injury, poisoning and other adverse effect.

In New South Wales, between July 2021 and June 2023, there were 1,137 hospitalisations due to assault among Aboriginal people, at a crude rate of 164 per 100,000 population. After adjusting for differences in the age structure between the two populations, Aboriginal people were 5.4 times as likely to be hospitalised for assault as non-Aboriginal Australians in New South Wales (Table D2.10.5).

Nationally, between July 2021 and June 2023, there were 13,869 hospitalisations due to assault among Aboriginal people, at a rate of 692 per 100,000 population (Table D2.10.5). After adjusting for differences in the age structure between the two populations, Aboriginal people were 13 times as likely to be hospitalised for assault as non-Aboriginal Australians (Figure 2.10.1).

Figure 2.10.1: Age-standardised rates of hospitalisation due to assault, by Aboriginal status and sex, New South Wales and Australia, July 2021 to June 2023



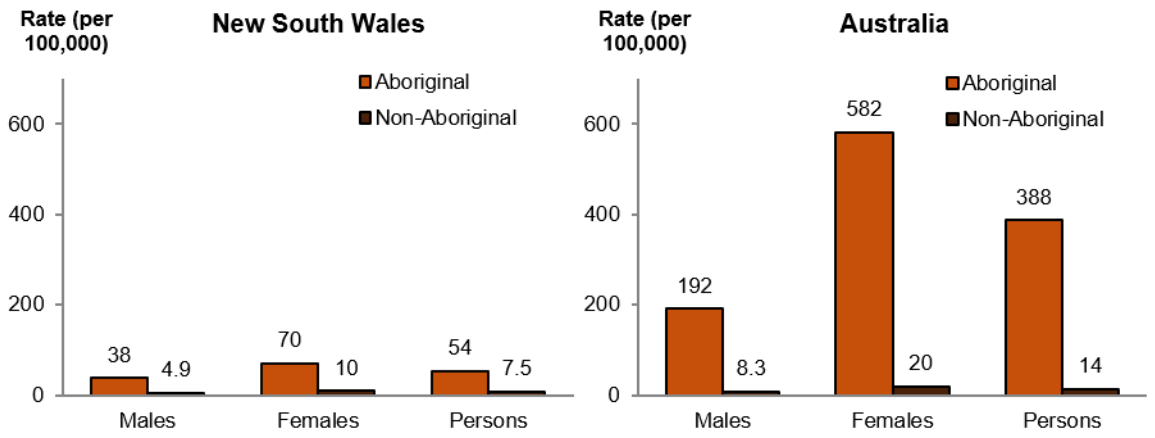
Source: National Hospital Morbidity Database (Table D2.10.5).

Hospitalisations for family violence-related assaults: This section includes hospitalisations for assault where the perpetrator was recorded as a spouse/domestic partner, parent, or other family member.

Between July 2021 and June 2023, there were 324 hospitalisations for family-violence related assaults among Aboriginal people in New South Wales, at a crude rate of 47 per 100,000 population. The rate was about twice as high among Aboriginal females as Aboriginal males in New South Wales (62 and 32 per 100,000, respectively) (Table D2.10.36). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for family violence-related assault for Aboriginal people was 7.2 times the rate for non-Aboriginal Australians in New South Wales (Figure 2.10.2).

Nationally, between July 2021 and June 2023, there were 6,828 hospitalisations for family-violence related assaults among Aboriginal people at a rate of 341 per 100,000 population (519 per 100,000 for females and 163 per 100,000 for males) (Table D2.10.36). After adjusting for differences in the age structure between the two populations, the rate of hospitalisations for family violence-related assault for Aboriginal people was 28 times the rate for non-Aboriginal Australians (Figure 2.10.2).

Figure 2.10.2: Age-standardised rates of hospitalisations for family violence-related assaults, by Aboriginal status and sex, New South Wales and Australia, July 2021 to June 2023

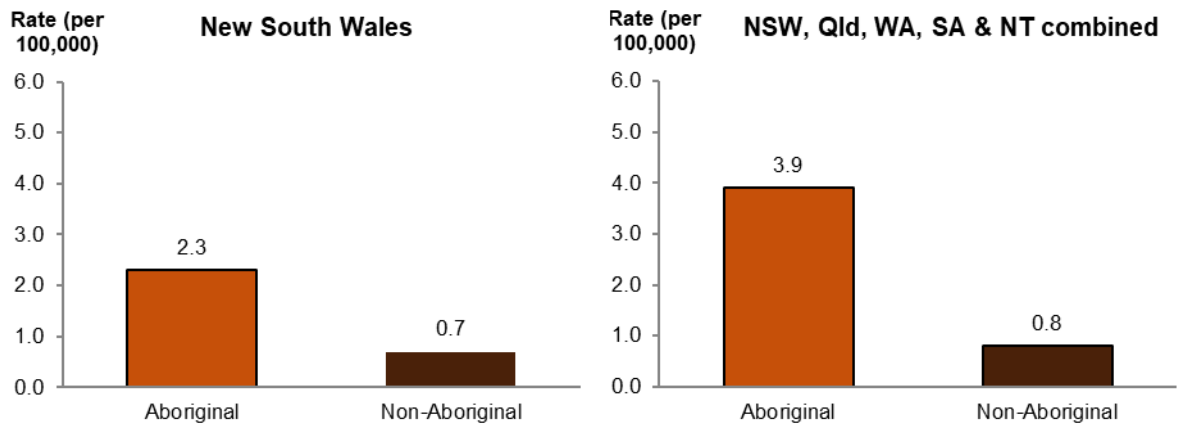


Source: National Hospital Morbidity Database (Table D2.10.36).

Homicide: Homicide data in this section includes murder and manslaughter but excludes driving causing death.

In New South Wales in the 5 years from 2019 to 2023, there were 35 deaths of Aboriginal people due to homicide, a rate of 2.3 homicides per 100,000 population (Table D2.10.9). After adjusting for differences in the age structure between the two populations, the rate of deaths due to homicide was statistically significantly higher, 3.1 times greater for Aboriginal people compared with non-Aboriginal Australians in New South Wales. In the 5 jurisdictions with adequate level of Indigenous identification (NSW, Qld, WA, SA and the NT combined), from 2019 to 2023, deaths due to homicide were 4.9 times as high for Aboriginal people as for non-Aboriginal Australians (Figure 2.10.3).

Figure 2.10.3: Deaths due to assault (homicide), by Aboriginal status, New South Wales and NSW, Qld, WA, SA and NT combined, 2019–2023



Source: National Mortality Database (Table D2.10.9).

2.11 Contact with the criminal justice system

Why it is important

This measure reports on young people under youth justice supervision and adults in prison custody. The majority of Aboriginal people have never been incarcerated. However, Aboriginal people experience contact with the criminal justice system – as both offenders and victims – at much higher rates than non-Aboriginal Australians (AIHW 2021b, 2021c; Royal Commission into Aboriginal Deaths in Custody 1991; SCRGSP 2020; Senate Community Affairs References Committee 2010). Imprisonment compounds existing social and economic disadvantage and affects family, children, and the broader community, with intergenerational effects.

Two Closing the Gap targets relate to over-representation of Aboriginal people in the criminal justice system:

- Target 11: By 2031, reduce the rate of Aboriginal and Torres Strait Islander young people (10–17 years) in detention by at least 30 per cent.
- Target 10: By 2031, reduce the rate of Aboriginal and Torres Strait Islander adults held in incarceration by at least 15 per cent.

See Targets 10 and 11 in the Closing the Gap Information Repository.

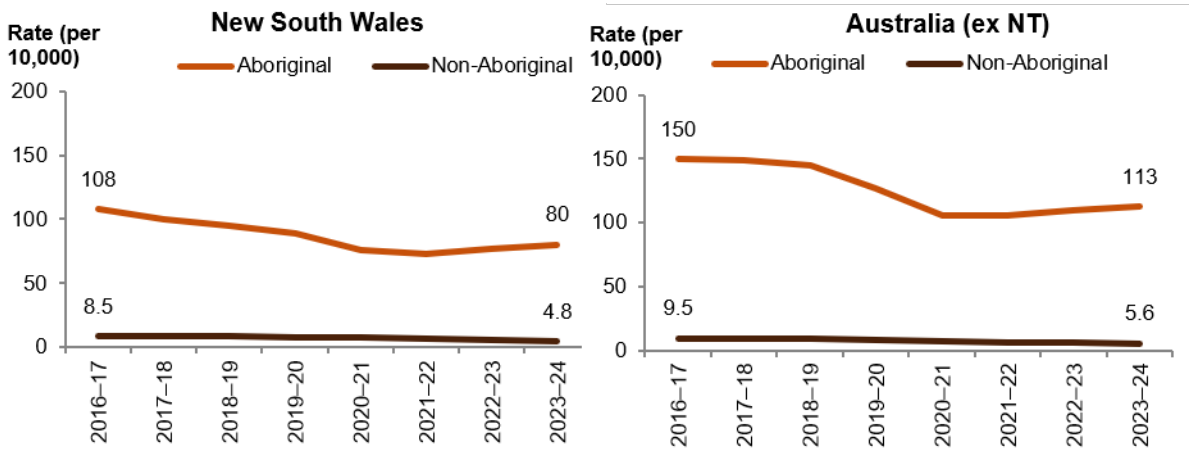
Key findings

Youth justice: In New South Wales, on an average day in 2023–24, 498 Aboriginal people aged 10–17 were under youth justice supervision corresponding to a rate of 80 per 10,000. For non-Aboriginal New South Wales residents aged 10–17, the rate was 4.8 per 10,000.

Nationally (excluding NT), on an average day in 2023–24, of Aboriginal people aged 10–17, 113 per 10,000 were under youth justice supervision, compared with 5.6 per 10,000 for non-Aboriginal people (Figure 2.11.1).

The proportion of Aboriginal youth aged 10–17 under youth justice supervision on an average day in New South Wales decreased from 108 per 10,000 in 2016–17 to 80 per 10,000 in 2023–24 – a 31% decrease (based on linear regression analysis). Over the same period, the rate difference between Aboriginal and non-Aboriginal youth under youth justice supervision decreased by an average of 4.0 per 10,000 population annually (Table D2.11.1).

Figure 2.11.1: Young people aged 10–17 under supervision on an average day, by Aboriginal status, New South Wales and Australia, 2016–17 to 2023–24



Source: AIHW Youth Justice National Minimum Dataset (Table D2.11.1).

Adult imprisonment: On 30 June 2025 in New South Wales, 34% (4,519) of people in prison custody were Aboriginal (a crude rate of 2,019 per 100,000) (Table D2.11.8). The age-standardised rate of Aboriginal adults in prison custody was 14 times the rate for non-Aboriginal people (Figure 2.11.2).

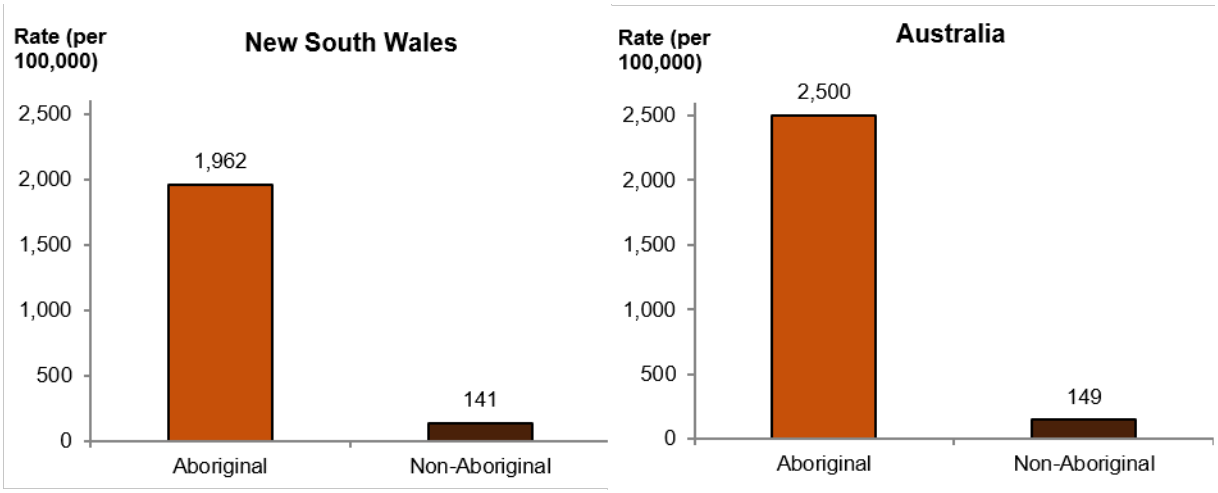
Nationally on 30 June 2025, 37% (17,432) of people in prison custody were Aboriginal (a crude rate of 2,643 per 100,000) (Table D2.11.8). The age-standardised rate for Aboriginal adults in prison custody was 17 times the rate for non-Aboriginal Australians (Figure 2.11.2).

In New South Wales, over the period 2016 to 2025, the age-standardised imprisonment rate for Aboriginal adults increased by 22%, based on linear regression analysis. Over the same period, the imprisonment rate for non-Aboriginal New South Wales adults decreased by 24%.

Nationally, over the same period, the age-standardised imprisonment rate for Aboriginal adults increased by 37%, and for non-Aboriginal adults decreased by 15%, based on linear regression analysis (Figure 2.11.3).

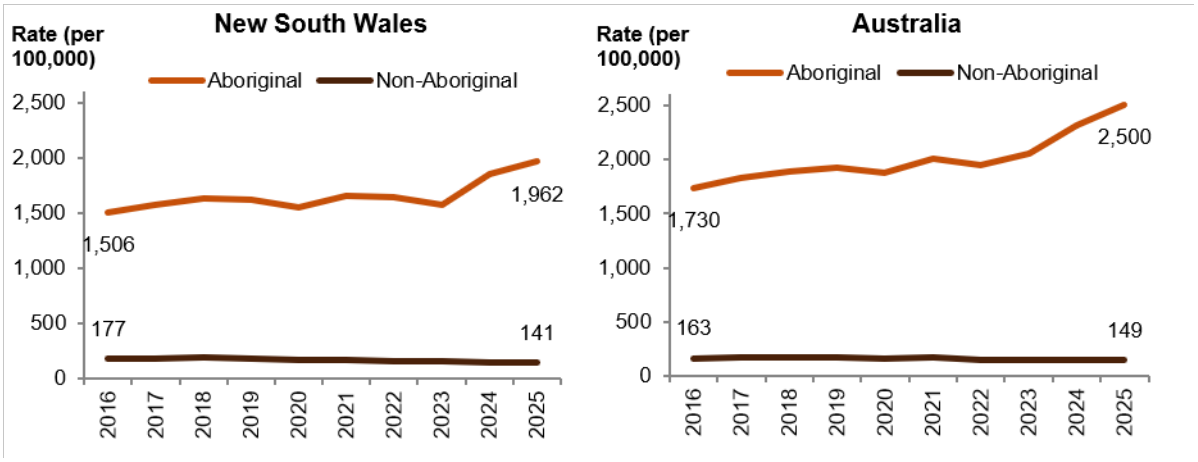
Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change (see Interpretation of results).

Figure 2.11.2: Age-standardised adult imprisonment rate, by Aboriginal status, New South Wales and Australia, 30 June 2025



Source: ABS National Prisoner Census data (Table D2.11.8).

Figure 2.11.3: Age-standardised adult imprisonment rate, by Aboriginal status, New South Wales and Australia, 2016 to 2025



Source: ABS National Prisoner Census data (Table D2.11.12).

2.12 Child protection

Why it is important

This measure reports on children aged under 18 who came into contact with the child protection system – this includes children who were the subjects of investigations for alleged child maltreatments, were on care and protection orders and/or in out-of-home care. The child protection system aims to protect children from maltreatment in family settings. Experience of maltreatment (physical, emotional and psychological abuse, neglect, sexual abuse and witnessing family violence) during childhood has serious and long-term effects on social and emotional wellbeing and health (Emerson et al. 2015). Aboriginal children are over-represented in the child protection system and this over-representation reflects systemic inequities and racism linked to colonial history and the legacy of past policies of forced child removal, intergenerational trauma, poverty, housing instability, family violence, substance use, and lack of culturally safe services. There are concerns that current approaches are not always well aligned to the cultural, social and community contexts of Aboriginal families, which may affect engagement with services and outcomes (AIHW 2025b, 2026e; David 2019), so reducing over-representation requires structural reforms to address systemic bias and racism in the child protection system.

Key findings

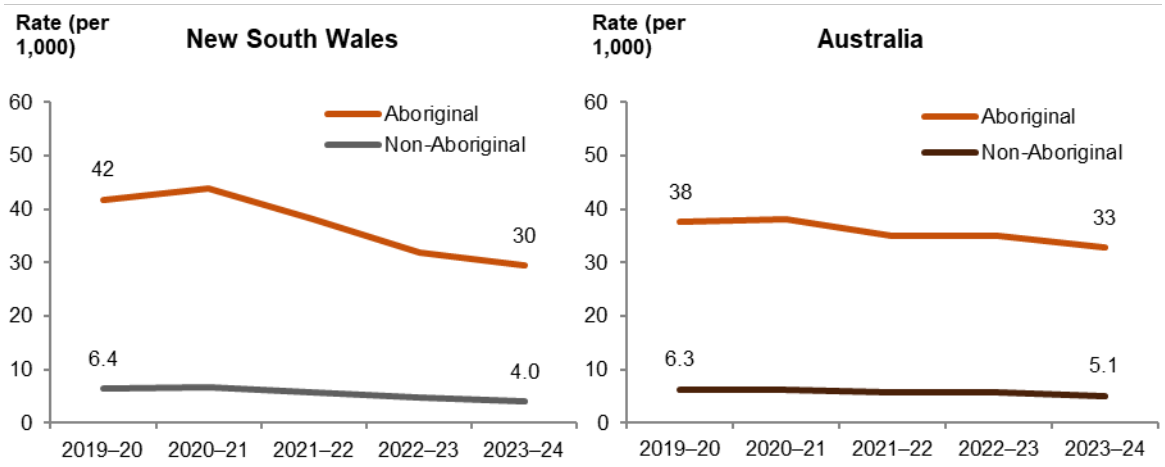
Overall: In New South Wales in 2023–24, 15,367 Aboriginal children (aged under 18) came into contact with the child protection system – corresponding to a rate of 110 per 1,000 Aboriginal children compared with 15 per 1,000 non-Aboriginal children in New South Wales (AIHW 2026h, Table S2.3).

Substantiated maltreatment: In 2023–24 in New South Wales, 4,116 Aboriginal children were the subjects of substantiated maltreatment (30 per 1,000 children), meaning an investigation has determined there is reasonable cause to believe a child has been, or is at significant risk of being maltreated. Nationally, the rate of substantiated maltreatment among Aboriginal children was 33 per 1,000 (Figure 2.12.1).

In 2023–24, the rate of substantiated maltreatment among Aboriginal children in New South Wales was 7.5 times the rate for non-Aboriginal children. Nationally, the rate among Aboriginal children was 6.4 times the rate for non-Aboriginal children (Table D2.12.3).

Substantiated maltreatment over time: Over the period 2019–20 to 2023–24, there was a statistically significant decrease in the rate of substantiated maltreatment among Aboriginal children in New South Wales (-3.6%) and Australia (-1.3%) (Figure 2.12.1).

Figure 2.12.1: Children aged under 18 who were the subjects of substantiated maltreatments, by Aboriginal status, New South Wales and Australia, 2019–20 to 2023–24



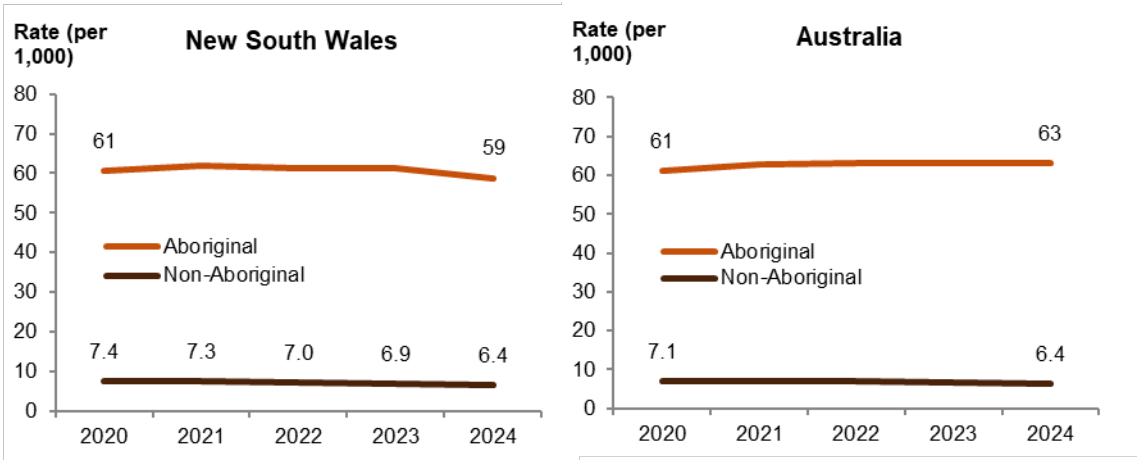
Source: AIHW Child Protection Collection 2019–20 to 2023–24 (Table D2.12.5).

Care and protection orders: At 30 June 2024 in New South Wales, there were 8,222 Aboriginal children on care and protection orders (59 per 1,000 children) (Table D2.12.7). Of these 8,222 children: 15% were aged under 5; 27% were aged 5–9; 35% were aged 10–14; and 22% were aged 15–17 (Table D2.12.6).

In 2023–24 the rate of Aboriginal children on care and protection orders in New South Wales was 9.2 times the rate for non-Aboriginal children. Nationally, the rate among Aboriginal children was 9.8 times the rate for non-Aboriginal children (Table D2.12.7).

Care and protection orders trend over time: Over the period from 30 June 2020 to 30 June 2024, there was a slight decrease in the rate of Aboriginal children who were on care and protection orders in New South Wales (from 61 to 59 per 1,000), although this decrease was not statistically significant. Nationally, over the same time period, the rate among Aboriginal children increased from 61 to 63 per 1,000 children although this rate was also not statistically significant (Figure 2.12.2).

Figure 2.12.2: Children aged under 18 on care and protection orders, by Aboriginal status, New South Wales and Australia, 30 June 2020 to 30 June 2024

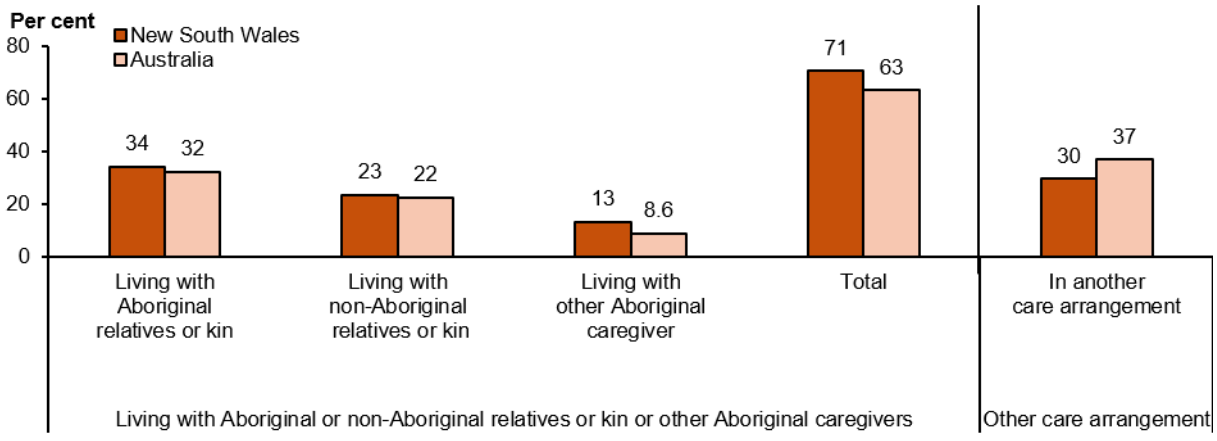


Source: AIHW Child Protection Collection 2019–20 to 2023–24 (Table D2.12.11).

Out-of-home care: At 30 June 2024 in New South Wales, there were 6,312 Aboriginal children in out-of-home care (45 per 1,000 children) (Table D2.12.12). Around 71% of these children were living with Aboriginal or non-Aboriginal relatives or kin or other Aboriginal caregivers (Figure 2.12.3).

Nationally, there were 19,987 Aboriginal children in out-of-home care at 30 June 2024 (50 per 1,000 children), with 63% living with Aboriginal or non-Aboriginal relatives or kin or other Aboriginal caregivers (Table D2.12.12, Figure 2.12.3).

Figure 2.12.3: Aboriginal children in out-of-home care, by relationship of carer, New South Wales and Australia, 30 June 2024



Note: 'In another care arrangement' includes children living with non-Aboriginal carers who are not relatives or kin, in residential care, in family group homes and children living independently.

Source: AIHW Child Protection Collection 2019–20 to 2023–24 (Table D2.12.13).

2.13 Transport

Why it is important

This measure reports on the use of transport, including walking, access to motor vehicles and perceived difficulty with transport. Transport is key to enabling access to health care, goods and services, and supports Aboriginal people to achieve education and employment outcomes and maintain cultural and kinship responsibilities (Cullen et al. 2017; Helps et al. 2010; Ivers et al. 2016). The reliability of transport options is also a critical barrier that Aboriginal people face in accessing appropriate health care, along with logistics, distance and cost (see measure 3.14 Access to services compared with need).

Key findings

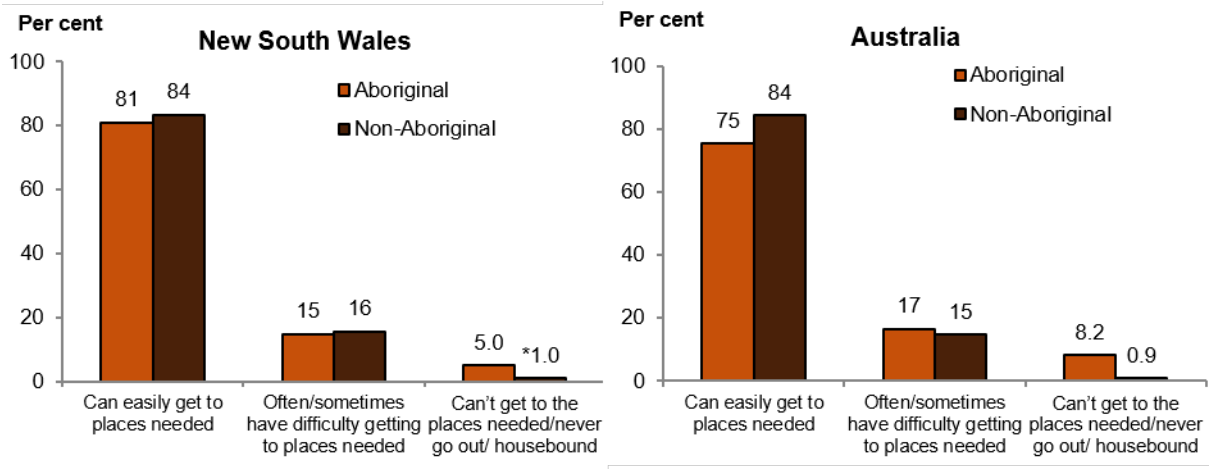
Note – the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) which collects detailed information on the social and cultural experiences of Aboriginal people has not been conducted since 2014–15. The following data therefore cannot be updated.

Overall: In New South Wales in 2014–15, 81% (112,100) of Aboriginal people aged 15 and over reported they could easily get to places needed; the proportion was 84% (4,900,700) for non-Aboriginal New South Wales residents.

Aboriginal people in New South Wales were 5 times as likely as non-Aboriginal people (5.0% compared with 1.0%) to report being unable to get to places they needed to/never going out/being housebound (note the non-Aboriginal estimate has a relative standard error of 25% to 50% and should be interpreted with caution).

Nationally in 2014–15, 75% of Aboriginal people aged 15 and over reported they could easily get to places needed, as did 84% of non-Aboriginal people. Nationally, Aboriginal people were 9.1 times as likely as non-Aboriginal people (8.2% compared with 0.9%) to report being unable to get to places they needed to/never going out/being housebound (Figure 2.13.1).

Figure 2.13.1: Perceived level of difficulty with transport for persons aged 15 and over, by Aboriginal status, New South Wales and Australia, 2014–15



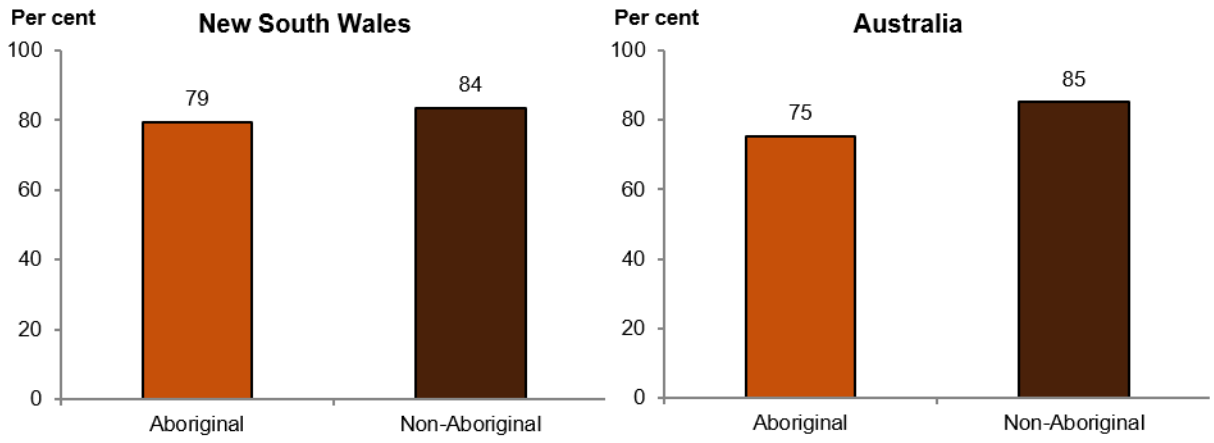
*Estimate has a relative standard error between 25% and 50% and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15 and General Social Survey 2014 (Table D2.13.4).

Access to a motor vehicle: In New South Wales in 2014–15, 79% (110,000) of Aboriginal people aged 15 and over reported that they had access to a motor vehicle. This was 0.9 times the proportion for non-Aboriginal people (84%).

Nationally in 2014–15, 75% (334,200) of Aboriginal people aged 15 and over reported that they had access to a motor vehicle, which was 0.9 times the proportion for non-Aboriginal people (85%) (Figure 2.13.2).

Figure 2.13.2: Australians aged 15 and over with access to a motor vehicle, by Aboriginal status, New South Wales and Australia, 2014–15



Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15 and General Social Survey 2014 (Table D2.13.8).

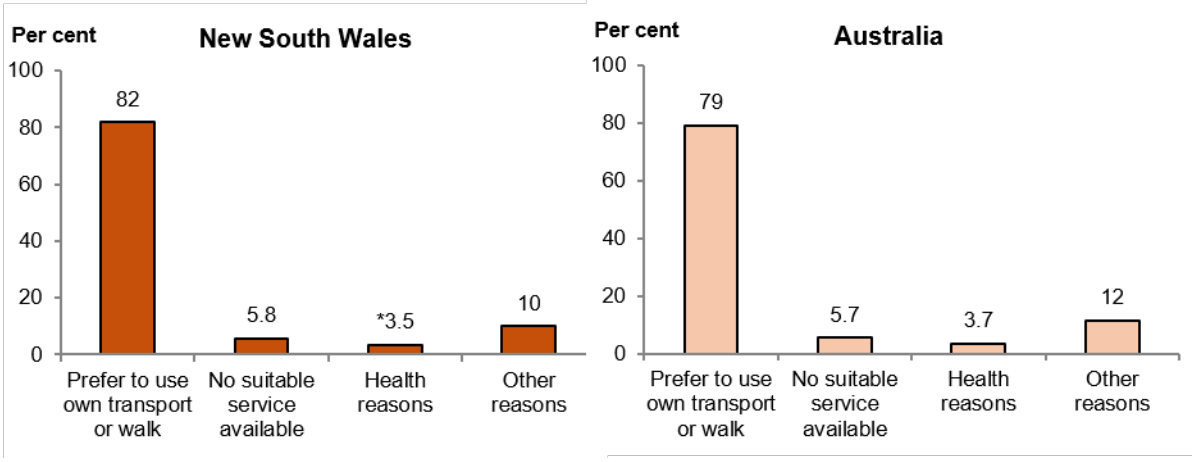
Use of public transport: In 2014–15 in New South Wales, an estimated 29% (40,600) of Aboriginal people aged 15 and over (who were not housebound) had used public transport in the last 2 weeks.

Nationally in 2014–15, an estimated 29% (129,200) of Aboriginal people (who were not housebound) had used public transport in the last 2 weeks (Table D2.13.9).

Access to public transport: In 2014–15 in New South Wales, public transport was available to 86% of Aboriginal people aged 15 and over. Of those who could access it, 82% reported they preferred to use their own transport or walk.

In 2014–15 nationally, public transport was available to 75% of Aboriginal people aged 15 and over. Of those who could access it, 79% reported they preferred to use their own transport or walk (Figure 2.13.3).

Figure 2.13.3: Aboriginal persons aged 15 and over who did not use public transport in the last 2 weeks in local areas where public transport was available, by reasons, New South Wales and Australia, 2014–15



*Estimate has a relative standard error between 25% and 50% and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Social Survey 2014–15 (Table D2.13.10).

2.14 Aboriginal people with access to their traditional lands

Why it is important

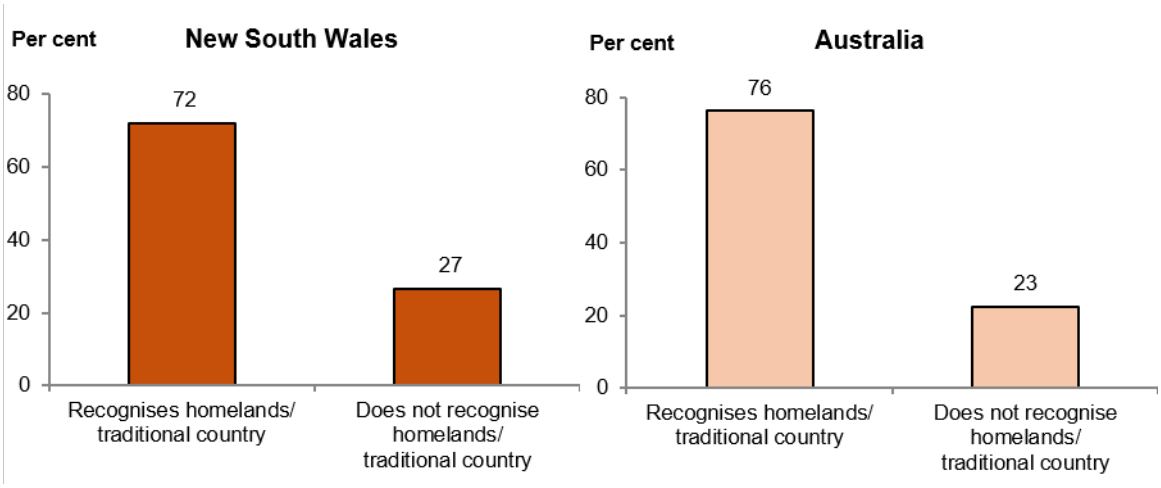
This measure reports on the proportion of Aboriginal people living on or visiting traditional areas of land with which they have ancestral or cultural links. Connection to family and community, land and sea, and cultural identity are integral to health from an Aboriginal perspective (NAHSWP 1989). Ongoing access to traditional lands also offers socio-political, economic and environmental benefits (Weir 2012). Access to traditional lands is a determinant of health in remote contexts where Aboriginal people are more likely to have ownership and control over their Country; it is also a determinant of health for those living in non-remote and urban areas.

Key findings

Overall: Based on the NATSIHS 2022–23, in New South Wales, 72% (141,800) of Aboriginal people aged 18 and over recognised their homelands or traditional Country as an area of land with ancestral and cultural links (Figure 2.14.1).

Nationally in 2022–23, 76% of Aboriginal people aged 18 and over recognised their homelands or traditional Country as an area of land with ancestral and cultural links (Figure 2.14.1). The proportion of Aboriginal people that recognised their homelands or traditional Country as an area of land with ancestral and cultural links was higher in remote than non-remote areas of Australia (87% compared with 74%) (Table D2.14.1).

Figure 2.14.1: Recognition of homelands or traditional Country, Aboriginal people aged 18 and over, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.14.6).

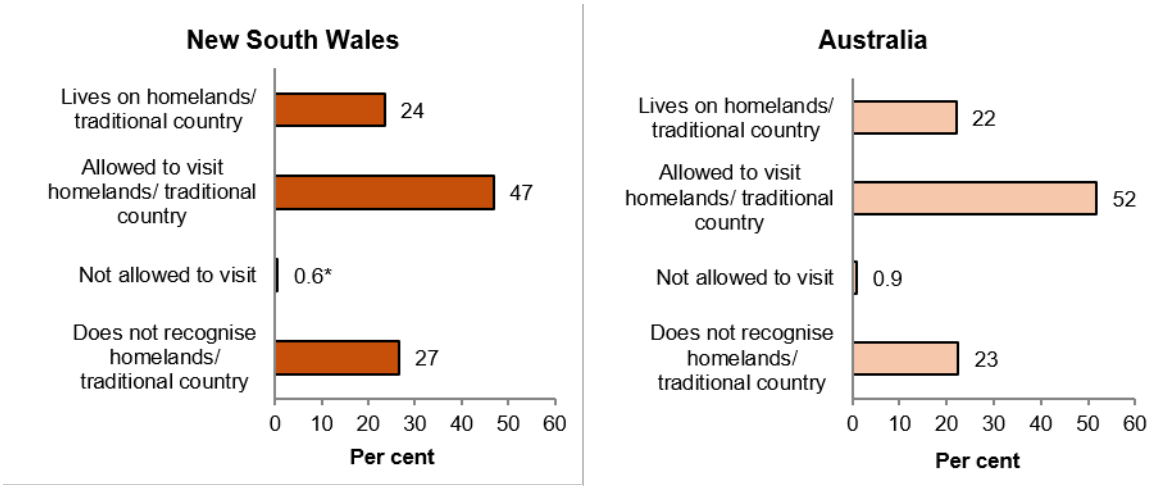
Living on homelands or traditional Country: In 2022–23 in New South Wales, 24% (46,300) of Aboriginal people aged 18 and over lived on their homelands or traditional Country.

Nationally in 2022–23, 22% of Aboriginal people aged 18 and over lived on their homelands or traditional Country (Figure 2.14.2).

Visiting homelands or traditional Country: In 2022–23 in New South Wales, 47% (92,100) of Aboriginal people aged 18 and over were allowed to visit their homelands or traditional Country, and 0.6% reported not being allowed to visit (this estimate has a high margin of error and should be interpreted with caution).

Nationally in 2022–23, 52% of Aboriginal people aged 18 and over were allowed to visit their homelands or traditional Country, and 0.9% reported not being allowed to visit (Figure 2.14.2).

Figure 2.14.2: Access to homelands or traditional Country, Aboriginal people aged 18 and over, New South Wales and Australia, 2022–23



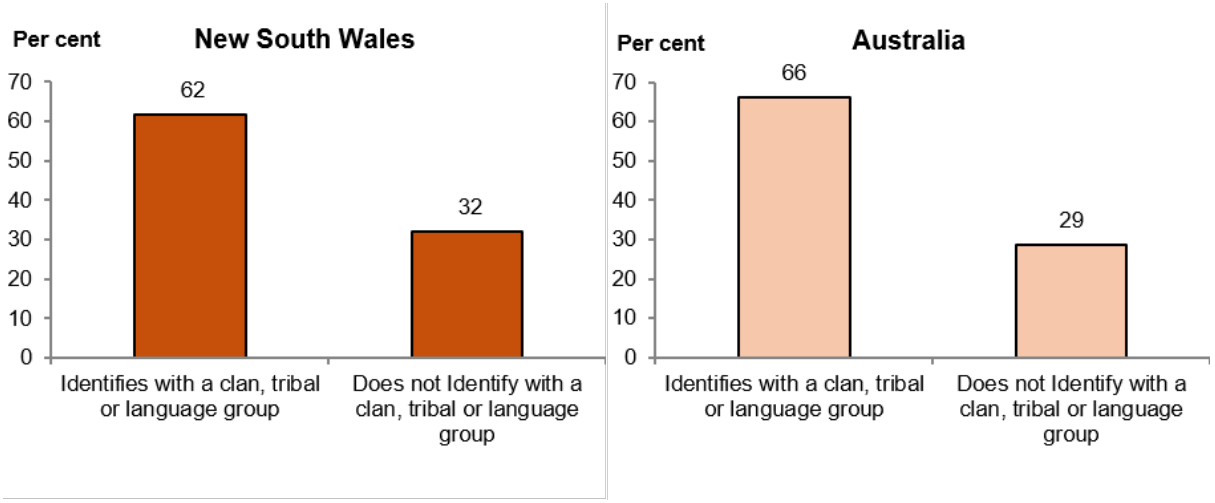
* Estimate has a relative standard error between 25% and 50% and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.14.6).

Identifying with a clan, tribal or language group: In 2022–23 in New South Wales, an estimated 121,500 (62%) Aboriginal people aged 18 and over identified with a tribal/language group or clan. The proportion that did not identify was 32%. The rest refused to or did not answer.

Nationally in 2022–23, 66% of Aboriginal people aged 18 and over identified with a tribal/language group or clan. The proportion that did not identify was 29% (Figure 2.14.3).

Figure 2.14.3: Cultural identification with a clan, tribal or language group, Aboriginal people aged 18 and over, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.14.6).

2.15 Tobacco use

Why it is important

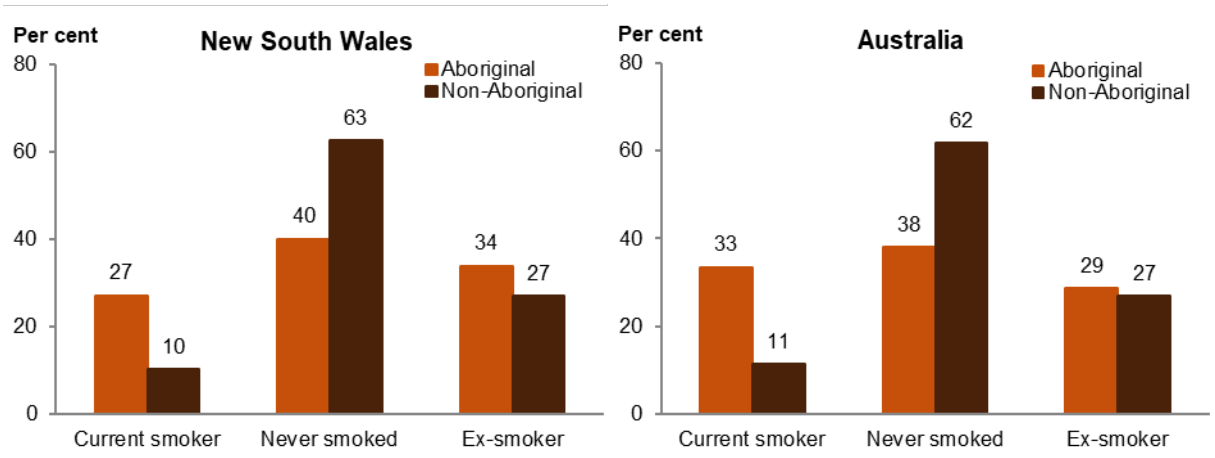
This measure reports on the smoking status. In 2018, tobacco use contributed 11.9% of the total disease burden for Aboriginal people, making it the leading risk factor contributing to disease burden and deaths (AIHW 2022b). In Australia, up to two-thirds of deaths in current smokers can be attributed to smoking, and current smokers are estimated to die an average of 10 years earlier than non-smokers (Banks et al. 2015). In 2018, tobacco use was estimated to contribute to almost 20,500 deaths in Australia (13% of all deaths) (AIHW 2021a). Smoking cessation reduces mortality, with earlier cessation resulting in greater reductions (Banks et al. 2015).

Key findings

Overall: Based on the NATSIHS 2022–23, in New South Wales, an estimated 25% (57,800) of Aboriginal people aged 15 and over reported they were current smokers, 30% (70,900) were ex-smokers and 44% (103,000) had never smoked (Table D2.15.7). After adjusting for differences in the age structure between the two populations, Aboriginal people aged 15 and over were 2.6 times as likely to be a current smoker as non-Aboriginal people in New South Wales (Figure 2.15.1).

Nationally in 2022–23, 32% (210,100) of Aboriginal people reported they were current smokers, 26% (170,400) were ex-smokers and 43% (286,400) had never smoked (Table D2.15.7). After adjusting for differences in the age structure between the two populations, Aboriginal people aged 15 and over were 3.0 times as likely to be a current smoker as non-Aboriginal people nationally (Figure 2.15.1).

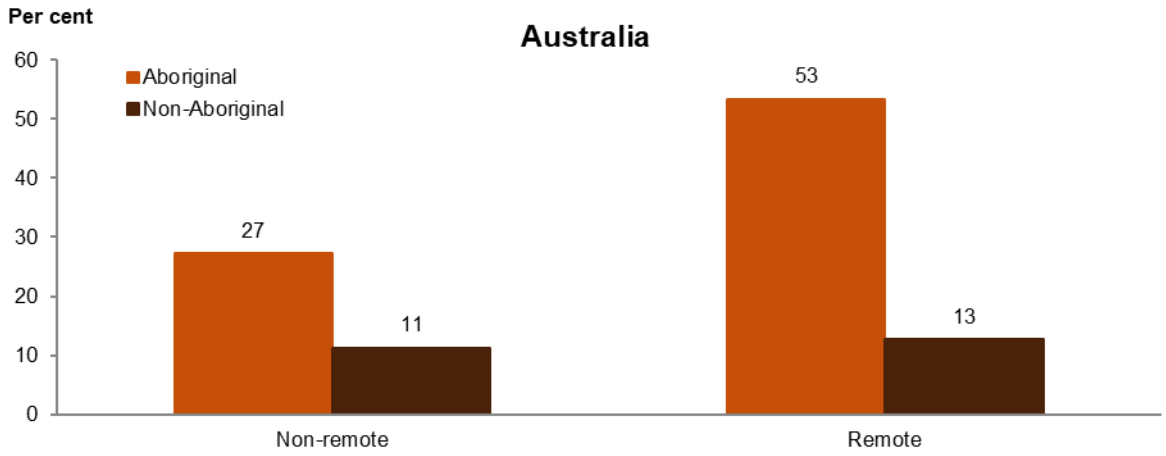
Figure 2.15.1: Smoking status (age-standardised rates) among people aged 15 and over, by Aboriginal status, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D2.15.7).

By remoteness: Nationally in 2022–23, after adjusting for differences in the age structure between the two populations, the proportion of Aboriginal people aged 15 and over who were current smokers was higher in remote areas than in non-remote areas (53% or 57,600 people compared with 27% or 152,700). For non-Aboriginal Australians aged 15 and over, the proportion of current smokers was slightly higher in remote areas than in non-remote areas (13% compared with 11%) (Figure 2.15.2).

Figure 2.15.2: Proportion of current smokers, by remoteness area and Aboriginal status, aged 15 and over, Australia, 2022–23

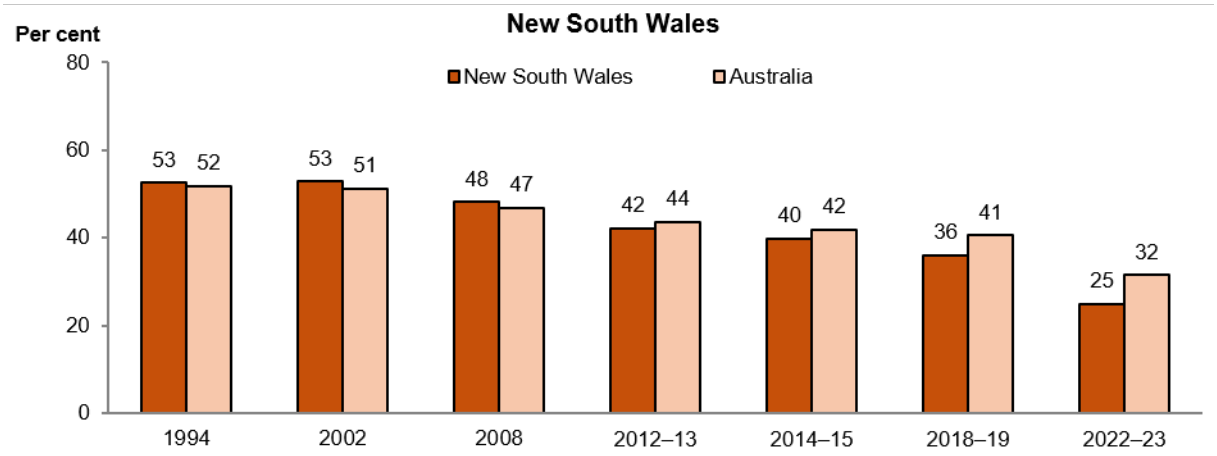


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D2.15.8).

Trend over time: The proportion of Aboriginal people aged 15 and over in New South Wales that were current smokers declined over time, from 53% in 2002 to 25% in 2022–23.

Nationally, the proportion for Aboriginal people aged 15 and over that were current smokers decreased from 51% in 2002 to 32% in 2022–23 (Figure 2.15.3). However, disaggregation by remoteness shows that while the proportion of Aboriginal people aged 15 and over that were current smokers in non-remote areas declined from 50% to 27%, in remote areas it changed only slightly from 55% to 53% between 2002 and 2022–23 nationally (Table D2.15.1).

Figure 2.15.3: Proportion of current smokers, Aboriginal people aged 15 and over, New South Wales and Australia, 2002 to 2022–23



Source: National Aboriginal and Torres Strait Islander Social Survey 2002, National Aboriginal and Torres Strait Islander Social Survey 2008, Australian Aboriginal and Torres Strait Islander Health Survey 2012–13, National Aboriginal and Torres Strait Islander Social Survey 2014–15, National Aboriginal and Torres Strait Islander Health Survey 2018–19, and AIHW analysis of National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.15.1).

2.16 Risky alcohol consumption

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
- **National alcohol and other drug hotline** 1800 250 015
- **Central Australian Aboriginal Congress Alcohol and other drug support** 1800 142 900
- **Alcoholic Anonymous Australia** 1300 222 222

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

Why it is important

This measure reports on alcohol consumption levels using self-reported data from NATSIHS 2022–23 and on hospitalisations related to alcohol use. Alcohol consumption is a complex, multi-determined behaviour, influenced by a range of biological and environmental factors, social and economic determinants and emotional wellbeing factors, including trauma, coping with stress, and peer pressure (House of Representatives Standing Committee on Indigenous Affairs 2015).

Excessive consumption of alcohol is associated with health and social problems in all populations (NHMRC 2009). It is a major risk factor for health conditions, including liver disease, pancreatitis, heart disease, stroke, diabetes, obesity and some types of cancer. It is also linked to social and emotional wellbeing, mental health and other drug issues. Harmful alcohol consumption can also affect families and communities. It has the potential to lead to anti-social behaviour, violence, assault, imprisonment and family breakdown (NHMRC 2020). Aboriginal people are more likely to abstain from alcohol than non-Aboriginal Australians; however, those who do drink are more likely to do so at dangerous levels.

The 2020 Australian Guidelines to Reduce Health Risks from Drinking Alcohol provide the current advice from the National Health and Medical Research Council (NHMRC) around alcohol consumption (NHMRC 2020). These guidelines have informed the survey data compiled for this measure. Persons exceeded the Australian Adult Alcohol Guideline if they consumed more than 10 standard drinks in the last week, or consumed 5 or more standard drinks on a single day at least 12 times in the last 12 months or both.

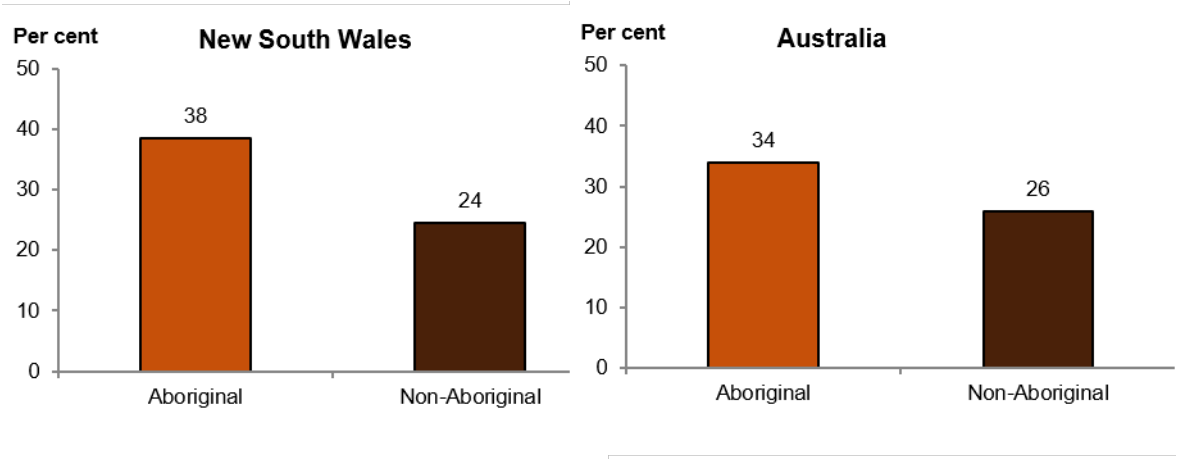
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Risky alcohol consumption: In 2022–23 in New South Wales, 37% (86,800) of Aboriginal people aged 15 and over reported consuming alcohol in quantities that exceeded the NHMRC 2020 guidelines. This is compared with 34% of Aboriginal people aged 15 and over nationally (Table D2.16.1).

After adjusting for differences in the age structure between the two populations, Aboriginal people aged 15 and over in New South Wales exceeded the NHMRC 2020 guidelines at 1.6 times the rate for non-Aboriginal people. Nationally, Aboriginal people exceeded the guidelines at 1.3 times the rate for non-Aboriginal people (Figure 2.16.1).

Figure 2.16.1: Age-standardised rates of risky alcohol consumption, people aged 15 and over, by Aboriginal status, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.16.2).

Hospitalisation: Over the period July 2021 to June 2023 in New South Wales, there were 2,754 hospitalisations of Aboriginal people with a principal diagnosis related to alcohol use. This corresponded to a rate of 398 hospitalisations per 100,000 population. These rates were more than twice as high among Aboriginal males as Aboriginal females (543 compared with 253 per 100,000). After adjusting for the differences in the age structure between two populations the rate of hospitalisations related to alcohol use for Aboriginal people was 1.8 times the rate for non-Aboriginal people in New South Wales (Table D2.16.23).

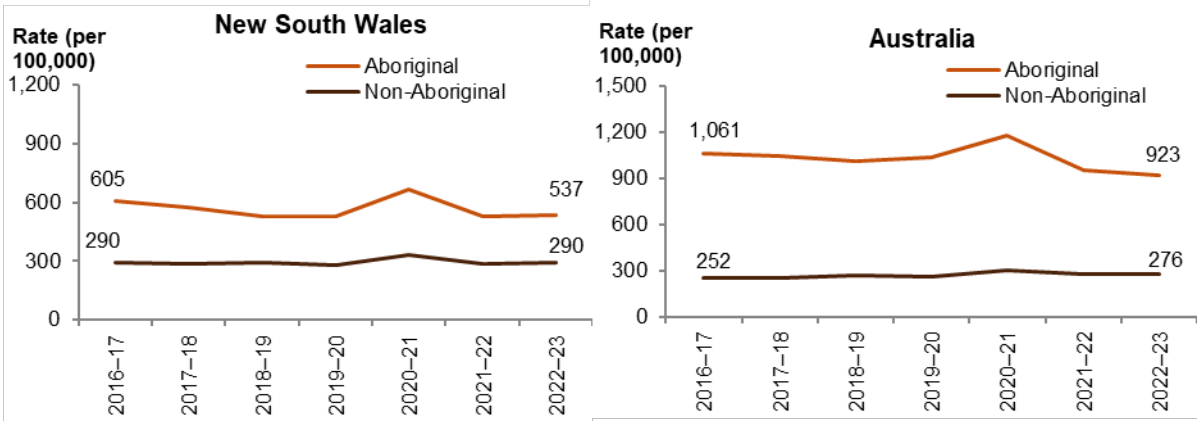
Nationally in the same period, there were 14,592 (728 per 100,000) hospitalisations of Aboriginal people with a principal diagnosis related to alcohol use. After adjusting for the differences in the age structure between two populations the rate of hospitalisations related to alcohol use for Aboriginal people was 3.4 times the rate for non-Aboriginal people nationally.

Hospitalisation rates related to alcohol use for Aboriginal people were higher in remote areas than in non-remote areas both in New South Wales and nationally in this time period (825 compared with 362 per 100,000 in New South Wales and 1,516 compared with 537 per 100,000 in Australia). The relative difference in the age-standardised alcohol-related hospitalisations rates (rate ratios) between Aboriginal and non-Aboriginal populations were also significantly higher in remote than in non-remote areas both in New South Wales (8.6 compared with 1.7) and nationally (9.3 compared with 2.6) (Table D2.16.23).

Hospitalisation trend over time: Between 2016–17 and 2022–23, the age-standardised rate of hospitalisations relating to alcohol use for Aboriginal people in New South Wales decreased by 5.8% based on linear regression analysis. In contrast, age-standardised rates for non-Aboriginal people increased by 3.6% over the same period (Table D2.16.13 NSW).

Nationally, between 2016–17 and 2022–23, the age-standardised hospitalisation rate related to alcohol use for Aboriginal people decreased by 8.4%, based on linear regression results. For non-Aboriginal people, the rate increased by 14% over the same period (Figure 2.16.2).

Figure 2.16.2: Age-standardised hospitalisation rates related to alcohol use, by Aboriginal status, New South Wales, and Australia, 2016–17 to 2022–23



Source: National Hospital Morbidity Database (Table D2.16.13 NSW).

2.17 Drug and other substance use including inhalants

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
- **National alcohol and other drug hotline** 1800 250 015
- **Central Australian Aboriginal Congress Alcohol and other drug support** 1800 142 900
- **Alcoholic Anonymous Australia** 1300 222 222

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

Why it is important

This measure reports on hospitalisations related to drug use and self-reported use of drugs and other substances, including any drug that is illegal to possess or use, as well as any legal drug used in an illegal manner. Drug and other substance use is a contributing factor to illness and disease, accident and injury, violence and crime, family and social disruption, education and workplace problems (SCRGSP 2014b).

Substance use is associated with mental health problems (Catto and Thomson 2008) and has been found to be a factor in suicides (Robinson et al. 2011). Risky sexual behaviour is also associated with alcohol and illicit drug use, leading to increased sexually transmitted infections among younger people (Wand et al. 2016). For communities, there is increased potential for social disruption, such as that caused by domestic violence, crime and assaults. Drugs and other substance use play a significant role in Aboriginal people's involvement in the criminal justice system (see measure 2.11 Contact with the criminal justice system).

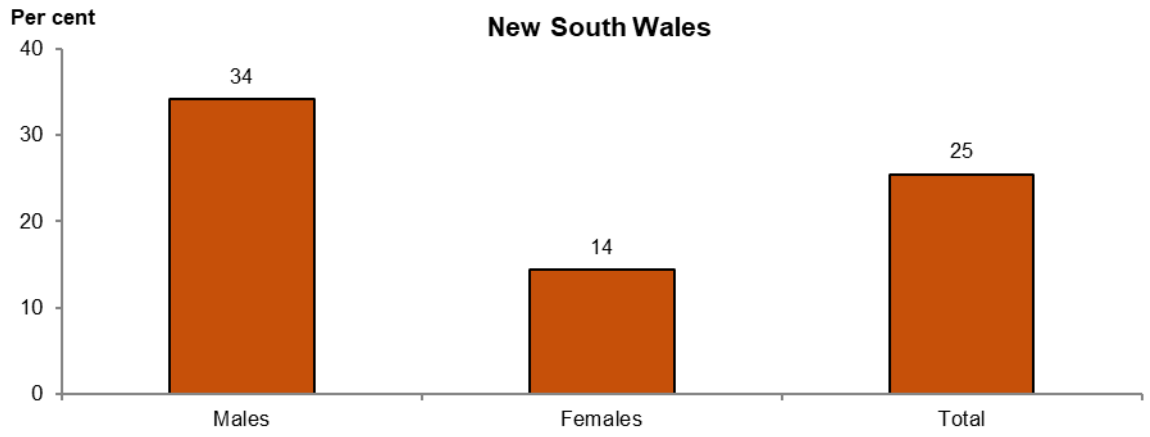
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Self-reported use: Based on 2022–23 NATSIHS in New South Wales, after adjusting for differences in the age structure between the two populations an estimated 25% (42,600) of Aboriginal people aged 15 years and over reported using substances in the last 12 months. An estimated 34% (27,800) of Aboriginal males and 14% (14,300) of Aboriginal females had used substances in the last 12 months (Figure 2.17.1).

Nationally, an estimated 27% of Aboriginal people aged 15 and over reported using substances in the last 12 months (Table D2.17.3).

Figure 2.17.1: Age-standardised rate of substance use in the last 12 months for Aboriginal people aged 15 and over, by sex, New South Wales, 2022–23

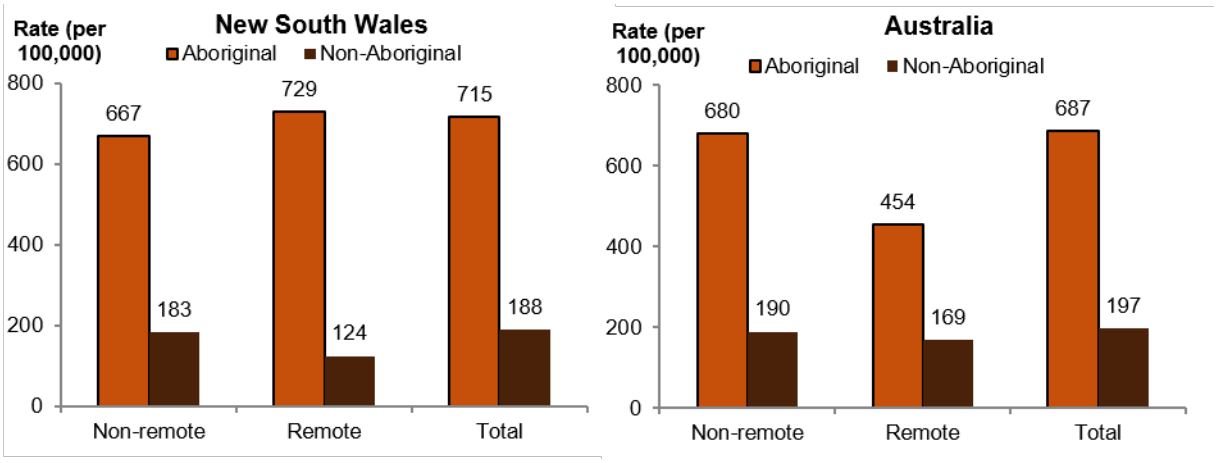


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.17.3).

Hospitalisations: In New South Wales, from July 2021 to June 2023, there were 4,375 hospitalisations of Aboriginal people with a principal diagnosis related to drug use, which corresponded to a rate of 633 hospitalisations per 100,000 population. Hospitalisation rates were higher in remote areas (655 per 100,000) than in non-remote areas (591 per 100,000) (Table D2.17.8, Figure 2.17.2). After adjusting for differences in the age structure between the two populations, the hospitalisation rate with a principal diagnosis related to drug use in New South Wales for Aboriginal people was 3.8 times the hospitalisation rate for non-Aboriginal people (Figure 2.17.2).

Nationally, from July 2021 to June 2023, there were 12,879 hospitalisations of Aboriginal people with a principal diagnosis related to drug use, which corresponded to a rate of 643 hospitalisations per 100,000 population. Unlike in New South Wales, hospitalisation rates were higher in non-remote areas (626 per 100,000) than in remote areas (472 per 100,000) nationally (Table D2.17.8). After adjusting for differences in the age structure between the two populations, the national hospitalisation rate with a principal diagnosis related to drug use for Aboriginal people was 3.5 times the hospitalisation rate for non-Aboriginal people (Figure 2.17.2).

Figure 2.17.2: Age-standardised rates of drug-related hospitalisations, by Aboriginal status and remoteness, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database (Table D2.17.8).

2.18 Physical activity

Why it is important

This measure reports on the levels of physical activity among Aboriginal people. Physical activity is crucial in maintaining good overall health, both physical and mental (ABS 2013). Regular participation in physical activity can reduce the risk of many chronic conditions, such as cardiovascular disease, type 2 diabetes and some forms of cancer (Brown et al. 2013; Gray et al. 2013; Sims et al. 2006; Wilmot et al. 2012). In 2018, physical inactivity accounted for 2.4% of the total disease burden for Aboriginal people, making it the 11th leading risk factor contributing to disease burden (AIHW 2022b).

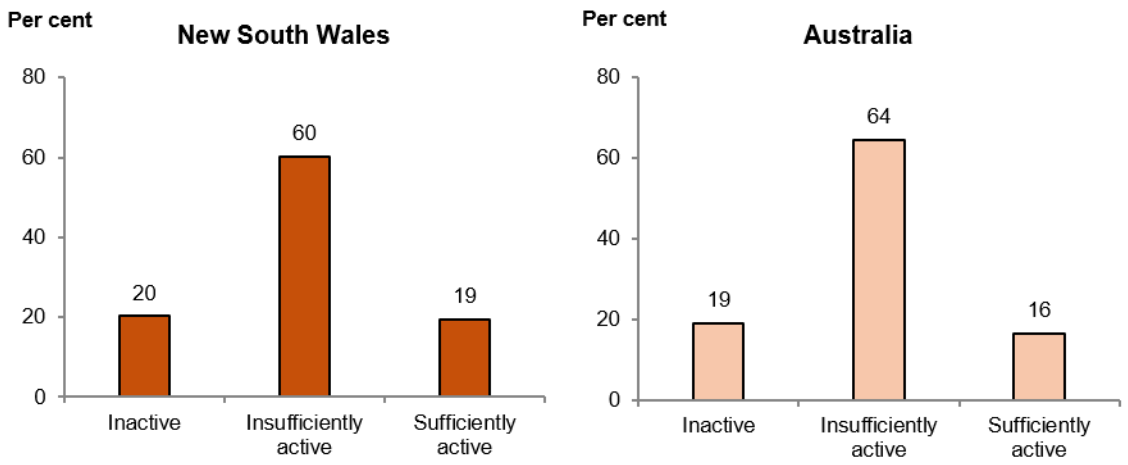
Key findings

Level of physical activity (aged 15+): The 2022–23 NATSIHS assessed physical activity undertaken by people based on an interpretation of Australia's Physical Activity and Sedentary Behaviour Guidelines set by the Department of Health in 2014. Respondents were asked how often they performed any of the following physical activities within the last week: walking for transport, walking for fitness, recreation or sport, moderate intensity exercise, vigorous intensity exercise and, strength or toning activities (ABS 2019).

In New South Wales in 2022–23, 19% (44,000) of Aboriginal people aged 15 and over in non-remote areas had undertaken a sufficient level of physical activity that meets the guideline in the week prior. Approximately 20% (45,900) had undertaken no physical activity in the last week.

Nationally in 2022–23, an estimated 16% of Aboriginal people aged 15 and over living in non-remote areas had undertaken a sufficient level of physical activity in the week prior. Approximately 19% had done no physical activity in the last week (Figure 2.18.1).

Figure 2.18.1: Proportion of Aboriginal people aged 15 and over reporting selected levels of physical activity, non-remote areas, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.18.8).

2.19 Dietary behaviour

Why it is important

This measure reports on dietary behaviour among Aboriginal people including fruit and vegetable consumption. Many of the principal causes of ill-health are nutrition-related diseases – heart disease, type 2 diabetes and renal disease. Of particular relevance in Aboriginal communities are dietary factors including insulin resistance, glucose intolerance, obesity (especially central fat deposition), hypertension, high blood triglycerides, perinatal and postnatal nutrition and childhood nutrition (Longstreet et al. 2008). While a diet high in saturated fats and refined carbohydrates increases the likelihood of developing these diseases, regular exercise and intake of fibre-rich foods, such as fruit and vegetables, can have a protective effect against disease (Wang et al. 2014). National Health and Medical Research Council's 2013 Australian Dietary Guidelines recommend a minimum number of serves of fruit and vegetables each day, depending on a person's age and sex, to ensure good nutrition and health. Access to affordable, nutritious food is influenced by factors such as income, food security and availability of fresh food, particularly in remote and disadvantaged areas, which may affect dietary choices and health outcomes (AIHW 2026o; AIHW and NIAA 2026).

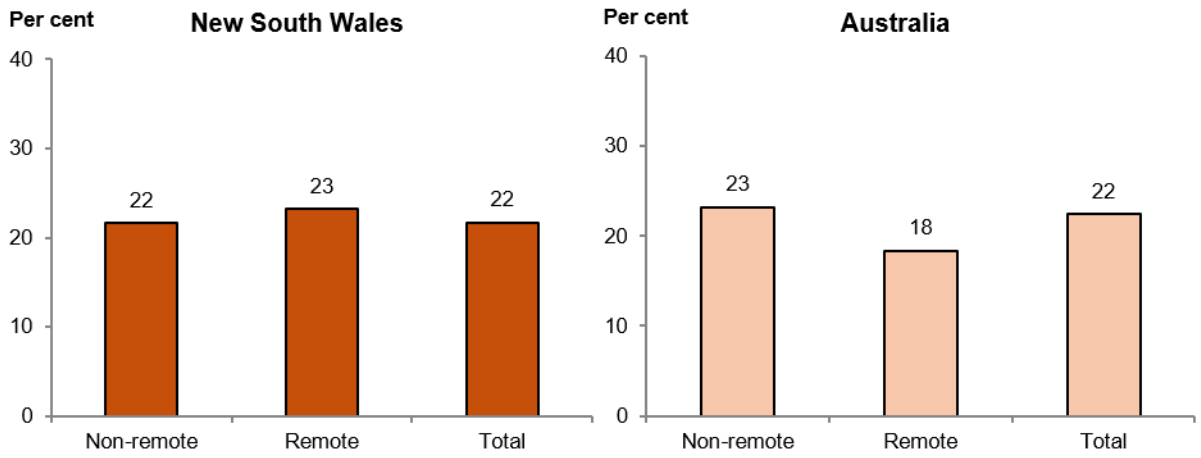
Key findings

Consumption of fruit: Based on 2022–23 NATSIHS, an estimated 44% (146,500) of Aboriginal people aged 2 and over in New South Wales ate the recommended daily amount of fruit. This was similar to the proportion at the national level (44%; 418,800) (Table D2.19.6).

In 2022–23 in New South Wales, an estimated 22% (72,400) of Aboriginal people aged 2 and over ate less than one serve of fruit a day. The proportion of Aboriginal people who ate less than one serve of fruit per day was similar in remote and non-remote areas of New South Wales (23% and 22%, respectively).

Nationally in 2022–23, an estimated 22% of Aboriginal people aged 2 and over ate less than one serve of fruit a day (23% in non-remote areas and 18% in remote areas) (Figure 2.19.1).

Figure 2.19.1: Aboriginal people (aged 2 and over) reported to eat less than one serve of fruit per day, by remoteness, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.19.2).

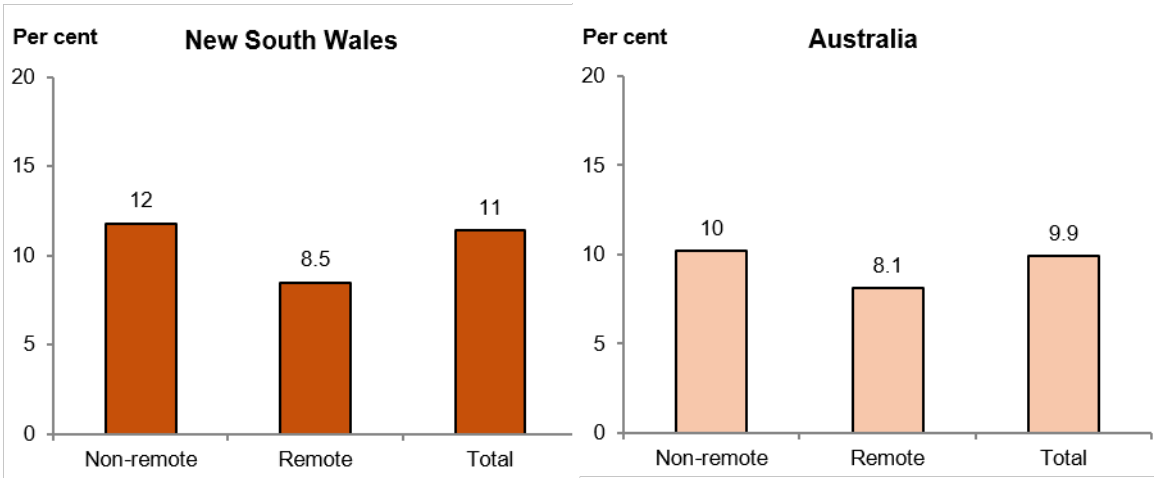
Consumption of vegetables: In New South Wales, 5.7% (19,100) of Aboriginal people aged 2 and over met the recommended daily vegetable intake in 2022–23, similar to the national proportion of 5.4% (51,000) (Table D2.19.6).

In 2022–23 in New South Wales, an estimated 11% (38,100) of Aboriginal people aged 2 and over reported eating less than one serve of vegetables a day.

Aboriginal people living in non-remote areas of New South Wales were more likely to eat less than one serve of vegetables a day than those living in remote areas (12% compared with 8.5%).

Nationally in 2022–23, 9.9% of Aboriginal people (aged 2 and over) ate less than one serve of vegetables a day (8.1% in remote areas and 10% in non-remote areas) (Figure 2.19.2).

Figure 2.19.2: Aboriginal people (aged 2 and over) reported to eat less than one serve of vegetables per day, by remoteness, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.19.3).

Children's consumption of fruit: In 2022–23 in New South Wales, 68% (67,700) of Aboriginal children aged 2–14 met the recommended guideline for daily fruit consumption. Approximately 61% (61,100) ate at least 2 serves, 31% (31,500) ate one serve to less than 2 serves and 8.6% (8,600) ate less than one serve of fruit a day.

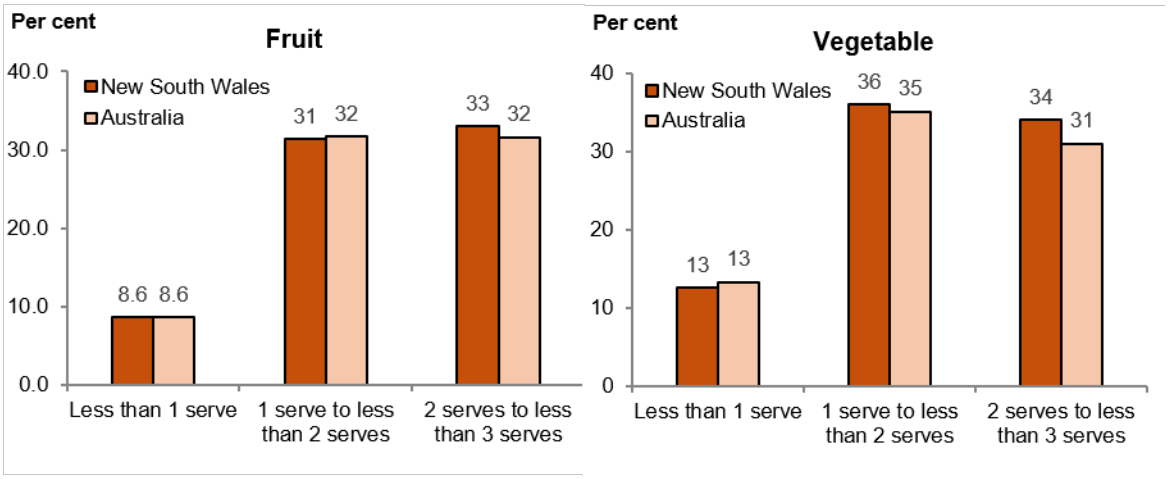
Nationally in 2022–23, 60% of Aboriginal children aged 2–14 ate at least 2 serves, 32% ate one serve to less than 2 serves, and 8.6% ate less than one serve of fruit a day (Table D2.19.9, Figure 2.19.3).

Children's consumption of vegetables: In 2022–23 in New South Wales, 5.8% (5,800) of Aboriginal children aged 2–14 met the recommended guideline for daily vegetable consumption. The estimated number of children meeting the guideline has a relative standard error between 25% and 50% and should be used with caution.

Approximately 34% (34,400) of Aboriginal children aged 2–14 in New South Wales ate 2 serves to less than 3 serves, 36% (36,400) ate one serve to less than 2 serves and 13% (12,600) ate less than one serve of vegetables daily. Estimates for children eating one to less than 2 serves, and 2 to less than 3 serves, have a high margin of error and should be interpreted with caution.

Nationally in 2022–23, 31% of Aboriginal children aged 2–14 ate 2 serves to less than 3 serves, 35% ate one serve to less than 2 serves and 13% ate less than one serve of vegetables a day (Figure 2.19.3).

Figure 2.19.3: Aboriginal children (aged 2–14), number of serves of fruit and vegetables consumed daily, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D2.19.9).

2.20 Breastfeeding practices

Why it is important

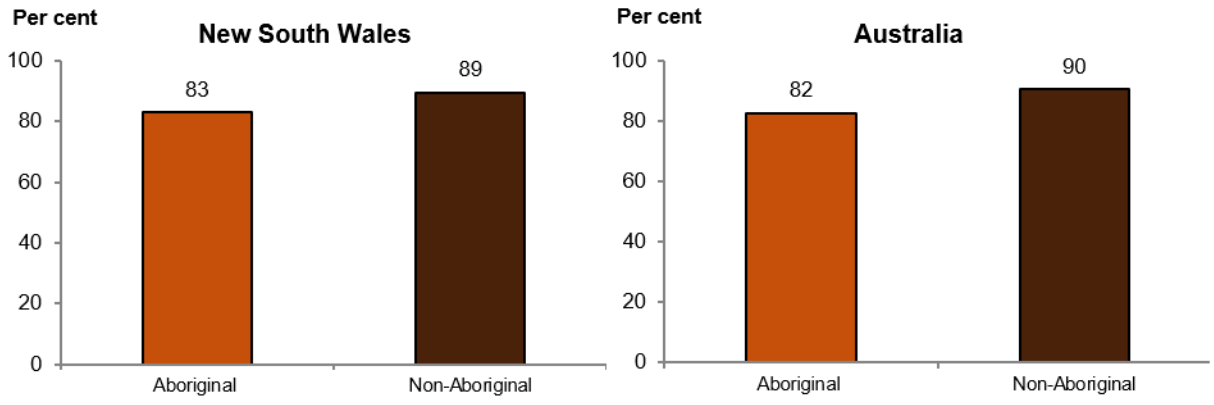
This measure reports on the breastfeeding status and duration of breastfeeding for Aboriginal infants. Breastfeeding brings a range of health benefits for both the infant and the mother. It enhances bonding and attachment between the mother and the baby and is associated with protection against various illnesses and conditions, including sudden infant death syndrome (SIDS), necrotising enterocolitis (NEC), diarrhoea, respiratory infections, otitis media, overweight or obesity, diabetes and childhood leukaemia. Breastfeeding also reduces the risk of hospitalisation for infants (Allen and Hector 2005; Duijts et al. 2009; Eidelman and Schanler 2012; Horta et al. 2015; Kramer et al. 2008).

Key findings

Children aged 0–3: In 2022–2023, based on NATSIHS, an estimated 83% (29,100) of Aboriginal children aged 0–3 in New South Wales had ever been breastfed (currently receiving breast milk or had received breast milk in the past but ceased), compared with 89% (334,500) among non-Aboriginal children of the same age.

Nationally, an estimated 82% of Aboriginal children aged 0–3 had ever been breastfed, compared with 90% of non-Aboriginal children (Figure 2.20.1).

Figure 2.20.1: Total ever breastfed (current or ceased), children aged 0–3 by Aboriginal status, New South Wales and Australia, 2022–23



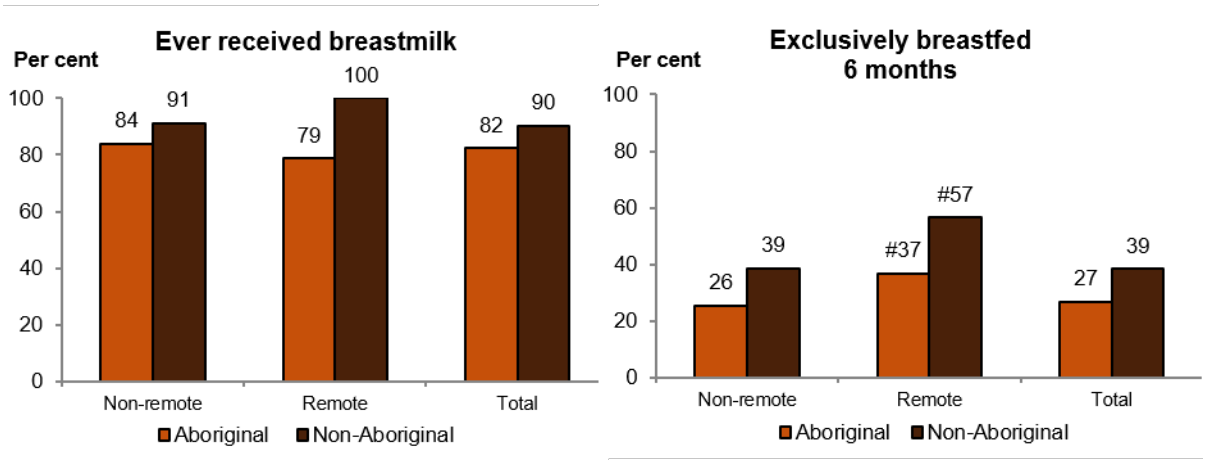
Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D2.20.2).

By remoteness (children aged 0–3): Nationally in 2022–23, the proportion of Aboriginal children aged 0–3 who were reported to have ever been breastfed was an estimated 84% (67,500) in non-remote areas and 79% (8,500) in remote areas. The proportion of non-Aboriginal children aged 0–3 nationally who were reported to have ever been breastfed was 91% in non-remote areas and 100% in remote areas (Figure 2.20.2).

Nationally in 2022–23, the proportion of Aboriginal children aged 0–3 who were reported to have met the breastfeeding guidelines (for exclusive breastfeeding for at least 6 months) was 26% (18,300) in non-remote areas and 37% (3,500) in remote areas (this proportion has a

high margin of error and should be used with caution). The proportion of non-Aboriginal children aged 0–3 who were reported to have met the breastfeeding guidelines in 2022–23 was 39% in non-remote areas and 57% in remote areas (this proportion also has a high margin of error and should be used with caution) (Figure 2.20.2).

Figure 2.20.2: Breastfeeding, children aged 0–3, by Aboriginal status and remoteness, Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D2.20.1).

2.21 Health behaviours during pregnancy

Why it is important

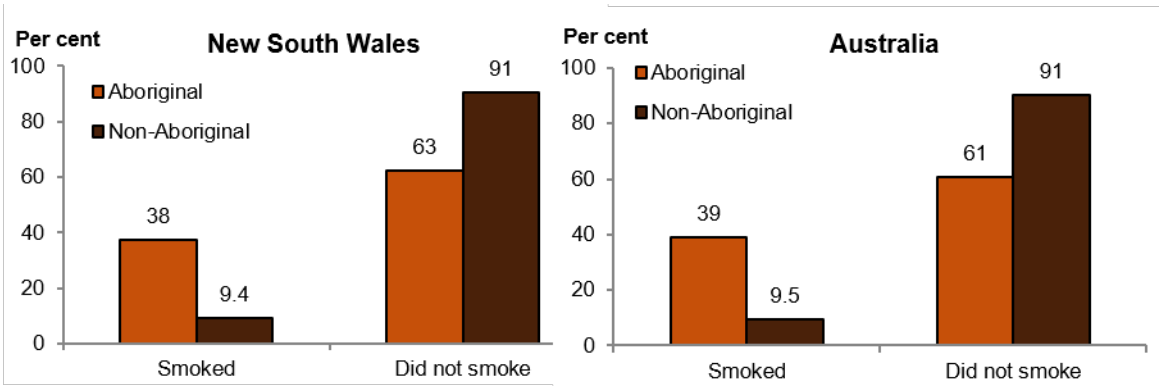
This measure reports on the use of tobacco, alcohol, illicit substances and other health related behaviours during pregnancy. Many Aboriginal women have healthy pregnancies (Clarke and Boyle 2014). The health and wellbeing of women during pregnancy is vitally important to ensuring healthy outcomes for mothers and their babies (AIHW 2020a, 2026c). Many factors contribute to and can have beneficial or adverse effects on the health and wellbeing of a mother and her baby during pregnancy and birth, as well as outcomes for children later in life. Women who eat well, exercise regularly and receive regular antenatal care are less likely to have complications during pregnancy. They are also more likely to give birth successfully to a healthy baby. Smoking, drinking, or taking illicit drugs can lead to increased risk of pregnancy complications, poor perinatal outcomes (such as preterm birth or low birthweight), and ongoing health concerns. These behaviours should also be understood in the context of broader social and cultural determinants of health, including socioeconomic conditions and broader life circumstances that influence health behaviours before and during pregnancy. In addition, racism and other upstream determinants including the pervasive effects of colonisation constitute a 'double burden' for Aboriginal people, affecting their health and access to adequate and timely health care services (Kildea et al. 2016).

Key findings

Smoking: In New South Wales, 63% (3,304) of Aboriginal women who gave birth in 2023 reported that they did not smoke during pregnancy. After adjusting for differences in the age structure between the two populations, this was about 0.7 times the proportion for non-Aboriginal New South Wales women (63% compared with 91%).

A similar pattern was seen nationally, with 61% (9,320) of Aboriginal women who gave birth in 2023 reporting that they did not smoke at any time during pregnancy. After adjusting for age differences between the two populations, this was 0.7 times the rate for non-Aboriginal women (61% compared with 91%) (Figure 2.21.1).

Figure 2.21.1: Age-standardised rate of tobacco smoking at any time during pregnancy, by Aboriginal status of the mother, New South Wales and Australia, 2023

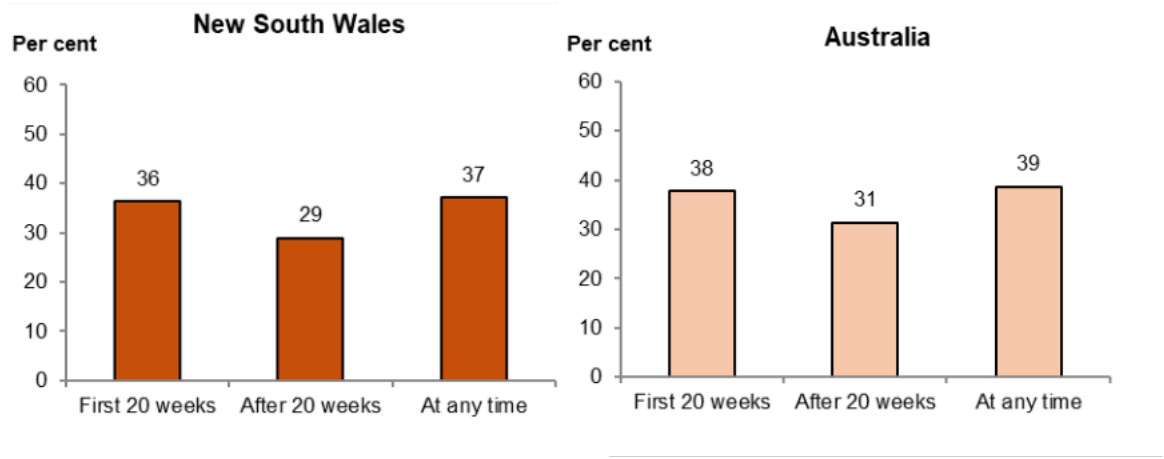


Source: National Perinatal Data Collection (Table D2.21.1).

In New South Wales, in 2023 the proportion of Aboriginal mothers who smoked after 20 weeks of pregnancy (29%, 1,518) was lower than the proportion who smoked in the first 20 weeks (36%, 1,908).

Nationally, in 2023 the proportion of Aboriginal mothers who smoked after 20 weeks of pregnancy (31%) was lower than the proportion who smoked in the first 20 weeks (38%) (Figure 2.21.2).

Figure 2.21.2: Aboriginal mothers who smoked during the first 20 weeks of pregnancy and after, New South Wales and Australia, 2023

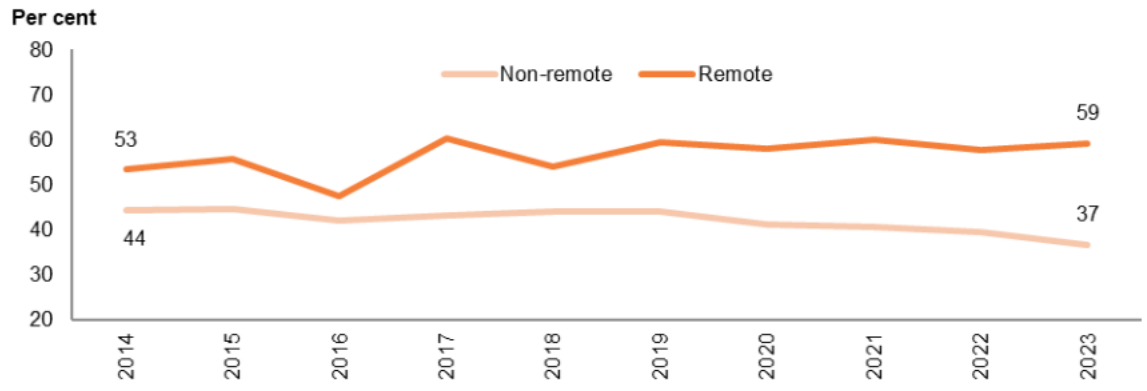


Source: National Perinatal Data Collection (Tables D2.21.1, D2.21.9 and D2.21.10).

By remoteness: In New South Wales in 2023, Aboriginal mothers in non-remote areas were less likely to smoke at any time during pregnancy than those in remote areas (37% compared with 59%). From 2014 to 2023, the age-standardised rate of smoking during pregnancy for Aboriginal mothers in non-remote New South Wales decreased by 14%. Over the same period, there was no statistically significant change in remote areas (Figure 2.21.3).

A similar pattern was seen nationally. Age-standardised rates of smoking during pregnancy for Aboriginal mothers were lower in non-remote areas and decreased by 13% from 2014 to 2023 for Aboriginal mothers in these areas.

Figure 2.21.3: Aboriginal mothers who smoked at any time during pregnancy, by remoteness areas, New South Wales, 2014 to 2023



Source: National Perinatal Data Collection (Table D2.21.22).

Alcohol and drug use during pregnancy: Based on NATSIHS 2022–23 in New South Wales, among mothers of Aboriginal children aged 0–3, most did not consume alcohol (96%) and did not use illicit drugs (97%) during pregnancy. Note that the estimate for illicit drug use has a high margin of error and should be used with caution.

Similar trends were observed nationally in 2022–23, where most mothers of Aboriginal children aged 0–3 did not consume alcohol (93%) and did not use illicit drugs (92%) during pregnancy (Table D2.21.6).

2.22 Overweight and obesity

Why it is important

This measure reports on the proportion of people who are overweight or obese, based on Body Mass Index (BMI). Overweight and obesity is a global health problem and is associated with a significant reduction in life expectancy (OECD 2019; Peeters et al. 2003; Sevoyan et al. 2019). Overweight and obesity refer to abnormal or excessive fat accumulation that may impair health (WHO 2025). Being overweight or obese increases the risk of various health conditions, including coronary heart disease, type 2 diabetes, kidney and urinary diseases, some cancers, respiratory problems, joint problems, sleep disorders, and social problems. Evidence suggests that some chronic conditions may occur at lower Body Mass Index (BMI) levels among Aboriginal people, which may affect how BMI relates to health risk in this population (Adegbija et al. 2017; Zheng et al. 2011).

Overweight and obesity is also associated with other health risk factors and social determinants of health. One example is prolonged financial stress, which is a predictor of obesity (see measure 2.08 Income) (Siahpush et al. 2014). Low income and food prices are associated with food security problems, and for these reasons, a nutritious diet is not always accessible for many Aboriginal people (see measure 2.19 Dietary behaviours) (Markwick et al. 2014). Evidence also shows that incarceration is associated with weight gain and obesity in Aboriginal youth (see measure 2.11 Contact with the criminal justice system) (Haysom et al. 2013). Other contributing factors include urbanisation, overcrowded housing and a lack of adequate access to health services (Sherriff et al. 2019). Weight stigma can also contribute to poorer health outcomes by creating barriers to accessing healthcare, including weight management and other health services (Markovic et al. 2022).

Based on NSW Population Health Survey, over the last 10 years in New South Wales, the proportion of Aboriginal people living with overweight or obesity increased from 58% in 2015 to 80% in 2024. This increase was driven by a rise in obesity, from 25% to 43%. Estimates vary over time due to the smaller population size (HealthStats NSW 2026b).

Key findings

The 2022–23 NATSIHS included height and weight measurements, to allow Body Mass Index (BMI) to be calculated. BMI is used to classify people into weight categories: underweight (BMI<18.5), normal weight (BMI 18.5–24.9), overweight (BMI 25–29.9) or obese (BMI>30.0).

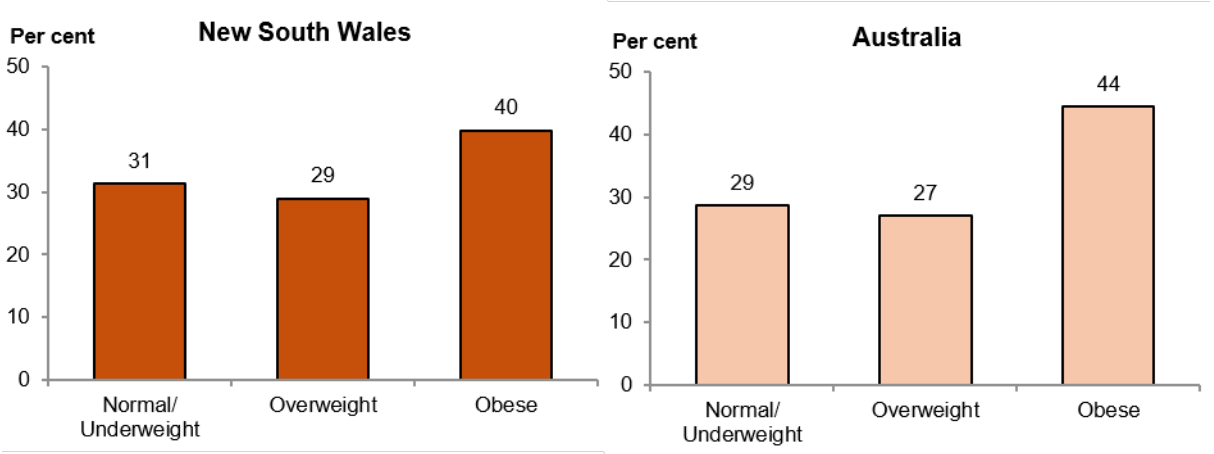
Body mass index (BMI) is a useful population-level indicator but has recognised limitations; it does not distinguish between fat and muscle, or fat distribution, and may not fully capture variation in body composition or health risk across population groups, including Aboriginal people, as it was developed using data from European populations and primarily for population-level analysis, which may limit its applicability for individual health assessment across diverse population groups (AIHW 2026d; Bays et al. 2022; Bray 2023; Buss 2014; Eknoyan 2008).

Overall: In New South Wales in 2022–23, an estimated 69% (144,700 people) of Aboriginal adults (aged 18 or over) had a BMI in the overweight or obese range (29% overweight and 40% obese) (Figure 2.22.1). Aboriginal females were more likely to have obesity than Aboriginal males (45% compared with 34%, respectively), and slightly less likely to live with

overweight than Aboriginal males (29% compared with 31%, respectively) (ABS 2024c, Table 29.3).

Nationally in 2022–23, an estimated 71% of Aboriginal adults had a BMI in the overweight or obese range (27% overweight and 44% obese) (Figure 2.22.1).

Figure 2.22.1: Proportion of Aboriginal people aged 18 and over by BMI category, New South Wales and Australia, 2022–23

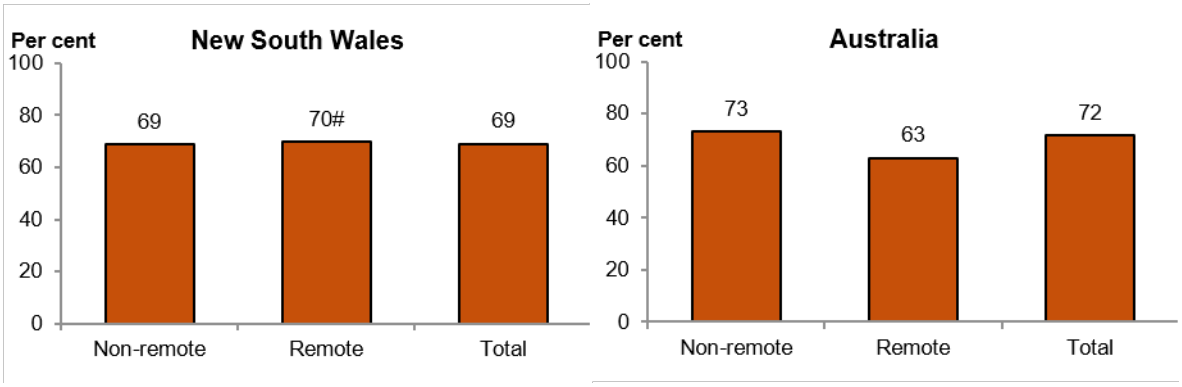


Source: National Aboriginal and Torres Strait Islander Survey 2022–23 (ABS 2024e, Table 29.3).

By remoteness: In New South Wales in 2022–23, the proportion of Aboriginal adults living with overweight or obesity were similar in remote and non-remote areas (70% or 3,700 people in remote areas and 69% or 140,200 in non-remote areas). Note that the proportion in remote areas has a high margin of error and should be used with caution.

Nationally in 2022–23, the proportion of Aboriginal adults living with overweight or obesity was 73% in non-remote and 63% in remote areas. (Figure 2.22.2).

Figure 2.22.2: Proportion of persons aged 18 and over who were living with overweight or obesity, by remoteness, New South Wales and Australia, 2022–23



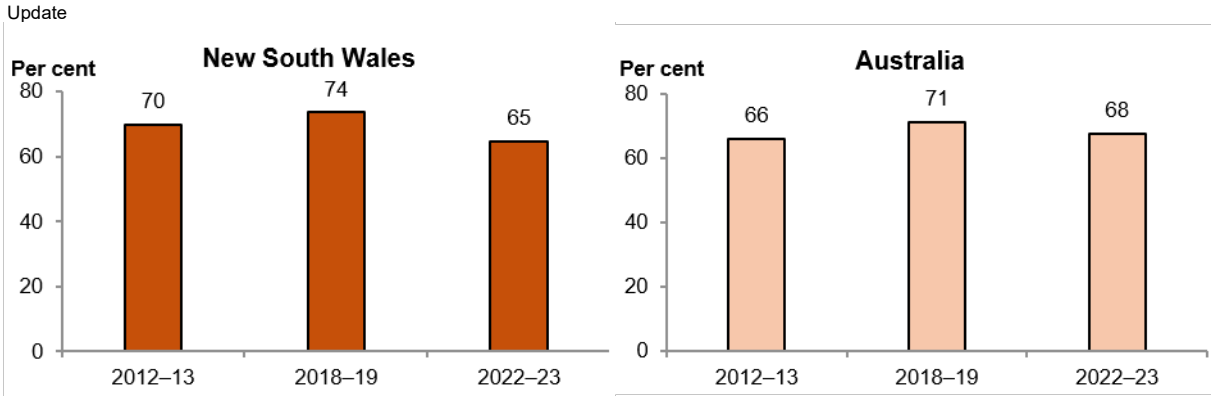
Note: Data for non-Aboriginal people in remote areas in NSW not available.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D2.22.3).

Trend over time: The proportion of Aboriginal people aged 15 and over in New South Wales who were living with overweight or obesity was varied over time, at 70% in 2012–13, 74% in 2018–19 and 65% in 2022–23.

Similarly, the proportion of Aboriginal people aged 15 and over nationally, who were living with overweight or obesity ranged between 66% in 2012–13, 71% in 2018–19 and 68% in 2022–23 (Figure 2.22.3).

Figure 2.22.3: Proportion of Aboriginal people aged 15 and over who were living with overweight or obesity, New South Wales and Australia, 2012–13, 2018–19 and 2022–23



Source: Australian Aboriginal and Torres Strait Islander Health Survey 2012–13 (ABS 2014, Table 3.3) and National Aboriginal and Torres Strait Islander Survey 2018–19 (ABS 2014, Table 3.3) and National Aboriginal and Torres Strait Islander Survey 2022–23 (ABS 2024d, Table 3.3).

Tier 3 – Health system performance

3.01 Antenatal care

Why it is important

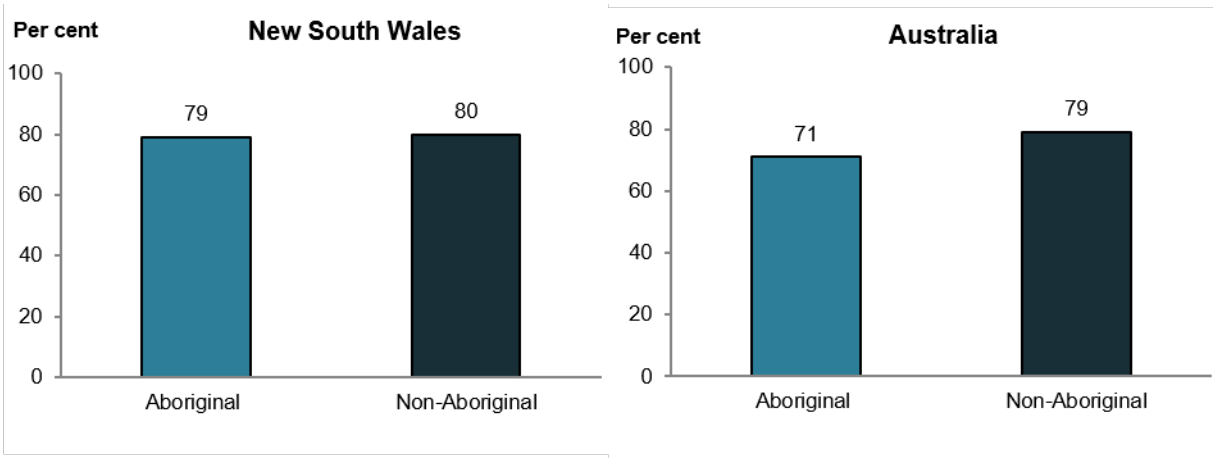
This measure reports the total number of antenatal visits, duration of pregnancy at first antenatal visit, and types of antenatal services used. Antenatal care is especially important for Aboriginal women because they are at higher risk of giving birth to preterm and low birthweight babies and have greater exposure to other risk factors and complications such as anaemia, poor nutritional status, chronic illness, hypertension, diabetes, genital and urinary tract infections, smoking and high levels of psychosocial stressors (AHMAC 2012; de Costa and Wenitong 2009). Early and regular antenatal care is associated with better maternal health in pregnancy, fewer interventions in late pregnancy and positive child health outcomes.

Key findings

First antenatal visit: In New South Wales in 2023, among Aboriginal mothers who gave birth at 20 weeks or more gestation, 81% (4,178) accessed antenatal care services during the first trimester (before 14 weeks of gestation) of their pregnancy. After adjusting for differences in the age structure between the two populations, Aboriginal and non-Aboriginal mothers had similar rates of first trimester antenatal care (79% and 80%, respectively) (Figure 3.01.1).

Nationally, among Aboriginal mothers who gave birth in 2023, 72% (10,982) accessed antenatal care services during the first trimester of their pregnancy. After adjusting for differences in the age structure between the two populations, Aboriginal mothers were 0.9 times as likely as non-Aboriginal mothers to have attended antenatal care services in the first trimester (Figure 3.01.1).

Figure 3.01.1: First antenatal visit in the first trimester, age-standardised proportion of women who gave birth at 20 weeks or more gestation, by Aboriginal status of the mother, New South Wales and Australia, 2023

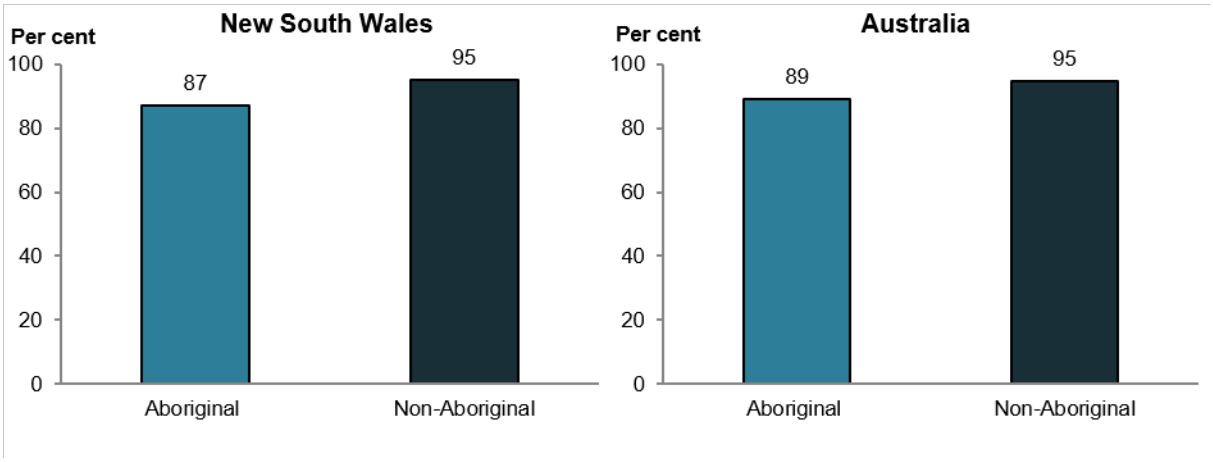


Source: National Perinatal Data Collection 2023 (Table D3.01.10).

Number of antenatal visits: In New South Wales in 2023, among Aboriginal women who gave birth at 32 weeks gestation or more, 87% (4,435) had 5 or more antenatal visits during pregnancy (Table D3.01.1). After adjusting for differences in the age structure between the two populations, Aboriginal women were 0.9 times as likely as non-Aboriginal New South Wales women to have had 5 or more antenatal visits (Figure 3.01.2).

Nationally in 2023, among Aboriginal women who gave birth at 32 weeks or more, 89% (13,326) had 5 or more antenatal visits during pregnancy. After adjusting for differences in the age structure between the two populations, Aboriginal women were 0.9 times as likely as non-Aboriginal women to have had 5 or more antenatal visits (Figure 3.01.2).

Figure 3.01.2: Age-standardised proportion of women who gave birth at 32 weeks' gestation or more and had 5 or more antenatal visits during their pregnancy, by Aboriginal status of the mother, New South Wales and Australia, 2023



Source: National Perinatal Data Collection 2023 (Table D3.01.1).

3.02 Immunisation

Why it is important

This measure reports on vaccination coverage rates for children aged 1, 2 and 5 years. Vaccinations are highly effective in reducing illness and death caused by vaccine-preventable diseases, and have been effective in reducing the disease disparities between Aboriginal and non-Aboriginal Australians (Menzies and Singleton 2009). Note that in this section, data for non-Aboriginal children is combined with data for children with unknown Aboriginal identity, therefore the category is referred to as ‘other children’.

Key findings

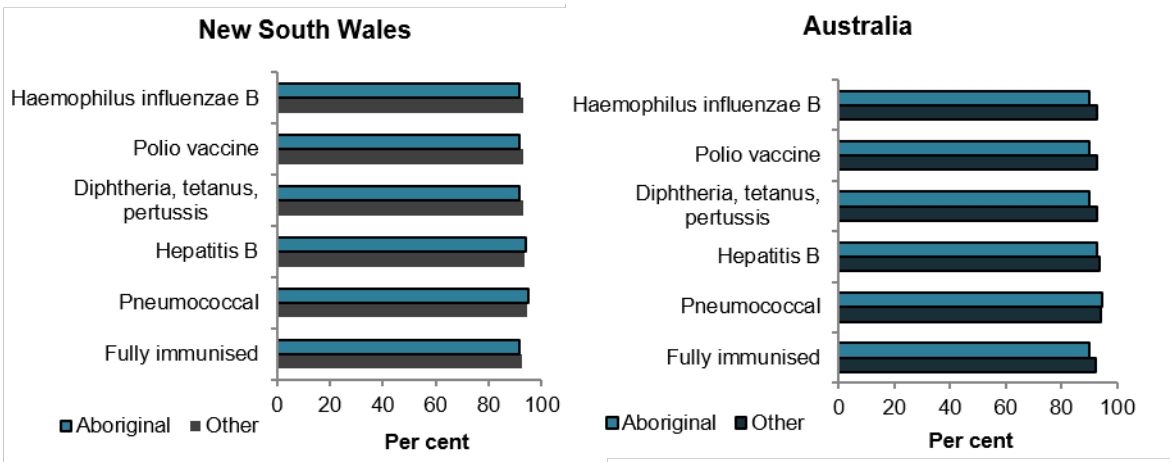
Overall: At 31 December 2024 in New South Wales, 92% of Aboriginal children were fully immunised at age 1, 90% were fully immunised at age 2, and 96% were fully immunised at age 5. For other New South Wales children, 92% were fully immunised at age 1, 91% were fully immunised at age 2, and 94% were fully immunised at age 5.

Nationally at 31 December 2024, 90% of Aboriginal children were fully immunised at age 1, 88% were fully immunised at age 2, and 95% were fully immunised at age 5. For other Australian children, 92% were fully immunised at age 1, 91% were fully immunised at age 2, and 94% were fully immunised at age 5 (Figure 3.02.1, Figure 3.02.2, Figure 3.02.3).

At age 1: In New South Wales at 31 December 2024, coverage at age 1 was similar for Aboriginal children and other children across all vaccinations. Coverage for hepatitis B was 94% for both groups. Coverage for DTP, polio and HIB was about 92% for Aboriginal children and about 93% for other children. Pneumococcal coverage was 95% for Aboriginal children and 94% for other children. The proportion fully immunised was 92% for Aboriginal children and 92% for other children.

Nationally, at 31 December 2024, coverage at age 1 was similar for Aboriginal children and other children across all vaccinations. Coverage for hepatitis B was about 93% for both groups. Coverage for DTP, polio and HIB was about 90% for Aboriginal children and about 93% for other children. Pneumococcal coverage was about 94% for both groups (Figure 3.02.1).

Figure 3.02.1: Vaccination coverage estimates for selected diseases for children at age 1, by Aboriginal status, New South Wales and Australia, at 31 December 2024



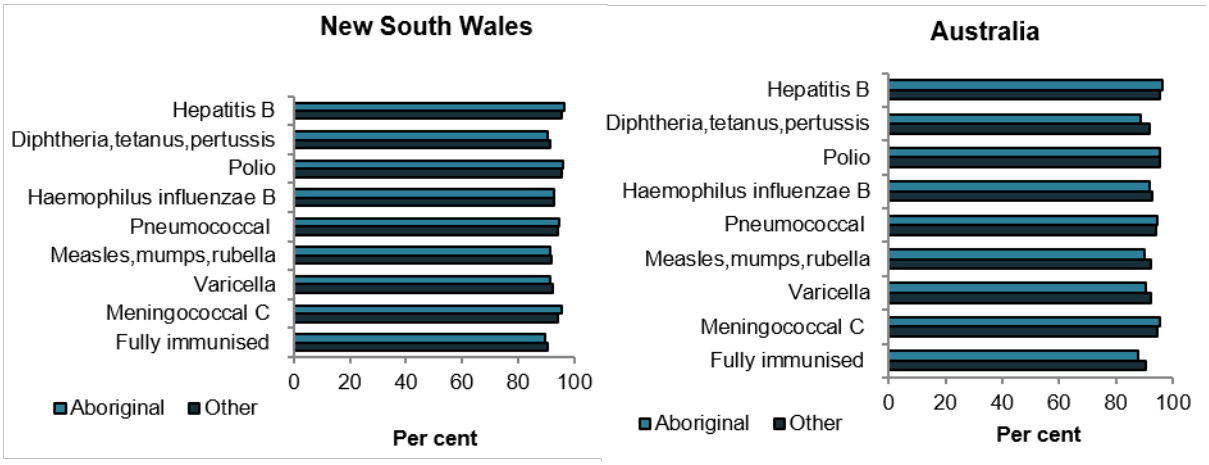
Note: Other children includes non-Aboriginal children and those whose Indigenous status was not stated or unknown.

Source: Australian Immunisation Register (AIR) 2024 (Table D3.02.2).

At age 2: In New South Wales at 31 December 2024, coverage at age 2 was similar for Aboriginal children and other children across most vaccinations. Coverage for hepatitis B, polio, pneumococcal and meningococcal C was slightly higher for Aboriginal children (97%, 96%, 95% and 96%, respectively) than for other children (96%, 95%, 94% and 94%). Coverage for DTP was slightly lower for Aboriginal children (91%) than for other children (92%). Coverage for Hib, MMR and varicella was similar for both groups (around 91% to 93%).

Nationally at 31 December 2024, coverage at age 2 was similar for Aboriginal children and other children across most vaccinations. Coverage for hepatitis B, pneumococcal and meningococcal C was slightly higher for Aboriginal children (96%, 95% and 96%, respectively) than for other children (96%, 94% and 94%). Coverage for DTP, Hib, MMR and varicella was lower for Aboriginal children (89%, 92%, 90% and 90%) than for other children (92%, 93%, 92% and 92%). Coverage for polio was similar for both groups (about 95%). (Figure 3.02.2).

Figure 3.02.2: Vaccination coverage estimates for selected diseases for children at age 2, by Aboriginal status, New South Wales and Australia, at 31 December 2024



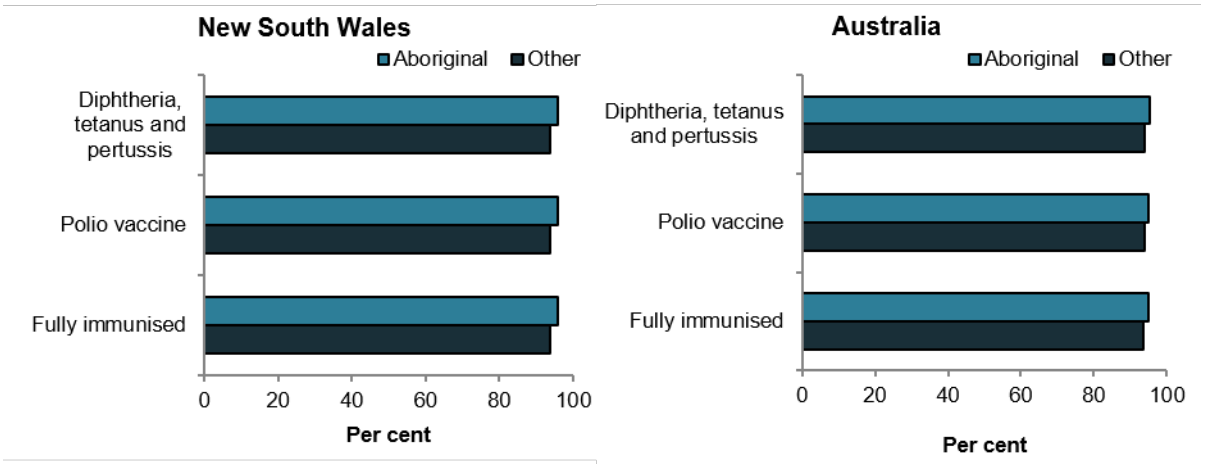
Note: Other children includes non-Aboriginal children and those whose Indigenous status was not stated or unknown.

Source: Australian Immunisation Register (AIR) 2024 (Table D3.02.3).

At age 5: In New South Wales at 31 December 2024, for children aged 5, the vaccination rates for DTP and polio were 96% for Aboriginal children and 94% for other New South Wales children.

Nationally at 31 December 2024, coverage for DTP and polio were higher for Aboriginal children (95% for both) than for other children (94% for both) (Figure 3.02.3).

Figure 3.02.3: Vaccination coverage estimates for selected diseases for children at age 5, by Aboriginal status, New South Wales and Australia, at 31 December 2024



Note: Other children includes non-Aboriginal children and those whose Indigenous status was not stated or unknown.

Source: Australian Immunisation Register (AIR) 2024 (Table D3.02.4).

3.03 Health promotion

Why it is important

This measure reports on GP or specialist consultations for Aboriginal people, including health issues discussed and health promotion programs and activities provided by Aboriginal primary health-care organisations. Aboriginal people currently experience higher levels of illness and death from potentially avoidable conditions than non-Aboriginal people (see measure 1.24 Avoidable and preventable deaths). This means there is a critical need to acknowledge the links between how Aboriginal people experience healthcare settings, learn about health and wellbeing, and make decisions about their own health. This will support proactive approaches to health promotion, prevention, and early intervention (NSW Health 2024).

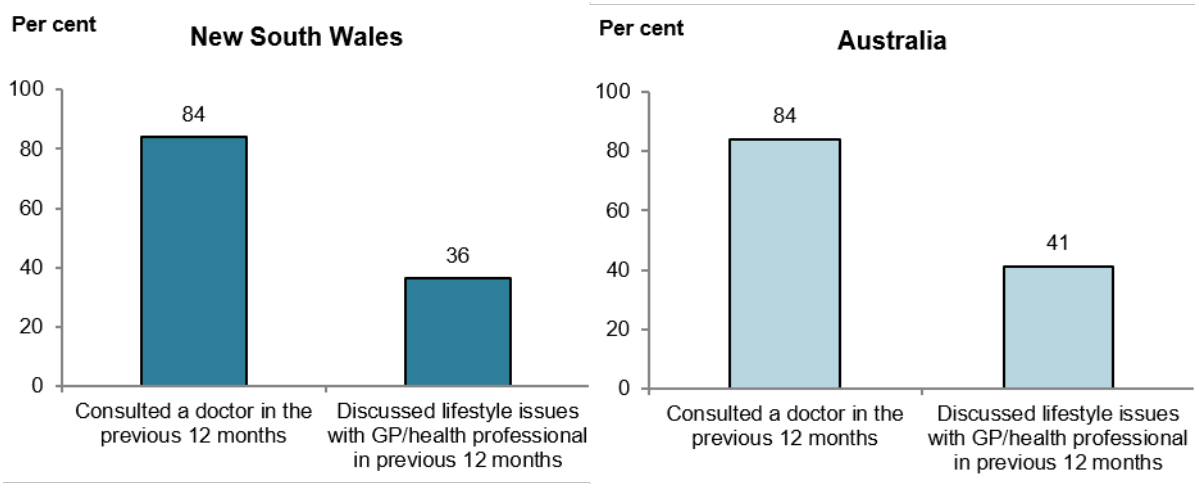
Health promotion is the process of enabling people to increase control over their health and its determinants, and improve their health as a result. It embraces not only actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental and economic conditions to alleviate their impact on public and individual health. Health promotion includes: public policy interventions (for example, packaging of cigarettes, seat belt laws); information to support healthy lifestyles (for example, smoking, alcohol and drug use, physical activity and diet); social marketing (for example, sunscreen use); and mass media campaigns (for example, drink driving, road safety) (WHO 2008).

Key findings

Consulted a GP or specialist: In New South Wales in 2022–23, an estimated 84% (195,100) of Aboriginal people aged 15 and over reported they had consulted a doctor or specialist in the previous 12 months.

Similarly, in 2022–23, 84% of Aboriginal people aged 15 and over nationally reported they had consulted a doctor or specialist in the previous 12 months (Figure 3.03.1).

Figure 3.03.1: Aboriginal people aged 15 and over who consulted a doctor, and who discussed lifestyle issues with a GP or health professional, New South Wales and Australia, 2022–23

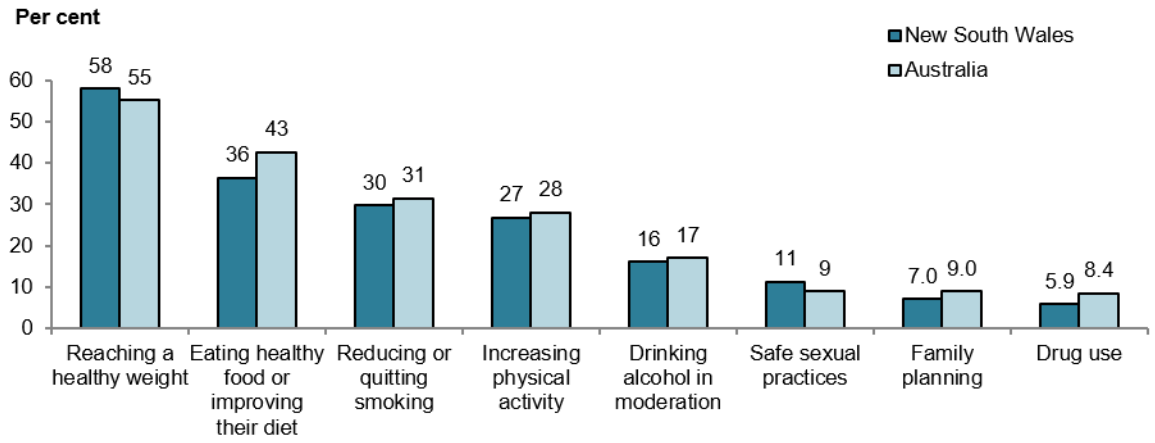


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.03.4).

Lifestyle issues discussed: In New South Wales in 2022–23, 36% (68,100) of Aboriginal people aged 15 and over discussed lifestyle issues with a GP or health professional (Figure 3.03.1). Of these, the most common issues discussed were reaching a healthy weight (58%), eating healthy food or improving their diet (36%) and reducing or quitting smoking (30%). The least common issues were drug use (5.9%) and family planning (7.0%) (Figure 3.03.2).

Nationally in 2022–23, 41% of Aboriginal people aged 15 and over discussed lifestyle issues with a GP or health professional (Figure 3.03.1). The most common issues discussed were similar to those in New South Wales, including reaching a healthy weight (55%), eating healthy food or improving their diet (43%) and reducing or quitting smoking (31%) (Figure 3.03.2).

Figure 3.03.2: Type of lifestyle issues discussed with a GP or health professional in the last 12 months (multiple responses allowed), by Aboriginal people aged 15 and over, New South Wales and Australia, 2022–23

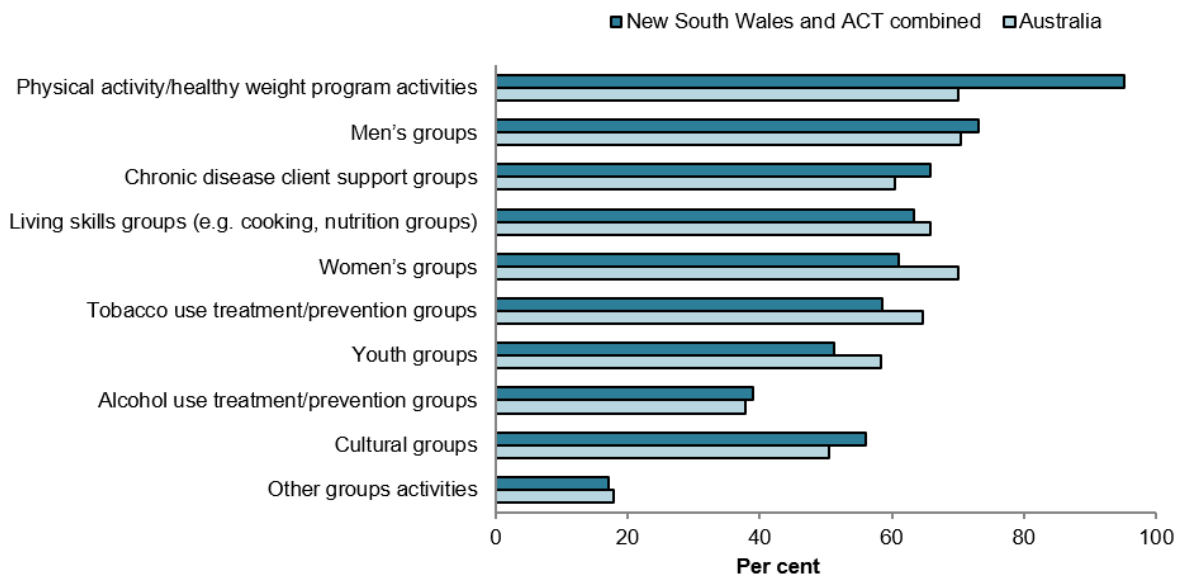


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.03.4).

Health promotion programs and activities: In New South Wales and the Australian Capital Territory combined, between July 2017 and June 2018, the most common type of health promotion activities and programs provided by Aboriginal primary healthcare organisations were physical activity or healthy weight program activities (95%, 39 organisations), men's groups (73%, 30), chronic disease client support groups (66%, 27) and living skills groups such as cooking or nutrition groups (63%, 26).

Nationally, between July 2017 and June 2018, the most common type of health promotion activities and programs provided by Aboriginal primary healthcare organisations were men's groups (71%), women's groups (70%), physical activity or healthy weight program activities (70%), living skills groups, such as cooking or nutrition groups (66%), and tobacco use treatment or prevention groups (65%) (Figure 3.03.3).

Figure 3.03.3: Aboriginal primary health-care organisations providing health promotion, by type of program or activity (multiple responses allowed), New South Wales and Australian Capital Territory combined, and Australia, 2017–18



Source: Online Services Report data collection 2017–18 (Table D3.03.10).

3.04 Early detection and early treatment

Why it is important

This measure reports on the early detection and early treatment of disease. Early detection is the discovery of a disease or condition at an early stage, often before symptoms occur. Early treatment is the provision of a treatment regime following as soon as possible after the detection and confirmatory diagnosis of disease. Early detection and treatment programs are most effective when there are systematic approaches to ensuring that assessment and screening occur regularly and at recommended intervals.

The Australian Government provides GP health assessments and checks for Aboriginal people under the Medicare Benefits Schedule (MBS). National cancer screening programs are designed to reduce illness and death through early detection of cancer or pre-cancerous abnormalities.

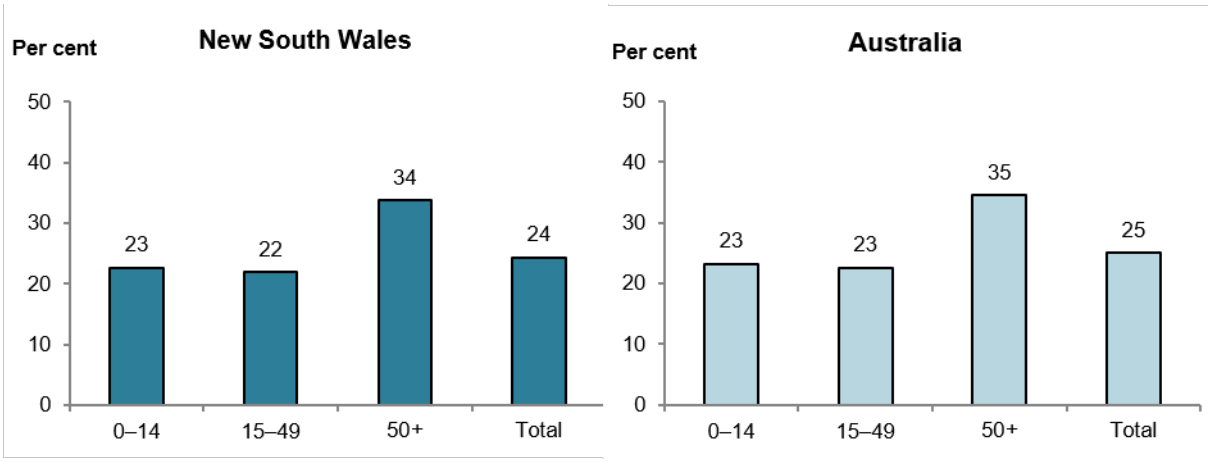
Key findings

Medicare health assessments: In 2023–24 in New South Wales, 90,403 health assessments were provided to 87,481 Aboriginal people. These included:

- 27,305 health checks for Aboriginal children aged 0–14 (23% of Aboriginal children in this age group)
- 39,132 health checks for Aboriginal people aged 15–49 (22%)
- 23,966 health checks for Aboriginal people aged 50+ (34%) (Figure 3.04.1).

Nationally in 2023–24, 268,572 health assessments were provided to 259,941 Aboriginal people. The uptake of health checks was highest among people aged 50 and over (35%) and lowest among people aged 15–49 (22.6%) (Figure 3.04.1).

Figure 3.04.1: Uptake of Aboriginal-specific MBS health checks claimed for Aboriginal people, by age group, New South Wales and Australia, 2023–24

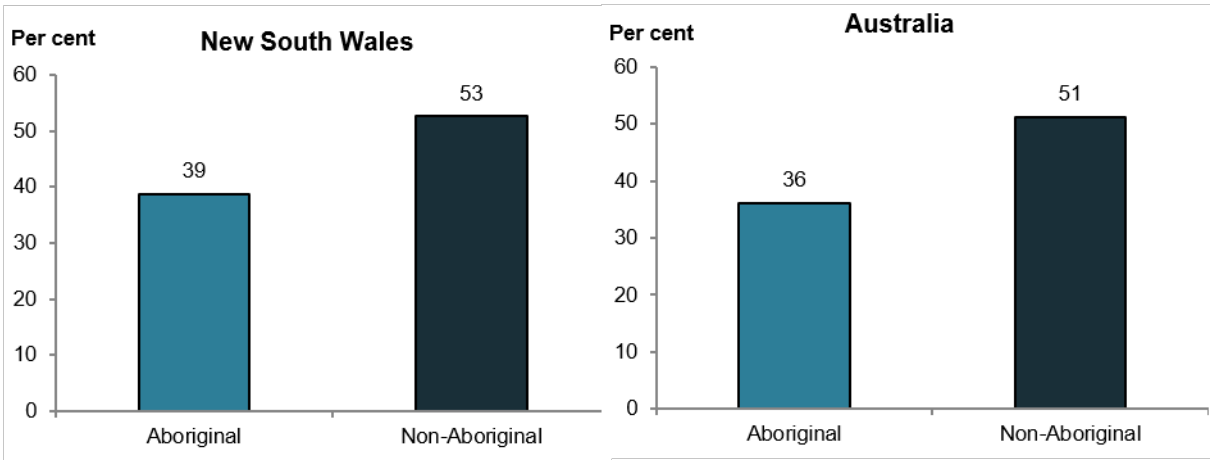


Source: Medicare data 2023–24 (Table D3.04.1).

Breast cancer screening: In 2022–2023 in New South Wales, the age-standardised rate for Aboriginal women aged 50–74 who had been screened for breast cancer through the BreastScreen Australia program was 39%, compared with 53% for non-Aboriginal women.

In 2022–2023 nationally, the age-standardised rate for Aboriginal women aged 50–74 who had been screened for breast cancer through the BreastScreen Australia program was 36%, compared with 51% for non-Aboriginal Australian women (Figure 3.04.2).

Figure 3.04.2: Age-standardised participation rates in BreastScreen Australia programs for women aged 50 to 74, by Aboriginal status, New South Wales and Australia, 2022–2023



Source: BreastScreen Australia 2022–2023 (Table D3.04.9).

Pap smear test: In 2022–23 in New South Wales, 53% of Aboriginal women aged 25–74 reported they had regular pap smear tests.

Nationally in 2022–23, 62% of Aboriginal women aged 25–74 reported they had regular pap smear tests (Table D3.04.13).

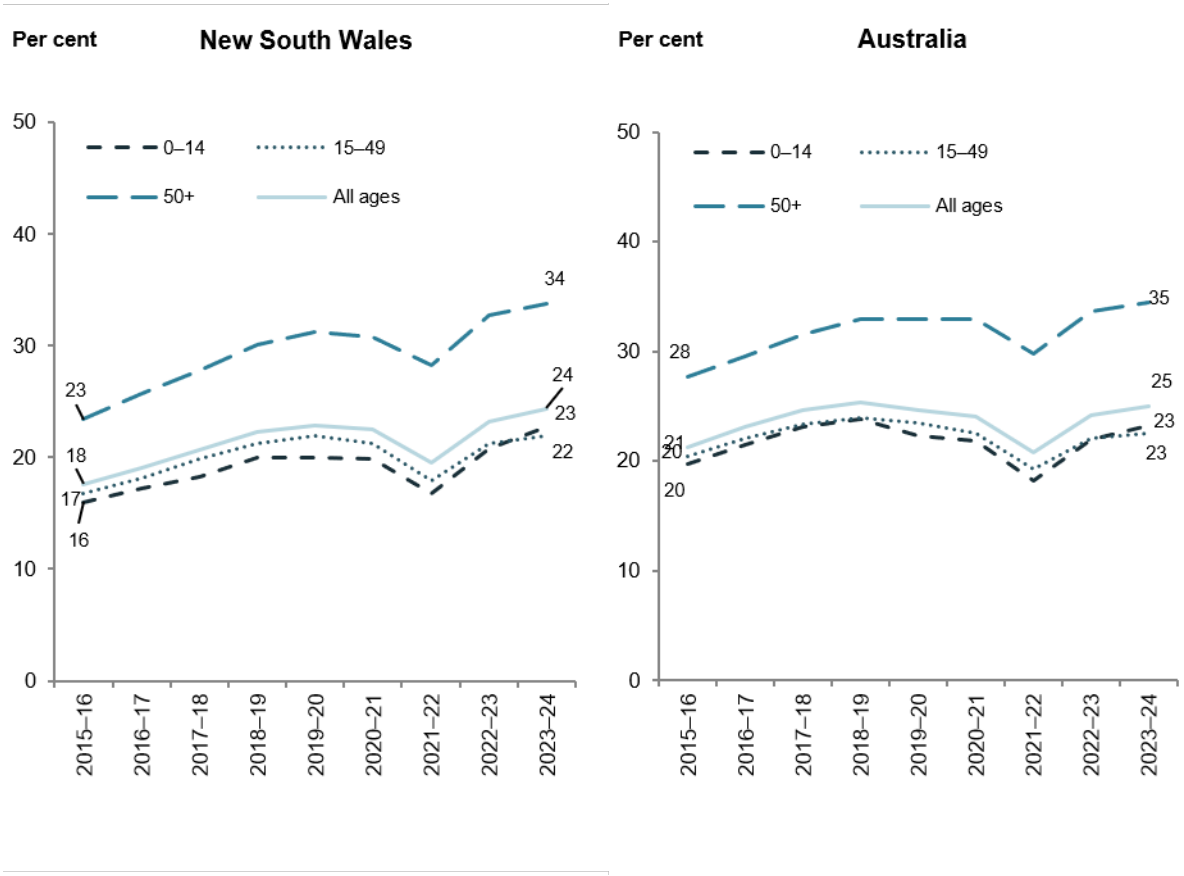
Bowel cancer screening: In 2022–23 in New South Wales, 23% of Aboriginal males and 25% of Aboriginal females aged 50–74 reported they had participated in bowel cancer screening tests. This estimate has a high margin of error and should be used with caution.

Nationally in 2022–23, 25% of Aboriginal males and 20% of Aboriginal females aged 50–74 reported they had participated in bowel cancer screening tests (Table D3.04.17).

Medicare health assessments trend over time: In New South Wales the rate of Aboriginal-specific MBS health checks claimed showed an increase from 18% in 2015–16 to 24% in 2023–24. There were statistically significant increases for those aged 0–14 (from 16% in 2015–16 to 23% in 2023–24) and those aged 50 and over (from 23% to 34%) (Figure 3.04.3).

Nationally, the uptake of Aboriginal-specific health checks increased from 21% in 2015–16 to 25% in 2023–24. Nationally, there was a statistically significant increase in the uptake of Aboriginal-specific health checks for those aged 50 and over (from 28% in 2015–16 to 35% in 2023–24) (Figure 3.04.3). A temporary decline in 2021–22 may reflect the impact of COVID-19–related disruptions to access and delivery of primary care services.

Figure 3.04.3: Rate of Aboriginal-specific MBS health checks claimed for Aboriginal people, by age group, New South Wales and Australia, 2015–16 to 2023–24



Sources: Medicare data 2015–16 to 2023–24 (Tables D3.04.3, D3.04.5, D3.04.6 and D3.04.7).

3.05 Chronic disease management

Why it is important

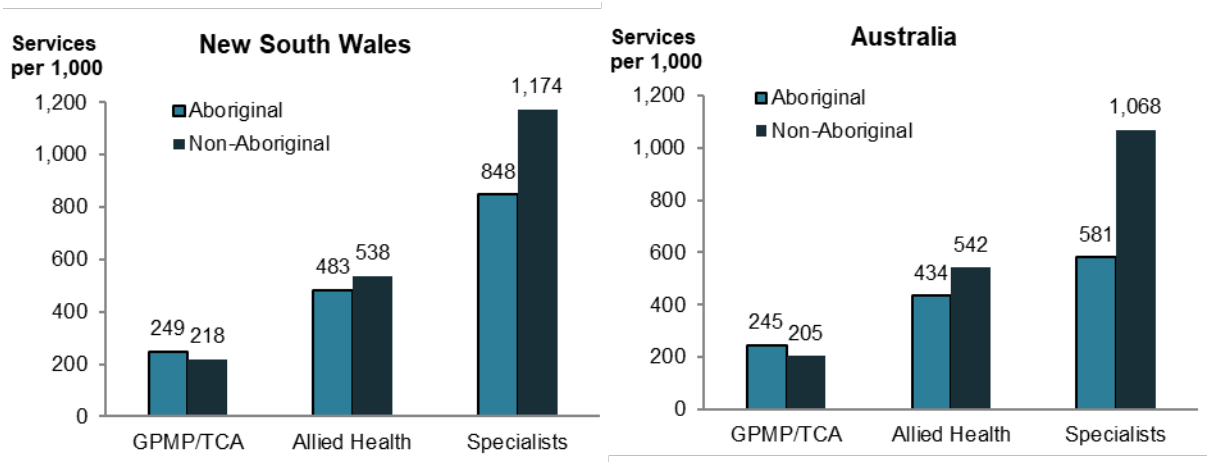
This measure reports on the management of chronic diseases. Chronic diseases are the leading causes of illness, disability and death among Aboriginal people and are estimated to be responsible for 70% of the health gap between Aboriginal and non-Aboriginal Australians (AIHW 2016b). Effective management of chronic disease can delay the progression of disease, improve quality of life, increase life expectancy, and decrease the need for high-cost interventions (Thomas et al. 2014; Zhao et al. 2014). It is therefore a key factor in meeting the target of closing the life expectancy gap between Aboriginal people and non-Aboriginal Australians within a generation.

Key findings

Medicare Benefits Schedule (MBS): The Medicare Benefits Schedule (MBS) includes items for general practitioner management plans (GPMPs) and team care arrangements (TCAs) to support a structured approach to the management of patients with chronic or terminal conditions. In New South Wales in 2023–24, for Aboriginal people, there were 32,372 MBS claims for the preparation of GPMPs and 28,272 for coordination of TCAs (Table D3.05.19).

Including people of all ages in New South Wales in 2023–24, the age-standardised MBS claim rate for Aboriginal patients for GPMP/TCAs combined was 1.1 times the rate for non-Aboriginal patients (249 compared with 218 per 1,000, respectively). The age-standardised claim rate for Aboriginal patients accessing specialists was 0.7 times the rate for non-Aboriginal patients (848 compared with 1,174 per 1,000, respectively) (Figure 3.05.1).

Figure 3.05.1: Age-standardised rate of selected MBS services claimed, by Aboriginal status, New South Wales and Australia, 2023–24

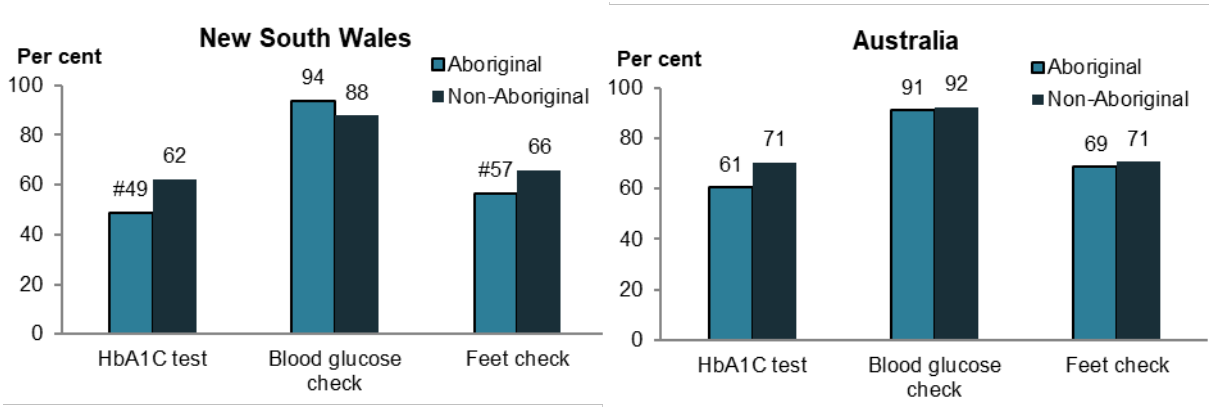


Source: Medicare data (Table D3.14.31).

Blood tests and foot checks: Based on self-reported data in 2022–23 NATSIHS, in New South Wales, of Aboriginal people with current and long-term diabetes or high sugar levels, an estimated 49% (8,200) reported having undergone HbA1c testing in the previous 12 months, 94% (16,500) had their blood glucose level checked, and foot checks had been completed for 57% (9,400). Note that these estimates have a high margin of error and should be used with caution. For non-Aboriginal people with current and long-term diabetes or high sugar levels, 62% had undergone HbA1c testing, 88% had their blood glucose level checked, and 66% had had their feet checked in the previous 12 months (see Diabetes: Australian Facts for more detail on diagnostic testing procedures) (Figure 3.05.2).

Nationally in 2022–23, 61% (34,200) of Aboriginal people with current and long-term diabetes or high sugar levels reported having undergone HbA1c testing in the previous 12 months, 91% (69,900) had had their blood glucose level checked and 69% (48,700) had foot checks completed. For non-Aboriginal people, 71% had undergone HbA1c testing, 92% had their blood glucose level checked and 71% had had their feet checked (Figure 3.05.2).

Figure 3.05.2: People with diagnosed, current and long-term diabetes or high sugar levels who had an HbA1c test, blood glucose check, or foot check in the previous 12 months, by Aboriginal status, New South Wales and Australia, 2022–23



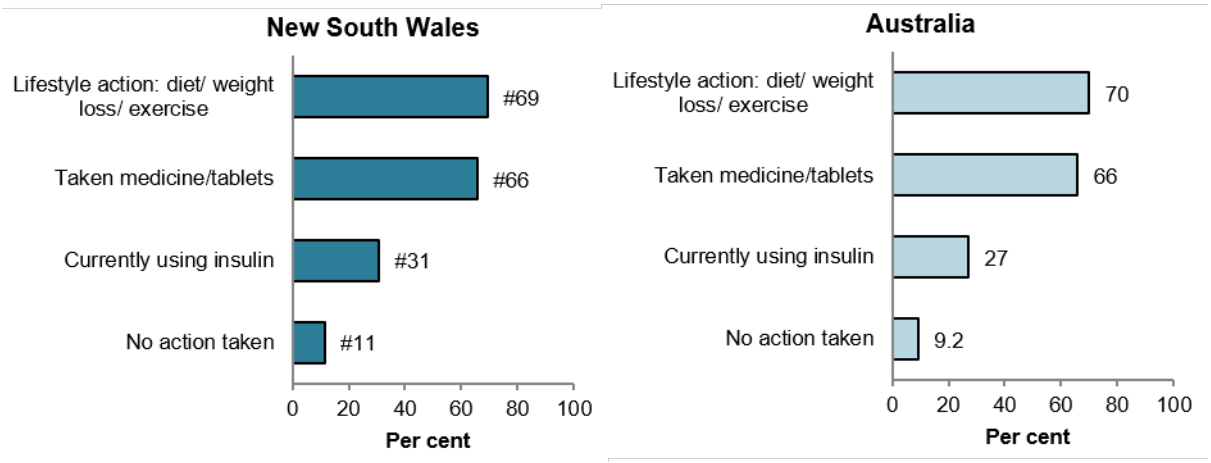
Note: Estimates marked with # have a high margin of error and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 and National Health Survey 2022 (Table D3.05.13).

Health actions taken: In New South Wales in 2022–23, among Aboriginal people with diagnosed, current and long-term diabetes or high sugar levels, the most commonly reported actions taken in the previous 2 weeks included: a lifestyle action such as diet, weight loss or exercise (69%, 11,500); taking medicine or tablets (66%, 10,900); and using insulin (31%, 5,100) (Figure 3.05.3). Note that these estimates have a high margin of error and should be used with caution.

Nationally in 2022–23, actions Aboriginal people had taken to manage current and long-term diabetes or high sugar levels included: a lifestyle action such as diet, weight loss or exercise (70%); taking medicine or tablets (66%); and using insulin (27%) (Figure 3.05.3).

Figure 3.05.3: Actions taken by Aboriginal people to manage diabetes or high sugar levels in previous 2 weeks, New South Wales and Australia, 2022–23



Note: Estimates marked with # have a high margin of error and should be used with caution.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.05.13).

3.06 Access to hospital procedures

Why it is important

This measure reports on hospitalisations with a procedure recorded. A procedure is defined as a clinical intervention that is surgical in nature, carries a procedural and anaesthetic risk, requires specialised training, and/or requires special facilities or equipment only available in an acute care setting. Procedures therefore encompass surgical procedures as well as non-surgical investigative and therapeutic procedures (AIHW 2022c). Studies have shown that while Aboriginal people are more likely to be hospitalised than non-Aboriginal Australians, they are less likely to receive a medical or surgical procedure while in hospital (ABS and AIHW 2008; Cunningham 2002). Significant factors associated with the likelihood of receiving a procedure when admitted to hospital include: whether the hospital was public or private; the principal diagnosis for which a person was admitted; the number of additional diagnoses; state/territory of usual residence; age group; remoteness of usual residence; and sex (see measure 3.06 Access to hospital procedures). However, these factors do not fully explain the disparities between Aboriginal people and non-Aboriginal people (Cunningham 2002).

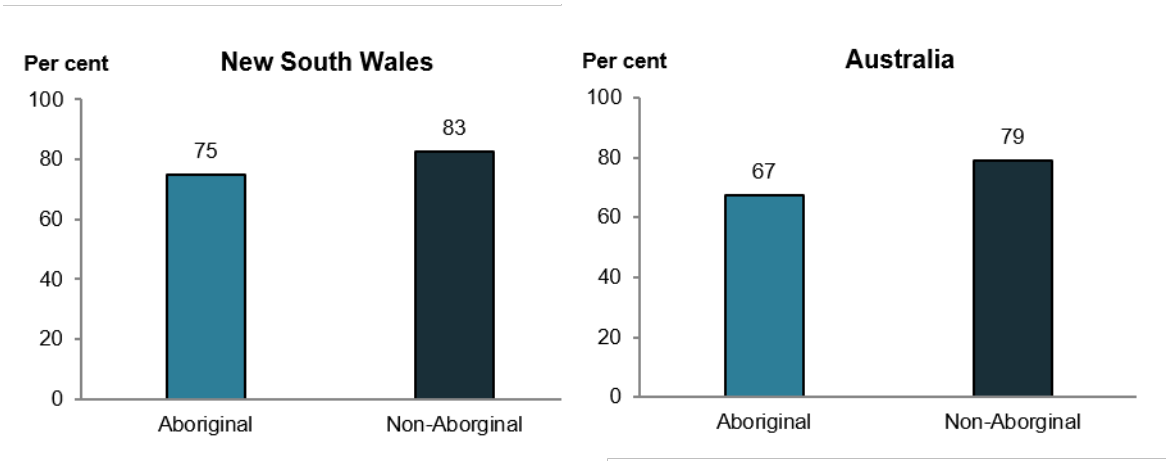
The reporting period (July 2021 to June 2023) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

Overall: In New South Wales between July 2021 and June 2023, 76% (147,798) of hospitalisations (excluding dialysis) for Aboriginal people had a procedure recorded (Table D3.06.1). Based on age-standardised proportions, Aboriginal people in New South Wales were less likely to have a procedure recorded than non-Aboriginal New South Wales residents (difference of 8 percentage points).

Nationally between July 2021 and June 2023, 68% of hospitalisations (excluding dialysis) for Aboriginal people had a procedure recorded. Based on age-standardised rates, Aboriginal people were less likely to have a procedure recorded than non-Aboriginal people (difference of 12 percentage points) (Figure 3.06.1).

Figure 3.06.1: Age-standardised proportion of hospitalisations with a procedure recorded, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023

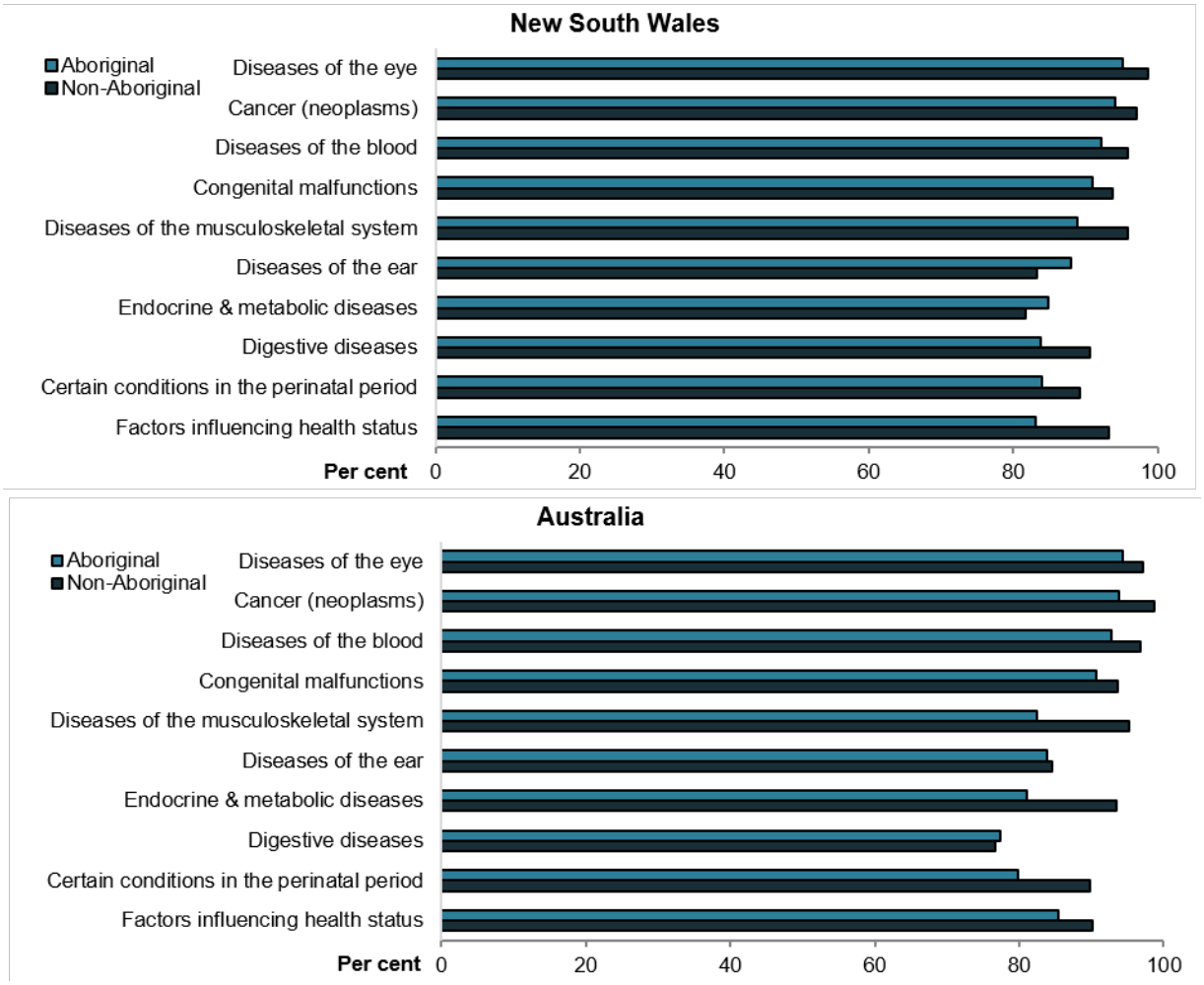


Source: National Hospital Morbidity Database 2023–25 (Table D3.06.1).

Procedures by age: Nationally between July 2021 and June 2023, the proportion of hospitalisations for Aboriginal people where a procedure was recorded generally increased with age – ranging from 59% for infants under 1, to 81% for those aged 65 and over. Across all age groups except infants under 1, hospitalisations for Aboriginal people were less likely to include a procedure than hospitalisations for non-Aboriginal people (Table D3.06.1).

Main diagnosis: Between July 2021 and June 2023, the conditions with the highest proportion of hospitalisations that included at least one procedure for Aboriginal people were similar in New South Wales and nationally. In both, the highest proportions were for diseases of the eye (95% in New South Wales; 94% nationally), followed by cancer (neoplasms) (94% in both) and diseases of the blood (92% and 93%, respectively) (Figure 3.06.2).

Figure 3.06.2: Proportion of hospitalisations with a procedure recorded, by selected principal diagnosis and Aboriginal status, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database 2021–23 (Table D3.06.2 NSW).

Trend over time: Nationally, from 2016–17 to 2022–23, there was a 12% increase in the age-standardised proportion of hospitalisations for Aboriginal people where a procedure was recorded, and a 5% increase for non-Aboriginal people, resulting in a decrease in the gap between Aboriginal and non-Aboriginal people (Table D3.06.11).

3.07 Selected potentially preventable hospital admissions

Why it is important

This measure reports on the number of Potentially Preventable Hospitalisations (PPH). PPH are hospitalisations for conditions that could potentially have been prevented through provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings. This is a key measure of the performance of the health system, in particular, it serves as a proxy measure of access to timely, effective and appropriate primary and community-based care (AIHW 2020b). Systematic differences in hospitalisation rates for Aboriginal people and non-Aboriginal people can indicate gaps in the provision of population health interventions (such as immunisation), primary care services (such as early interventions to detect and treat chronic disease), and continuing care support (such as care planning for people with chronic illnesses, for example congestive heart failure).

The reporting period (July 2021 to June 2023) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

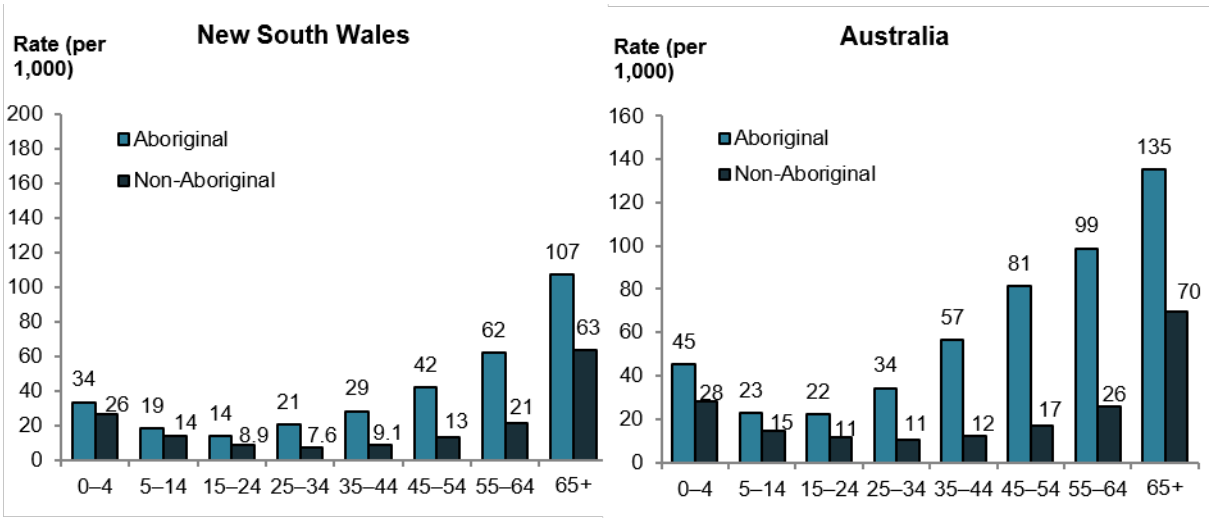
Overall: In New South Wales from July 2021 to June 2023, there were 21,891 hospitalisations for Aboriginal people that were potentially preventable. Among Aboriginal people, the PPH rate was higher for females than males (34 and 29 hospitalisations per 1,000, respectively) (Table D3.07.2). After adjusting for differences in the age structure between the two populations, Aboriginal people in New South Wales were hospitalised for potentially preventable conditions at a rate 2.1 times that for non-Aboriginal New South Wales residents (40 and 19 per 1,000 population, respectively) (Table D3.07.2).

Nationally, between July 2021 and June 2023, the PPH rate was higher for Aboriginal females than Aboriginal males (54 and 42 hospitalisations per 1,000, respectively). The PPH rate for Aboriginal people was 2.7 times the rate for non-Aboriginal people (Table D3.07.2).

By age: For Aboriginal people in New South Wales, the PPH rate was lowest for those aged 15–24 and increased with age (Figure 3.07.1). Older age groups had the highest crude rates of PPH for both Aboriginal and non-Aboriginal people. However, the largest relative disparities between Aboriginal and non-Aboriginal people occurred among those aged 35–44 and 45–54 years, where rates for Aboriginal people were 3.1 times those for non-Aboriginal people, as measured using rate ratios (Table D3.07.1 NSW).

Nationally, the PPH rate was higher for Aboriginal than non-Aboriginal people across all age groups, with the largest relative difference in the 45–54 age group (Figure 3.07.1).

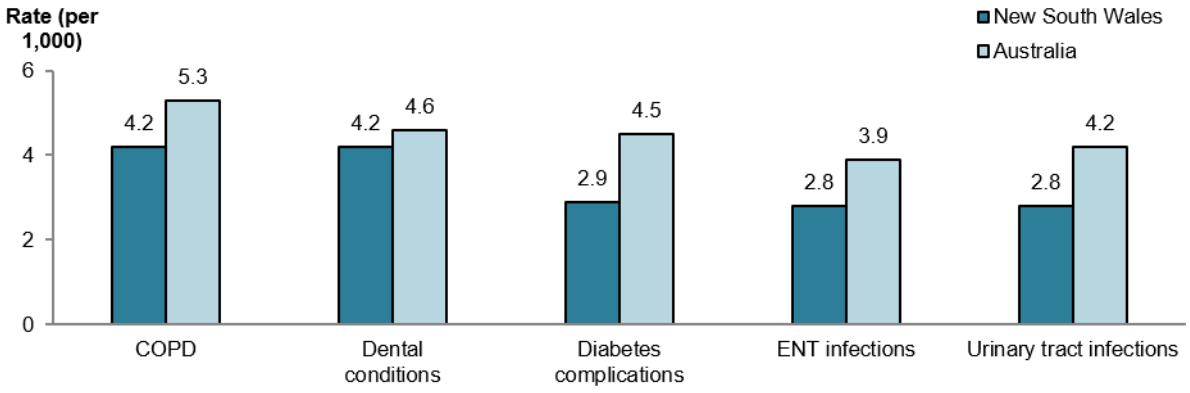
Figure 3.07.1: Age-specific hospitalisation rates for potentially preventable hospitalisations, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database 2021–23 (Table D3.07.1 NSW).

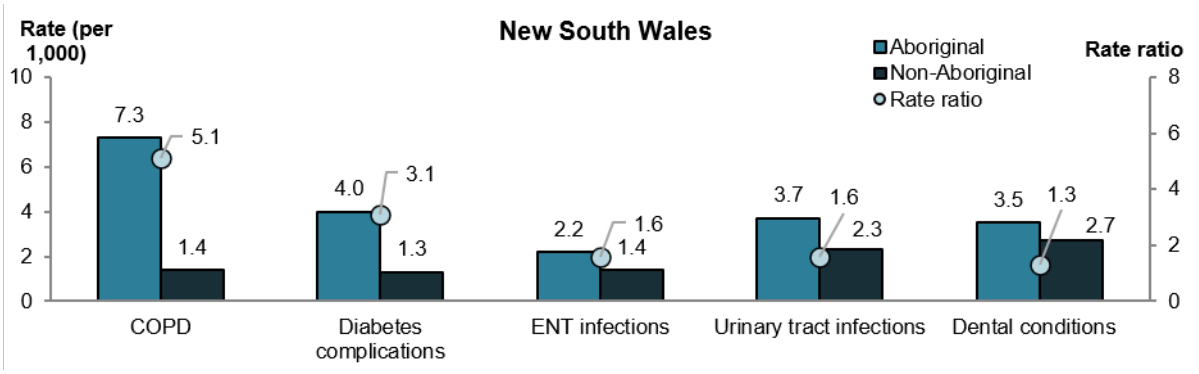
Leading causes of PPH: Between July 2021 and June 2023, the 5 leading causes of PPH among Aboriginal people in New South Wales were: chronic obstructive pulmonary disease (COPD), dental conditions, diabetes complications, ear, nose and throat (ENT) infections, and urinary tract infections (Figure 3.07.2). When accounting for age-standardisation, PPH rates were higher for Aboriginal than non-Aboriginal residents of New South Wales for all 5 causes, with the greatest relative difference for COPD (rate ratio 5.1) (Figure 3.07.3).

Figure 3.07.2: Crude rates for top 5 potentially preventable hospitalisations among Aboriginal people, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database 2021–23 (Table D3.07.5 NSW and D3.07.5).

Figure 3.07.3: Age-standardised rates and rate ratios for top 5 potentially preventable hospitalisations among Aboriginal people in New South Wales, by Aboriginal status, July 2021 to June 2023



Source: National Hospital Morbidity Database 2021–23 (Table D3.07.5 NSW).

Nationally, between July 2021 and June 2023, the 5 leading causes of PPH among Aboriginal people were COPD, cellulitis, dental conditions, diabetes complications, and urinary tract infections. Aboriginal people had higher age-standardised PPH rates than non-Aboriginal people for all 5 causes. The largest relative difference was for COPD, where the hospitalisation rate for Aboriginal people was 5.8 times the rate for non-Aboriginal people (Table D3.07.5). Chronic hepatitis B ranked 8th among the leading causes of PPH for Aboriginal people nationally. Despite this, it had the highest relative difference of the top 10 causes, with Aboriginal people 7.2 times as likely as non-Aboriginal people to be hospitalised (Table D3.07.5).

3.08 Cultural competency

Why it is important

This measure presents self-reported data from Aboriginal people on their experiences of the Australian health system. This data can be considered one aspect of measuring cultural competency. Cultural competency and related concepts are ways of mediating some of the harmful effects of colonisation and its continuing impacts (including discrimination and racism) on the health and health care of Aboriginal people. Improving the cultural competency of health care service providers can increase access to health care for Aboriginal people, increase the effectiveness of the care that is provided, and improve disparities in health outcomes (Freeman et al. 2014). However, there is limited data available on the cultural competency of health services (Paradies et al. 2014) and on the effectiveness of interventions to address cultural competency in health care for Aboriginal people (Clifford et al. 2015).

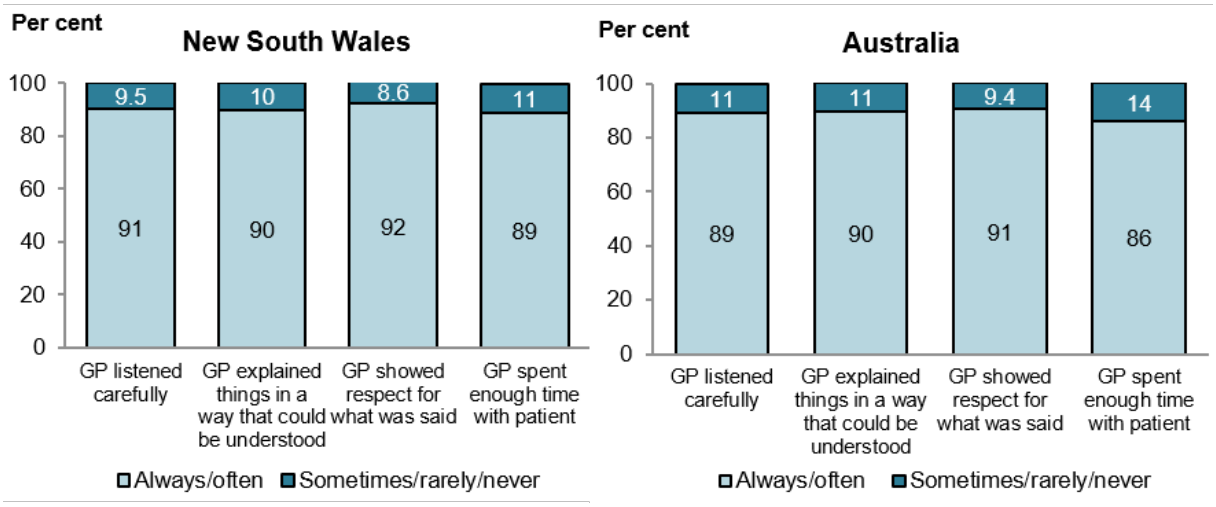
Key findings

Patient experience: The 2022–23 NATSIHS showed that an estimated 71% (115,000) of Aboriginal people aged 15 and over in New South Wales who had seen a doctor in the last 12 months rated the health care they received as 'excellent' or 'very good' (Table D3.08.7).

In 2022–23 in New South Wales, 92% of Aboriginal people who had seen a doctor in the last 12 months reported that their general practitioner (GP) showed respect for what was said (149,700 people), always/usually listened carefully to them (91%; 147,000), explained things in a way that could be understood (90%; 146,000), and spent enough time with them (89%; 143,800).

These findings were consistent with the national results for Aboriginal people aged 15 and over (Figure 3.08.1).

Figure 3.08.1: Patient experience in the last 12 months, Aboriginal people aged 15 and over, New South Wales and Australia, 2022–23

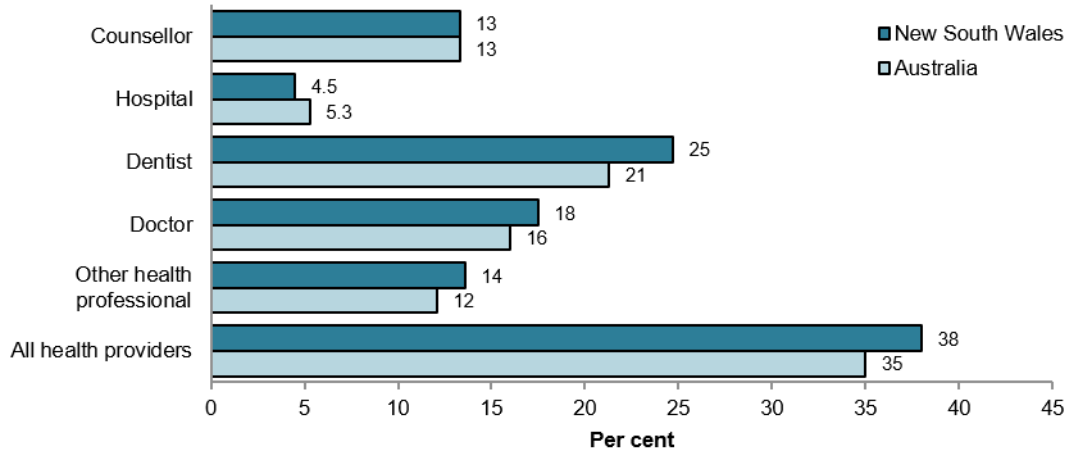


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.08.7).

Did not access health care when needed to: In New South Wales in 2022–23, 38% (133,000) of Aboriginal people reported that they did not access health care when they needed to in the past 12 months. This includes not visiting a dentist (for people aged 2 and over) or not visiting a doctor, other health professional, hospital or counsellor (for people aged 18 and over). The dentist was the most common service not accessed when needed (25%, 82,400), with 'cost' being the most common reason given for not accessing the service (38%). Among Aboriginal people in New South Wales, 18% (61,100) reported not accessing a doctor when needed and 4.5% (15,700) reported not accessing hospital care when needed in the previous 12 months (Tables D3.08.4, D3.08.5).

Similarly, at a national level in 2022–23, 35% of Aboriginal people reported that they did not access health care when they needed to in the past 12 months. The dentist was the most common service not accessed when needed (21%), with 'cost' being the most common reason given for not accessing the service (45%) (Figure 3.08.2).

Figure 3.08.2: Proportion of Aboriginal people not accessing a health provider when needed, by health provider type, New South Wales and Australia, 2022–23

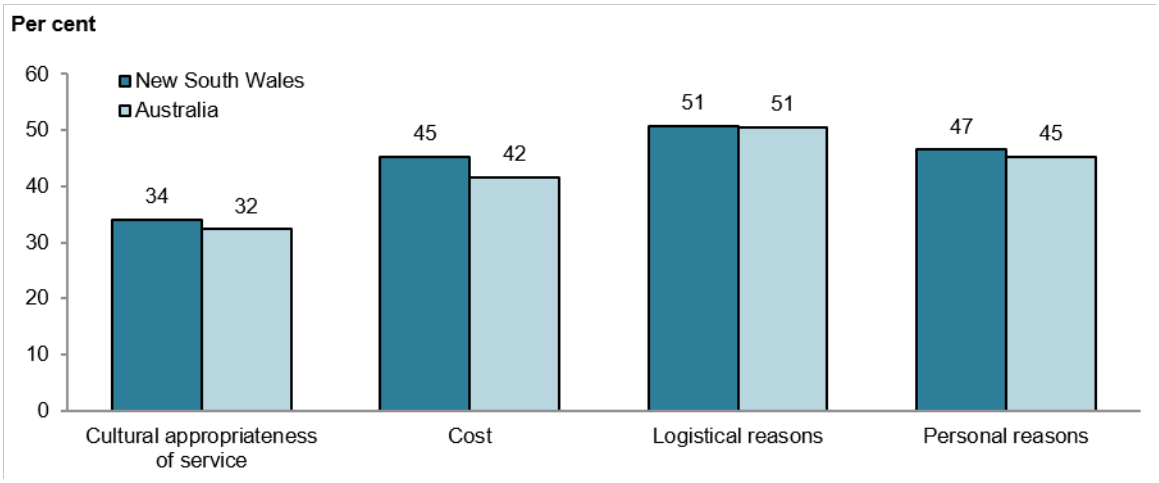


Source: National Aboriginal and Torres Strait Islander Health Survey 2018–19 (Table D3.08.4).

Cultural barriers to accessing health care: In 2022–23 in New South Wales, of the Aboriginal people who did not access health care when needed, 34% reported a reason related to cultural appropriateness of service (dislikes service/professional, embarrassed, afraid; felt it would be inadequate; does not trust service/provider; discrimination/not culturally appropriate/language problems). Other reasons reported by Aboriginal people in New South Wales were logistical reasons (51%), personal reasons (47%) and cost (45%). Reasons do not total 100% as more than one response was allowed.

Nationally, 32% of Aboriginal people who did not access health care when needed reported reasons relating to the appropriateness of the service (Figure 3.08.3).

Figure 3.08.3: Reasons for Aboriginal people not accessing health services when needed in the last 12 months, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2018–19 (Table D3.08.4).

3.09 Self-discharge from hospital

Why it is important

This measure reports on the rate at which people self-discharge from hospital. People who leave hospital before discharge are more likely to re-present to emergency departments and have higher death rates (Shaw 2016). Rates of self-discharge provide an indirect measure of the responsiveness of health services to patient needs and may reflect missed opportunities to provide care. The outcomes of self-discharge from health services for Aboriginal people need to be understood in context. Reasons that patients self-discharge from hospital are varied, and can include dissatisfaction with care, poor communication, long waiting times, and feeling better, as well as external factors such as family and employment responsibilities. These factors, together with a lack of cultural safety, and interpersonal and institutional racism, contribute to the disproportionately high rates of Aboriginal people self-discharging from hospital (Askew et al. 2021).

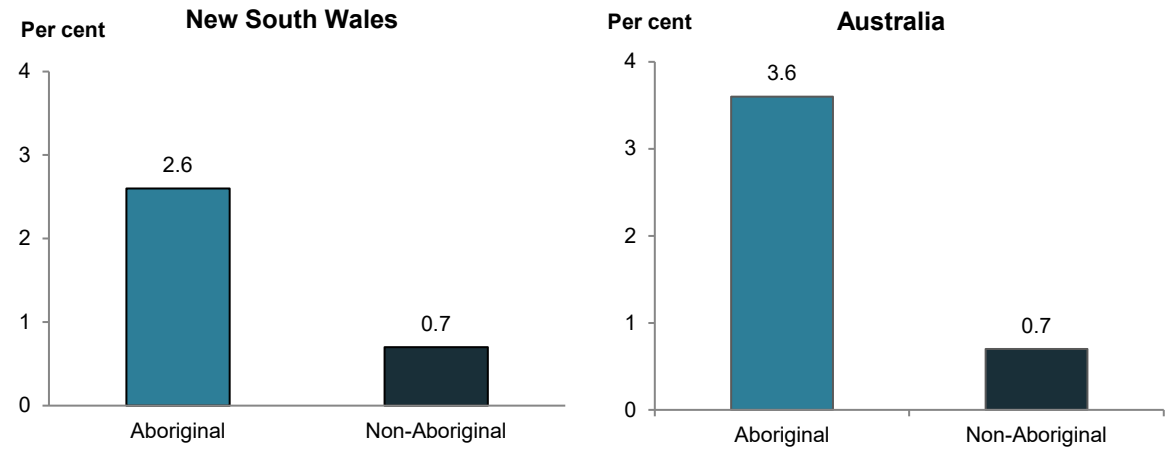
The reporting period (July 2021 to June 2023) included the COVID-19 pandemic. Readers should interpret findings in the context of pandemic-related impacts described in the report introduction.

Key findings

Self-discharge hospitalisations: In New South Wales between July 2021 and June 2023, there were 5,096 hospitalisations (excluding dialysis) for Aboriginal people that ended in self-discharge from hospital. This equated to 2.6% of all hospitalisations for Aboriginal people in New South Wales (Table D3.09.3). After adjusting for differences in the age structure between the two populations, the age-standardised proportion for Aboriginal people was 3.5 times that for non-Aboriginal people in New South Wales (Figure 3.09.1).

Nationally between July 2021 and June 2023, the proportion of hospitalisations (excluding dialysis) for Aboriginal people that ended in self-discharge from hospital was 3.7%. After adjusting for differences in the age structure between the two populations, the proportion for Aboriginal people was 5.1 times that for non-Aboriginal people (Figure 3.09.1).

Figure 3.09.1: Age-standardised proportion of hospitalisations that ended in self-discharge, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023

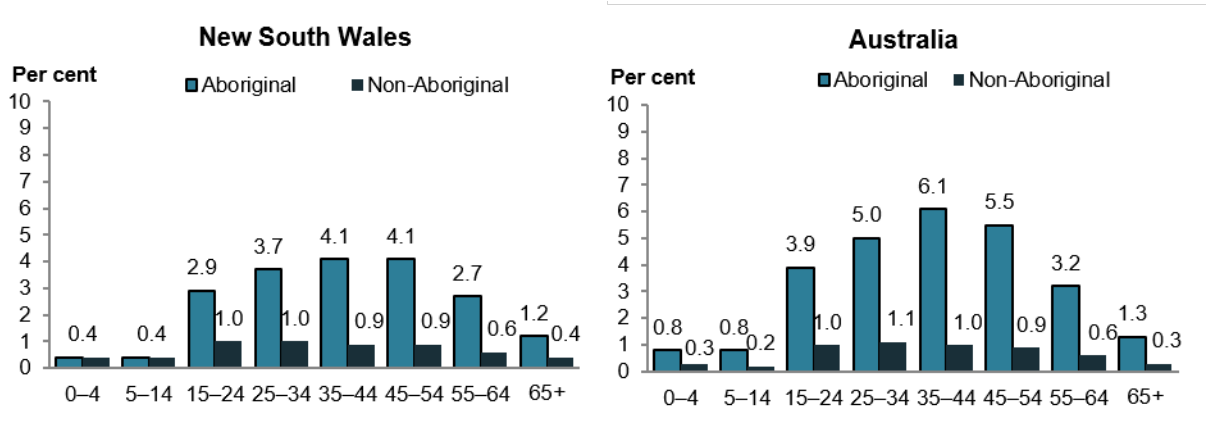


Source: AIHW National Hospital Morbidity Database 2021–23 (Table D3.09.3).

Self-discharge hospitalisations by age group: In New South Wales between July 2021 and June 2023, the proportion of hospitalisations that ended in self-discharge from hospital was highest for Aboriginal people aged 35–44 and 45–54 (both at 4.1% of all hospitalisations). The proportions of hospitalisations that ended in self-discharge from hospital was higher for Aboriginal people than non-Aboriginal people in all age groups.

Nationally between July 2021 and June 2023, Aboriginal people aged 35–44 had the highest proportion of hospitalisations that ended in self-discharge from hospital (6.1%). Aboriginal people had higher proportions of hospitalisation that ended in self-discharge from hospital than non-Aboriginal people in all age groups (Figure 3.09.2).

Figure 3.09.2: Hospitalisations that ended in self-discharge, by Aboriginal status and age group, New South Wales and Australia, July 2021 to June 2023

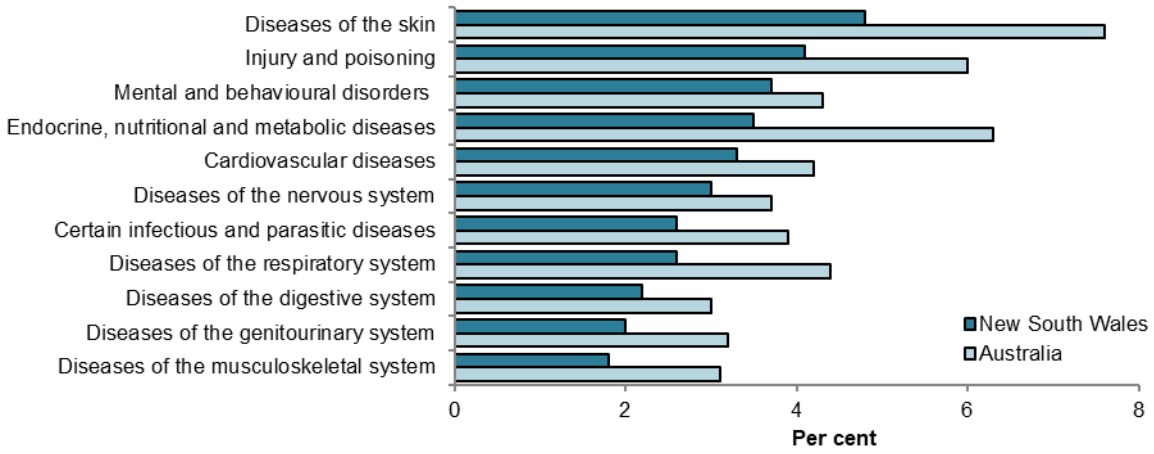


Source: National Hospital Morbidity Database 2021–23 (Table D3.09.1 NSW).

Self-discharge hospitalisations by principal diagnosis: In New South Wales between July 2021 and June 2023, the highest age-standardised proportion of hospitalisations for Aboriginal patients that ended in self-discharge was for diseases of the skin and subcutaneous tissue (for example, sunburn) (4.8%) followed by injury and poisoning (for example, fracture) (4.1%) and mental and behavioural disorders (3.7%).

Nationally, the highest proportion of hospitalisations for Aboriginal people that ended in self-discharge from hospital was also for diseases of the skin (7.6%) followed by endocrine, nutritional and metabolic disorders (6.3%) and injury and poisoning (6.0%) (Figure 3.09.3).

Figure 3.09.3: Hospitalisations for Aboriginal people that ended in self-discharge, by main diagnosis, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database 2021–23 (Table D3.09.7 NSW).

3.10 Access to mental health services

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.

Why it is important

This measure reports on access to psychologist and psychiatric care, and hospitalisations for mental health-related conditions. Aboriginal people experience a higher rate of mental health issues than non-Aboriginal people (see measure 1.18 Social and emotional wellbeing). While Aboriginal people use some mental health services at higher rates than non-Aboriginal people, it is difficult to assess whether this use is as high as the underlying need. Leading Aboriginal mental health researchers and advocates maintain that mental health care for Aboriginal people remains inadequate and inequitable (Dudgeon et al. 2020).

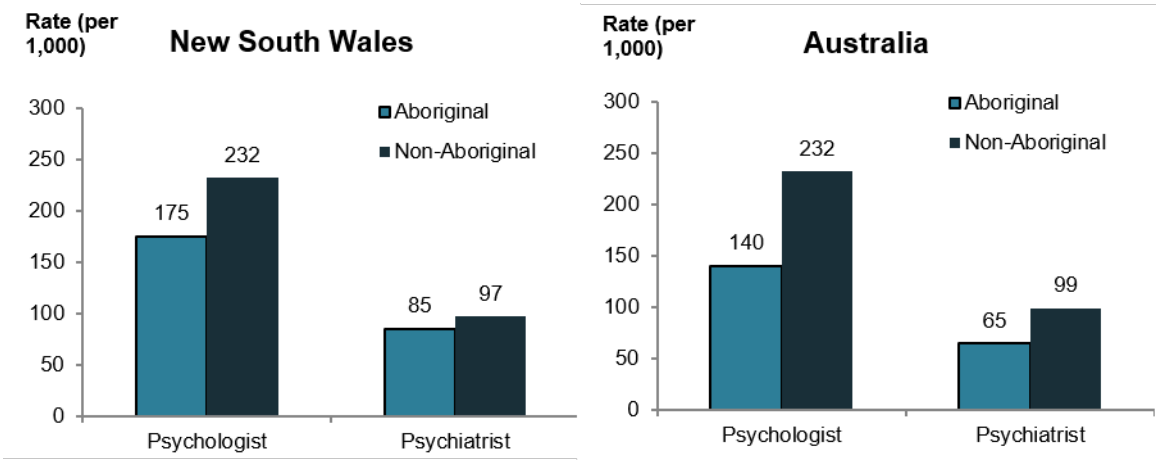
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Psychologist and psychiatric care: In 2023–24, Aboriginal people in New South Wales claimed 58,561 psychologist services and 26,902 psychiatrist services through Medicare, at rates of 165 and 76 per 1,000 population, respectively (Table D3.10.2). After adjusting for differences in the age structure between the two populations, the rate at which non-Aboriginal people claimed a psychologist service was 1.3 times the rate for Aboriginal people. For psychiatrist services, the rate for non-Aboriginal people was 1.1 times the rate for Aboriginal people (Figure 3.10.1).

Nationally in 2023–24, Aboriginal people claimed 138,278 psychologist services and 59,956 psychiatrist services through Medicare, at rates of 134 and 58 per 1,000 population, respectively (Table D3.10.2). After adjusting for differences in age, the rate at which non-Aboriginal people claimed a psychologist service was 1.6 times the rate for Aboriginal people. For psychiatrist services, the rate for non-Aboriginal people was 1.5 times the rate for Aboriginal people (Figure 3.10.1).

Figure 3.10.1: Age-standardised rate of MBS services claimed (VII adjusted), psychologists and psychiatrists, by Aboriginal status, New South Wales and Australia, 2023–24

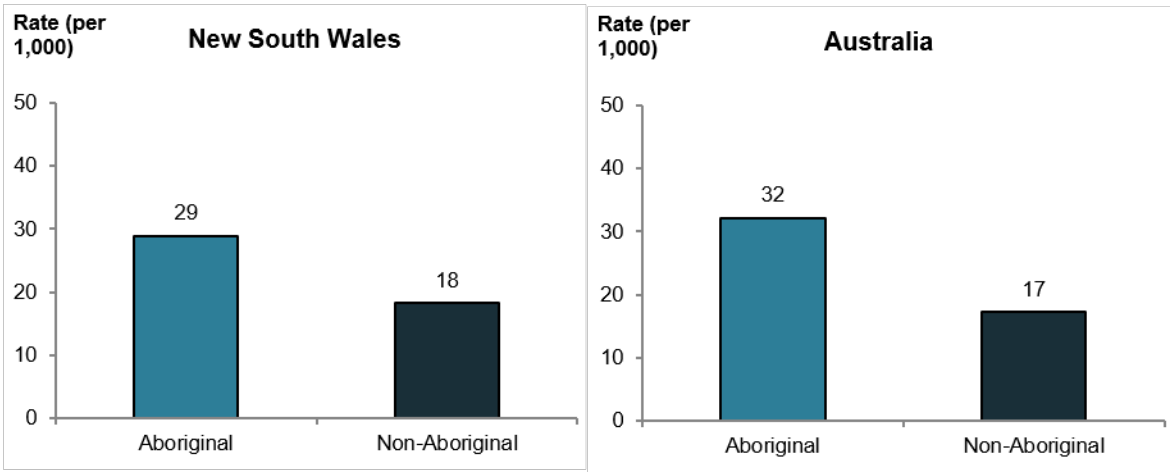


Source: Medicare data 2023–24 (Table D3.10.2).

Hospitalisations for mental health-related conditions: In New South Wales, from July 2021 to June 2023, there were 16,481 hospitalisations for Aboriginal people with a principal diagnosis of mental health-related conditions, at a rate of 24 per 1,000 population (Table D1.18.15). After adjusting for differences in the age structure between the two populations, the hospitalisation rate for mental health-related conditions among Aboriginal people in New South Wales was 1.6 times the rate for non-Aboriginal New South Wales residents (Figure 3.10.2).

Nationally, between July 2021 and June 2023, there were 54,580 hospitalisations for Aboriginal people with a principal diagnosis of mental health-related conditions, at a rate of 27 per 1,000 population (Table D1.18.15). The age-standardised hospitalisation rate for mental health-related conditions among Aboriginal people was 1.9 times the rate for non-Aboriginal people (Figure 3.10.2).

Figure 3.10.2: Age-standardised rate of hospitalisations for mental health-related conditions (based on principal diagnosis), by Aboriginal status, New South Wales and Australia, July 2021 to June 2023



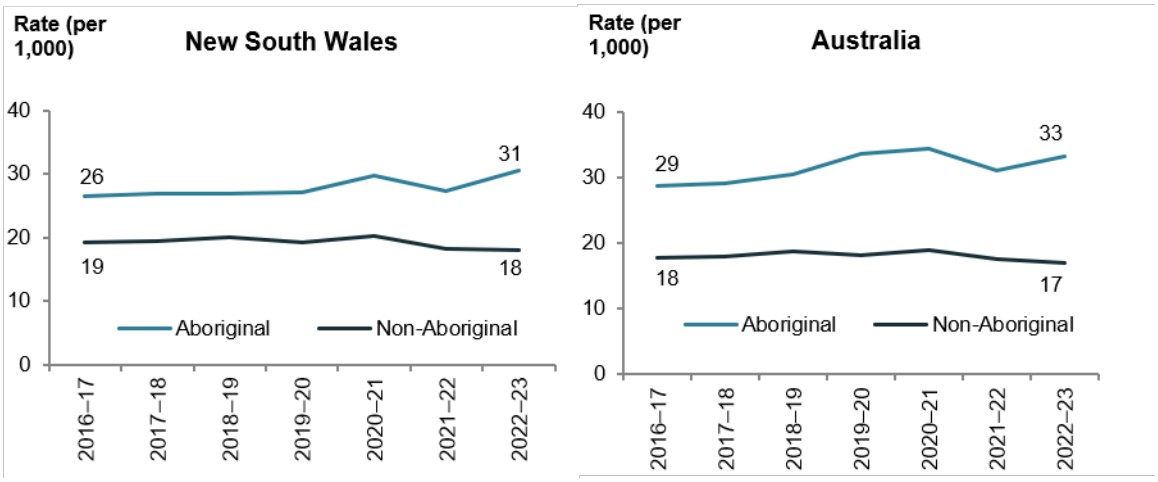
Source: National Hospital Morbidity Database 2021–23 (Table D1.18.15).

Hospitalisations trend over time: Note that the per cent change over time data may appear inconsistent with the first and last rates in the series due to the use of linear regression to calculate the per cent change (see Interpretation of results).

In New South Wales, from 2016–17 to 2022–23, the age-standardised hospitalisation rate for mental health-related conditions (principal diagnosis) for Aboriginal people increased by an estimated 13% using linear regression to summarise the trend across all years. Over the same period, the rate for non-Aboriginal people decreased by an estimated 6.0% using linear regression.

Nationally from 2016–17 to 2022–23, the age-standardised hospitalisation rate for mental health related conditions for Aboriginal people increased by an estimated 16%. Over the same period, for non-Aboriginal people the age-standardised hospitalisation rate decreased by an estimated 4.0% (Figure 3.10.3).

Figure 3.10.3: Age-standardised hospitalisation rate for mental health-related conditions, by Aboriginal status, New South Wales and Australia, 2016–17 to 2022–23



Note: Based on principal diagnosis.

Source: National Hospital Morbidity Database 2016–17 to 2022–23 (Table D1.18.20 NSW).

Use of mental health services: In 2022–23, an estimated 25% (51,300) of Aboriginal people aged 15 and over in New South Wales, had accessed health services for their own mental health in the previous 12 months, and 23% (47,900) would have liked to seek mental health support but did not (Table D3.10.12).

3.11 Access to alcohol and drug services

Where to find help and support: This measure presents material that some people may find distressing. If this material raises any issues for you, or if you have concerns about your own or someone else's alcohol or drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Other services available 24/7 are 13YARN on 13 92 76, and Lifeline on 13 11 14. Go to the AIHW support services page for a full list of support services.

Why it is important

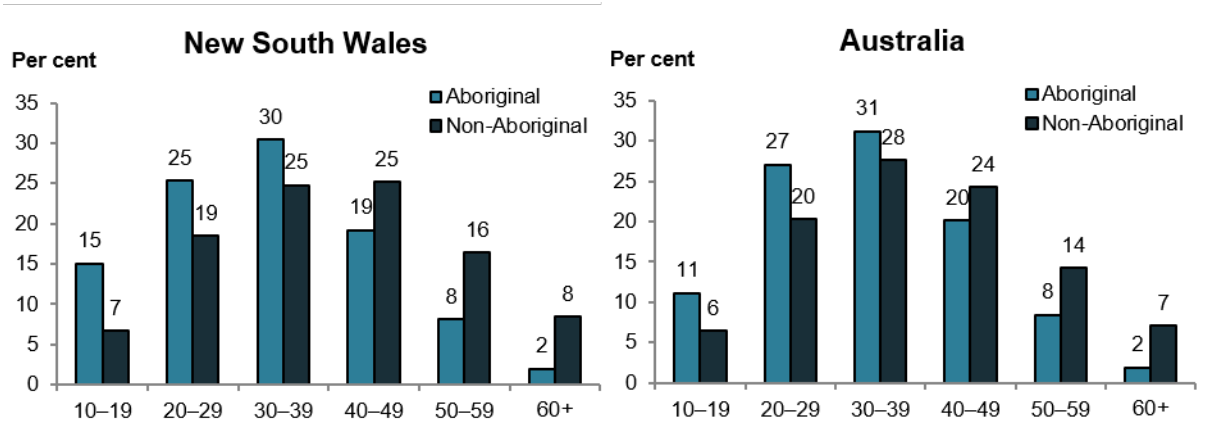
This measure reports on access to alcohol and drug services. Alcohol and other drug (AOD) treatment services provide a variety of interventions and support that seek to address harmful AOD use and restore the physical, social and emotional wellbeing of clients and their families (NIDAC 2014). Data include clients accessing AOD treatment services through a range of referral pathways, including self or family referrals, and diversion referrals through police or courts, which are captured in the national AOD Treatment Services National Minimum Data Set (AODTS NMDS). Treatment services for AOD-related problems include a range of interventions, such as counselling, withdrawal management, psycho-social therapy, residential rehabilitation and pharmacotherapy maintenance (AIHW 2026b).

Key findings

Alcohol and other drug (AOD) treatment services: In 2024–25, 513 publicly funded AOD treatment agencies in New South Wales provided 47,437 treatment episodes to 27,928 clients aged 10 and over. In New South Wales, 22% of all clients of these publicly funded AOD treatment agencies identified as Aboriginal people, which is consistent with the national proportion (19%) (AIHW 2026m).

Of the 10,849 treatment episodes for Aboriginal clients in New South Wales in 2024–25, 56% were provided to clients aged 20–39, similar to the proportion recorded at the national level (58%) (AIHW 2026f, Figure 3.11.1).

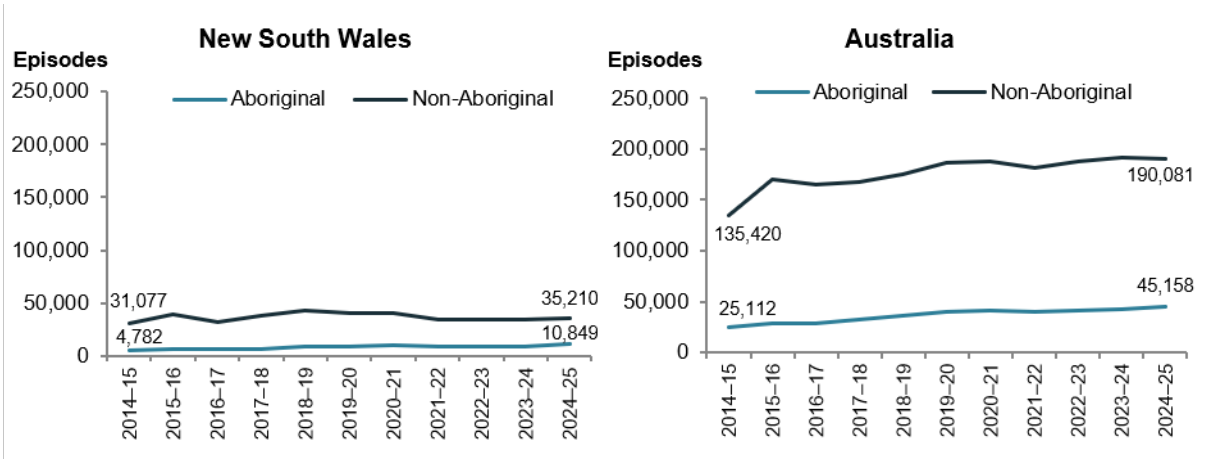
Figure 3.11.1: Closed treatment episodes for alcohol and other drug treatment, by Aboriginal status and age group, New South Wales and Australia, 2024–25



Source: Alcohol and Other Drug Treatment Services National Minimum Data Set 2024–25 (AIHW 2026f).

In New South Wales between 2014–15 and 2024–25, the number of treatment episodes for Aboriginal clients more than doubled (from 4,782 to 10,849), representing a 127% increase. Over the same time frame, the number of treatment episodes for non-Aboriginal clients increased by 13%. Nationally, treatment episodes increased by 80% for Aboriginal clients and by 40% for non-Aboriginal clients between 2014–15 and 2024–25 (Figure 3.11.2).

Figure 3.11.2: Number of closed treatment episodes for alcohol and other drug treatment, by Aboriginal status, New South Wales and Australia, 2014–15 to 2024–25

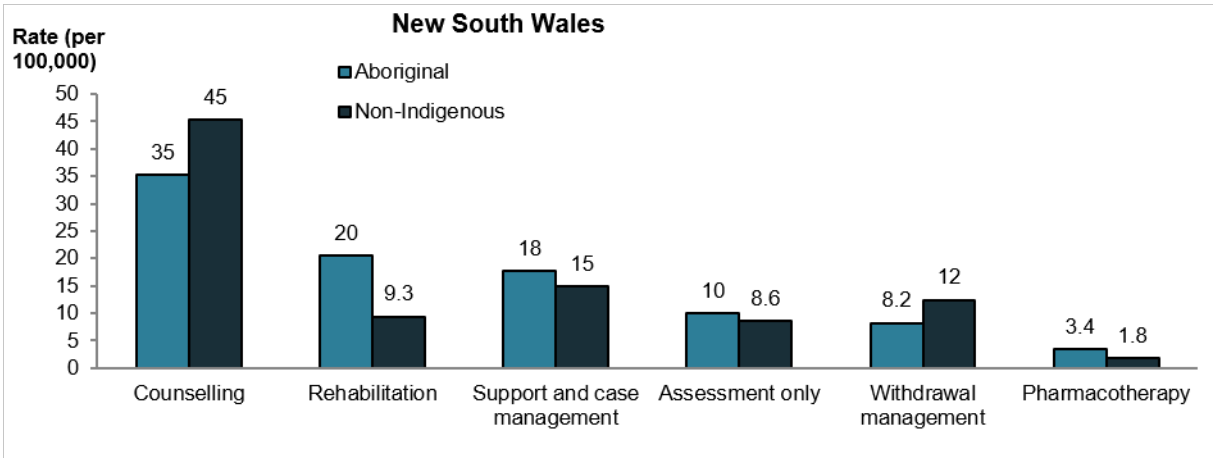


Source: Alcohol and Other Drug Treatment Services National Minimum Data Set 2014–15 to 2024–25 (AIHW 2026f).

Drugs of concern: People may access AOD treatment services for use of one or several substances (including alcohol). The principal drug of concern is the main substance that the client stated led them to access treatment. In New South Wales in 2024–25, for Aboriginal clients, methamphetamines were the most common principal drug of concern (31%), followed by alcohol (23%) and cannabis (19%) (AIHW 2026g, Table SC NSW.7).

Type of AOD treatment services: In New South Wales in 2024–25, counselling was reported as the main treatment type for 35% of Aboriginal and 45% of non-Aboriginal clients receiving help for their own alcohol or drug use. Rehabilitation was the second most reported main treatment type, followed by support and case management for Aboriginal clients in 2024–25 (20% and 18%, respectively) (Figure 3.11.3).

Figure 3.11.3: Alcohol and drug treatment clients by selected main treatment type for own drug use, by Aboriginal status, New South Wales, 2024–25



Source: Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2026g, Table SC NSW.15).

Pharmacotherapy: The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides information about clients receiving opioid pharmacotherapy treatment. Data are reported on a snapshot day in June each year.

On a snapshot day in June 2025, 4,197 Aboriginal people were receiving pharmacotherapy treatment for their opioid dependence in New South Wales. The rate of Aboriginal pharmacotherapy clients in New South Wales was higher than the national rate (115 and 67 clients per 10,000 Aboriginal people, respectively) (AIHW 2026i, Table S9).

3.12 Aboriginal and Torres Strait Islander people in the health workforce

Why it is important

This measure reports on people employed in the health workforce. Aboriginal people are significantly under-represented in the health workforce, which potentially contributes to reduced access to health services for the broader Aboriginal population. There is evidence to suggest that Aboriginal health workers may help improve attendance at appointments, acceptance of treatment and assessment recommendations, reduce discharge against medical advice, increase patient contact time, enhance referrals and improve follow up (Jongen et al. 2019). Additionally, patient experience surveys indicate having the support of an Aboriginal health worker makes a marked difference to some of the most important aspects of experience for Aboriginal patients, including kind and compassionate care, provision of information and timely and coordinated care (Bureau of Health Information 2025). While the Aboriginal workforce plays an important role in the provision of culturally appropriate services, it is the responsibility of the health-care system to ensure that mainstream health services are culturally competent through high quality professional development and training, appropriate management where cultural respect is lacking, and staff developing awareness of their own unconscious bias (AHMAC 2016).

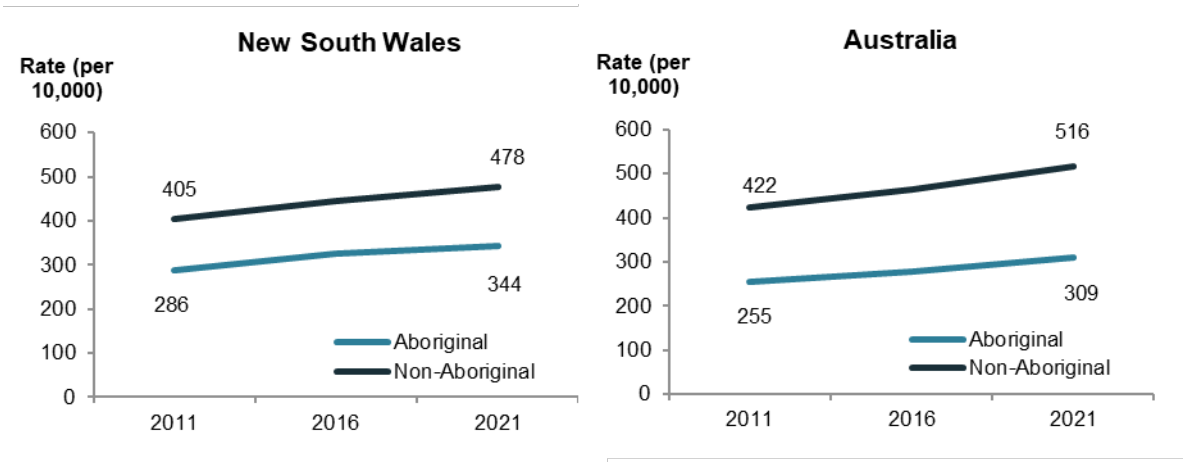
Key findings

Health-related workforce: Based on the ABS 2021 Census, in New South Wales 3.4% (6,300) of Aboriginal people aged 15 and over were employed in health-related occupations in 2021 (Table D3.12.13).

From 2011 to 2021, the rate of Aboriginal people employed in health-related occupations in New South Wales increased from 286 to 344 per 10,000 population. In 2021, non-Aboriginal New South Wales residents were employed in health-related occupations at 1.4 times the rate for Aboriginal people.

Nationally, from 2011 to 2021, the rate of Aboriginal people employed in health-related occupations increased from 255 to 309 per 10,000 population. In 2021, non-Aboriginal people were employed in health-related occupations at 1.7 times the rate for Aboriginal people (Figure 3.12.1).

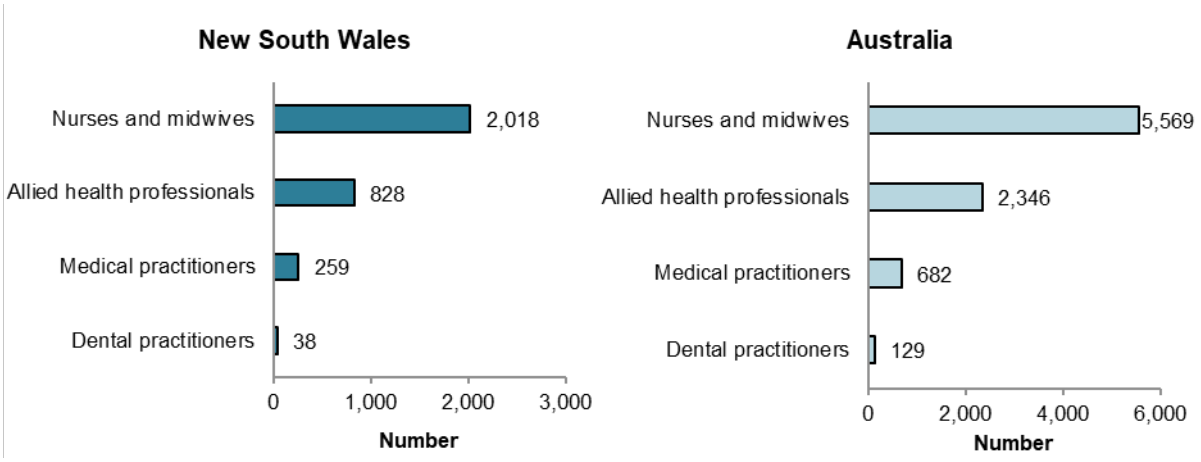
Figure 3.12.1: Rate of people aged 15 and over employed in health-related occupations, by Aboriginal status, New South Wales and Australia, 2011 to 2021



Source: ABS Census of Population and Housing 2011, 2016, and 2021 (Table D3.12.13).

Registered health professionals: The National Health Workforce Data Set provides information on registered health professionals. It shows that in New South Wales in 2023, 1.5% (3,143) of registered health professionals employed in their registered profession identified as being Aboriginal people. Of these 3,143 Aboriginal people, 64% (2,018) were employed as a nurse and/or midwife, 26% (828) as an allied health professional, 8.2% (259) as a medical practitioner, and 1.2% (38) as a dental practitioner (Figure 3.12.2).

Figure 3.12.2: Number of Aboriginal people aged 15 and over registered and employed in selected health professions, New South Wales and Australia, 2023

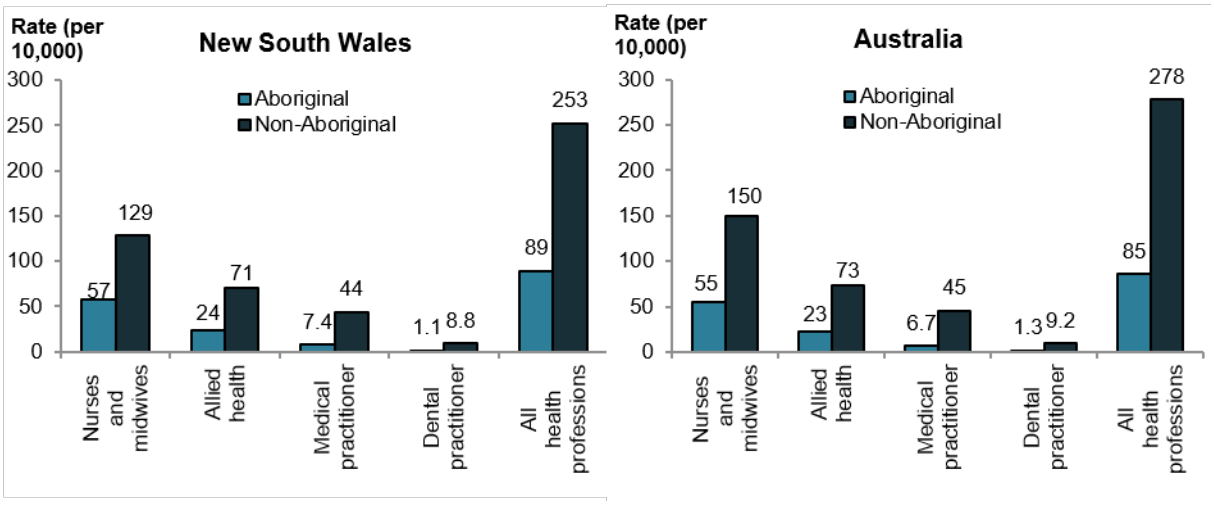


Source: National Health Workforce Data Set 2024 (Table D3.12.4).

In 2023, non-Aboriginal New South Wales residents were employed in registered health professions at 2.8 times the rate for Aboriginal people.

Nationally in 2023, 1.2% (8,726) of registered health professionals employed in their registered profession identified as being Aboriginal. Non-Aboriginal people were employed in registered health professions at 3.3 times the rate for Aboriginal people (Figure 3.12.3).

Figure 3.12.3: Rate of people aged 15 and over registered and employed in selected health professions, by Aboriginal status, New South Wales and Australia, 2023



Source: National Health Workforce Dataset 2024 (Table D3.12.4).

3.13 Competent governance

Why it is important

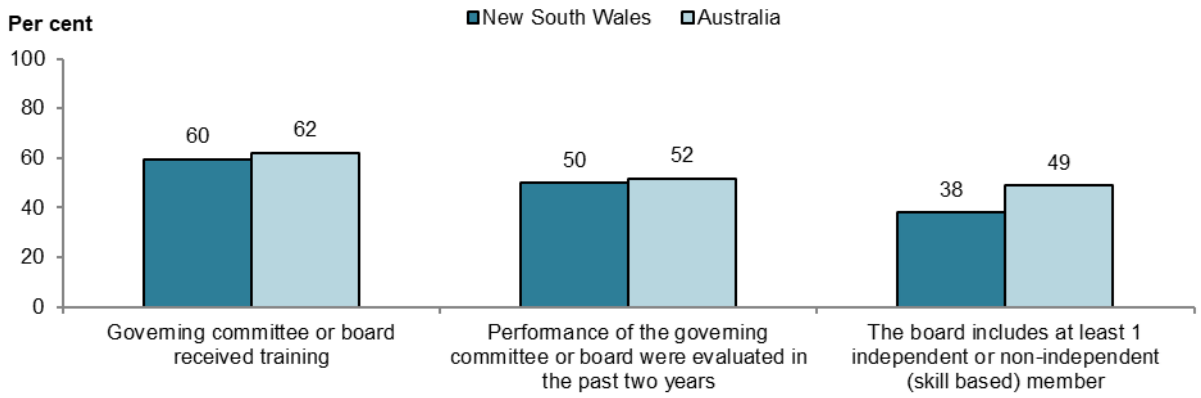
This measure reports on governance in Aboriginal-specific and mainstream health services. Governance refers to the evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve things that matter to them (Hunt et al. 2008). The manner in which governance functions are performed has a direct effect on the wellbeing of individuals and communities.

Key findings

Aboriginal primary health-care organisations: In 2024–25 in New South Wales, all 42 Aboriginal primary health-care organisations had a governing committee/board. Of these organisations, 25 (60%) had members who had received training related to governance issues, 21 (50%) had the performance of the governing committee or board evaluated in the past 2 years and 16 (38%) included at least one independent or non-independent (skill-based) member (Figure 3.13.1).

Nationally in 2024–25, of the 180 Aboriginal primary health-care organisations that reported having a governing committee/board, 112 (62%) had members who had received training related to governance issues, 93 (52%) had the performance of the governing committee or board evaluated in the past 2 years and 88 (49%) included at least one independent or non-independent (skill-based) member (Figure 3.13.1).

Figure 3.13.1: Governing committee or board information, Aboriginal primary health-care organisations, New South Wales and Australia, 2024–25



Source: Online Services Report data collection 2024–25 (Tables D3.13.3 and D3.13.3 NSW).

3.14 Access to services

Why it is important

This measure reports on the use of various types of health services (for example, primary care, hospital, dental and allied health and post-acute care and palliative care). Aboriginal people have significantly poorer health outcomes than non-Aboriginal people. Inequalities in health care access and use are considered important drivers of this discrepancy (de Looper and Lafortune 2009). Therefore, access to health care commensurate with the level of need is essential to closing the gap in life expectancy between Aboriginal and non-Aboriginal people.

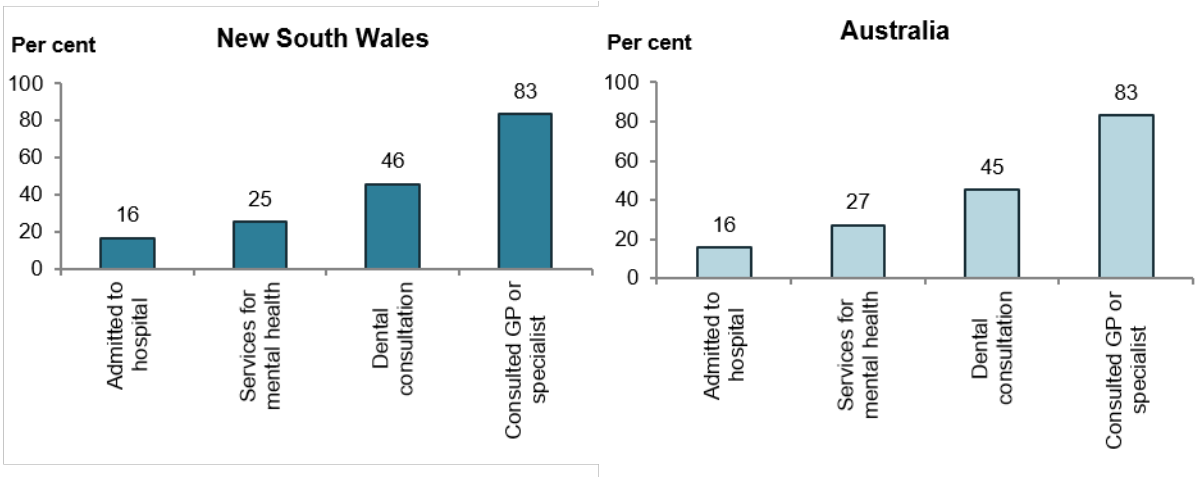
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

Self-reported use of services: Based on NATSIHS, in 2022–23 in New South Wales, in the previous 12 months, an estimated 83% (291,500) of Aboriginal people had consulted a doctor or specialist, 46% (151,800 of those aged 2 and over) had seen a dentist or dental professional, and 25% (51,300 of those aged 15 and over) had accessed services for mental health. In the previous 12 months, 16% (57,300) had been admitted to hospital (ABS 2024e, Table 27.1 and Table 27.3) (Figure 3.14.1).

Similar patterns were observed nationally in 2022–23, where in the previous 12 months, 83% of Aboriginal people had consulted a doctor or specialist, 45% (of those aged 2 and over) had seen a dentist or dental professional, and 27% (of those aged 15 and over) had accessed services for mental health. In the previous 12 months, 16% had been admitted to hospital (ABS 2024e, Table 27.3) (Figure 3.14.1).

Figure 3.14.1: Aboriginal people accessing health-care services in the previous 12 months, New South Wales and Australia, 2022–23

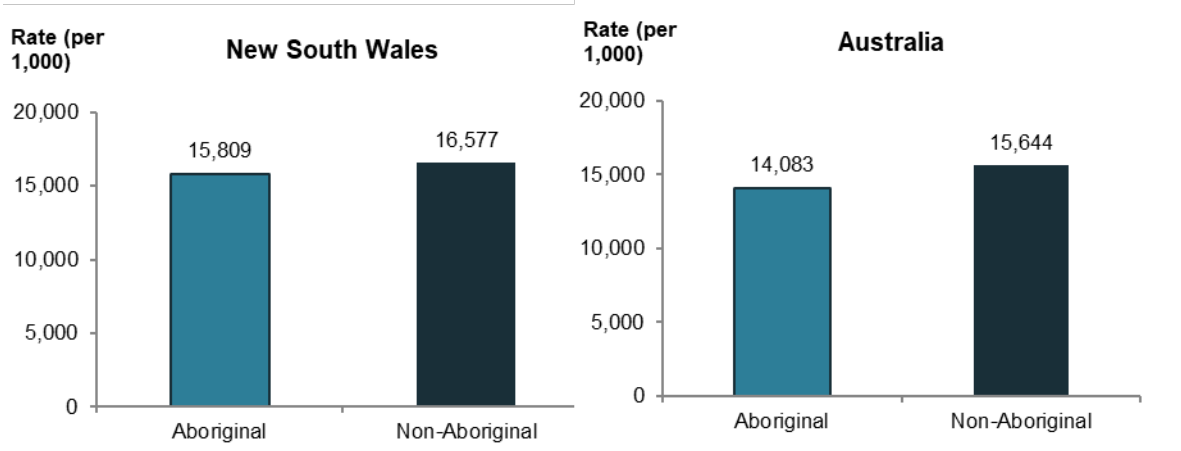


Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (ABS 2024e, Table 27.3).

Services claimed through Medicare: In 2023–24 in New South Wales, about 4.7 million Medicare claims were made for services provided to Aboriginal people, at a rate of 13,278 per 1,000 population (Tables D3.14.29 and D3.14.30). The age-standardised rate of claims for Aboriginal people was 0.95 times the rate for non-Aboriginal people (Figure 3.14.2).

Nationally in 2023–24, the rate of claimed MBS services for Aboriginal people was 11,869 per 1,000 population (Table D3.14.30). The age-standardised rate of claims for Aboriginal people was 0.9 times the rate for non-Aboriginal people (Figure 3.14.2).

Figure 3.14.2: Age-standardised rate of total MBS services claimed (VII adjusted), by Aboriginal status, New South Wales and Australia, 2023–24



Note: Rates have been adjusted for under-identification in the Medicare Australia Voluntary Indigenous Identifier (VII) database.

Source: Medicare data 2023–24 (Table D3.14.31).

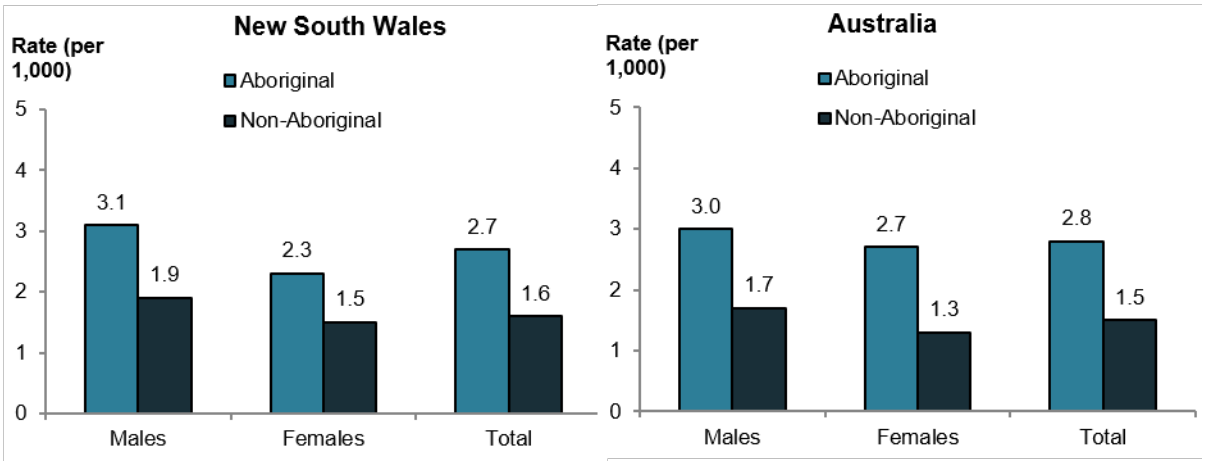
Hospitalisation for palliative care: Between July 2021 and June 2023 in New South Wales, there were 985 hospitalisations for palliative care for Aboriginal people, equivalent to 1.4 per 1,000 population (Table D3.14.48). After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised for palliative care at 1.6 times the rate for non-Aboriginal people in New South Wales (Figure 3.14.3).

Nationally between July 2021 and June 2023, there were 2,917 hospitalisations for palliative care for Aboriginal people, equivalent to 1.5 per 1,000 population (Table D3.14.48). After adjusting for differences in the age structure between the two populations, Aboriginal people were hospitalised for palliative care at 1.9 times the rate for non-Aboriginal Australians (Figure 3.14.3).

Elective surgery: Between July 2021 and June 2023 in New South Wales, 12% of Aboriginal elective surgery patients had a waiting time of more than 1 year, which was the similar to the proportion of non-Aboriginal New South Wales patients (11%).

Nationally over the same period, 8.5% of Aboriginal elective surgery patients had a waiting time of more than 1 year, compared with 8.0% for non-Aboriginal Australian patients (Table D3.14.51).

Figure 3.14.3: Age-standardised rate of hospitalisations for palliative care, by Aboriginal status and sex, New South Wales and Australia, July 2021 to June 2023



Source: National Hospital Morbidity Database 2021–23 (Table D3.14.48).

3.15 Access to prescription medicines

Why it is important

This measure reports on people's expenditure on pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS) as well as access to prescription medicines. Essential medicines save lives and improve health when they are available, affordable and quality-assured, and properly used. Affordable access to medicines is important for many acute and chronic illnesses. For chronic illnesses, such as diabetes, hypertension, heart disease and renal failure, multiple medications might be required for many years to avoid complications (WHO 2017). It is important to ensure that Aboriginal people, who experience high rates of acute and chronic illnesses, are able to access appropriate prescription medications when required.

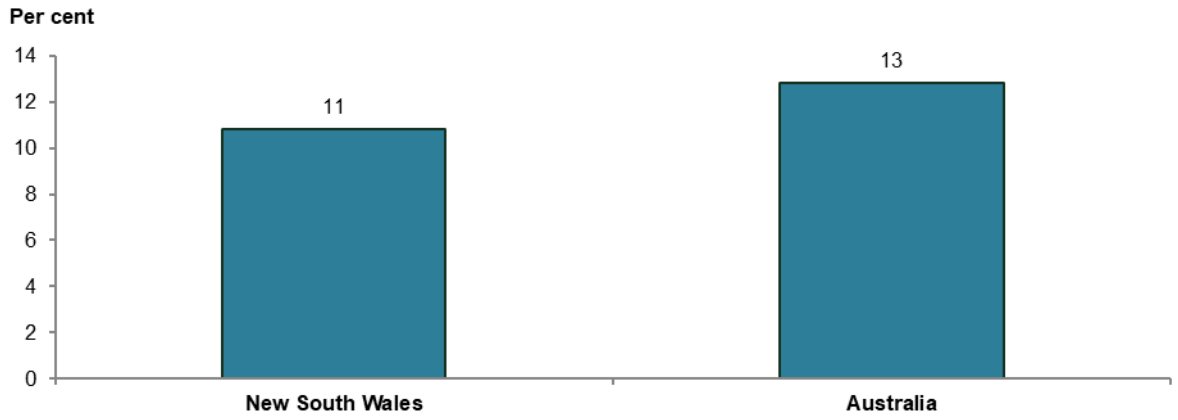
Key findings

This section presents data on expenditure on medicines subsidised through the PBS only. This excludes expenditure on medicines covered by the Repatriation Pharmaceutical Benefits Scheme (RPBS), state government expenditure on medicines in hospitals and prisons, over-the-counter medicines and private prescriptions.

Access to prescription medicines: In New South Wales in 2022–23 based on NATSIHS, an estimated 11% (24,400) of Aboriginal people aged 15 and over in non-remote areas reported they had a prescription that did not get filled in the last 12 months (Figure 3.15.1). Common reasons for not having a prescription filled included deciding it was not needed (34%, 8,200), cost (31%, 7,600) and didn't want to (21%, 5,000) (Figure 3.15.2). These estimates have a high margin of error and should be used with caution.

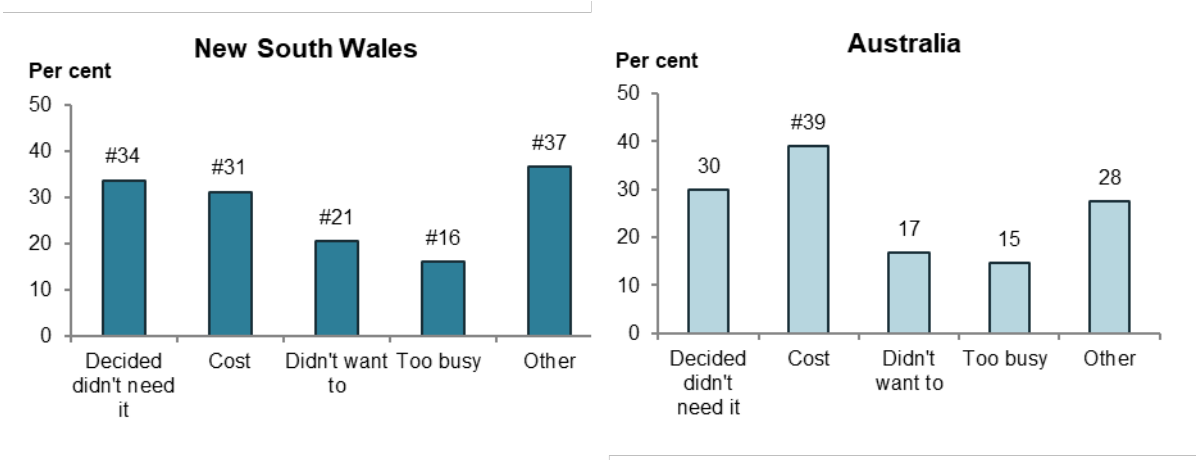
Nationally in 2022–23, 13% (71,200) of Aboriginal people aged 15 and over in non-remote areas reported they had a prescription that did not get filled in the last 12 months (Figure 3.15.1). Common reasons for not having a prescription filled included cost (39%, 27,800) and deciding it was not needed (30%, 21,300) (Figure 3.15.2).

Figure 3.15.1: Aboriginal people aged 15 and over (in non-remote areas only) who did not have a prescription filled in the last 12 months, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.15.5).

Figure 3.15.2: Reasons for not filling prescriptions, Aboriginal people aged 15 and over (in non-remote areas), New South Wales and Australia, 2022–23



Note: 'Other' reasons for not filling prescriptions include transport issues, lost the prescription and other reasons.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.15.5).

Total expenditure per person: Nationally in 2022–23, total expenditure (government and non-government) on benefit-paid pharmaceuticals for Aboriginal people was $685 million, equivalent to $677 per person on average. For non-Aboriginal people, the average expenditure was $758 per person (Table D3.15.1).

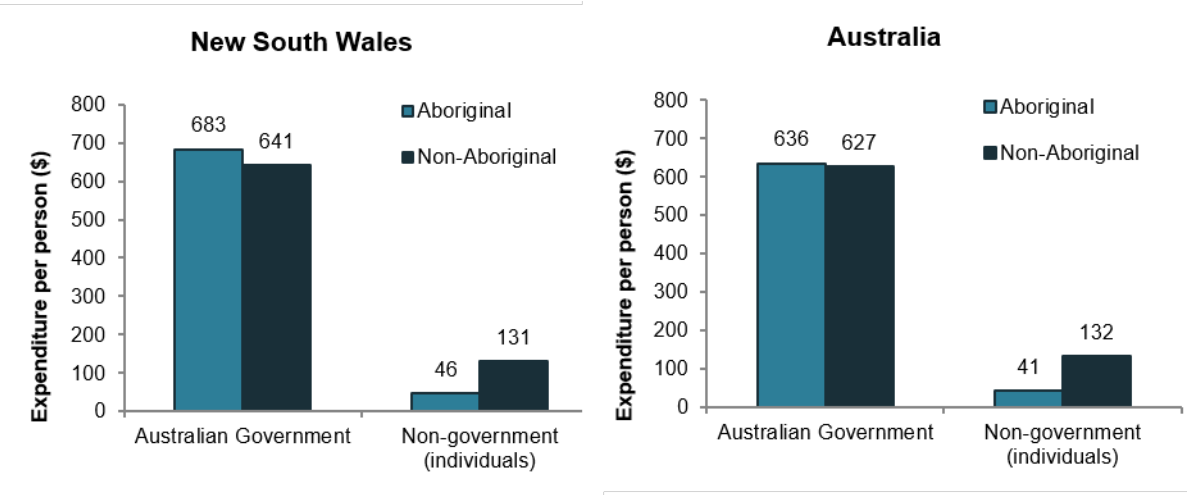
Australian Government expenditure: In New South Wales in 2022–23, expenditure on benefit-paid pharmaceuticals by the Australian Government was $683 per person for Aboriginal people. For non-Aboriginal people in New South Wales, the average expenditure on benefit-paid pharmaceuticals was $641 per person.

Nationally in 2022–23, expenditure on benefit-paid pharmaceuticals by the Australian Government was $636 per person for Aboriginal people. For non-Aboriginal Australians, the average expenditure on benefit-paid pharmaceuticals was $627 per person (Figure 3.15.3).

Individual expenditure: In New South Wales in 2022–23, expenditure on benefit-paid pharmaceuticals by individuals was $46 per person for Aboriginal people. For non-Aboriginal Australians in New South Wales, the average expenditure on benefit-paid pharmaceuticals was $131 per person.

Nationally in 2022–23, expenditure on benefit-paid pharmaceuticals by individuals was $41 per person for Aboriginal people. For non-Aboriginal Australians, the average expenditure on benefit-paid pharmaceuticals was $132 per person (Figure 3.15.3).

Figure 3.15.3: Per person expenditure on benefit-paid pharmaceuticals[(a)(b)], by source and Aboriginal status, New South Wales and Australia, 2022–23



(a) Excludes expenditure directly administered by state and territory governments and the Repatriation Pharmaceutical Benefits Scheme.

(b) Includes section 85, section 100, Closing the Gap PBS items and PBS items supplied to approved Remote Area Aboriginal Health Services.

Source: PBS data 2024 (Table D3.15.2).

3.16 Access to after-hours primary health care

Why it is important

This measure reports on access to after-hours primary health care. ‘After hours’ refers to services provided at any time other than 8 am to 8 pm on weekdays or 8 am to 1 pm on a Saturday. An important component of comprehensive primary health-care services is the capacity for patients to access services after hours. The absence of after-hours primary health care may result in delays by patients to seek care and the importance of after-hours care for ongoing treatment should be recognised.

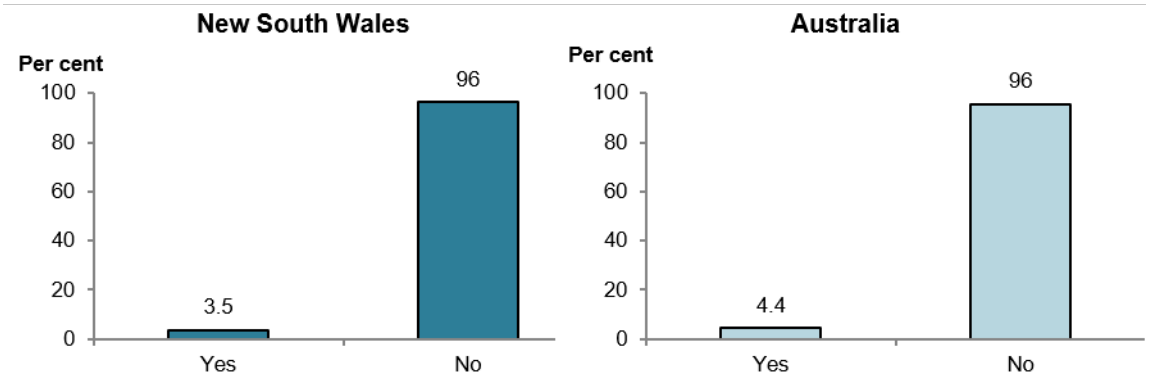
Some data presented in this measure cover the period July 2021 to June 2023, which included the COVID-19 pandemic. Readers should interpret results from this period in the context of pandemic-related impacts described in the report introduction.

Key findings

After hours doctor: Based on NATSIHS, in 2022–23 in New South Wales, an estimated 3.5% (12,000) of Aboriginal people living in non-remote areas who saw a doctor in the previous 12 months did so outside normal business hours.

Nationally in 2022–23, 4.4% of Aboriginal people living in non-remote areas who saw a doctor in the previous 12 months did so outside normal business hours (Figure 3.16.1).

Figure 3.16.1: Proportion of Aboriginal people who saw a doctor[(a)] after hours in the last 12 months (non-remote areas), New South Wales and Australia, 2022–23



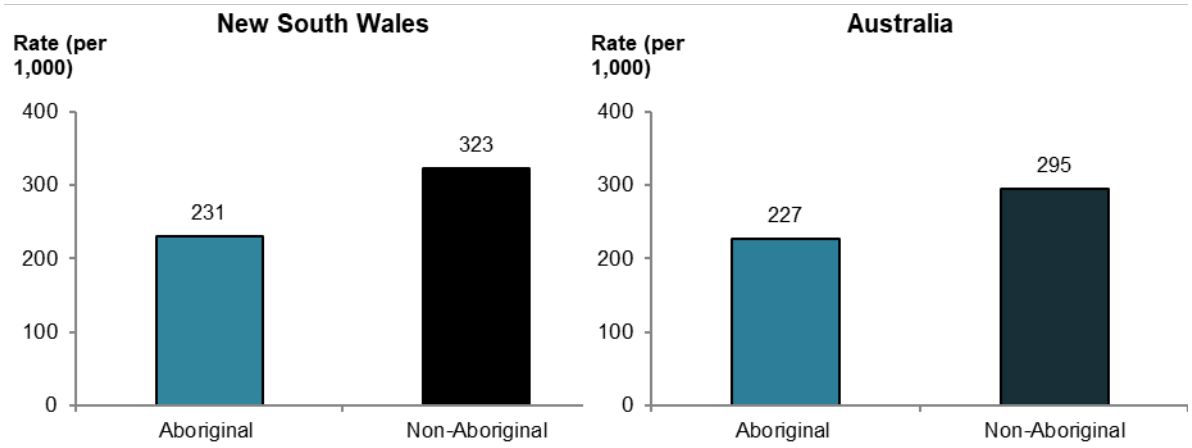
(a) Doctor includes general practitioners and specialists such as surgeons, pathologists, gynaecologists, radiologists, psychiatrists and so forth. This item includes all consultations with a doctor in the reference period, regardless of the type of treatment/service provided.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.16.1).

After-hours services claimed through Medicare: In 2023–24 in New South Wales, there were 79,504 MBS claims for after-hours services provided to Aboriginal people, at a rate of 224 per 1,000 population (Table D3.16.3). After adjusting for differences in the age structure between the two populations, the rate of after-hours MBS services claimed for Aboriginal people was 0.7 times that for non-Aboriginal people (Figure 3.16.2).

Nationally, the rate for MBS services claimed by Aboriginal people for after-hours care items in 2023–24 was 222 per 1,000 (Table D3.16.3). The age-standardised rate for Aboriginal people was 0.8 times the rate for non-Aboriginal people (Figure 3.16.2).

Figure 3.16.2: Age-standardised rate of MBS services claims for after-hours care (VII adjusted), by Aboriginal status, New South Wales and Australia, 2023–24

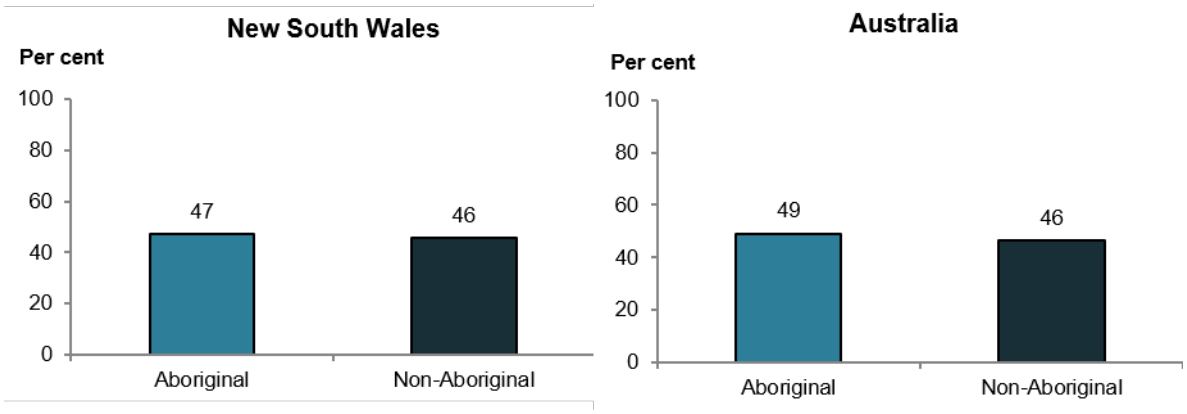


Source: Medicare data 2023–24 (Table D3.16.3).

Emergency department presentations, overall: In New South Wales, between July 2021 and June 2023, 47% (236,106) of emergency presentations for Aboriginal people occurred after hours. This was similar to the proportion for non-Aboriginal people in New South Wales (46%).

Nationally, between July 2021 and June 2023, 49% of emergency presentations for Aboriginal people occurred after hours. This was higher than the proportion for non-Aboriginal people (46%) (Figure 3.16.3).

Figure 3.16.3: Proportion of emergency department presentations that were after hours, by Aboriginal status of the patient, New South Wales and Australia, July 2021 to June 2023



Source: National Non-admitted Patient Emergency Department Care Database 2021–23 (Table D3.16.10).

Emergency department presentations, semi-urgent or non-urgent: In New South Wales, between July 2021 and June 2023, 52% (122,132) of emergency department presentations for Aboriginal patients that occurred after-hours were classified as semi-urgent or non-urgent. This was higher than the proportion for non-Aboriginal patients for after-hours emergency department episodes of care (47%).

Nationally, between July 2021 and June 2023, 46% of emergency department presentations for Aboriginal patients that occurred after hours were classified as semi-urgent or non-urgent. This is higher than the proportion for non-Aboriginal patients for after-hours emergency department episodes of care (42%) (Table D3.16.11).

3.17 Regular general practitioner or health service

Why it is important

This measure reports on Aboriginal people who have a regular doctor/general practitioner (GP) or health service. Having a usual primary health-care provider is associated with good communication between the patient and provider, greater levels of trust and satisfaction with providers and better health outcomes for patients (Mainous et al. 2001; Schers et al. 2005; Starfield 1998; Starfield and Shi 2004). Primary care includes care provided through nurses, allied health professionals, midwives, pharmacists, dentists and Aboriginal health workers. In Australia, general practice is often the first point of contact in the health care system, with more than 80% of Australians seeing a GP at least once each year (AIHW 2025e).

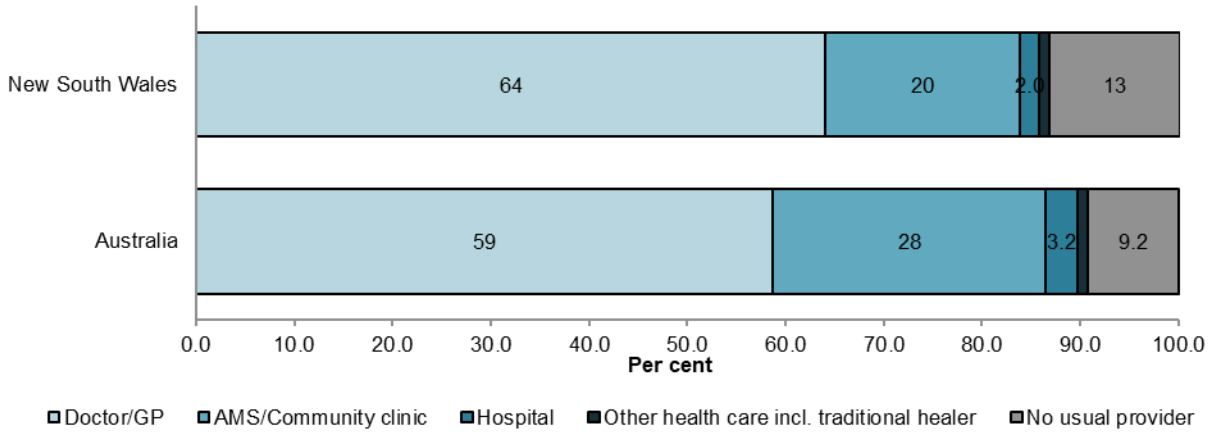
Key findings

Overall: Based on self-reported data from the 2022–23 NATSIHS, 87% (300,900) of Aboriginal people in New South Wales had a usual place to go for health problems and advice:

- 64% (222,300) usually went to a doctor/GP
- 20% (68,900) usually went to an Aboriginal Medical Services (AMS) or community clinic
- 2% (7,100) usually went to a hospital (note that the estimate for those who usually went to a hospital has a relative standard error of 25% to 50% and should be used with caution).

Nationally, 91% of Aboriginal people had a usual place to go for health problems and advice, with 59% usually going to a doctor/GP and 28% usually going to an AMS or community clinic (Figure 3.17.1).

Figure 3.17.1: Usual source of health care by type, Aboriginal people, New South Wales and Australia, 2022–23



Note: Estimate for 'Other health care including traditional healer' are not presented for New South Wales due to data quality issues.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.17.1).

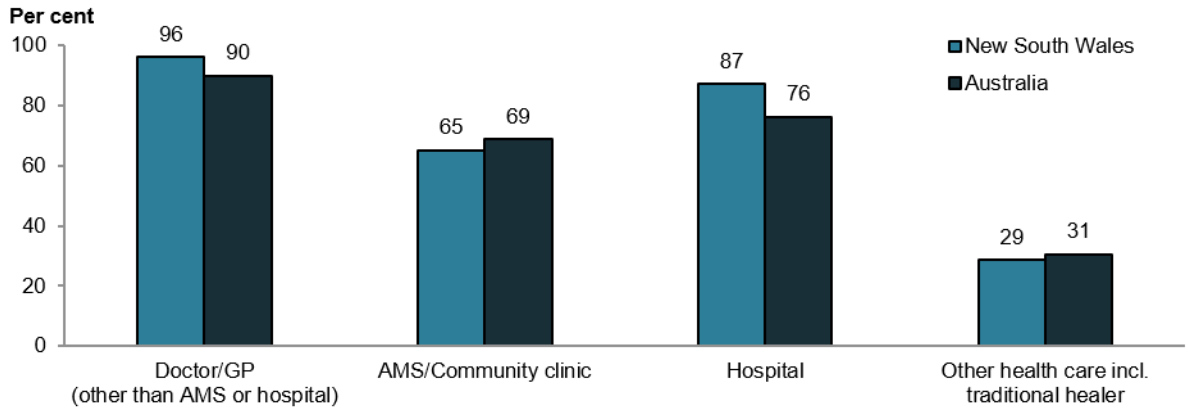
Health care available in local area: The usual place that people go for health problems and advice depends on what services are available, accessible or affordable and the type of health problem. In 2022–23 in New South Wales, Aboriginal people reported that:

- a doctor or GP was locally available (96%, 336,500)
- an AMS or community clinic was locally available (65%, 227,700)
- a hospital was locally available (87%, 304,700).

Other health care, including traditional healers, were locally available for 29% (100,200) of Aboriginal people in New South Wales.

Nationally in 2022–23, 69% of Aboriginal people reported that an AMS or community clinic was locally available (Figure 3.17.2).

Figure 3.17.2: Health services available in local area for Aboriginal people, New South Wales and Australia, 2022–23



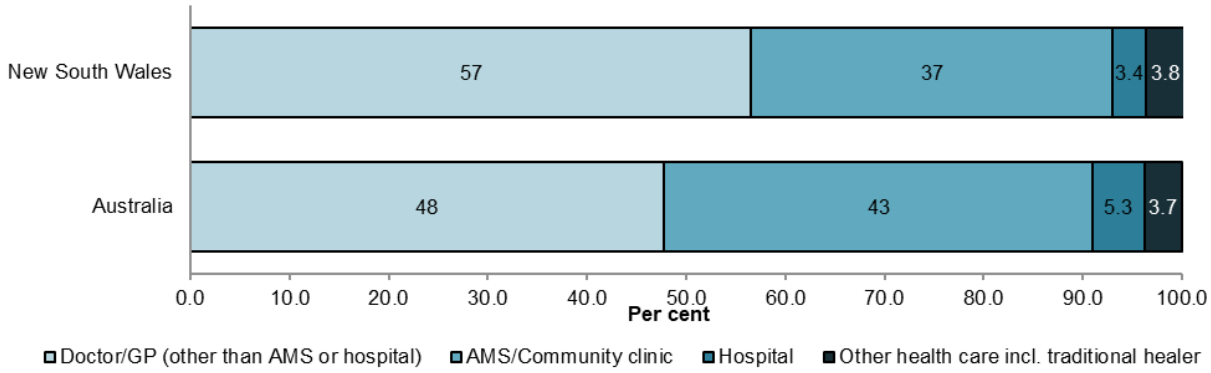
Note: Estimates for 'No services available' are not presented due to data quality issues.

Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.17.1).

Preferred health care: The NATSIHS asked where people would like to go if they were sick or needed advice about their health. In 2022–23 in New South Wales, 57% (197,700) of Aboriginal people reported they would prefer to go to a doctor/GP, 37% (127,600) preferred an AMS or community clinic a doctor/GP, 3.8% (13,200) preferred other health care (including traditional healer), and 3.4% (11,900) preferred a hospital. Note that the estimated preference for other health care has a relative standard error of 25% to 50% and should be used with caution.

Nationally in 2022–23, 48% of Aboriginal people reported that they preferred to go to a doctor/GP, 43% preferred an AMS or community clinic, 5.3% preferred a hospital, and 3.7% preferred other health care (including traditional healers) (Figure 3.17.3).

Figure 3.17.3: Preferred source of health care by type, Aboriginal people, New South Wales and Australia, 2022–23



Source: National Aboriginal and Torres Strait Islander Health Survey 2022–23 (Table D3.17.1).

3.18 Care planning for chronic diseases

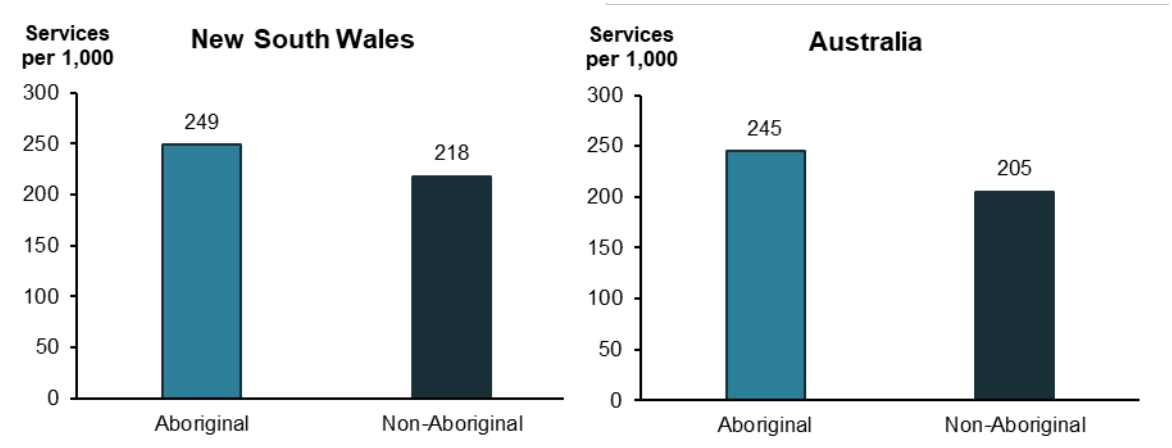
Why it is important

This measure reports on care planning for the management of chronic disease. Chronic diseases are major causes of illness, disability and death among Aboriginal people. An estimated 70% of the health gap between Aboriginal and non-Aboriginal Australians is attributed to chronic diseases (AIHW 2016b). Effective management of chronic diseases can delay the progression of disease, reduce the need for high-cost interventions, improve quality of life and increase life expectancy. Good quality care for people with chronic diseases generally involves multiple healthcare providers across multiple settings. As a result, care plans are one way the client and primary healthcare provider can ensure appropriate care is arranged and coordinated. General practitioners (GPs) are encouraged to develop care plans through several items under the Medicare Benefits Schedule (MBS), including GP Management Plans (GPMPs) and Team Care Arrangements (TCAs).

Key findings

Medicare GPMP and TCA claims: In New South Wales in 2023–24, there were 32,372 MBS claims for the preparation of GPMPs and 28,272 for the coordination of TCAs for Aboriginal people aged 15 and over (Table D3.05.19). The age-standardised MBS claim rate for Aboriginal patients (of all ages) for GPMP/TCAs was 1.1 times the rate for non-Aboriginal patients in New South Wales. This was similar to the national pattern (Figure 3.18.1).

Figure 3.18.1: Age-standardised rate of GPMPs/TCAs claimed through Medicare (VII adjusted), by Aboriginal status, New South Wales and Australia, 2023–24



Source: Medicare data 2023–24 (Table D3.14.31).

Primary health care (PHC) patients with diabetes with GPMPs and TCAs: Commonwealth-funded Aboriginal-specific PHC organisations provide data on a range of process of care measures related to chronic disease management. In New South Wales and the Australian Capital Territory combined, of regular Aboriginal patients of PHC organisations (that is, patients who had visited a particular PHC provider 3 or more times in the previous 2 years) who had type 2 diabetes:

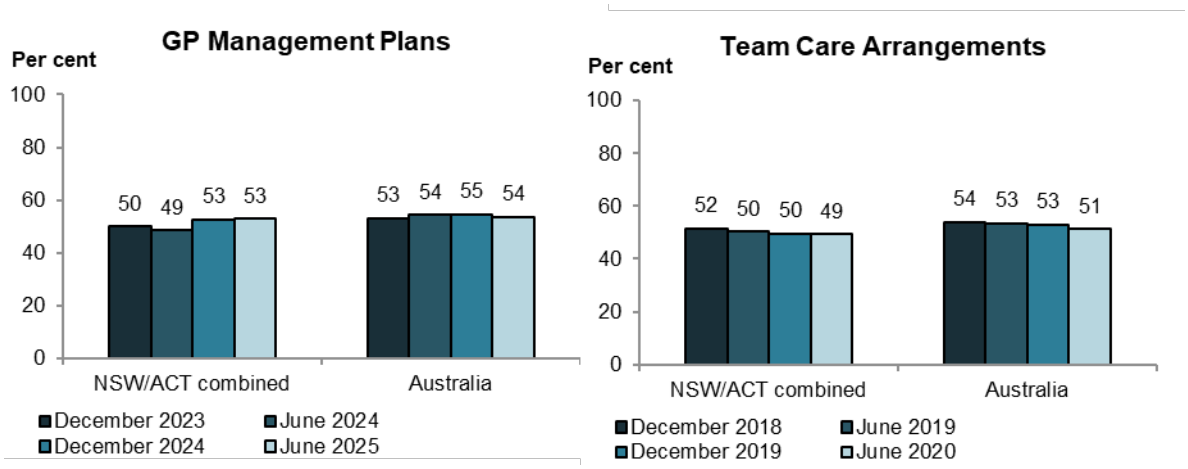
- 53% had a GPMP in the 2 years to June 2025, an increase of 2.8 percentage points from December 2023
- 49% had a TCA in the 2 years to June 2020, a decrease of 2.3 percentage points from December 2018 (Figure 3.18.2).

Nationally, of regular Aboriginal patients of PHC organisations who had type 2 diabetes:

- 54% had a GPMP in the 2 years to June 2025, an increase of 0.6 percentage points from December 2023
- 51% had a TCA in the 2 years to June 2020, a decrease of 2.6 percentage points from December 2018 (Figure 3.18.2).

Note that the collection of TCA data ceased after June 2020, so these results cannot be updated.

Figure 3.18.2: Aboriginal regular clients with type 2 diabetes who had a GPMP or TCA in the last 2 years, Aboriginal-specific primary health-care services, New South Wales and Australia, 4 most recent periods



Note: Collection of information on Team Care Arrangements ceased after June 2020.

Source: National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care collection 2023–2025 (Table D3.18.1).

Asthma management: An individualised written asthma action plan is a key element of effective asthma management (NACA 2025).

In 2022–23 in non-remote areas of New South Wales, 43% of the estimated 58,600 Aboriginal people living with asthma had a written asthma action plan. Of the estimated 657,000 non-Aboriginal people living with asthma, 35% had a written asthma action plan (Table D3.18.5). Note that these estimates have a high margin of error and should be used with caution.

3.19 Accreditation

Why it is important

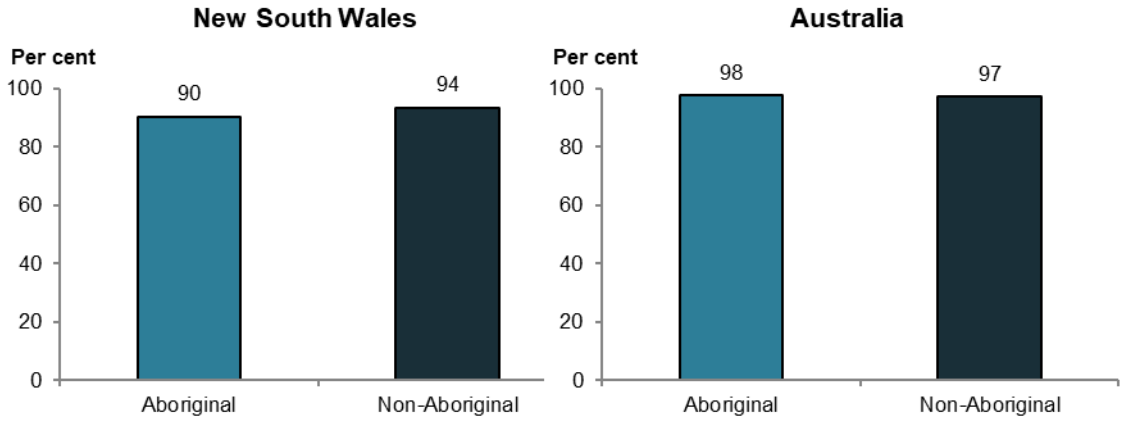
This measure reports on the proportion of hospitalisations in accredited public hospitals and the number of accredited general medical practices. Accreditation is a process through which a recognised external body assesses the extent to which a health care organisation meets applicable quality standards. Quality standards typically address issues that present a significant risk of harm to patients and may include topics such as clinical governance, infection control, medication safety, comprehensive care, communicating for safety, and recognising and responding to patient deterioration. All public and private hospitals, day procedure services and public dental practices in Australia are required to be accredited to the National Safety and Quality Health Service (NSQHS) Standards. In general practice, accreditation involves assessment against standards set by the Royal Australian College of General Practitioners (RACGP). There are currently 4 approved providers of general practice accreditation: Australian General Practice Accreditation Limited (AGPAL), Quality Practice Accreditation (QPA), the Australian Council on Health-care Standards (ACHS) and Global-Mark (ACSQHC 2026). The most recent general practice accreditation data are for 2019, and are available for 3 of these organisations; AGPAL, QPA and ACHS.

Key findings

Hospitalisations in accredited hospitals: In New South Wales between July 2021 and June 2023, 90% (194,532) of hospitalisations for Aboriginal people occurred in accredited hospitals. The remaining hospitalisations occurred in non-accredited hospitals (8.9%, 19,149) or in hospitals where the accreditation was unknown (0.8%, 1,795). The proportion of hospitalisations for non-Aboriginal people in accredited hospitals in New South Wales was 94% (3,177,508 hospitalisations) (Figure 3.19.1).

Nationally between July 2021 and June 2023, 98% (1,067,860) of hospitalisations for Aboriginal people in public hospitals occurred in accredited hospitals. The proportion of hospitalisations for non-Aboriginal people in accredited hospitals was 97% (12,371,737 hospitalisations) (Figure 3.19.1).

Figure 3.19.1: Public hospitalisations in accredited hospitals, by Aboriginal status, New South Wales and Australia, July 2021 to June 2023



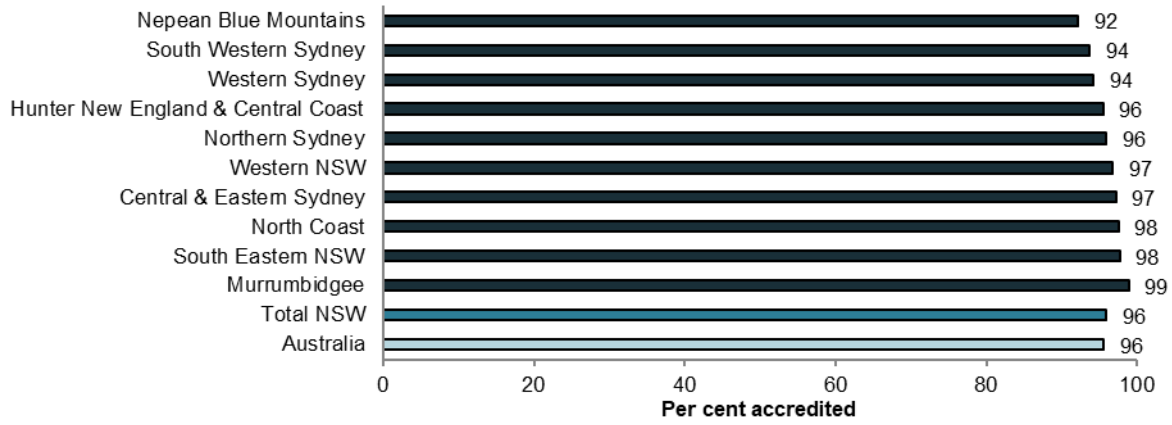
Source: National Hospital Morbidity Database and National Public Hospitals Establishment Database 2021–23 (Table D3.19.1).

General practice accreditation (overall): In New South Wales in 2019, 96% (2,014) of general practices registered with AGPAL, QPA or ACHS were fully accredited by the respective organisation (Figure 3.19.2).

Nationally 96% (6,185) of general practices registered with AGPAL, QPA or ACHS were fully accredited by the respective organisation in 2019 (Figure 3.19.2).

General practice accreditation by Primary Health Network (PHN): In 2019, within PHNs in New South Wales, the proportion of general practices registered with AGPAL, QPA or ACHS that were fully accredited ranged from 99% in Murrumbidgee to 92% in Nepean Blue Mountains (Figure 3.19.2).

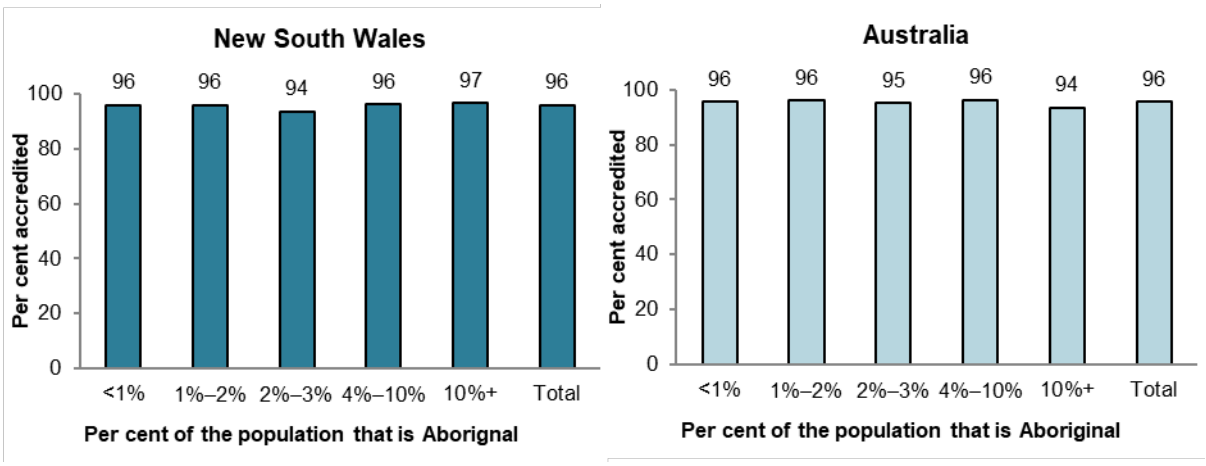
Figure 3.19.2: Proportion of general practices registered for accreditation through AGPAL, QPA or ACHS that had been accredited, by Primary Health Network area, New South Wales, 2019



Source: Australian General Practice Accreditation Limited and Quality Practice Accreditation data (as at 30 June 2019) and the Australian Council on Healthcare Standards data (as at September 2019) (Tables D3.19.8 and D3.19.5 NSW).

When the general practices in New South Wales are disaggregated into categories representing the proportion of the population in the PHN they service that are Aboriginal people, the rate of accreditation was lowest in areas where Aboriginal people made up 2–3% of the population (94% accredited). However, rates of accreditation of general practices were similar in all Aboriginal population size categories (94–97%). Similar distribution was observed for the general practices nationally (94–96%) (Figure 3.19.3).

Figure 3.19.3: Proportion of general practices registered for accreditation through AGPAL, QPA or ACHS that had been accredited, by per cent of the population that is Aboriginal, New South Wales and Australia, 2019



Source: Australian General Practice Accreditation Limited and Quality Practice Accreditation data (as at 30 June 2019) and the Australian Council on Healthcare Standards data (as at September 2019) (Tables D3.19.5 NSW and D3.19.5).

3.20 Aboriginal and Torres Strait Islander people training for health-related disciplines

Why it is important

This measure reports on the participation of people in tertiary education for health-related disciplines. Improving and supporting the participation of Aboriginal people in tertiary education for health-related disciplines is crucial to increasing participation in the health workforce, in which Aboriginal people are significantly under-represented. Vocational Education and Training (VET) can provide essential pathways for Aboriginal people to enter tertiary education and the health professions (Gwynne et al. 2019).

Key findings

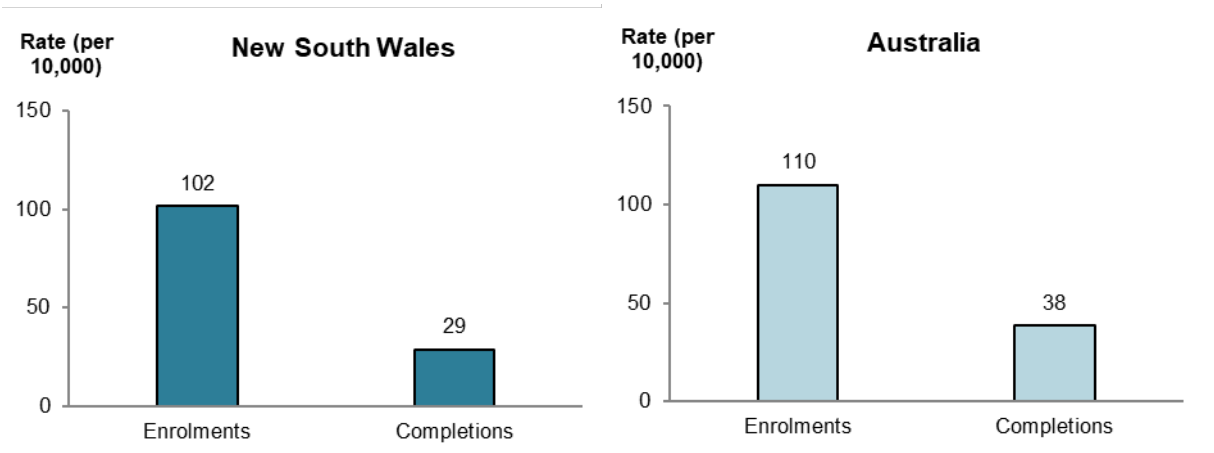
Vocational Education and Training (VET) enrolments: In New South Wales in 2024, there were 2,456 enrolments of Aboriginal students aged 15 and over in VET health-related courses (on a government-funded or fee-for-service basis), a rate of 102 enrolments per 10,000 population (Figure 3.20.1). In New South Wales, Aboriginal students accounted for 7.3% of total enrolments in VET health-related courses.

Nationally in 2024, Aboriginal students accounted for 4.7% of enrolments in VET health-related courses, and the enrolment rate was 110 per 10,000 population (Figure 3.20.1).

Vocational Education and Training (VET) completions: In New South Wales in 2024, Aboriginal students aged 15 and over completed 694 VET health-related courses (on a government-funded or fee-for-service basis), a rate of 29 completions per 10,000 population (Figure 3.20.1). In New South Wales, Aboriginal students accounted for 4.6% of course completions in VET health-related courses (Table D3.20.38).

Nationally in 2024, Aboriginal students accounted for 3.6% of course completions in VET health-related courses, and the completion rate was 38 per 10,000 population (Figure 3.20.1).

Figure 3.20.1: Vocational Education and Training (VET) health-related course enrolments and completions for Aboriginal students aged 15 and over, New South Wales and Australia, 2024

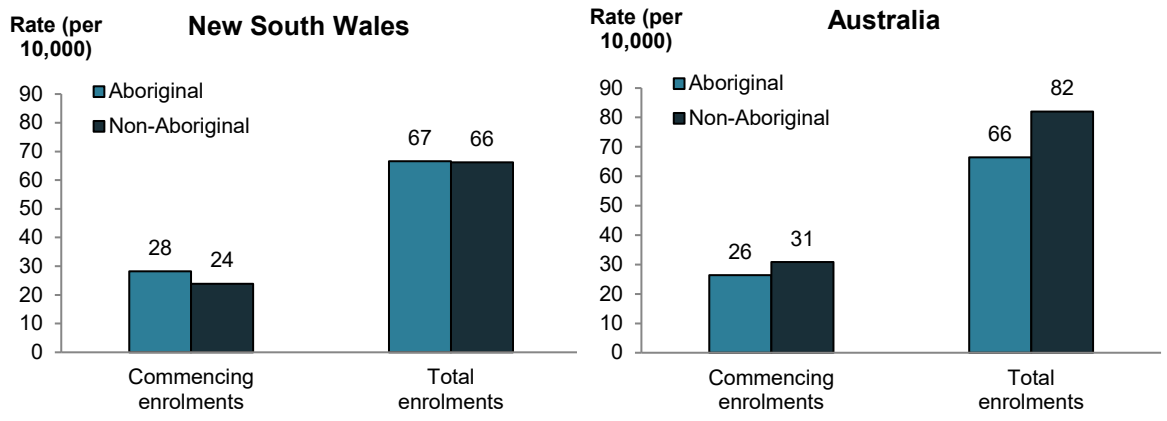


Source: VOCSTATS (NCVER 2025) (Tables D3.20.37 and D3.20.38).

Higher education enrolments for health-related courses: In New South Wales in 2024, there were 682 commencements and 1,608 total enrolments for health-related higher education courses for Aboriginal undergraduate and postgraduate students aged 15 and over, rates of 28 commencements and 67 enrolments per 10,000 population, respectively. These rates were slightly above those for non-Aboriginal students in New South Wales (Figure 3.20.2).

Nationally in 2024, the commencement rate for Aboriginal undergraduate and postgraduate students in health-related higher education courses was 26 per 10,000 population and the total enrolment rate was 66 per 10,000 population. These rates were lower compared with those for non-Aboriginal students (Figure 3.20.2).

Figure 3.20.2: Enrolments in undergraduate and postgraduate health-related courses, students aged 15 and over, by Aboriginal status, New South Wales and Australia, 2024

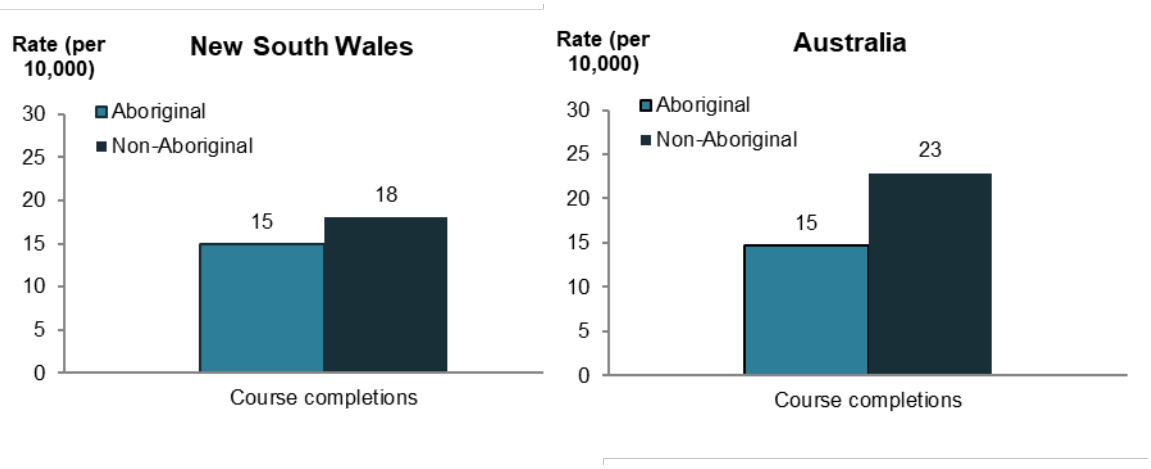


Source: Department of Education Higher Education Statistics Collection 2024 (Table D3.20.27).

Higher education completions for health-related courses: In 2024 in New South Wales, there were 359 completions in health-related higher education courses for Aboriginal undergraduate and postgraduate students aged 15 and over, a rate of 15 completions per 10,000 population. This was lower than the completion rate for non-Aboriginal students in New South Wales (18 per 10,000).

Nationally in 2024, the completion rate for Aboriginal undergraduate and postgraduate students was 15 completions per 10,000 population. This rate was lower than the completion rate for non-Aboriginal students in Australia (23 per 10,000) (Figure 3.20.3).

Figure 3.20.3: Completions of undergraduate and postgraduate health-related courses, students aged 15 and over, by Aboriginal status, New South Wales and Australia, 2024



Source: Department of Education Higher Education Statistics Collection 2024 (Table D3.20.27).

3.21 Expenditure on Aboriginal and Torres Strait Islander health

Why it is important

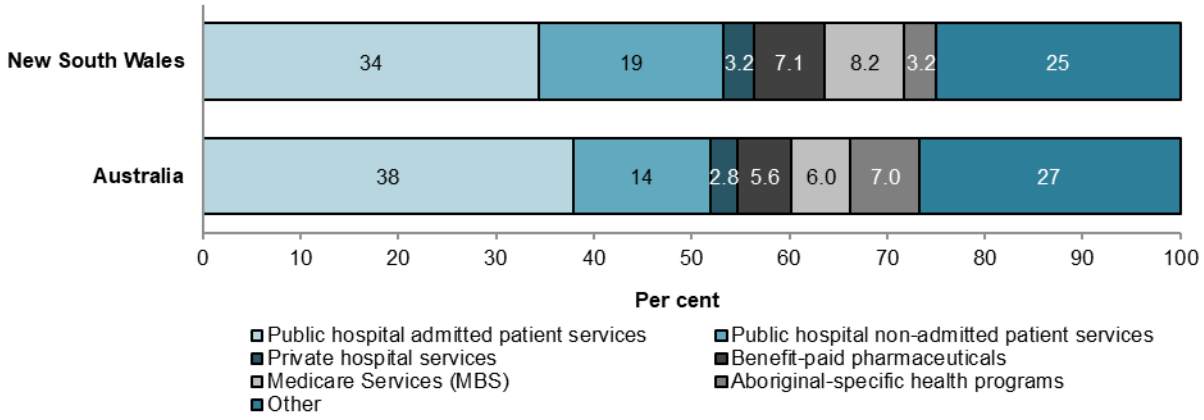
This measure presents information on health expenditure, which is defined as spending on health goods and services by all levels of governments, as well as non-government entities such as individuals, private health insurers, and others. A basic principle of equity is that everyone should have equal opportunity to be healthy, and so the distribution of health resources should reflect the relative needs for health services. Inequities in health are exacerbated by a lack of proportionate resource allocation, particularly for disadvantaged populations (Braveman and Gruskin 2003; Whitehead 1991; WHO n.d.–a). Data presented in this measure are recurrent expenditures and do not include capital expenditures.

Key findings

Total health expenditure: In 2022–23 in New South Wales, health expenditure for Aboriginal people was $3,560 million in total, accounting for 5.1% of the overall health expenditure in New South Wales. Of this amount 34% ($1,223 million) was spent on admitted patient services in public hospitals, 19% ($672 million) on non-admitted patient services in public hospitals, 8.2% ($291 million) on Medicare services, and 7.1% ($254 million) on benefit paid pharmaceuticals. Under the Indigenous Australians' Health Programme (IAHP) 3.2% ($116 million) of overall health expenditure was spent on Australian Government Aboriginal-specific health programs. Health expenditure for non-Aboriginal people was $66,540 million (Figure 3.21.1).

Nationally in 2022–23, health expenditure for Aboriginal people was $12,286 million, accounting for 5.2% of overall health expenditure. Of this amount 38% was spent on admitted patient services in public hospitals, 14% on non-admitted patient services in public hospitals, 6.0% on Medicare services and 5.6% on benefit paid pharmaceuticals. Health expenditure for non-Aboriginal people was $225,402 million (Figure 3.21.1).

Figure 3.21.1: Health expenditure for Aboriginal people, by area of expenditure, New South Wales and Australia, 2022–23



Note: 'Other' category includes expenditure on patient transport services, dental services, community health services, public health, other professional services, non-MBS medical services, aids and appliances, over-the-counter medications, research, health administration, non-IAHP and Department of Health, Disability and Ageing Cost centres

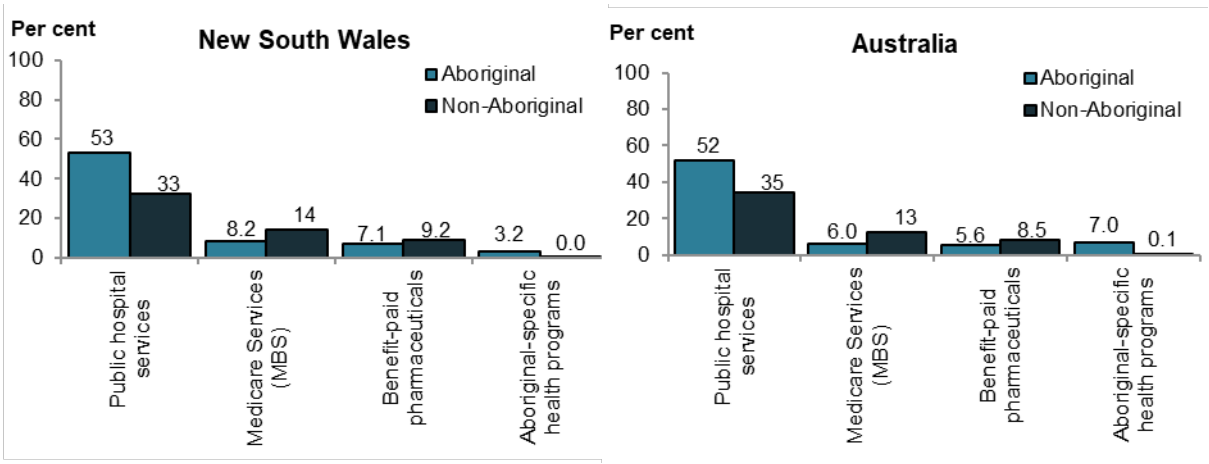
Source: AIHW health expenditure data 2022–23 (Table D3.21.3).

Public hospital services: In New South Wales in 2022–23, 53% ($1,895 million) of the health expenditure for Aboriginal people was for public hospital services (both admitted and non-admitted services). For non-Aboriginal people, expenditure on public hospital services accounted for 33% of the total ($21,658 million). Nationally, 52% ($6,379 million) of the health expenditure for Aboriginal people and 35% ($77,962 million) of that for non-Aboriginal people was for public hospital services (Figure 3.21.2).

Medicare services: In 2022–23 in New South Wales, 8.2% ($291 million) of health expenditure for Aboriginal people was for Medicare services (including both government and individual contributions), while for non-Aboriginal people Medicare services accounted for 14% ($9,421 million) of the total. Nationally, spending on Medicare services accounted for 6.0% ($737 million) of health expenditure for Aboriginal people, and 13% ($28,277 million) of that for non-Aboriginal people (Figure 3.21.2).

Benefit-paid pharmaceuticals: In 2022–23 in New South Wales, health expenditure on benefit-paid pharmaceuticals (including both government and individual contributions) for Aboriginal people was $254 million (7.1%) and for non-Aboriginal people $6,101 million (9.2%). Nationally in 2022–23, health expenditure on benefit-paid pharmaceuticals for Aboriginal people was $685 million (5.6%) and for non-Aboriginal people was $19,203 million (8.5%) (Figure 3.21.2).

Figure 3.21.2: Health expenditure on selected services, by Aboriginal status, New South Wales and Australia, 2022–23



Note: Expenditure on Aboriginal-specific health programs can include expenditure on services also used by some non-Aboriginal people, such as ACCHOs.

Source: AIHW health expenditure data 2022–23 (Table D3.21.3).

3.22 Recruitment and retention of staff

Why it is important

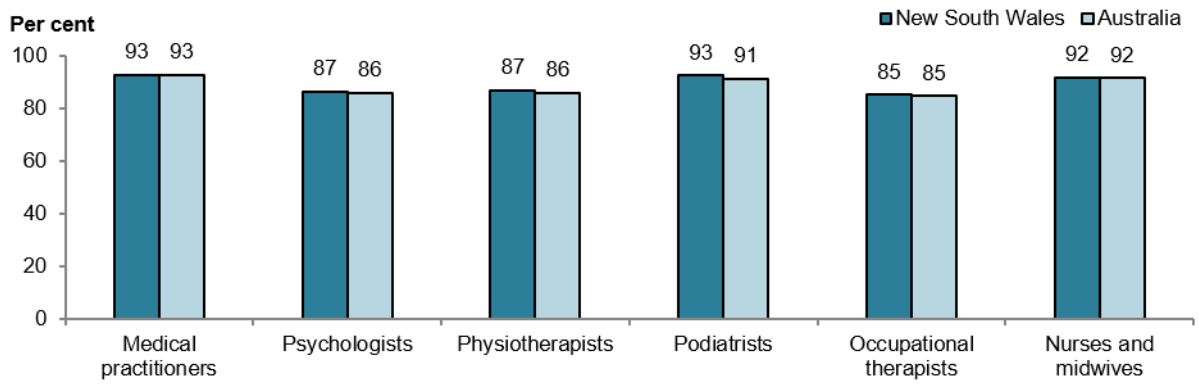
This measure reports on the number of medical practitioners and the recruitment and retention of staff in Aboriginal primary health care organisations. Aboriginal people respond better to health care when it is delivered in a culturally safe and appropriate way. The capacity to recruit and retain non-Aboriginal staff who are culturally safe is essential for health services to deliver appropriate, continuous and sustainable health care for Aboriginal people. While the Aboriginal workforce plays a vital role in the provision of culturally safe services, it is the responsibility of the health care system to ensure that mainstream health services are culturally safe through high-quality professional development and training, appropriate management when cultural respect is lacking, and staff developing awareness of their own unconscious bias (AHMAC 2016).

Key findings

Medical practitioners: In New South Wales in 2023, there were 36,517 registered medical practitioners in the medical workforce, 93% of whom were employed as clinicians. Registered medical practitioners not in the medical workforce included those not looking for work in medicine (1,497), retired (849), or overseas (514) (Table D3.22.1). There were 115,089 nurses and midwives in the nursing/midwifery workforce in New South Wales, 92% of whom were employed in nursing or midwifery (Figure 3.22.1).

Nationally in 2023, there were 120,230 registered medical practitioners in the medical workforce, 93% of whom were employed as clinicians (Figure 3.22.1).

Figure 3.22.1: Medical practitioners in their field's labour force employed as clinicians in their field, by type of profession, New South Wales and Australia, 2023



Source: National Health Workforce Dataset 2023 (Tables D3.22.1, D3.22.5, D3.22.6, D3.22.7, D3.22.9 and D3.22.10).

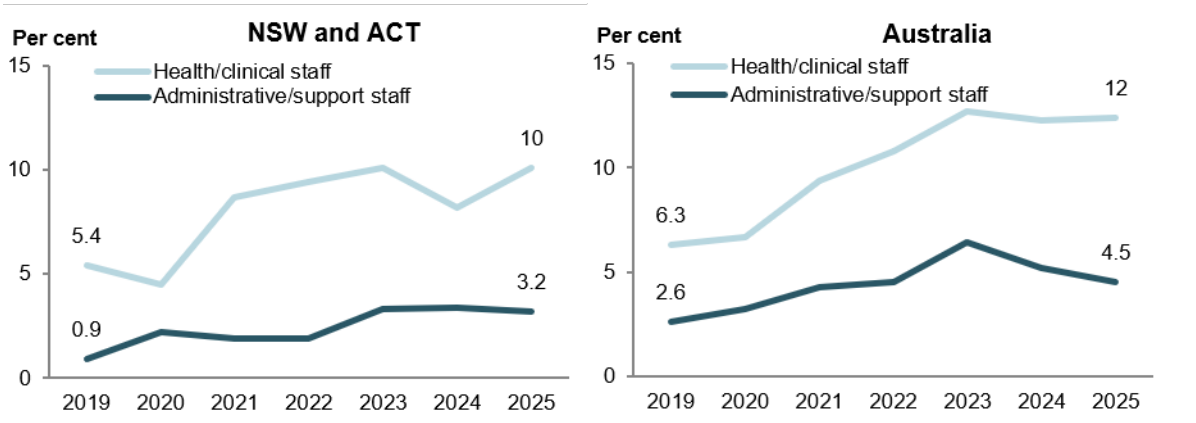
Aboriginal primary health care organisations: In New South Wales and the Australian Capital Territory combined, as at 30 June 2025, there were 1,136 full-time equivalent (FTE) health/clinical staff and 765 FTE administrative and support staff within Commonwealth-funded Aboriginal primary health care organisations (AIHW 2026n, OSR Table S2.2). The vacancy rate was 10% for health/clinical staff positions and 3.2% for administrative and support staff positions (Table D3.22.29). Vacancies for health/clinical staff were highest for

Aboriginal health worker/practitioners (44 FTE), followed by doctors (21 FTE) and nurses (13 FTE) (AIHW 2026n) (OSR Table S2.21).

In New South Wales the Australian Capital Territory combined, the vacancy rates increased between 2019 and 2025, from 5.4% to 10% for health/clinical positions and from 0.9% to 3.2% for administrative and support positions. This is consistent with broader evidence that the COVID-19 pandemic exacerbated pre-existing workforce shortages across the health system, including in Aboriginal health services (AH&MRC 2023).

Nationally, the vacancy rates for health/clinical staff positions grew from 6.3% to 12% between 2019 and 2025, while administrative and support position vacancies grew from 2.6% to 4.5% (Figure 3.22.2).

Figure 3.22.2: FTE vacant positions in Aboriginal primary health-care organisations, by position type, NSW and ACT, and Australia, 2019 to 2025

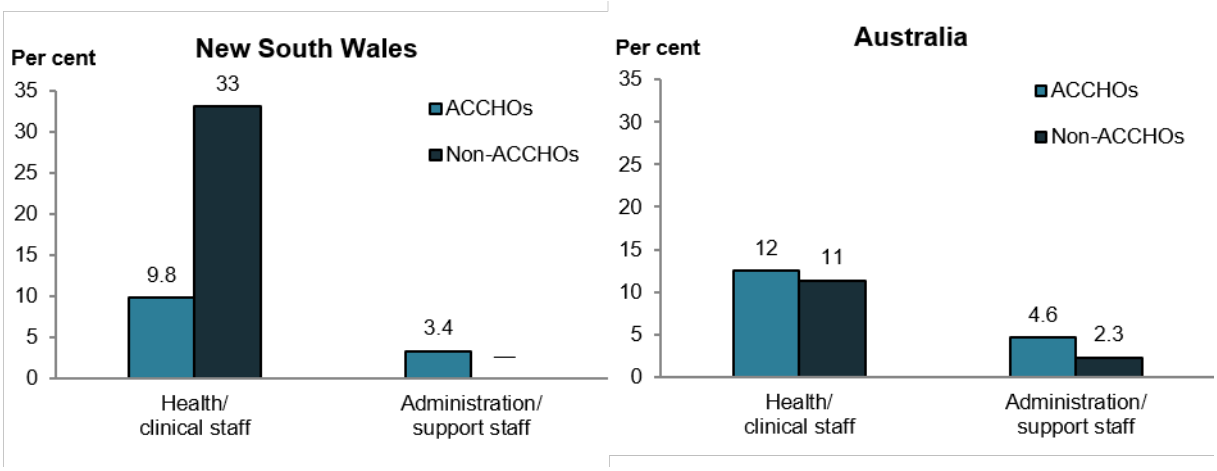


Source: Online Services Report data collection 2019–2025 (Tables D3.22.12 and D3.22.29).

Vacancy rates in ACCHOs: In New South Wales, as at 30 June 2025, within Commonwealth-funded Aboriginal primary health-care organisations, the vacancy rates for health/clinical staff were 9.8% (123 FTEs) in Aboriginal Community Controlled Health Organisations (ACCHOs) and 33% (5 FTEs) in non-ACCHOs. For administration/support staff the rate was 3.4% (27 FTEs) in ACCHOs. Equivalent data were not available for administration/support staff in non-ACCHOs (Figure 3.22.3).

Nationally, as at 30 June 2025, within Commonwealth-funded Aboriginal primary health-care organisations, the vacancy rates for health/clinical staff in ACCHOs were slightly higher than in non-ACCHOs (12% compared with 11%). Vacancy rates for other staff were also higher in ACCHOs than in non-ACCHOs (4.6% compared with 2.3%) (Figure 3.22.3).

Figure 3.22.3: Percentage of FTE positions that are vacant in Aboriginal primary health-care organisations, by position type and organisation type, New South Wales and Australia, at 30 June 2025



Source: Online Services Report data collection 2025 (AIHW 2026a, Tables S2.5 and S2.19).

Additional information

Interpretation of results

Geography: While most results are presented for New South Wales alongside national data, some indicators are reported only at the national level because state-level data are unavailable or insufficiently reliable.

Reference periods: The report draws on multiple data sources, and the reference periods reported may vary between measures. For some measures, changes in geographic coverage, reporting practices or analytical methods may affect comparability with previously published results. Where relevant, these limitations are noted in the measure text and should be considered when interpreting trends over time.

Changes in Indigenous identification: Improvements in data quality and changes in Indigenous identification in several important data sets have a major bearing on the interpretation of findings and trends. This is particularly relevant for mortality data, Census-based data and the population estimates derived from the Census that are used as denominators for many rates and statistics reported across data sets.

Age standardisation: Given the differences in the age structure between the Aboriginal and non-Aboriginal populations, age-standardised rates are used where appropriate when comparing populations and examining change over time. Where age-standardised rates have been used, this is stated in the relevant sections of the report.

Age groups: Unless otherwise specified, data presented in this report relate to the total Aboriginal population (all ages). Where results relate to a specific age group or age range, this is stated in the relevant measure, table or figure.

Trend data: For most measures, annual and per cent change estimates are based on linear regression analysis using all available data points and may therefore differ from estimates derived using only the first and last data points in a series. For further information, see the Statistical terms and methods section of the HPF Technical Appendix.

Population estimates based on Census: Unless otherwise specified, rates presented in this report are calculated using ABS estimates and projections (medium series) of the Aboriginal and Torres Strait Islander population based on the 2021 Census.

Changes to Census-based population estimates, estimation methods and Indigenous identification can affect the interpretation of rates and trends over time. A larger number of people identified as Aboriginal and/or Torres Strait Islander in the 2021 Census compared with previous Census results, with more than half of the increase being attributed to factors other than natural demographic change, including an increase in propensity to identify. This affects the population estimation for historical data as well. Most trend analyses in this report are based on 2021 Census-based estimates and projections and are generally limited to 2016–17 onwards.

Cancer incidence measures use a different denominator methodology and may not be directly comparable with previously published estimates. Comparisons with historical rates and trends should therefore be interpreted with caution.

Survey data: For survey data, estimates with high relative standard errors (RSEs) or margins of error (MoE) are identified in the data tables and should be interpreted with

caution. Estimates may be annotated where sampling variability is high. In particular, estimates with an RSE between 25% and 50% should be used with caution, while estimates with an RSE greater than 50% are considered too unreliable for general use. Proportion estimates may be preceded by a hash (#) where the margin of error exceeds 10 percentage points or where the corresponding confidence interval extends beyond the natural limits of a proportion (0% to 100%). Such estimates should be interpreted with caution.

Small numbers: Some estimates in this report are based on small numbers and should be interpreted with caution. To protect privacy and maintain confidentiality, some data may be suppressed or not reported.

Mortality (deaths) data quality considerations: Information about deaths and causes of death is mostly drawn from the AIHW National Mortality Database, which includes death registration data, coronial information and ABS-coded causes of death. Mortality data are affected by issues relating to both the number of deaths recorded and the population used to calculate rates.

The number of deaths for Aboriginal people can be influenced by the accuracy of Aboriginal status information in death records and by changes to death registration forms and processing systems. Due to the relatively small size of the Aboriginal population, these factors can significantly affect trends over time and comparisons between jurisdictions.

In 2022, additional information from the Medical Certificate of Cause of Death for deaths registered in New South Wales was made available to the ABS to assist in determining Aboriginal status. In 2023, the ABS also received approval to use information from the National Coronial Information System to assist in determining a deceased person's Aboriginal status. From 2023, this method has been used across all states and territories. These changes improved the identification of Aboriginal deaths but created breaks in the mortality time series. As a result, mortality data for New South Wales and the combined jurisdictions from 2022 onwards are not directly comparable with earlier years. These changes also affect aggregated mortality data reported for recent periods (2019–2023) spanning the break in series.

Death rates in this report are based on ABS Aboriginal and Torres Strait Islander population estimates and projections derived from the 2021 Census. Changes in the age and sex structure of the updated population estimates mentioned above may also affect the direction and magnitude of trends. In addition, differences between Aboriginal identification recorded in death registrations and the Census may affect the accuracy of estimated death rates.

Comparisons of death rates over time, and between New South Wales and the 5 jurisdictions combined, should therefore be interpreted with caution. For more information, see the National Mortality Database (NMD) section of the HPF Data sources and quality page.

Remoteness areas: Many measures in this report include comparisons by remoteness area. Unless otherwise stated, remoteness classifications are based on the Australian Statistical Geography Standard (ASGS). Measure 1.14 (Disability) uses the Modified Monash Model (MMM), which is used by some government programs, including the National Disability Insurance Scheme, to determine eligibility and service access.

Impact of the COVID-19 pandemic: Several measures in this report include data collected during, or shortly after, the COVID-19 pandemic (mostly covering 2020–2023). Public health restrictions, disruptions to health services, changes in care-seeking behaviour, reduced screening activity and changes in social interactions may have influenced both health outcomes and service use. For some outcomes, including cancer incidence and screening-

related measures, reductions observed during the pandemic may reflect delayed diagnosis or reduced access to services rather than a true reduction in disease occurrence. Where evidence suggests that COVID-19-related factors had a substantial impact on a specific measure, this is discussed in the measure narrative. Results covering the COVID-19 period should therefore be interpreted with caution, as observed changes may reflect temporary pandemic-related effects rather than underlying long-term trends.

Methodological revisions: Some indicators in this report have undergone methodological revisions, including updates to case definitions, coding practices, statistical methods, data sources and population denominators. Where methodological changes are substantial, results may not be directly comparable with previously published estimates. Changes to classification systems, coding standards and data processing practices may also affect comparability over time. Readers should refer to the relevant measure notes, tables and footnotes for measure-specific definitions and inclusions.

For more information on data sources, data quality, comparability, statistical methods and measure-specific considerations, see the HPF Data and resources pages, including the Data sources and quality and Statistical terms and methods sections.

Symbols

Symbol	Definition
n.a.	not available, not applicable
n.p.	not published
. . (2 spaced full stops)	no data/insufficient data
− (minus)	negative or minus values
#	survey estimate with high margin of error

Acknowledgements

We acknowledge the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

This report was prepared by Clare Desmet, Che Munro, Shampa Barua and Taylah Okely at the Australian Institute of Health and Welfare (AIHW). The authors would like to acknowledge members of the Health Performance Framework Unit at the AIHW for the provision of data and assistance in preparing the report.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACHS	Australian Council of Healthcare Standards
ACT	Australian Capital Territory
AGPAL	Australian General Practice Accreditation Limited
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AOD	alcohol and other drugs
ARF	acute rheumatic fever
BMI	Body Mass Index
Census	Census of Population and Housing
COPD	chronic obstructive pulmonary disease
DALY	disability-adjusted life year
DTP	diphtheria, tetanus, pertussis
FTE	full-time equivalent
GP	general practitioner
GPMP	General Practitioner Management Plan
HPF	Health Performance Framework
HIB	*haemophilus influenzae* type B

HIV	Human Immunodeficiency Virus
MBS	Medicare Benefits Schedule
MMR	measles, mumps, rubella
MoE	margin of error
NAPLAN	National Assessment Program – Literacy and Numeracy
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSQHS	National Safety and Quality Health Service
NSW	New South Wales
NT	Northern Territory
PBS	Pharmaceutical Benefits Scheme
PHC	primary heath care
PPH	potentially preventable hospitalisations
Qld	Queensland
QPA	Quality Practice Accreditation
RACGP	Royal Australian College of General Practitioners
RHD	rheumatic heart disease
RPBS	Repatriation Pharmaceutical Benefits Schedule
SA	South Australia
SEIFA	Socio-Economic Indexes for Areas
SHS	Specialist Homelessness Services
SIDS	sudden infant death syndrome
Tas	Tasmania
TCA	Team Care Arrangement
VET	vocational education and training
Vic	Victoria
VII	Voluntary Indigenous Identifier
WA	Western Australia
WHO	World Health Organization

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The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) was developed to monitor progress towards health equity for First Nations people. The HPF brings together information about health outcomes, broader determinants of health like housing and education, health protective and risk factors, and access to health services. This report presents key findings from the HPF for First Nations people in New South Wales

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